



Focus

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A Medicaid primer

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In 1993, 14.9 percent of the U.S. population, approximately 38 million persons, had incomes below the federal poverty level; another 9.7 percent, or 25 million persons, were considered to be near-poor—that is, they had incomes above the poverty level but less than 1.49 times that level.¹ How do these families access health care, and how do they pay for it?

By far the largest portion of the poor—nearly 43 percent—are covered through Medicaid. Not quite 16 percent have private coverage or are insured through the military’s program of coverage, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). Another 12.5 percent are covered through Medicare. Nearly 29 percent have no insurance coverage at all.² Among the near-poor, the proportion without coverage is nearly as great—28 percent; of those covered, far fewer fall under Medicaid, far more have private insurance. Within these two income groups, young children (under 6 years of age) are the most likely to be

covered by Medicaid (64 percent), young adults the least likely to be covered; while 42 percent of people aged between 19 and 44 are without health insurance.

People without health insurance receive care from a variety of sources. Federal and state programs provide some access for those without other means of payment. There are federal grant programs for maternal and child health services, community health centers (which provide care on a sliding fee schedule), migrant health services (for seasonal and migrant workers), and other federal programs such as the Indian Health Service. Some states and counties provide general assistance, although this source of help is declining. Hospitals also provide uncompensated care to the poor; these costs are borne largely by other payers, including Medicare, although there is increasing pressure not to shift such costs.

How important is the Medicaid program for the poor? Before it was introduced in 1965, as a companion to Medicare, most poor persons were without the financial resources to pay for medical care. In 1963, 54 percent of the poor did not see a physician. Access improved considerably with the passage of the program. In 1993, 13 percent of the population—about 30 million people—were covered by Medicaid; 11 percent of all Medicare recipients were also entitled to Medicaid.

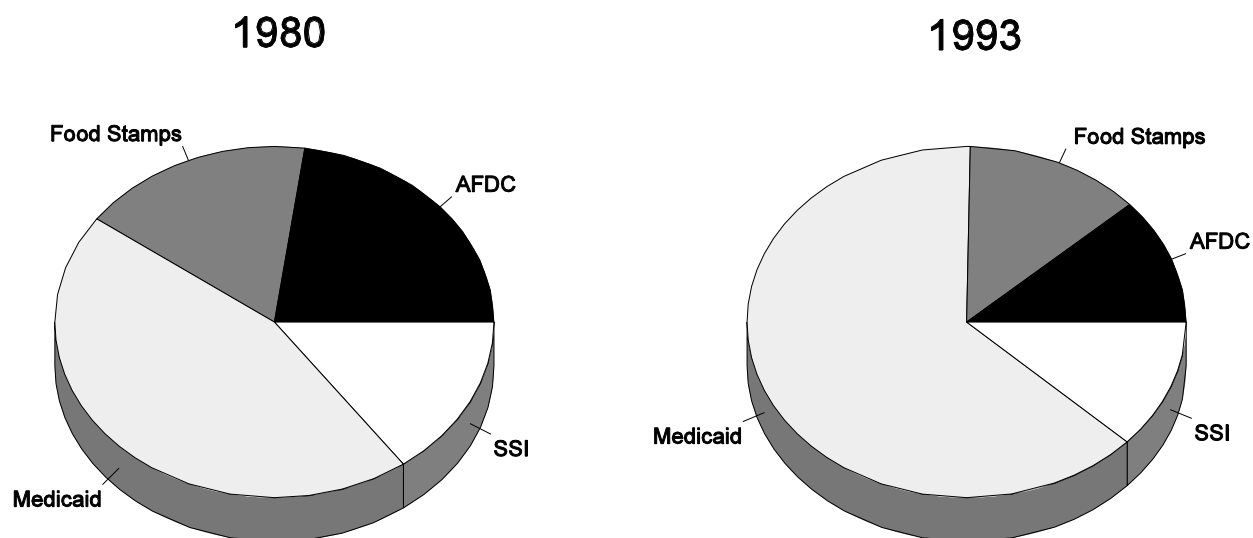


Figure 1. Medicaid share of public assistance outlays.

Source: U.S. House of Representatives, Committee on Ways and Means, *Overview of Entitlement Programs: 1994 Green Book* (Washington, D.C.: U.S. Government Printing Office, 1994).

Note: Deflated using implicit price index for gross domestic product.

Medicaid is the largest part of the so-called federal safety net. It is a joint federal-state program that pays for medical and long-term care for certain of the poor, the elderly, and the disabled. The federal share of Medicaid costs averaged 57.5 percent in 1994. Medicaid is a means-tested program, the growth of which has been far beyond expectations. There have been some studies, but the scholarly community, the media, and the public at large have given the program surprisingly limited attention, considering its size, rate of growth, and importance. This is especially striking when one considers the attention paid to Aid to Families with Dependent Children (AFDC), which is far smaller in terms of expenditures and persons served.

Medicaid is the fastest growing component of public assistance (see Figure 1). From 1980 to 1993, expenditures grew by nearly 200 percent, so that by 1993 Medicaid accounted for nearly two-thirds of all spending on public assistance—64 percent—whereas in 1980 it accounted for less than half—45 percent. Much of this growth in expenditures is accounted for by the growing numbers of poor persons covered by Medicaid, though part of it is due to the increasing cost of medical care. Recent federal mandates have expanded the eligible population, especially among children. Children and their parents now account for more than 70 percent of recipients but, since the average cost of their care is low relative to that of other covered groups such as the low-income disabled and elderly, they account for less than 30 percent of Medicaid expenditures (see Figure 2).

Who is covered under Medicaid?

Under Medicaid, there are two broad groups of eligibles, those categorically eligible and those who may be covered as individual states determine.

The *categorically eligible group* includes:

Those receiving AFDC or federal Supplemental Security Income (SSI) in most states—these are the groups originally covered;

Children younger than 6 and pregnant women in families with incomes up to 133 percent of the federal poverty line (mandatory under the Omnibus Reconciliation Act [OBRA] of 1989; optional coverage had been extended to 100 percent of the poverty level under OBRA 1986);

Children born after September 30, 1983, in families with incomes below the poverty level (such children are covered up to age 19; under the 1984 Deficit Reduction Act, children were covered to the AFDC eligibility level regardless of family type, and under the 1990 OBRA, coverage was extended to children with family incomes below 100 percent of the poverty level);

Recipients of adoption assistance and foster care who are covered under Title IV-E of the Social Security Act (coverage was expanded by the Consolidated Omnibus Budget Reconciliation Act of 1985).

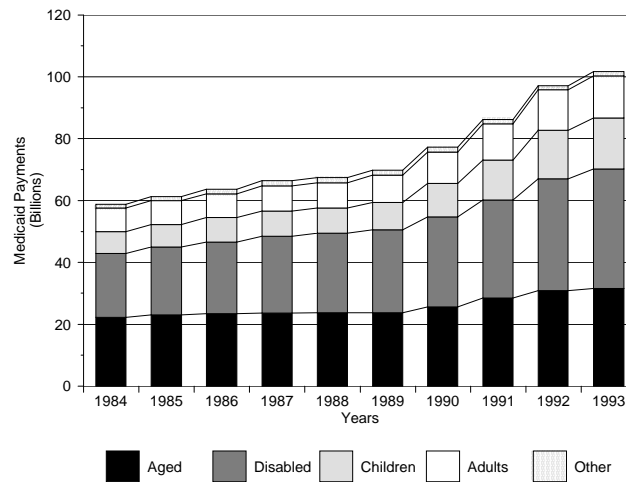
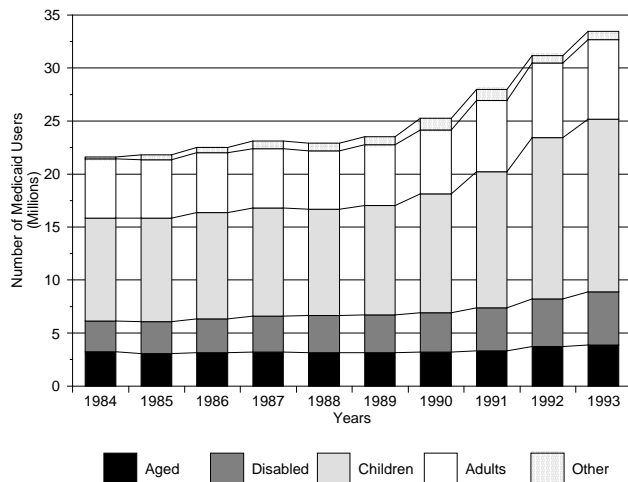


Figure 2. Low-income Medicaid users and Medicaid payments, by eligibility group, 1984–1993.

Source: Health Care Financing Administration, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1995* (Baltimore, MD: HCFA Office of Research and Demonstrations, 1995), pp. 359, 387.

Note: Dollar amounts in 1993 dollars, adjusted using a personal consumption expenditure index for medical services, U.S. Department of Commerce, Bureau of Economic Analysis.

Those in the group that may be *eligible under state rules* include:

Infants up to one year old and pregnant women who are not covered under the mandatory rules, but whose family income is no more than 185 percent of the poverty level (the exact percentage is set by each state);

Children under age 21 who meet the AFDC income and resources requirements, but who otherwise are not eligible for AFDC;

Recipients of state SSI payments;

Certain aged, blind, or disabled adults who have incomes above the level at which coverage is mandated, but below the poverty level;

Persons receiving care under home and community-based waivers;

Institutionalized individuals with income and resources below specified limits;

The “medically needy”: other qualified persons with significant health care expenses who have incomes greater than mandatory or optional “categorically needy” levels. Such persons may “spend down” to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their “excess” income, thereby reducing it to a level below the maximum income allowed by that state’s Medicaid plan.

For Medicaid recipients, a set of benefits is mandated by the federal government. These include: inpatient and outpatient hospital services; physician, laboratory and X-ray services; skilled nursing home and home health care services for adults; prenatal care; and early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21. Beyond these federal mandates and requirements for benefits, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; and sets the rate of payment for services. In all of these aspects, Medicaid programs vary substantially from state to state, and within each state over time.

Several conditions shape the Medicaid program:

States may impose small deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Many Medicaid recipients must be excluded from cost sharing, including pregnant women, children under age 18, and hospital or nursing home patients.

Federal payments to states are not capped, but states are required to contribute according to a formula based on the state’s average per capita income.

States are required to provide “disproportionate share” payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income persons.

Managed care—mandatory enrollment of beneficiaries in health care plans that make use of health maintenance organizations (HMOs) or otherwise limit the choice of providers—is permitted and has been growing rapidly. In 1994, nearly 8 million Medicaid recipients were enrolled in such plans.

In 1994, the average payment per recipient was about \$3,000, but it varied greatly across groups, from about \$1,000 per child to \$55,300 for a person in an intermediate care facility for the mentally retarded.

A major component of Medicaid expenditures now pays for long-term care. On average, Medicaid has paid for almost 45 percent of care for persons using nursing facility or home health services in the United States in recent years. Medicaid paid a much larger percentage for those persons who used more than four months of such long-term health care. Payments for institutional and community-based long-term care in 1994 totaled almost \$46 billion.

Problems of Medicaid

The major problems of the program are its increasing cost; the large remaining pool of low-income uninsured; and the all-or-nothing nature of the program and the possibly perverse incentives that this feature, often called the “Medicaid notch,” creates.

Cost of the program

An official of the Health Care Financing Administration in the federal Department of Health and Human Services explains the rising costs of Medicaid as follows:

Since its inception, increases in expenditures for the Medicaid program have exceeded the consumer price index, and have exceeded the increase in total numbers of persons served and the increase in services provided. This continually increasing growth in Medicaid expenditures seems primarily due to four factors:

- the increase in rates of payments to providers of medical and health care services, when compared to general inflation;
- the results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive, but in need of continued extensive and very expensive care;
- the increase in the numbers of very old and disabled persons requiring extensive acute and/or long term health care and various related services; and

- the increase in the size of the Medicaid-covered populations (a result of the economic recession and Federal mandates).

Data indicate that over 40 million persons [at some point in the year] were enrolled in Medicaid in 1994. Of these, 35.5 million received at least some health care service in 1994 through the Medicaid program. Total 1994 outlays for the Medicaid program include vendor payments of \$109 billion, payments for various premiums (for HMOs, Medicare, etc.) of almost \$11 billion, payments to disproportionate-share hospitals of nearly \$17 billion, plus administrative costs. Total increase was from \$126 billion for 1993 to \$137 billion for 1994 (\$79 billion in Federal and \$58 billion in State monies). This meant an average 1994 Medicaid payment to vendors of \$3,070 per Medicaid recipient.

Medicaid’s compound rate of growth for the existing program is now projected to be nine percent per year between the years 1994 and the year 2000. Thus, if current expenditure trends continue, and there are no significant changes to the Medicaid program, then payments for the total (Federal and State) Medicaid programs may exceed \$230 billion by the year 2000.³

That projected growth, of course, is dependent upon many factors, including the state of the economy, in terms both of a recession and of inflation; program eligibility; payments to providers; the extent and effects of managed care—still largely unknown; and administrative costs. All of these make accurate projections difficult. There is, in addition, the very large unknown of legislative change. At the end of 1995, there were bills pending in Congress to change Medicaid either into a block grant program or a per capita cap program. Both would have significant impact on projected program growth as well as on the division of program costs between the federal government and the states.⁴

Failures in program coverage

A second difficulty with Medicaid is that under current law (in 1995) many persons with low incomes are not covered. As was noted above, more than 11 million poor persons (29 percent) had no health insurance at all during 1994. This rate is about double that of the nonpoor. Some changes proposed in Congress would increase the proportion of the poor without health insurance: for instance, they would reduce Medicaid coverage of children aged 13–19. Public health insurance for the near-poor would be affected even more by proposals limiting guaranteed or mandated coverage for pregnant women and children under age 5 to those with incomes below 100 percent of the poverty level, rather than the currently mandated 133 percent.

A related problem is that of access. Low reimbursement rates for provider services in various states may reduce access to needed medical care, though the evidence suggests that this may be more of a problem for access to specialists than to generalists. Two articles in this issue of *Focus*—“Expanding Eligibility for Medicaid” (pp. 16–23) and the evaluation of the Missouri Medicaid program (pp. 24–30) provide evidence on this hard-to-resolve issue.

The “Medicaid notch”

The third problem with Medicaid is its “all-or-nothing” character. Most low-income persons are either fully eligible for Medicaid or not eligible at all. If an individual’s income goes up by one dollar above the eligibility level (whether that eligibility is based on AFDC or SSI receipt, or is assessed relative to poverty status), Medicaid eligibility is lost. For some, this means an incentive to become eligible and stay eligible for AFDC or for SSI (see “Expanding Eligibility for Medicaid,” pp. 16–23). For still others, it is an incentive to ensure that their income does not rise above the eligibility limit. The less likely these persons are to be offered coverage at their place of employment, the stronger these incentives are. Recent reductions in private health care coverage would seem to encourage such patterns.⁵

Related to this characteristic of Medicaid is the incentive it offers to remain “uninsured.” Among those who would be eligible for Medicaid if they had an expensive illness (that is, if they became “medically indigent”) or whose incomes are close to eligibility, there is an incentive not to purchase private health insurance. In a real sense, Medicaid serves as a substitute for private insurance—a type of catastrophic coverage for these individuals and their families. There is little reason for low-income families who are potentially eligible to purchase private coverage to do so—for them, the expected benefit from such private coverage is likely to be less than its cost, the premium.

Evaluating Medicaid policy

Numerous policy issues have arisen with regard to Medicaid. Some have already been alluded to: these include the extent and nature of federal mandates, which are questioned in a number of states; the required benefits and their generosity; the rapid growth of expenditures; the incentives created by Medicaid for single parents to opt for AFDC and to remain on AFDC in order to have health insurance coverage; the all-or-nothing nature of the coverage; and the fact that the majority of those who are poor are not covered by Medicaid, including most single persons, childless couples, older children, and the working poor.

For all of these reasons, if not simply because of concern about the rate of increase in Medicaid expenditures, it seems clear that there will be changes in the program, either through state waivers or through reforms at the national level. Cutbacks could take the form of limiting eligibility to fewer people (reversing the trend of the last decade), fewer services for those covered, reduced compensation for providers, and reduced administrative costs. Each choice will have different consequences with a widening circle of ramifications, affecting not only those currently or potentially eligible and those no longer eligible, but also providers, other payers of health care expenses, those linked to persons whose access is cut off or reduced, and the general population of citizens and taxpayers.

Whether changes are national or local, policy makers would do well to consider what we know about the likely impacts of Medicaid and of potential modifications in the program. The articles that follow this primer report upon current research into issues related to Medicaid reform.

Karl Kronebusch, writing about Medicaid politics and group differences from the perspective of a political scientist (pp. 7–11), provides insight into some factors that might affect spending and allocation of Medicaid dollars if federal funding is disbursed as block grants to the states. First, he notes that there is evidence of “inter-generational competition” among Medicaid recipient groups—the elderly, and children and their low-income parents. Second, he notes that the political composition of the state legislature plays a substantial role in determining the size of the program. Finally, he points out how important federal mandates are in determining both the number of nonelderly recipients and the level of spending upon them. Writing on the effects of state restrictions on Medicaid funding of abortions (pp. 12–15), Phillip Levine and his colleagues find that states with restrictions indeed have a lower rate of both abortions and pregnancies, but find some other surprising differences across states which suggest that passage of restrictions is linked to state attitudes—thus reflecting issues also raised by Kronebusch.

Two articles in this issue of *Focus*, “Expanding Eligibility for Medicaid” (pp. 16–23) and “Reform of State Medicaid Programs” (pp. 24–30), sample research exploring the consequences of perhaps the most significant changes to Medicaid in the decades since 1979: the expansions of Medicaid coverage among pregnant women and children.

In the first group of studies reported in “Expanding Eligibility for Medicaid,” Janet Currie and Jonathan Gruber explore two different forms of the expansions: the first, in the early 1980s, to a narrowly defined popu-

lation with very low incomes; the second, in the late 1980s, to women with incomes to 133 percent (in some cases, 185 percent) of the federal poverty level. The authors found improvements in birth outcomes (numbers of low-birthweight babies and infant mortality rates both declined), but they also found that the improvements were much more significant and more cost effective for the group at greater need—the lower-income population. Comparing these eligibility expansions to alternative ways of improving access to health care and health outcomes, Currie and her colleagues examined whether the relative generosity of Medicaid physician fees affected health outcomes for newborn infants. They found a statistically significant relationship between higher fees and measures of the health of newborns, and examined the relative costs and benefits of higher fees versus broad expansions of eligibility. Exploring how effective the expansions were in reaching a broader goal—improving the health of children under the age of 6—they again found significant health gains as well as smaller racial disparities in health care.

In a second group of studies of the Medicaid expansions, Aaron Yelowitz looks at the effects of the expansions on other welfare programs (AFDC and SSI) among three recipient groups: mothers with young children, the elderly, and the disabled. Among mothers with young children, he found that expanding eligibility without regard to AFDC receipt weakened the Medicaid notch effect described earlier, and these expansions have had a modest impact on increasing the labor force participation of these mothers. In similar studies of Medicaid expansions among the elderly, he found significant reductions in the SSI caseload and costs when Medicaid eligibility was not tied to SSI participation. But the rapid increase in the numbers of disabled SSI participants can be explained, in part, by the continuing required links between Medicaid receipt and SSI status.

Based on evaluations by Abt Associates, “Reform of State Medicaid Programs” focuses on recent state inno-

ventions in the delivery of medical care—in Missouri, to pregnant women under the Medicaid expansions; in Florida, to schoolchildren through school-based managed care under federal waivers. Did the programs increase access and improve health outcomes? The study of prenatal care in Missouri provides a mixed picture. Substitution effects came into play, so that the amount of care available to this low-income population did not increase; and availability, cost, and access to transportation proved to be significant obstacles to obtaining care. But those newly covered women who did receive care saw significant improvement in health outcomes. Studies of the Florida managed-care experiment turned up results that were both unexpected and encouraging: in the first place, families whose children were covered under the program used care efficiently; in the second, and partly because of the efficient use, the program was less costly than its initiators had anticipated. ■

¹In 1993, the federal poverty level was \$11,890 for a family of three; thus a three-person family classified as near-poor had an income less than \$17,834.

²These data are from the Current Population Survey, March 1993.

³Mary Onnis Waid, in the Office of the Actuary, Health Care Financing Administration, N3-01-23,7500 Security Blvd., Baltimore, MD 21244-1851. The national health expenditures data and estimates were prepared by the Office of National Health Statistics, also in the Office of the Actuary, HCFA. Historical information in this article is based on Vol. 56, No. 4, Winter, 1993 edition of the *Social Security Bulletin*.

⁴In addition to legislative proposals, the Medicaid proposal adopted by the National Governors’ Association on February 6, 1996, would cut back on existing coverage and grant much greater leeway to the states. For instance, it would repeal the coverage guarantee now being phased in for poor children over age 12, and, in place of the federal standard of disability would permit each state to define what “disabled” meant.

⁵See, for example, Robert Moffitt and Barbara Wolfe, “The Effect of the Medicaid Program on Welfare Participation and Labor Supply,” *Review of Economics and Statistics* 74, no. 4 (November 1992): 615–26 (also available as IRP Reprint no. 686).

Medicaid politics and group differences

Karl Kronebusch

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Within social welfare programs, various kinds of group differences create a potential for differential and possibly inequitable treatment. Medicaid, for example, is often regarded as a federal program with essentially uniform rules, but upon closer examination one finds great variation in basic program design. The challenge for policy and administration is to develop an understanding of the kinds of differential treatment that are likely to exist, to allow for those that are appropriate, and to design methods to eliminate those that are inappropriate. Among the diverse groups with a direct interest in the Medicaid program are obvious ones: the medical providers who actually deliver the services reimbursed by Medicaid, and the four major groups of recipients—the elderly, the disabled, children in low-income families, and adults receiving Aid to Families with Dependent Children (AFDC). The decisions of state policy makers—governors, legislators, and administrators—affect the allocation of program resources among these different groups. Using data from 46 states for the period 1979–1990, I analyzed total Medicaid spending, the number of Medicaid recipients, and the level of spending per recipient. I found that a wide variety of state-level influences are associated with variations in the level and allocation of Medicaid spending among the recipients and medical providers. They include the ideological positions of state residents, party control of state legislatures, location in the South, political competition, legislative professionalization, sociodemographic characteristics, per capita income, federal matching rates, and the supply of physicians and nursing home beds.

The main features of the Medicaid program, established in 1965, are described in the article by Barbara Wolfe (this issue, pp. 1–6). Important for the argument here is the substantial administrative discretion granted the states, which has led to large variations among the states in the level of spending and its distribution across several groups of recipients.

The “generosity” of a state’s program does not consist of a single dimension, but of three dimensions: eligibility standards, reimbursement rates for medical providers, and the types of medical services covered by the program. Politically, these dimensions differ because

the interests of potential recipients are strongest concerning eligibility criteria, whereas medical providers are more interested in the coverage of medical services and reimbursement rates, which directly affect the potential revenues that they can obtain for treating Medicaid recipients.

Despite the differences between the various Medicaid recipient groups and a potential divergence between the interests of medical providers and Medicaid recipients, previous research on the determinants of Medicaid spending has largely neglected the potential variation in political influences across these multiple claimant groups.

Policy making and the politics of group differences

Multiple claimants

The competing claims of the groups who benefit from Medicaid—the program’s multiple claimants—reflect the diversity of the recipient population and the interests of medical providers. Politics and policy making are unlikely to have a similar impact on the multiple claimant groups, but will instead vary along three important dimensions: politics, needs, and economic constraints.

First, the groups differ politically. The recipient and provider groups vary in their political resources and the extent of their political activity expressed through voting and interest group membership. The elderly vote at a relatively high rate and are represented by prominent interest organizations such as the American Association of Retired Persons (AARP), whereas AFDC recipients are largely poor women and children whose political participation is much more limited. Differences also arise from the way in which others view the groups; do other political actors consider them to be deserving of government benefits or electorally useful? Compared to AFDC-receiving adults, the elderly are seen as more deserving; because they vote in high numbers, they are an attractive group for electoral appeals.

Second, the diverse medical and social needs of the members of the recipient groups may lead policy makers to treat them differently. Children, for instance, require well-child care, immunizations, and other preventive services, young adult women require primarily prenatal care and acute care services, the disabled and the elderly require the full range of acute and chronic care services. Medicare coverage meets most needs of the elderly for acute care services, but provides little coverage for

chronic care services; thus many rely on Medicaid to cover these services. The expense of these services varies substantially from the relatively inexpensive needs of most children to the relatively expensive needs of many elders.

Third, economic constraints are different among the groups. For all of them, policy makers face the constraint of limited financial resources. But the groups differ with regard to the political economy of welfare programs, including the connections between social welfare programs and labor market policy. The elderly and children are generally not expected to work. Many people with disabilities are also not expected to work, but considerable attention is given to designing requirements to limit benefits to those who are seriously disabled. AFDC adults, in contrast, are under increasing pressure to take actions that will lead to participation in the paid labor force.

Finally, the Medicaid recipient groups have differing relationships to medical providers—physicians, hospitals, and nursing homes—who represent another source of potentially competing claims, and who may set cooperation constraints that limit policy makers' options. Although all Medicaid spending is paid to medical providers, the design of each state's Medicaid program involves choices between reimbursement generosity, the expansiveness of eligibility, and the coverage of optional medical services. Several politically relevant characteristics of medical providers may affect policy makers' choices. Health care providers work under several different types of ownership structures, which may affect their goals, motivations, and incentives. There will also be strategic interactions and negotiations between Medicaid policy makers and medical providers concerning their participation in the program. The challenge for policy makers is to secure the cooperation of providers, who are not required to treat Medicaid patients, in the actual delivery of services.

Orientations

Total Medicaid spending is a function of both the number of recipients and the level of spending per recipient. These two components reflect different orientations that policy makers may adopt. A state that emphasizes a *recipient orientation* will have relatively expansive eligibility standards, allowing a greater proportion of its residents to qualify for Medicaid. Alternatively, a state may expand the generosity of payments for a given pool of recipients, raising the level of spending per recipient. This alternative may reflect a *provider orientation*, that is, a desire by policy makers to make sure that providers are "adequately" reimbursed. Policy makers may make tradeoffs between the recipient and provider orientations, deciding to favor potential recipients with expansive eligibility standards or providers with generous reimbursement. But if reimbursement rates are "too

low," Medicaid recipients may have difficulty in finding medical providers who are willing to treat them (see "Reform of State Medicaid Programs," this issue, p. 24, on Missouri problems with providers).

Policy makers may also seek to target program resources on recipients with high costs or extensive needs—a *targeting orientation*. Targeting distributes Medicaid resources to those who are "most needy," and allows the total tax burden to be kept lower than would be required under more inclusive, universal approaches. But this approach can become politically vulnerable when those targeting criteria coincide with political disadvantages, such as the lack of individual or group political resources or an unfavorable group image.

Another way to consider these orientations is to distinguish between breadth of coverage and depth of coverage. It is likely that both recipients and providers place some weight on both: providers care not only about the level of payment for a given recipient, but also about the probability that their patients are deemed eligible for the program; recipients care about eligibility and the nature of the care they are given. But although the preferences of both groups include both eligibility and the level of payments, recipients place a relatively stronger weight on eligibility, providers on reimbursement generosity.

Understanding group differences

To determine how these differences among recipient groups, the potential differences between providers and recipients, and the differing policy orientations might affect state-to-state variations in Medicaid policy, I used administrative data from state Medicaid programs for the period 1979–1990. The explanatory variables for this analysis are drawn from the literature on the determinants of policy in the American states and on the development of the welfare state. Policy makers are situated in several overlapping contexts that determine policy outputs: political-institutional influences, sociodemographic needs, and economic constraints (see Table 1). The political context includes ideological preferences of state residents, political participation, policy makers' party affiliations, party competition, and the levels of interest group membership. Institutional features include the presence of the line-item veto and legislative professionalization—that is, states where legislatures have higher salaries, a greater number of staff, and longer sessions. Medical and social needs are proxied by policy-relevant sociodemographic characteristics. Finally, policy makers face resource constraints, and they must secure the cooperation of medical providers to deliver services. I include several features of the medical care sector to capture this, including prevailing medical prices, ownership types, and the supply of different types of medical providers.

Table 1
Investigating the Politics of Medicaid: Relevant Variables

EXPLANATORY VARIABLES

Political-Institutional Context

- Ideology (gen. pop. avg.)
- Voter turnout
- Minority party share
- Governor is Democrat
- Southern state
- Legis.: Dem.-Dem. (North)
- Legis.: Dem.-Rep. (North) (omitted category Rep.-Rep.)
- American Medical Association membership
- American Hospital Association membership
- AARP membership
- Gov. has line item veto
- Legislative professionalism

Sociodemographic Context

- Population
 - % aged 65 and over
 - % younger than 18
- Poverty rate
- Female-headed households/100 pop.
- % African American or Hispanic

Economic Context

- Federal matching rate
- Income per capita
- Medicare payments/beneficiary
- Physicians/1,000 pop.
- Hospital beds/1,000 pop.
- Nursing home beds/1,000 pop.
- % for-profit hospital beds
- % public hospital beds (omitted category % nonprofit)
- % public nursing home beds (omitted category % nonprofit)

DEPENDENT VARIABLES

Payments per capita

- Elderly
- Disabled
- AFDC adults
- Children in low-income families

Recipients per capita

- Elderly
- Disabled
- AFDC adults
- Children in low-income families

Payments per recipient

- Elderly
- Disabled
- AFDC adults
- Children in low-income families

To test my argument that the Medicaid groups are likely to be treated differently, the analysis separates Medicaid spending by recipient group—the elderly, disabled, children in low-income families, and adults receiving AFDC. In addition, the level of spending is disaggregated into two components: the number of recipients relative to population, and the level of spending per recipient, paralleling the distinction between a recipient orientation and a provider/targeting orientation. (The provider and targeting orientations are grouped together because they are observationally equivalent with the data used in this research.)

Medicaid spending priorities

The results show that variations in Medicaid spending priorities are related to a number of variables in the three contexts of policy making.

The ideological preferences of a state’s residents were measured using an index of the mean position of state residents on the continuum from liberal to moderate to conservative, as estimated from public opinion polling data. As expected, a more conservative state population is associated with lower spending on the welfare-related recipient groups, especially AFDC adults. Ideological conservatism reduces the number of welfare-related recipients, but it is also associated with a higher level of spending per recipient. Thus, more liberal states adopt a recipient orientation, whereas more conservative states adopt a provider/targeting orientation.

Partisan control of the state legislature has an effect on Medicaid policy, but this effect is limited to the “welfare”-receiving groups: States where the legislature is under non-southern Democratic party control spend nearly 16 percent more on AFDC adults than legislatures under Republican control. The increased spending is associated with a higher number of recipients, not a higher level of spending per recipient. Party control of the governorship, in contrast, appears to have little effect on spending per capita, though governors may have greater influence in nonincremental policy change or in altering spending at the margin. In analyzing the effects of party, however, it is important to control for the regional differences associated with location in the South. Southern states provide eligibility to a relatively greater number of elderly recipients while reducing the number of welfare-related recipients, reinforcing the effect on Medicaid spending of the relatively more conservative populations of these states. After controlling for ideology, Southern states, on average, spend about 28 percent more per capita on the elderly who are covered by Medicaid than do states outside the South.

A party system that is more competitive, that is, one in which the Democratic and Republican parties are more evenly balanced in terms of their electoral success, is associated with increased spending on children and AFDC adults. A higher level of political participation, measured by the voter turnout rate, leads to reduced spending on AFDC adults. Institutional features are not neutral, but are associated with differing spending patterns. States in which the governor has an item veto have a lower level of spending per recipient and a higher number of recipients. States with more professionalized legislatures set different priorities, spending more by increasing the number of recipients, but not changing the level of spending per recipient.

The sociodemographic variables (Table 1) proxy the level of medical and social needs. The states are re-

sponding to at least one aspect of the needs of poor populations: the relative number of female-headed households increases the number of recipients. However, the poverty rate itself has little effect. The results also provide some support for the existence of racial discrimination: increases in the African-American or Latino percentage of a state's population appear to reduce the number of recipients among the welfare-receiving groups—children and AFDC adults, of whom a disproportionate share will be members of minority groups. The racial composition of a state's population, in contrast, has little effect on the number of elderly and disabled Medicaid recipients, who are less likely to be members of racial minorities.

Because the Medicaid program provides coverage for people of different ages—children, young parents, and the elderly—decisions might become politicized along age lines. These results provide some evidence of intergenerational competition for program resources. A higher percentage of elderly persons in the population lowers the share of Medicaid recipients who are AFDC adults and increases the share who are elderly. The proportion of the population who are under age 18 increases the number of AFDC adult recipients and reduces the number of elderly recipients. The number of members of AARP has a negative effect on the number of recipients among all recipient groups. In results that are only suggestive, it also appears that AARP membership is associated with a shift of spending to older age groups; it is related to increased spending per elderly recipient and reduced spending per recipient for the two welfare-related groups.

The effects of the medical care sector on Medicaid policy arise primarily through the number of medical providers, rather than through membership in provider interest groups. The impact of medical providers, measured by the number of physicians and of nursing home beds per capita, is on the level of spending per recipient but not on the number of recipients; thus a larger medical provider sector is associated with a provider orientation in state policy. In contrast, higher levels of membership in physician and hospital interest groups such as the American Medical Association or the American Hospital Association have little effect on spending. Differences between nonprofit, for-profit, and public ownership also appear to have only weak effects.

Available economic resources are potentially an important constraint in policy making. Higher levels of per capita income are associated with an increase in the level of spending per recipient but a decrease in the number of recipients, reflecting a preference for a provider/targeting orientation over a recipient orientation. Higher-income states are apparently choosing different spending priorities, perhaps because policy makers in those states are more removed from the problems of population groups who are in need. The models control

for the percentage of the population with incomes below the poverty line, but because this is not a perfect control for need, the observed effects of per capita income may also be capturing unmeasured variations in need.

The federal matching rate reduces the net cost to a state of expanding the Medicaid program. The higher the matching rate, the greater the number of recipients. But large changes in the matching rate are required to offset the effects of other variables. Controlling for other variables in the model, southern states have, on average, 21–23 percent fewer child and AFDC adult recipients per capita than nonsouthern states. These estimates imply that the matching rate would need to be raised 52 percent for children and 36 percent for AFDC adults in order to offset the effect of being in the South. But most southern states already have matching rates that range between 62 and 80 percent. For a state with a 70 percent matching rate, a 36 percent increase would imply an increase of 25 percentage points, to 95 percent, whereas a 52 percent increase would represent a change of 36 percentage points, or a matching rate that exceeds 100 percent. In other words, full or nearly full federal funding would be required to offset the effect of being in the South.¹

In contrast to the weak effects of the matching rate, federal mandates do increase the reciprocity rate. Acting under such mandates, states in the late 1980s significantly increased Medicaid spending, through increases in both the number of child recipients and the level of spending per recipient for both children and AFDC adults.

Research and policy implications

The Medicaid program serves diverse recipient groups and reimburses services provided by a variety of medical providers. Group identities within a recipient population interact with politics, resulting in a different allocation of program resources among the recipient groups. Moreover, political differences affect policy makers' orientations, shifting the allocation of resources between recipients and medical providers.

In one sense, this is not surprising, because politics is often concerned with the question of who will benefit from a particular decision. But much of the existing literature has not addressed how political differences across groups will affect the allocation of spending. Indeed, research that models the aggregate level of Medicaid spending or the total number of recipients does so as if Medicaid recipients were a homogeneous group. The discussion above suggests that this overlooks an important aspect of Medicaid policy making.

My results imply, further, that the states are not neutral agents for the administration of federal-state programs,

but that they instead respond to state-level political influences. The states differ in how they allocate spending across the Medicaid recipient groups, as well as in the relative emphasis placed on expanding the number of recipients or enhancing the level of spending per recipient. Thus the choice of state administration rather than federal administration is also a choice about the distribution of spending.

Recently, state policy makers have expressed concerns about “unfunded mandates.” State officials argue that the federal government has imposed a variety of requirements on the states, without providing additional funding, as a way of shifting the burden of new programs to state budgets. The results presented here suggest that one reason for this may be that “incentive” approaches have only a limited impact. My results on the effects of the federal matching rate, for instance, reveal that the state response to this particular incentive is limited compared to the effects of other political influences. Realizing the limits of the states’ likely responses, federal officials turned to mandatory requirements, such as the mandates to cover pregnant women and young children in poor families. These mandates created a substantial state response. So although federal requirements impose budgetary and programmatic pressures on the states, such requirements may be an effective method for improving access for population groups who are not politically popular.

Current policy discussions are not oriented toward imposing mandates on the states, but toward enhancing state discretion and flexibility, both through the granting of waivers from federal requirements and through the consolidation of funding into block grants. These changes open up the possibility that states will reduce spending on the groups that have fewer political resources and that are politically less popular, potentially reversing the increased spending on children that was associated with the federal mandates of the 1980s. ■

¹One limitation of all empirical results on the effects of the federal matching rate is that, because the matching rate formula is based on the square of a state’s per capita income, it is difficult to distinguish the effect of the matching rate from the effects of income.

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The effects of state restrictions on Medicaid funding of abortions

Phillip B. Levine, Amy B. Trainor, and David J. Zimmerman

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A natural experiment

Women's access to abortion is an issue evoking considerable passion. It is, therefore, difficult to view policies curtailing that access through an objective and undistorted lens. Yet these are decisions with public consequences, and their effects should be subject to the same kinds of evaluation as are less controversial ones. Many pragmatic questions can, indeed, be asked about state and federal policies regarding Medicaid funding of abortions. What are the behavioral effects of restricting access to abortion among women eligible for Medicaid—that is, among poor women? Do such rules accomplish their presumed immediate goal of reducing the number of abortions? What other aspects of fertility might be affected? Are women subject to such restrictions more likely to engage in behavior reducing the risk of pregnancy? If so, what is the impact on births? And how can researchers begin to answer such questions, in an area where experimentation using random assignment of subjects is not feasible?

As it happens, the fluctuating legislative and judicial history of Medicaid policies restricting payment for abortion creates a natural experiment for examining the impact of those policies.¹ The Supreme Court decision in *Roe v. Wade* (1973) established that the right to privacy included a qualified right to choose to terminate a pregnancy, and that states could not abrogate this right. The Court's decision did not, however, guarantee access to abortion; thus state authority to make it more difficult for women to exercise this right remained ambiguous for some time. In 1976 Congress enacted the Hyde Amendment, which prevents federal Medicaid funds from being used to pay for most abortions and allows states to impose similar funding restrictions. A court injunction temporarily prevented enforcement of the amendment through October of 1977, but then it became effective until February of 1980, when it was

once again enjoined. Later that same year, the Supreme Court finally ruled that the amendment was constitutional. It has been in effect since October of 1980.

Thus from 1974 to 1976, Medicaid funding for abortions was generally available; between 1977 and 1980, the status of the law was unclear, as judicial decisions first went one way, then the other. By 1981, the Supreme Court decisions had eliminated all ambiguity, and states that wanted to restrict Medicaid funding for abortions could do so. Almost immediately, 27 states instituted definitive, enforceable Medicaid funding restrictions. These states largely had already passed funding restriction legislation, and the Supreme Court decision simply activated these laws. By 1990, an additional ten states had enacted such laws. It is, therefore, possible to compare fertility behavior in a "treatment" group of states whose laws changed shortly after a court ruling and a "control" or comparison group where no restriction was in place. Differences in women's fertility behavior in both groups of states before and after the change give us insight into the effects of such legislation. Because the date of actual implementation was determined by the Supreme Court and not the state legislative process, the specific timing of legal enforcement should be largely exogenous to other concurrent changes in the environment surrounding issues of reproductive rights in these states. To examine the effects of Medicaid funding restrictions in the quasi-experimental framework, data on state abortion laws were assembled from 50 states for 1977–90 and aggregate, state-level fertility and abortion data from several sources for 1977–88. Additional data from the National Longitudinal Survey of Youth (NLSY) were also utilized. This survey interviewed 6,283 women, aged 14–21 as of 1979, each year between 1979 and 1990.²

Potential responses to Medicaid funding restrictions

How would women's fertility behavior be affected by these abortion restrictions? For Medicaid-eligible women, one might expect to observe a decrease in the number of abortions performed. The restriction works like a price increase for these women and the higher price may reduce the demand for abortions. If the abortion rate declines, what would one expect to happen to birth rates? If women's sexual activity and contraceptive choices remain constant, then every abortion pre-

Table 1
Medicaid Abortion Funding: Restricted versus Unrestricted States

Variable	Aggregate Data ^a		NLSY-All Women ^b		NLSY-Poverty Subsample	
	(1) Restr.	(2) Unrestr.	(3) Restr.	(4) Unrestr.	(5) Restr.	(6) Unrestr.
Abortion rate	21.6	31.4	8.6	16.9	10.6	21.9
Birth rate	68.1	66.5	107.0	97.5	111.6	117.7
Pregnancy rate	89.7	97.9	128.2	129.7	133.0	159.6
Pregnancy loss rate	—	—	15.6	17.7	16.3	21.8
Age	29.2	28.8	23.8	21.6	23.1	20.7
Years of education	12.5	12.4	12.2	11.7	11.2	10.8
% Nonwhite	15.0	15.7	29.4	25.7	48.8	39.5
% Married	69.3	66.5	42.6	29.8	18.3	12.8
No. of physicians per 100,000 residents	166.3	197.6	159.8	184.1	148.9	170.0
Sample size	233	267	25,020	26,792	5,450	5,650

Note: Rates are per 1,000 women aged 15–44 in aggregate data and per 1,000 women in the sample in the NLSY data. The pregnancy rate in the aggregate data is defined to be equal to the sum of the birth rate and abortion rate and does not include lost pregnancies.

^aMeans estimated from the aggregate data are weighted by the number of women aged 15–44 in each state/year. Statistics reported for personal characteristics refer to the mean for women aged 15–44 in each state and year. These statistics were estimated from Current Population Survey outgoing rotation group data from 1979–88. Statistics for 1977–78 were obtained by linear interpolation.

^bThe final sample size of 51,812 is less than $6,283 \times 11$ (the number of women and the number of years of fertility data, respectively) because of sample attrition and incomplete information.

vented would lead to one additional birth. If, however, women change their behavior, then we would not see a one-for-one trade-off between abortions and births. For example, women who would otherwise have a Medicaid-funded abortion may now practice abstinence or use contraceptives more efficiently and would not get pregnant in the first place. In this case, a reduction in abortions is not matched by any increase in births.

Still another possible outcome may be observed. Some women who have chosen to get pregnant—or who have not avoided pregnancy—may be confronted with unanticipated shocks that alter their willingness to give birth: loss of a job, departure of the father, or an unhealthy fetus, for instance. For such women, the unrestricted availability of abortion protects them against some of the risks and uncertainties of getting pregnant. In an unrestricted world, many of these women would eventually have given birth if the shock did not occur. In a restricted world, however, these women may choose to delay pregnancy until a time when the risk of a shock is lower. In this case, the funding restriction would actually reduce the number of births. What little empirical evidence there is suggests that this may indeed happen. For instance, one study examined what happens if a local abortion provider shuts down, obliging women seeking an abortion to travel farther. This relatively modest increase in costs was linked either to no change or to a drop in local birth rates.³ In summary, Medicaid funding restrictions on abortion have an ambiguous ef-

fect on births, which may increase, stay the same, or even decrease in response.

Restricted versus unrestricted states

Table 1 reports summary statistics by state restriction status for the aggregate data, and, separately, for all women and for poor women from the NLSY. Overall, for every 1,000 women of childbearing age (aged 15–44) in the aggregate sample, about 67 gave birth each year, and 28 had an abortion. Strikingly, abortions are at least 50 percent more likely in those states without Medicaid funding restrictions. Birth rates are also lower in these states. On the basis of this information alone, it is impossible to ascertain whether the relationship between funding status, abortion, and births is causal or merely a representation of other general differences in the atmosphere surrounding reproductive activity between states. The NLSY data provide the ability to explore other aspects of fertility behavior, such as pregnancy losses. As reported in Table 1, the same pattern in birth and abortion rates by Medicaid funding restriction status observed in the aggregate data is found in the NLSY sample as well.⁴ Pregnancy losses also appear to be more common in unrestricted states. In comparison with the aggregate data, however, there are more births and fewer abortions in the NLSY, regardless of restriction status. These differences occur because the younger

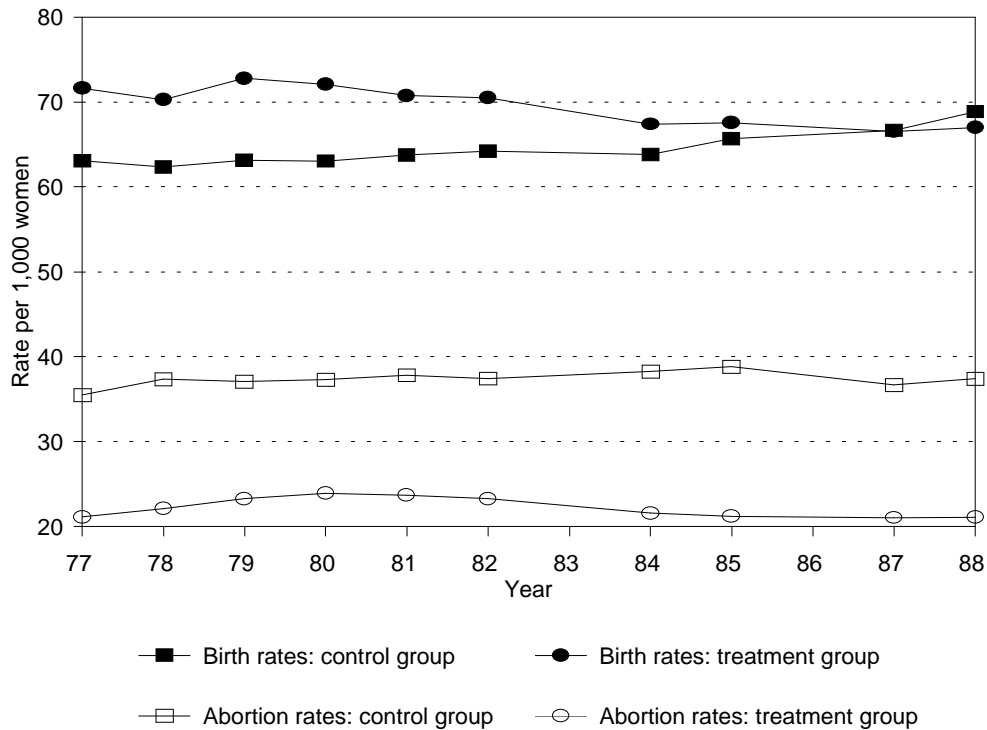


Figure 1. Medicaid funding restrictions, abortion rates, and birth rates, 1977–88, for aggregate data.

Source: P. B. Levine, A. B. Trainor, and D. J. Zimmerman, “The Effect of Medicaid Abortion Funding Restrictions on Abortions, Pregnancies, and Births,” National Bureau of Economic Research Working Paper no. 5066, Cambridge, MA, March 1995.

Note: Control group: Medicaid funding of abortion unrestricted; treatment group; Medicaid funding restricted. Abortion and birth rates per 1,000 women aged 15–44.

NLSY sample has a higher birth rate, and abortion is severely underreported in the NLSY data (see endnote 2). If abortion underreporting is positively correlated with Medicaid funding restrictions, then these data may provide biased estimates of the effects of Medicaid funding restrictions.

Figure 1 represents an examination of the natural experiment previously described, where the treatment group represents states imposing Medicaid abortion funding restrictions in 1981 and control group states are those that have never imposed restrictions. State-level aggregate data are used in this analysis. Abortion rates in unrestricted states (control group) are much higher than those observed in restricted states (treatment group) throughout the period. Abstracting from the difference in levels, states with funding restrictions imposed in 1981 experienced a drop in abortion rates over the next few years. Abortion rates were relatively constant in control group states, suggesting that funding restrictions do lead to fewer abortions. Patterns in birth rates exhibit contradictory trends, for the most part rising in control group states and falling in treatment group states over time. In neither set of states, however, does there appear to be any deviation from the trend around the time restrictions were imposed in 1981. Therefore, births appear to be reasonably unaffected by the reduction in abortions brought about by funding restrictions.

This experimental approach may be flawed if some characteristics of treatment group states are changing over time in ways that are different from those in control group states. An alternative approach would be to compare two states that appear to have many similar characteristics, with the key exception of different Medicaid funding policies. In an analogous exercise, fertility behavior in the states of Ohio and Pennsylvania was compared. State abortion rates were comparable in 1977, before any abortion funding restrictions were put in place. Ohio responded to the 1981 Supreme Court decision by implementing funding restrictions, whereas Pennsylvania did not impose such a restriction until 1985 because of a state judicial ban. Thus Pennsylvania acts as a control for Ohio in 1981, Ohio as a control for Pennsylvania in 1985. Figure 2 shows that abortion rates were slightly higher in Ohio from 1977 to 1980, except for 1978—the only year of these four during which Ohio had a funding restriction in place for the entire year, and Pennsylvania did not. From 1981 to 1984, abortion rates in the two states were virtually identical; Ohio shows a small relative decline in response to the funding restriction. After the Pennsylvania funding restriction was imposed in 1985, the abortion rate fell relative to Ohio. In each case, the imposition of a funding restriction led to a small relative drop in abortion rates. There was, however, no obvious corresponding change in birth rates between the states.

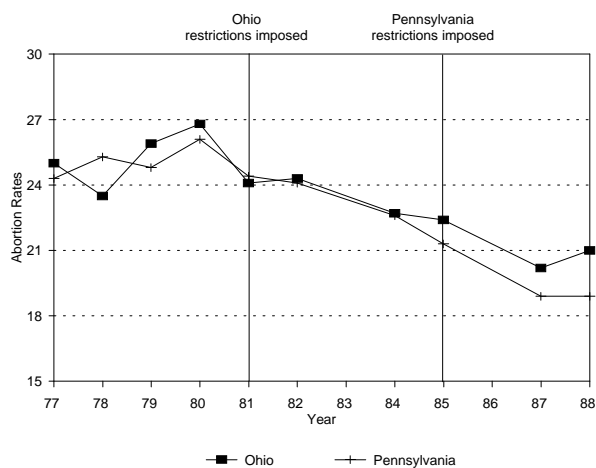


Figure 2. Abortion rates in Ohio and Pennsylvania, by year, aggregate data.

Source: P. B. Levine, A. B. Trainor, and D. J. Zimmerman, "The Effect of Medicaid Abortion Funding Restrictions on Abortions, Pregnancies, and Births," National Bureau of Economic Research Working Paper no. 5066, Cambridge, MA, March 1995.

Note: Abortion rate per 1,000 women aged 15–44.

In additional work designed to disentangle the effects of Medicaid abortion restrictions from some of the other factors that might be determining fertility behavior, multivariate analyses were conducted that took into account possible differences within states over time. Such differences might include, for example, the business cycle, the number of abortion providers, availability of abortion in a neighboring state, and attitudes toward abortion. Findings from these analyses were mainly consistent with those discussed above. Restrictions led to a significant decline in abortion rates in those states instituting them, yet birth rates did not appear to rise. In some model specifications, births are actually found to have fallen somewhat.

How big were the predicted effects? Estimates suggest that Medicaid funding restrictions would reduce the number of abortions performed by roughly 3–5 percent, or 40,000–80,000 abortions annually if imposed nationwide. In 1980, when a court injunction required Medicaid to fund abortions during most of the year, Medicaid paid for roughly 200,000 abortions, indicating that perhaps 20–40 percent of those abortions would not have taken place if Medicaid funding restrictions were being enforced. The number of births would decrease by 30,000–100,000 from the almost 4 million births that occurred annually throughout the sample period. Pregnancies would also decline by about 70,000–180,000.

These estimates, which are based on aggregate data, fail to identify whether the effects of funding restrictions are observed only among the poor population whose fertility behavior is being targeted by Medicaid funding restrictions. The availability of data on individuals in the

NLSY allows an examination of the differential impact of restrictions on poor and nonpoor women. Results of this analysis suggest that funding restrictions have no significant effect on the outcomes for nonpoor women, as would be expected. For the sample of poor women from the NLSY, however, Medicaid funding restrictions are estimated to have caused a decline of 7.5 to 8 abortions per 1,000 women. No significant impact on births are identified for these women. Consistent with these findings, pregnancies among poor women are shown to decline substantially in response to a Medicaid funding restriction.

This empirical analysis follows several different pathways and uses two different sets of data to arrive at essentially similar conclusions: that policies restricting Medicaid funding of abortion do reduce the number of abortions performed; and that they have no effect, or negative effects, on the number of births. If abortions go down, yet births remain stable or decline, the number of pregnancies must have dropped. The formidable complexity of human behavior when pregnancy and child-bearing are at issue make it very difficult to give categorical explanations for these findings. What the analysis suggests is the possibility, and the importance, of objective evaluation of even the most value-laden policy decisions. ■

¹A full report is contained in P. B. Levine, A. B. Trainor, and D. J. Zimmerman, "The Effect of Medicaid Abortion Funding Restrictions on Abortions, Pregnancies, and Births," National Bureau of Economic Research Working Paper no. 5066, Cambridge, MA, March 1995.

²The NLSY sampled African Americans, Hispanics, and lower-income families at twice the rate proportional to the population. The small size of the NLSY sample (roughly 600 abortions over the entire 12-year period) and the evidence of significant underreporting of abortion by participants make it less than ideal. The NLSY abortion rate is not even half that found in the aggregate data, yet the younger age of the population should have provided a higher rate. However, the more complete fertility histories (including information on pregnancy losses), the ability to examine poor women separately, and the significant background information on women in the sample are a significant benefit.

³T. Kane and D. Staiger, "Teen Motherhood and Abortion Access," Kennedy School of Government Working Paper no. H-95-8, Harvard University, October 1995.

⁴The number of pregnancies is slightly less than the sum of births, abortions, and pregnancy losses mainly because some women have more than one pregnancy in a year, and it may lead to different outcomes. For instance, if a woman loses a pregnancy, then gets pregnant again and bears a child, each outcome would be reported, but only one pregnancy.

Expanding eligibility for Medicaid: What does it accomplish?

The federal government has consistently tried to improve health care for poor Americans by expanding the Medicaid program to provide public health insurance to more people, and especially more children.¹ Yet much about these policy changes is still unclear. Does expanded eligibility necessarily produce better access to care or better quality of care? How has the design of the expansion programs affected the way they work, and their cost? Have other changes been more effective or more efficient in providing health care to poor families? And, since no program operates in isolation, how effective have the Medicaid eligibility changes been in the broad context of welfare programs?

A clearer understanding of how the Medicaid expansions have played out in practice is crucial to the success of efforts toward state welfare reform. This article offers a sampling of the growing body of research that is exploring these issues. Janet Currie, Jonathan Gruber, and their colleagues compared different programs expanding eligibility among poor women, asking whether it matters if a program is targeted upon rather narrow groups or is broadly based. They also examined the relative effectiveness of a supply-side approach—paying physicians more—versus a demand-side approach—expanding eligibility—in improving health care services for poor infants and children. Aaron Yelowitz examined the ways in which the Medicaid expansions interacted with other welfare programs to affect the behavior of two broad groups of Medicaid recipients, mothers of young children and recipients of Supplemental Security Income (SSI). He compared the labor supply responses of AFDC mothers and of those mothers made newly eligible, and also the different responses of elderly and disabled SSI recipients to the rather different health care choices facing them.

The Medicaid eligibility expansions for pregnant women and young children

Comparing expansions in Medicaid coverage to pregnant women

Have broad expansions of eligibility for public health insurance among mothers and children translated into improved health, or even into increased use of health care? With this question in mind, Janet Currie and Jonathan Gruber examine the dramatic changes in Medicaid eligibility for pregnant women that took place between 1979 and 1992.²

Their starting point is the two most frequently examined indicators of infant health: the incidence of low birthweight and the infant mortality rate. *Low birthweight* is a measure of the underlying health of the fetus; it is associated with greater risk of neonatal mortality and with post-neonatal mortality rates 10–15 times higher than those among infants with normal birthweights. *Infant mortality rates* reflect not only the health of the fetus but also the effect of any interventions that occur during or shortly after birth. New technologies have had dramatic effects upon the survival of low-birthweight infants, but at very high cost, and these infants are at risk of serious handicaps such as cerebral palsy, seizures, blindness, and learning disorders.

Targeted versus broad eligibility changes. Medicaid policy makers have two basic choices in attempting to reduce infant mortality rates, which are high in the United States compared to other industrialized nations. They can seek to increase use of prenatal care, thereby ensuring heavier and healthier infants, or they can increase access to the very expensive interventions necessary to keep unhealthy infants alive. In two sets of policy changes implemented during the 1980s, they emphasized the first option.³ The first set provided coverage to narrowly defined groups of women whose incomes were below the AFDC eligibility level, but who did not otherwise qualify for AFDC: first-time pregnant women (who did not qualify because they did not yet have a child); teenagers, regardless of family structure; two-parent families; and the “Medically Needy,” those whose large medical expenses brought their net incomes below the cutoffs. These changes can all be considered “targeted changes.”

Beginning in 1987, the income cutoffs for pregnant women were also greatly liberalized, and by April 1990, a uniform minimum threshold had been established: all states were required to cover pregnant women with incomes up to 133 percent of the poverty line, and could, if they chose, cover women up to 185 percent of the poverty line. These relaxations of the income requirements can be considered “broad eligibility changes.”

One reason for separately exploring the effects of the targeted and the broad changes in Medicaid eligibility is immediately apparent from Table 1, which reports information drawn from the March Current Population Survey. It shows clearly that individuals who became eligible under both sets of changes were disadvantaged relative to the general population of women aged 15–44 years (the full March CPS sample). But those eligible

Table 1
Characteristics of the Population Covered under the Targeted and Broad Medicaid Expansions between 1979 and 1992

Characteristic	Full Sample 1979 ^a	Targeted Changes ^b	Full Sample 1986 ^a	Broad Changes ^c
Income ^d	\$36,148	\$5,393	\$36,037	\$18,135
S.D.	(27, 170)	(5,902)	(30,821)	(7,906)
Poor	16.1%	80.1%	19.7%	11.6%
No. of children	1.08	0.77	1.01	1.19
S.D.	(1.31)	(1.36)	(1.20)	(1.28)
White	86.4%	75.2%	84.6%	82.5%
Age	27.9	25.0	29.2	28.7
S.D.	(8.30)	(7.06)	(8.28)	(7.44)
Married	54.9%	33.3%	52.5%	48.8%
Working ^e	70.5%	54.2%	73.6%	74.5%
Received public assistance	5.4%	10.1%	5.7%	2.64%
Health insurance status				
Uninsured	14.4%	37.6%	17.0%	25.6%
Employer-provided	32.3%	10.0%	35.2%	33.7%
Private	76.8%	41.5%	73.2%	66.6%

Note: Data from 1980 and 1987 samples of the March Current Population Survey.

^aMeans for full sample of women aged 15–44.

^bMeans for women who were not eligible for Medicaid in 1979, but who would have been eligible under a targeted program in 1992.

^cMeans for women who were not eligible for Medicaid in 1986, would not have been eligible under a targeted program in 1992, but who were eligible under broad guidelines in 1992.

^dPersonal income for older children living at home, family income for family heads, spouses, children.

^eWorked at least one week in previous year.

under the broad changes were much more like the full sample than were those eligible under the targeted changes: they were older, and more likely to be white and married. They were also more likely to be working and to have health insurance, and much less likely to be poor or to receive public assistance. These differences between the groups suggest that the two types of eligibility changes could have had very different effects.

Eligibility and birth outcomes. Under the new program rules, the percentage of women who were potentially eligible for Medicaid coverage if they became pregnant rose from 12.4 in 1979 to 43.3 percent in 1990.⁴ Within this group, the 30-percentage-point rise in eligibility was associated with a significant decline of 8.5 percent in the infant mortality rate. Results for low-birthweight babies were less robust—a reduction of only 1.9 percent in the incidence of low birthweight.

This general result, however, masks very different effects. Targeted eligibility had much stronger effects on both measures of infant health than did broad eligibility. For infant mortality, the decline under the targeted programs was 11.5 percent, under the broad programs, 2.9 percent. A 30-percentage-point increase in eligibility under the targeted programs was associated with a highly significant decline of 7.8 percent in the incidence of low birthweight; the decline under the broad programs was only 0.2 percent.

Why were the targeted changes so much more successful in improving outcomes? The authors believe that part of the answer may lie in the way in which the

different groups of women made eligible under these two policies responded to the opportunity.

Translating eligibility into coverage. It is well known that eligibility for social insurance and welfare programs does not automatically translate into coverage—for example, only about two-thirds of women eligible for AFDC actually take up their benefits.⁵ How many of the women newly eligible for Medicaid, and which ones, took advantage of the program changes?

Currie and Gruber estimate that, for every 10 percent rise in eligibility, Medicaid coverage increased by roughly 0.56 percent under the targeted programs, and by less than 0.2 percent under the broad programs. That is, three women in the targeted group took advantage of their new eligibility for every one in the broad group. Differences in health insurance coverage alone (see Table 1) do not explain the large difference in take-up rates. The authors believe that the newly eligible women may not have been effectively informed about the program. Women in the targeted programs had more frequent interactions with government assistance programs, and it may have been easier for program administrators to find and notify them. Women who had never received any sort of social assistance proved harder to reach, either because they did not know about the Medicaid program changes or because of the stigma attached to “welfare.”

The cost-effectiveness of targeted versus broad Medicaid eligibility changes. What were the costs of these improvements in birth outcomes? Overall, each addi-

tional eligible woman added \$203 per year to Medicaid expenditures. Inpatient hospital spending accounted for \$155, physician spending for \$33, outpatient spending for \$15. The low takeup rates under the broad eligibility expansions suggest that program expenses would be lower, but this was not so. Medicaid spending increased by \$224 for each woman who became eligible under the targeted changes, and by \$284 for each woman under the broad changes. Moreover, spending patterns were quite different: among the targeted group, only about half of spending was on inpatient hospital services, compared to over 90 percent among the broad group.

Why did the broad expansions cost more than the targeted expansions? The answer may lie in the response of hospitals to Medicaid policies. Hospitals are required to treat any patient who comes to them for emergency care, and if they participate in Medicaid are specifically prohibited from turning away women in labor. They therefore have strong incentives to ensure that eligible women who arrive at the hospital to deliver are enrolled in the Medicaid program. These incentives have always existed, but they have intensified with the broad eligibility changes, which cast a much wider net. Then, once individuals are enrolled in Medicaid, they most likely will receive more expensive services than their uninsured counterparts, leading to a corresponding increase in hospital costs.⁶ Doctors in private practice, on the other hand, have fewer opportunities and fewer incentives to assist patients to establish Medicaid eligibility. Payments to physicians rose significantly only under the targeted changes, a finding that, again, suggests a communication problem: individuals needed to be aware of their eligibility and to seek coverage in advance before they gained greater access to physicians.

The costs of saving a life. The literature on risk assessment finds it useful to estimate the cost-effectiveness of medical treatments or public health and safety measures by asking: “What was the cost of each life saved?” Currie and Gruber calculate that under the targeted changes this cost was \$840,000; under the broad changes, the cost was \$4.2 million—five times as large.

To gain some perspective, these figures can be compared against estimates of the value of a human life—an arena of uncertain accounting and many unknowns. One study exploring people’s willingness to pay for a small change in the probability of survival estimated the value of a life at \$1.66 million; other studies of risk of death on the job reached estimates ranging from \$4 million to \$7 million per life saved.⁷ These, however, are adult lives, and the cost of death includes foregone investments in human capital, education, and training. Newborns have no such investments, so that the results of this standard analysis may overstate the economic value of their lives.

Another way of estimating the cost-effectiveness of the Medicaid interventions is to compare their costs to those of other government interventions that save lives. One study that estimated the cost of 53 different public policy interventions calculated that 34 of these interventions cost over \$1.4 million per life saved.⁸ Child restraint systems in cars, for example, cost \$73,000 per life/year saved, or almost \$5.5 million for a child with an average 74.8-year life expectancy (in 1986).

By the metric of adult lives or of life-saving government policies, then, both sets of Medicaid expansions were fairly cost-effective, but the targeted ones were clearly more so. The broad expansions of Medicaid eligibility, Currie and Gruber conclude, had lesser effect upon birth outcomes because they were not effectively translated into increased Medicaid coverage. As the targeted increases showed, improving health insurance eligibility can improve health outcomes at reasonable cost—but only if the newly eligible take up their benefits! The broad eligibility changes may become more effective over time, as more women learn about the benefits to which they are entitled. But clearly eligibility must be translated into better prenatal care to be truly effective.

Alternatives to expanding Medicaid eligibility. In economists’ terms, policies expanding eligibility for Medicaid are “demand-side” policies. These policies have their difficulties: increasing eligibility, as we have just seen, may not improve either access to health care or health itself. Nor does increasing demand for prenatal, obstetrical, and neonatal care among the poor guarantee that the services will be available (see the next article, “Reform of State Medicaid Programs,” on the Missouri Medicaid experiment). Policy makers must also address the “supply side”—increasing the supply of physicians and other providers of health care to pregnant women.

One of the simplest supply-side policies is manipulation of the Medicaid fee structure.⁹ There exists ample evidence that higher Medicaid payments to physicians will increase the numbers of doctors who are willing to participate in the Medicaid program. But many poor women and children already receive care from clinics and emergency rooms, so shifting to physicians as the primary source of care will have no effect on their health unless the quality of care is significantly higher in physicians’ offices. Poor women also tend to live in areas that are underserved by physicians, so that fee increases must be large enough to induce physicians to move into those markets.

Using state-level data on physicians’ fees from a variety of sources, and exploiting the substantial variations among states and over time, Janet Currie, Jonathan Gruber, and Michael Fischer compared infant mortality

rates in each state to the ratio between Medicaid and private-sector obstetrical and gynecological payments.¹⁰ They then asked whether raising Medicaid fees to physicians is a cost-effective way to reduce infant mortality. Finally, they compared the effectiveness of raising fees to the demand-side policy of expanding eligibility.

Higher fee ratios, they demonstrate, had a statistically significant, though fairly small, effect in reducing infant mortality. For example, raising the relative Medicaid fee by 100 percentage points would lower infant mortality by 0.56 deaths per 1,000 births (the mean U.S. infant mortality rate from 1980 to 1992 was 10 per 1,000 births). These fee hikes would raise physician expenditures under the Medicaid program by \$9.60 for each woman between 15 and 44. Given an average fertility rate for these women of 6.5 percent, the increase in physician fees implies a cost of \$1.32 million to save one infant life in every thousand born.

Are higher payments to physicians offset by lower costs elsewhere in the medical system? Do patients, for example, shift from clinics and hospital emergency rooms or outpatient centers to physicians' offices? The evidence so far is mixed. Currie and her colleagues found that an increased fee ratio was associated with slightly lower hospital costs, and that the net effect on total Medicaid expenditures was insignificant. In that sense, the increase in physicians' fees was somewhat of a "free lunch": infant mortality improved without an increase in overall Medicaid expenditures. So, if all we measure is physicians' costs, fee raises appear to have similar effects to policies expanding Medicaid eligibility. But that is only part of the story. Under all the specifications that the researchers used, eligibility expansions brought very large increases in hospital expenses. When Medicaid fees to physicians were raised, total payments to hospitals did not go up.

If the goal, then, is reducing infant mortality, there is more than one way to reach it, and the choice of policy may have very different implications both for health outcomes and for program costs. The work by Currie, Gruber, and their colleagues suggests that targeted eligibility is more successful, and more cost-effective, in reducing infant deaths than are broad expansions of eligibility. Simply increasing payments to physicians may be at least as effective as either. But change the goal, and the dynamics of outcomes and costs will change. Do the cost-benefit relationships reported here hold, for instance, if the horizon is widened to include the health of children from birth until 6 years of age?

The Medicaid expansions and children's health

Children aged 1–4 years old in the United States have a 14 percent higher mortality than Canadian children, and

U.S. children under 15 are also sick more often and hospitalized more often than Canadian children. These problems are particularly acute for African-American children, whose mortality rates are 63 percent higher than those of whites. As with infant mortality, the policy makers' remedy has been to emphasize the importance of expanding health insurance eligibility for children. Yet there has, so far, been little convincing evidence that this will actually improve their health. In another study, Currie and Gruber take up this issue, drawing on data from the varied state responses to the Medicaid expansions and combining it with information from the National Health Interview Survey.¹¹

In general, they found, the steep increase in eligibility from 1984 to 1992 was not matched by equivalent increases in coverage. They estimate that for each 100 children made eligible, only 23 actually enrolled in the Medicaid program. One reason for this low takeup may be that many of the children made eligible already had private insurance; among the 32 percent of children made eligible who were uninsured, the takeup rate may have been as high as 71 percent. In related work, Gruber and David Cutler have estimated that many of the new enrollees under the Medicaid expansions may have been children whose families dropped their private insurance coverage to sign them up for Medicaid.¹² As with pregnant women, then, much attention needs to be paid to ensuring that those newly eligible are made aware of their benefits and that Medicaid does not merely substitute for private insurance.

These takeup results from the Medicaid expansions, though lower than hoped for, are nonetheless significant. And they were associated with large increases in care by physicians and in hospital treatment. In particular, the authors find that the odds that the children went a year without a doctor's visit dropped by one-half when those children were made eligible for Medicaid; the odds of a hospital admission within the previous year doubled. Since hospital costs are much higher than costs in physicians' offices, the second finding may suggest that services to the newly eligible are not being rendered in the most efficient way possible. On the other hand, if those served in the hospital were previously receiving no care, then this still may be an efficient expansion of access to care.

How did the increases in utilization affect child health? This is somewhat hard to estimate, for data on both subjective and objective measures of individual health are inadequate. But child mortality—although only a crude approximation to overall health improvements—is an important objective measure of health outcomes. Currie and Gruber found that the 15.1-percentage-point rise in eligibility between 1984 and 1992 was associated with a 4.5 percent decline in mortality. That decline is

significant by any measure. Calculations of the cost per life saved suggest a figure of roughly \$1.6 million.

Did the eligibility expansions lessen the glaring racial disparities in care? Currie and Gruber found that eligibility increased the probability of health care more significantly for African-American than for white children. The greater likelihood of care for African-American children was associated with a more dramatic reduction in their mortality than in that of the newly eligible white children. Significantly, care for African Americans was more likely to be delivered in a hospital than in a doctor's office, perhaps reflecting the proximity of many inner-city blacks to urban hospitals and the relative dearth of physicians in the inner cities.

This study raises a number of interesting questions. How might the impact of public insurance differ if takeup among eligible individuals were increased? Are newly eligible people who don't take up insurance less needy, or covered elsewhere, or do they face larger informational and other barriers? What is the most efficient way to deliver care to the publicly insured? We know that hospitals are not, but what about the school system? What other supply-side policies are practicable? As the pace of program change accelerates and the size of program budgets shrinks, these kinds of questions have more than academic interest.

Medicaid and welfare

The Medicaid expansions and AFDC participation

The Medicaid notch. Before the Medicaid expansions, people simultaneously became qualified for both AFDC and Medicaid by having net income below a particular state's eligibility limit. Full public health insurance benefits were retained as long as a recipient earned less than the "AFDC break-even level"—the point where AFDC benefits drop to zero—and then were entirely lost. This discontinuous drop in benefits has been known as the "Medicaid notch." Because fewer than half of the low-wage jobs typically available to women leaving welfare offer health insurance, fear of losing Medicaid coverage for their families is crucial in work/welfare decisions made by women on AFDC.¹³ The Medicaid benefit is financially important to many families: in fiscal year 1991, the combined federal-state Medicaid expenditure of \$21.9 billion for 12.6 million AFDC recipients exceeded their cash benefits of \$20.9 billion.

The Medicaid expansions. The Medicaid expansions of coverage for children that occurred in the 1980s (see endnote 1) explicitly severed the link between AFDC and Medicaid eligibility. Although these expansions did not remove the Medicaid notch, they materially shifted it, opening up the possibility of work without the atten-

dant risk of losing health care coverage for a much wider spectrum of women. But they also created even greater variation in eligibility, length of coverage, and income limits. For instance, after July 1, 1991, a mother with a 5-year-old child could earn up to 133 percent of the federal poverty line before the child would lose Medicaid coverage, whereas a mother with a 6-year-old could earn only up to 100 percent of the poverty line.

Labor force and welfare effects. Making use of the March CPS for the years 1989–1992, the period during which the largest Medicaid expansions occurred, Aaron Yelowitz examined the labor force participation of women aged 18–55 with at least one child under age 15 present.¹⁴ In his sample, 32 percent were AFDC recipients; 68 percent were working, and roughly half of them had employer-provided health insurance; 40 percent of the children were covered by Medicaid. Among the families in this CPS sample, 42 percent became eligible under the Medicaid expansions. The takeup rate among all these newly eligible families was 29 percent; among the families that lacked employer-provided health insurance, it was 47 percent.

Yelowitz estimated that uncoupling Medicaid and AFDC brought only a small change in the probability of labor force participation, around 1.4 percent. It brought a larger reduction in the AFDC caseload, approximately 3.5 percent. But these effects upon the total AFDC caseload between 1988 and 1991 were dominated by other factors, especially the economic consequences of the recession; in those years, the average number of families that participated in AFDC each month grew by 17 percent.

When Yelowitz examined smaller subgroups of the sample, interesting differences emerged. The first was the critical nature of the income eligibility limit. Of the 6,782 families eligible for Medicaid, 4,169 had incomes so low that the AFDC income limit was still higher than the new Medicaid income limit; these families had little incentive to leave welfare under the expansions. The Medicaid income limit was raised above the AFDC limit for only 2,613 families. Among these families, the probability of working increased by 3 percentage points, and the probability of welfare participation decreased by 4.5 percentage points.

A second difference was region: the expansions had a larger impact on welfare participation in the South—a result that is almost certainly related to the less generous AFDC benefits of southern states.

Yet another difference was marital status: among ever-married women, the expansions increased the probability of labor force participation by 1.6 percent, and reduced the probability of AFDC participation by 4.6 percent.¹⁵ Yet for women who had never been married, the effects were negligible. This, at first appearance, is

puzzling. Ever-married women are much more likely to have health insurance than never-married women, so expanding access to coverage should be less important for them than for the never married.¹⁶ Yelowitz speculates that women who are never-married mothers are more likely to be long-term welfare dependents or to have earnings prospects so low that leaving AFDC is simply not an option; the Medicaid notch is above the maximum earnings they could expect from full-time work. This speculation is buttressed by his findings that the expansions had a larger effect for women who had high school diplomas—and were presumably more employable—than for those who had never completed high school.

Medicaid and SSI participation

Although children and their families constitute the largest share of Medicaid recipients, the greatest part of the Medicaid budget, by far, goes to provide care for the elderly and disabled (see B. Wolfe, “A Medicaid Primer,” Figure 1). It is, therefore, especially important to disentangle possible interactions between Medicaid and other programs providing aid to these populations.

The SSI program provides assistance to elderly, blind, and disabled individuals who are poor. It is federally financed by the Social Security Administration, and in 1993 paid out \$23.6 billion in cash relief for recipients (as a comparison, \$22.3 billion was paid out through the AFDC program). In addition to cash benefits, SSI recipients receive public health insurance through Medicaid.¹⁷

Between 1987 and 1992, the number of elderly SSI beneficiaries was essentially stable, with an SSI participation rate among all elderly people ranging between 6.5 and 6.8 percent. In contrast, the number of disabled SSI beneficiaries rose dramatically, at an annual average rate of 9.2 percent.¹⁸ What explains these concurrent and opposite trends? Aaron Yelowitz argues that at least part of the explanation may lie in changes in Medicaid policies.¹⁹

Qualified Medicare Beneficiary programs for the elderly. Beginning in 1987, the legislation that expanded health care coverage for poor families also created the Qualified Medicare Beneficiary (QMB) programs. Under QMB programs, poor elderly people who were not on SSI were eligible for some of the same health insurance benefits as SSI recipients, such as the payment of Medicare premiums, deductibles, and copayments. Moreover, QMB programs usually offered Medicaid coverage to a higher income level than did SSI; in 1992, elderly individuals with incomes under \$6,729 qualified for Medicaid coverage under QMB, whereas the federal SSI limit was only \$5,304. These benefits were not trivial: in 1993, the national average actuarial value of the QMB to an elderly individual was \$950. If a benefi-

ciary had a typical hospitalization and skilled nursing facility stay during the course of a year, out-of-pocket costs would be reduced by over \$2,300.

How much did the QMB program cost? By 1992, about 1.4 million people (50–60 percent of the eligible population) had joined, for an estimated total cost of \$1,330 million. Using March CPS data for 1987–1992, the author found that increasing the Medicaid income limit for the elderly significantly reduced their participation in SSI. Without the QMB expansions, he estimated, SSI participation would have been 25–40 percent higher than it actually was. In 1992, these reductions in the total SSI caseload amounted to 1.47 million and generated program savings of between \$883 million and \$1,411 million. On balance, the QMB program appears to have been virtually self-financing.

The decline in SSI participation was not uniformly the same among all groups of the elderly. African Americans, those who never finished high school, and women have slightly higher propensities to participate in SSI, and an increase in the Medicaid income limits reduced their SSI participation much more than for white men or for the better educated.²⁰ Yelowitz speculates that these groups may be less likely to have retiree health insurance from a previous employer and may be more dependent upon SSI to provide such insurance. They were thus more likely to respond to a program change that offered health insurance without also requiring SSI participation.²¹

Do Medicaid policies also help to explain the explosive growth of disabled recipients of SSI?

The value of Medicaid for the disabled. For disabled, poor adults, SSI is almost the only route to public health insurance. Every state offers Medicaid insurance to disabled SSI recipients. Although each state has considerable leeway in setting policies for access and scope of care, it is nonetheless possible to estimate the average value of that insurance. Comparing average SSI benefits and Medicaid expenditures per disabled person for the years 1987–1993, Yelowitz found that SSI benefits, which are indexed to inflation, remained essentially flat, within a range from \$7,074 to \$7,218 (in 1990 dollars). Medicaid benefits, in contrast, rose steadily, from an estimated average of \$6,700 to \$9,491 (again in 1990 dollars). Rising cash benefits cannot explain the rising SSI participation rates, but Yelowitz is able to demonstrate that the rising value of the Medicaid benefit explains as much as one-third of the growth in the SSI rolls.²²

If access to Medicaid is an important determinant of SSI participation among the disabled, then offering health insurance without requiring participation in SSI may reduce total program costs. If it also encourages some disabled adults who had rejected the stigma associated

with SSI receipt to enroll in a Medicaid-only program, costs might rise, but health care coverage will be extended to otherwise uncovered and needy individuals—the ultimate goal, after all, of the Medicaid expansions.

Conclusions

Without better knowledge of the complex interactions among programs for poor Americans, policy makers considering radical change in Medicaid are explorers setting out into uncharted terrain. As the studies reported here have suggested, what is expected to happen may be very different from what actually happens: real effects may run counter to public perception and standard assumptions. Solid knowledge from experimental programs and serious evaluations is, however, beginning to accumulate on these and other issues. The next article reports on some of those evaluations. ■

¹In 1990, all children under age 6, with family incomes up to 133 percent of the federal poverty level, became eligible for Medicaid. In 1991, coverage was mandated for all children born after September 1983, up to 100 percent of the poverty level. Between 1984 and 1992, the percentage of all children eligible for Medicaid rose from 16.1 percent to 31.2 percent. J. Currie and J. Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," *Quarterly Journal of Economics*, 1996, forthcoming, Table 1.

²J. Currie and J. Gruber, "Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women," unpublished paper, 1995.

³The next article, "Reform of State Medicaid Programs," discusses the extent to which expanded eligibility actually resulted in improvements in prenatal care in the Missouri program.

⁴These calculations were made using March Current Population Survey data for 1979–1992. The aggregate trends mask considerable variation among and within states. For example, in Mississippi, eligibility rose steadily from 1979 to 1987, with a roughly equal increase from 1987 to 1992. In Alabama, eligibility rose only slightly between 1979 and 1987 but skyrocketed thereafter: the increase from 1987 to 1992 was seven times as large. The growth under the targeted changes was very dramatic in some states, e.g., Colorado and North Carolina, but eight states experienced reductions in eligibility during this period.

⁵See also Currie and Gruber, "Health Insurance Eligibility," for a review of take-up rates of public health insurance under the Medicaid expansions.

⁶Uncompensated charges to hospitals amounted to \$25 billion in 1989, and childbirth was the single largest component, accounting for 17.4 percent of the total. About one-third to one-half of all Medicaid applications are denied; half of these denials occur because the applicant did not complete all the necessary paperwork. Thus many hospitals have in recent years established offices or contracted with private firms to help Medicaid-eligible patients claim benefits.

As for the treatment received, one study of the Medicaid expansions found that although newly eligible mothers were no more likely to use prenatal care services or to have higher-birthweight babies, they were more likely to have Cesarean sections, all other things being equal. See J. S. Hass, S. Udarhelyi, and A. M. Epstein, "The Effect of Health Coverage for Uninsured Pregnant Women on Maternal Health and the Use of the Cesarean Section," *Journal of the American Medical Association* 270 (July 7, 1993): 61–64.

⁷Examples of these studies are W. G. Manning and others, "The Taxes of Sin: Do Smokers and Drinkers Pay Their Way," *Journal of the American Medical Association* 261 (March 17, 1989): 1604–9; K. Viscusi, *Fatal Tradeoffs* (New York: Oxford University Press, 1992).

⁸S. Breyer, *Breaking the Vicious Cycle: Toward Effective Risk Regulation* (Cambridge, MA: Harvard University Press, 1993).

⁹J. Currie, J. Gruber, and M. Fischer, "Physician Payments and Infant Mortality: Evidence from Medicaid Fee Policy," NBER Working Paper no. 4930, Cambridge, MA, 1994.

¹⁰Currie and Gruber calculated fee ratios using three different specifications, in part because of the varying estimates of private fees that they drew upon; the results reported here are for their first specification, Ratio A. By this calculation, the ratio of Medicaid to private fees ranged from .11, in New York, to 1.31, in South Carolina.

¹¹Currie and Gruber, "Health Insurance Eligibility."

¹²D. M. Cutler and J. Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics*, forthcoming.

¹³Only 43 percent of those who leave AFDC are covered by private health insurance. See P. F. Short, J. C. Cantor, and A. C. Monheit, "The Dynamics of Medicaid Enrollment," *Inquiry* 25, no. 4 (Winter 1988): 504–16.

¹⁴His sample contained approximately 16,000 women; 39 percent of them had never married, 40 percent were divorced, and 20 percent were separated. Slightly less than one-quarter had never completed high school, slightly less than one-third had attended college. The never-married women were younger (but still had an average age of 27), and 45 percent of them were receiving AFDC. During this four-year window, the Medicaid expansions never affected children over the age of 8; thus using children up to age 14 was intended to provide an adequate control for variation in the benefit schedule within states. See A. Yelowitz, "The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions," *Quarterly Journal of Economics* 110, no. 4 (November 1995): 909–39.

¹⁵In another paper, not discussed here, Yelowitz explored whether extending Medicaid to two-parent families encouraged marriage. He found, on balance, a positive effect, though the expansions also provided some incentives to divorce. See Aaron Yelowitz, "Will Extending Medicaid to Two-Parent Families Encourage Marriage?" unpublished paper, 1995.

¹⁶Among divorced women, 34 percent have health care coverage through their children's father. Figures for separated women are 22 percent, for never-married women, 6.3 percent.

¹⁷In 31 states and the District of Columbia, SSI eligibility automatically entitles the recipient to Medicaid coverage. The remaining states require a second application and may impose more restrictive income or asset requirements.

¹⁸In January 1994, SSI recipients included 1,465,300 elderly, 85,500 blind, and 4,398,100 disabled; women made up 73.8 percent of the total elderly caseload; 55.4 percent of recipients were white, 22 percent African American, and 19.4 percent "other races." U.S. House of Representatives, Ways and Means Committee, *Overview of Entitlement Programs: 1994 Green Book* (Washington, D.C.: U.S. Government Printing Office, 1994), p. 239.

¹⁹A.S. Yelowitz, "Using the Medicare Buy-in Program to Estimate the Effect of Medicaid on SSI Participation," unpublished paper, 1996, and "Why Did the SSI-Disabled Program Grow So Much? Disentangling the Effect of Medicaid," IRP Discussion Paper, forthcoming.

²⁰The percentages of SSI recipients in each demographic group are as follows: African Americans, 15.7; high school dropouts, 8.2; women, 5.5; whites, 3.3; men, 2.5; better educated, 1.4.

²¹An alternative explanation is that African Americans and people with less than high school educations have higher participation rates in SSI because more have participated in other welfare programs such as

“Time-limited benefits in France,” by Sylvie Morel: A comment

The article, “Time-Limited Benefits in France” appeared in Focus 17, no. 2 (Fall/Winter 1995). This comment by Sheila B. Kamerman and Alfred J. Kahn, Co-Directors of the Cross-National Studies Program at the Columbia University School of Social Work, expands upon Dr. Morel’s description of the French family support system. Professor Kahn is a member of the IRP National Committee.

As students of comparative social and family policies, we were delighted to see an article on a French policy in *Focus*. We would like to suggest, however, that by emphasizing the similarity between the French single-parent allowance (API) and the U.S. AFDC policy, and limiting the discussion of policy differences to the availability of an additional safety-net program in France (RMI), Dr. Morel sells French family policy short and limits American understanding and appreciation of the extensiveness of the French social protection system for children.

Our main point is that not only is there another safety net in France when the API ends (after one year or when the youngest child is three), but more important, the French provide an extensive system of cash benefits and free or heavily subsidized services that support child well-being and facilitate mothers’ attachment to the labor market, helping most lone mothers to avoid use of both the means-tested assistance benefits.

To illustrate:

The French have a universal maternal and child health care system, thus eliminating the need for a poor mother to qualify for assistance in order to obtain health care (as in the U.S.).

The French have a cluster of cash family benefits, some income-tested (at high levels) and some universal, which act as a supplement to low earnings.

The French have a universal (for all children), free, and voluntary preschool program for children aged 2–6 years, covering a school day that usually runs from 8:30 AM to 4 PM with “wrap-around services” at subsidized and income-related fees for after-school hours and when school is closed, that assures working mothers of child care for their young children.

The French provide a more extensive system of child care subsidies for younger children than does the U.S., a paid maternity leave at childbirth for all working mothers and a two-year unpaid but job-protected leave following that for parents who work in medium or large firms, and a guaranteed minimum child-support benefit for children in lone-mother families.

When their children are 3 years or older, single mothers in France are far more likely to work than comparable American mothers because the French have a firm social infrastructure in place for all children and their families that makes work more feasible.

Thus the French do have a time-limited, means-tested benefit for lone mothers, but not only do they have another safety net available when that ends, they also have a package of benefits and services that protect poor lone mothers when children are very young and, even more important, a still larger package that facilitates and supports work. For single-parent families may constitute 5 percent of all families (however defined), but in 1990 they accounted for more than 13 percent of all families with children, according to the Caisse Nationale des Allocations Familiales (the French National Family Allowance Fund).

Expanding eligibility for Medicaid (continued)

AFDC; more African Americans also live in urban areas, where access to information and to welfare offices is easier.

²²There are other possible explanations. For instance, if standards for evaluating disability become easier, or if states attempt to shift their General Assistance beneficiaries onto the SSI caseload, the caseload may grow; but then relatively healthier people will be entering SSI,

and average per capita expenditure, allowing for price or service changes, should go down, not up. To correct for possible biases, Yelowitz incorporated into his analyses measures reflecting variation in the generosity of the state’s Medicaid package—access to and quality of care, medical prices, and scope of services—and changing definitions of disability.

Reform of state Medicaid programs

Larger by far than AFDC, and far more available to poor, working families, state Medicaid programs have in the last few years seen great changes—both federally mandated expansions of coverage and waiver-based state experiments. Because Medicaid is central in the provision of health care to large segments of the American public (see “A Medicaid Primer,” pp. 1–6, earlier), the effects of these program changes deserve serious consideration before further major revision is undertaken. In this article, we report on some evaluations of different state programs.

The impetus for state experiments

1. Legislative expansions of coverage. Since 1986, federal legislation has first allowed, then mandated, expansion of Medicaid eligibility, particularly to pregnant women and children. For instance, the Omnibus Budget Reconciliation Act (OBRA) of 1987 allowed states to raise Medicaid income thresholds for pregnant women and children to as much as 185 percent of the federal poverty level. Under the Medicare Catastrophic Care Amendments (MCCA) of 1988 and OBRA 1989, states were required to cover, at a minimum, pregnant women and children up to age 6 with family incomes below 133 percent of the federal poverty level, beginning in 1990. The national consequences of these changes were evaluated by Abt Associates in a report of December 1995 to the Health Care Financing Administration.¹ Some conclusions are summarized here, with particular attention to the Missouri program.

2. Medicaid Extension grants for demonstration programs, mandated under OBRA 1989. These grants had very specific goals: to encourage employer health insurance coverage for children in low-income, working families; to test innovative approaches to publicizing the programs; to implement streamlined eligibility processes; and to incorporate innovative ways of delivering care. Three state programs—in Florida, Maine, and Michigan—were evaluated by Abt Associates. We report here on the Florida experiment, which incorporated an unusual partnership of private entities with state Medicaid agencies.²

3. Section 1115 waivers. Under Section 1115 of the Social Security Act, six states have implemented state-wide Medicaid changes, and more are pending—the first such demonstrations since Arizona began its managed care program in 1982.³ These new plans have two key elements in common: the use of mandatory managed care in place of fee-for-service care, and the expansion of Medicaid to previously ineligible groups, partly based upon the savings anticipated from managed

care. Evaluations of some of these waiver programs are just beginning.⁴

The Medicaid expansions and the health of mothers and children

The Medicaid expansions of the late 1980s were a direct response to the worsening statistics for maternal and infant health.⁵ In the 1980s, longstanding downward trends in infant mortality slowed among whites and virtually halted among nonwhites. By the mid-1980s, use of prenatal care in the United States, already low, was declining. Most worrisome, these declines were disproportionately among young, poor, uneducated, unmarried, and minority mothers, precisely those who, judging by birth outcomes, were most in need of care.⁶ The implications of the declines were not entirely clear, because there are some uncertainties about the effects of prenatal care on birth outcomes and maternal health, but they could not be ignored. Financial barriers that hampered the access of poor women to health care also worsened. By 1984, the proportion of the poor who were covered by Medicaid had declined to 38 percent, from a 1976 level of 65 percent. At the same time, effective state eligibility ceilings had declined from 73 percent of the poverty line for a family of three (in 1975) to 56 percent (in 1986).

Partly in response, Congress passed the Medicaid eligibility expansions. By 1990, all states had met the mandates of these expansions, providing coverage to pregnant women at 133 percent of the poverty threshold; 23 states had gone further, raising eligibility to the optional maximum level of 185 percent. Most had also streamlined eligibility processes. These statutes were one of the major social policy initiatives of the 1980s, and they came at great cost.⁷ Did they achieve the results policy makers intended?

Expected effects of the expansions

The goals of the expansions of Medicaid eligibility were:

1. To increase enrollment among women who otherwise could not afford appropriate care.
2. To increase the timeliness and adequacy of prenatal care.
3. To improve birth outcomes in measurable ways.

Many unanswered questions surrounded these expansions. They might, for some women, simply shift to Medicaid the financing of care that would have been received in other ways. Financial costs other than the

Table 1
Births to Medicaid Enrollees in Missouri

Characteristics	Medicaid Share of Births (%)		
	Baseline Period ^a	Expansion Period ^b	% Change
All live births	13.2	22.5	70.5
Race ^c			
Black	39.7	49.0	23.4
White	8.4	17.3	106.0
Other	5.2	16.4	215.4
Age ^d			
Teenaged	27.7	50.3	81.6
Adult	11.0	17.9	62.7
Marital status ^e			
Married	4.1	10.6	158.5
Unmarried	42.2	54.5	29.1
Education ^f			
Under 12 yrs.	31.8	50.9	60.1
12 or more yrs.	8.5	15.1	77.6
Income-defined zip quartile			
Lowest	27.0	40.9	51.5
Second	14.1	26.7	89.4
Third	8.9	16.8	88.8
Highest	2.5	5.5	120.0
Residence ^g			
Urban	12.4	19.9	60.5
Rural	15.2	28.5	86.3

Note: Births represent a percentage of all single live births.

Source: C. V. Irvin, D. Kidder, and K. A. Calore, *The 1988 Expansion of Medicaid Eligibility for Pregnant Women in Missouri: Effects on Medicaid Enrollment, Prenatal Care Access, and Birth Outcomes*, Report by Abt Associates to the Health Care Financing Administration, 1995.

^aPregnancies ending in single, live births in 1987 ($N = 73,263$).

^bPregnancies 1988 through 1989 and ending in single, live births ($N = 94,390$).

^cRace unknown for approx. 25 percent of the population in both periods.

^dIn expansion period, 9.5 percent unknown.

^eIn baseline period, marital status unknown for 72.8 percent of population.

^fEducation unknown for 19.4 percent in baseline period, 34.2 percent in expansion period.

^gResidence rural or urban unknown for 42.9 percent in baseline period, 56 percent in expansion period.

direct cost of care (transportation, loss of work hours) might continue as barriers to care. Available care might be limited, thus rationing access. Such issues complicated evaluations that were already intrinsically difficult. First, there was no natural control group against which to measure participants (the expansions were open to all eligible pregnant women). Second, adverse birth outcomes are relatively rare, even among low-income women. Finally, there are many differences between women who seek prenatal care and those who don't—for example, in the risk factors that simultaneously determine the likelihood of obtaining care and the outcome of the pregnancy. In their efforts to resolve these and other difficulties, Abt Associates used differ-

ent and complementary evaluation designs, national datasets such as the 1988 National Maternal and Infant Health Survey (NMIHS), which took place early in the stream of state Medicaid expansions, and a small-area study—a qualitative and quantitative analysis of the Medicaid expansions in Missouri.⁸

Enrollment of pregnant women and infants

During the second half of the 1980s, Medicaid enrollment substantially increased among low-income pregnant women. In 12 states between 1988 and 1990, Medicaid-covered deliveries grew by 44 percent, Medicaid's share of total deliveries by 29 percent, and Medicaid payments for deliveries by over 400 percent. In Missouri, the Medicaid share of single live births among low-income pregnant women increased from 34 percent in 1987 to 53 percent in 1989. These increases were greater for pregnant women from demographic groups that had previously been underrepresented: white, teenaged, high-school-educated, and married women. (See Table 1.)

For children less than 2 years of age, Missouri expanded eligibility to families with incomes at or below the poverty line. The results were similar to those for pregnant women: enrollment increased by 58 percent among children born in 1988 and 1989, and infants in the expansion program were more likely to have mothers who were white, married, and had higher educational levels.

What proportion of the newly eligible population actually enrolled? In ten states for which claims data on deliveries were available from 1987 to 1990, a 10-percentage-point increase in the Medicaid-eligible population was associated with an increase of approximately 5 percent in Medicaid-financed deliveries.⁹

Utilization of prenatal care

One clear objective of the Medicaid expansion was to improve the timing and adequacy of prenatal care among low-income, pregnant women. The Missouri data contain good news and bad news (Table 2):

1. Among enrolled teenaged and adult mothers, the percentage with some care and timely care increased; among their unenrolled counterparts, it deteriorated, both absolutely and relative to enrollees.
2. Overall, the percentage of low-income women who used any prenatal care *declined* between the baseline period and the expansion period, as did the proportion who initiated care within the first two trimesters.
3. For Medicaid-enrolled, black, and unmarried low-income mothers, the proportions with some care and with timely care decreased, and the proportion with inadequate care increased (not in Table 2).

Table 2
Utilization of Prenatal Care by Missouri Women
(in percentages)

Characteristics	Some Care		Timely Care ^a	
	Baseline Period ^b	Expansion Period ^c	Baseline Period	Expansion Period
Teenagers				
All women	96.2	95.8	88.5	87.7
Low-income women ^d	96.0	95.8	87.6	87.4
Medicaid-enrolled ^e	96.4	96.8	86.8	88.2
Not enrolled	95.8	94.6	88.0	86.2
Adults				
All women	98.4	97.8	95.7	95.1
Low-income women	96.6	94.9	90.5	88.4
Medicaid-enrolled	96.3	95.0	89.1	87.4
Not enrolled	96.8	94.9	91.2	89.4

Source: C. V. Irwin, D. Kidder, and K. A. Calore, *The 1988 Expansion of Medicaid Eligibility for Pregnant Women in Missouri: Effects on Medicaid Enrollment, Prenatal Care Access, and Birth Outcomes*, Report by Abt Associates Inc. to the Health Care Financing Agency, 1995.

^aCare initiated during first two trimesters.

^bPregnancies ending in single live births in 1987.

^cPregnancies beginning in 1988 through 1989 and ending in a single live birth.

^dWomen estimated to be living in households with incomes less than 200 percent of FPL (*N*, in expansion period, 9,104 teens, 18,381 adults).

^eIncludes women qualifying under AFDC and expansion requirements.

Ideally, if prenatal care improves birth outcomes, the expansion program should reach women who have less access to or are less likely to use such care.¹⁰ Instead, the data suggest that, in Missouri, expansion enrollees had a greater propensity to use prenatal care both before and after the expansions. Pregnancy risk factors among newly enrolled white and married women might well be lower than in the larger population from which enrollees were drawn. This said, it was also the case that utilization rates, particularly among black, teenaged, and unmarried women who enrolled in the program, either rose in comparison with or declined more slowly than rates among eligible women who did not enroll.

The effects of prenatal care

Analyses of national data from the NMIHS suggest that there is a clear association between timely prenatal care and positive birth outcomes. Specifically, a one-month delay in prenatal care is associated with a reduction in birth weight of 20–33 grams for white women, and 22–56 grams for black women.¹¹

In Missouri, low-income women did not, as noted, increase their use of prenatal care services, despite a substantial increase in enrollment. Nevertheless, birth

outcomes in general remained stable. Both before and after the expansion, neonatal and infant mortality rates for infants born to low-income, unenrolled women were higher than for Medicaid-enrolled women. Medicaid's relative advantage was greater for black mothers: the mortality rate was approximately one-third the rate for unenrolled women. Among enrolled white women, the reduction was one-half, relative to white women not covered by Medicaid. A second, case-control study of Missouri data for 1987–89 suggested that the use of prenatal care does reduce the risk of low birthweight and infant mortality.¹² The contrary also holds true: the absence of any prenatal care increases sevenfold the relative risk of a very low birthweight infant.

The effects of the Medicaid expansions on the state health care system in Missouri

The Medicaid expansions were implemented as part of a complex, imperfectly documented system of care for poor, pregnant women.¹³ The Missouri findings regarding utilization, though they must be interpreted cautiously, suggest that although provision of Medicaid coverage is necessary, it is not sufficient without administrative and payment changes that reduce the indirect costs of using medical services among low-income women.¹⁴

How the state of Missouri implemented the Medicaid expansions and their effects on existing state health care systems and health policy are both critical questions. In particular, the Missouri data point to two serious problems: although demand increased, levels of physician participation were unchanged, and the expansions were financed from limited state budgets at the expense of other important programs providing prenatal services to poor women.

Physician participation. From 1987 to 1990, the Medicaid share of all live births in Missouri increased substantially (see Table 1), especially among high-risk populations: the numbers of pregnant women who sought care increased by approximately 90 percent. Yet the numbers of providers increased by only 12 percent (for providers of prenatal care and delivery) and 46 percent (for providers of prenatal care only). Inevitably, the caseloads of those who provided prenatal care to Medicaid recipients increased, by between 29 and 73 percent.

In its efforts to increase physicians' participation in Medicaid, Missouri in July 1990 almost doubled Medicaid global reimbursement for obstetric fees. The state also attempted to eliminate administrative obstacles to wider participation (physicians' objections centered on both inadequate fees and red tape). For example, the state obtained a federal waiver permitting non-Medicaid physicians participating in a call-rotation arrangement with Medicaid physicians to deliver Medicaid babies. These and other policy changes did increase the number

of Medicaid women receiving obstetrical services from the state's doctors. But according to state officials, this increase reflected additional Medicaid patients for doctors already participating, rather than larger numbers of participating doctors.

Effects on other state programs. If the Medicaid expansions merely substituted Medicaid payments for other financing, but did not increase the amount of care available to poor, pregnant women, they would bring little improvement. Utilization data from Missouri suggest that such was indeed the case. Worse, there is evidence to indicate that other systems of care were contracting as Medicaid expanded.

In Missouri, the system of prenatal clinics run by county and large city health departments was financed in part by state and federal funds under Title V Maternal and Child Health block grants. On the eve of the Medicaid expansions in 1988, four large cities and 113 counties were served by the prenatal clinic program. These clinics were designed to be particularly accessible to poor populations: they had simple, inclusive eligibility criteria and procedures; easy summary billing with few regulations; few limits on services, who performed them, and where they were performed; and less stigma for patients. The clinics provided a prenatal service at least comparable in size to Medicaid, possibly larger.

When the Medicaid expansions began, the expected costs were \$6.8 million per year for pregnant women in the expansion programs, and \$12.8 million for women and children. The marginal increases in funds needed were supplied by reducing funds for other programs, including the Title V prenatal clinics. State officials anticipated that the clinics would expand their billings to Medicaid on a fee-for-service basis rather than relying on Title V. However, little was done to train, equip, or otherwise adapt the clinics to the more central role of Medicaid. The result was perhaps predictable. As funding dropped, a major crisis ensued within the city/county clinics. By the fall of 1988, prenatal clinics serving 67 of the state's 114 counties had closed or threatened to close. Thereafter, state officials worked very hard, and with some success, to stabilize the new system.

The Missouri experience argues against the assumption that merely expanding the number of women served by Medicaid necessarily improves the system of prenatal care. Given the way that Missouri implemented the expansion—by drawing funds from another public program and not offering enough incentives to increase the pool of Medicaid providers—one cannot say that the program “failed”; it is clear, however, that although it is easy to increase eligibility, it will be impossible to improve utilization and birth outcomes if the capacity of a system is not simultaneously increased.

A Medicaid Extension Demonstration program: Florida Healthy Kids

The Florida Healthy Kids demonstration began in March of 1992.¹⁵ It represented a mixed public-private model for working within a wholly public setting, the public schools, to extend health care coverage to children. Schools provided the group eligible for coverage—enrolled students 19 and younger—and the nexus for marketing and administering that coverage. To simplify administration, the school lunch program was used as a gatekeeper, so that only students enrolled in the program qualified for subsidized coverage.¹⁶ Applicants filled out a simple one-page document obtainable through the school. Deliberately, links to the Medicaid program were kept in the background, so as not to discourage potential enrollees who might be concerned about the stigma of “welfare.”

Much of the state-level administration of the program was privatized. Florida set up a private, not-for-profit organization, the Florida Healthy Kids Corporation, to orchestrate agreements with private contractors, local school districts, and state agencies. The state hoped to create a more flexible and efficient project than if it were run by a state agency. Care was also privatized. A private contractor, Florida Health Care Plan, one of the few HMOs in the demonstration area, was to provide medical coverage at a fixed price per enrollee, subject to minimum coverage and access requirements; it would also bear short-run utilization risks. The price was to be subject to annual renegotiation.

Florida Healthy Kids ran for three years as a demonstration in Volusia County, where 93 percent of children enrolled in school had family incomes at or below 185 percent of the federal poverty level. Total school enrollment was about 54,000, and about one-quarter of the students were uninsured at any point in time before the demonstration began. Nearly 7,000 children were enrolled over the course of the demonstration—a major reduction in the problem of uninsured students in the county schools, especially if students with pressing health needs were more likely to enroll. Meanwhile, the Florida Healthy Kids Corporation worked with the state and local districts to expand the concept. By January, 1995, six additional counties had added Florida Healthy Kids programs funded by state and local bodies. By July 1, 1995, over 15,000 children were enrolled statewide.

Whom does Florida Healthy Kids serve?

Florida Healthy Kids covers uninsured children at any income level, but only children with family income at or below 185 percent of the federal poverty level will have their premiums partially subsidized. Family payments are based on a sliding scale; for instance, families with incomes below 130 percent of the poverty level pay a

Table 3
The Florida Healthy Kids Program: Characteristics of Enrollees

Age	
1–4 yrs	4%
5–12 yrs	67%
13–17 yrs	27%
18–19 yrs	1%
Income Group	
At or below poverty line	35%
101–130% poverty line	53%
131–185% poverty line	9%
Missing/other	3%
Percentage male	52%
Months of program enrollment (by age)	
1–4	9.3
5–12	13.8
13–17	13.0
18–19	9.8
Avg. for all enrollees	13.3
Avg. for disenrollees only	8.7

Source: Abt Associates, *Evaluation of the Medicaid Extension Demonstrations: Final Report*, Report by Abt Associates for the Health Care Financing Administration, 1995.

premium ranging between \$5 and \$20 per month, depending on the location, to enroll one child, whereas families at 200 percent pay at least \$43 per month. Some services also require small copayments.

Some basic characteristics of the participants are given in Table 3. The high percentage of children in the lowest age group may be because eligibility is based on the school lunch program: younger children have a higher rate of participation than do older children.¹⁷ Attrition from the demonstration program in Volusia County was within expected limits: 56 percent of all children who left did so because they moved or were no longer eligible for other reasons, another 31 percent because they had obtained other insurance. These numbers do point up the problems of basing a health care reform upon a geographic unit as small as a school district; inevitably, people move out of such narrow areas and lose eligibility.

Utilization of the program

Program statistics for Volusia County provide only weak evidence that there was a pent-up demand for medical care among low-income families: beneficiaries used only a slightly disproportionate share of services in the first three months of their enrollment, and primary care visits by enrollees declined rapidly in the early months of the program. One result is, however, striking. As part of the risks of serving a previously uninsured population, Florida Health Care Plan had expected inefficient patterns of use—greater use of emergency room (ER) services, for example. ER use was indeed high at the beginning of the program, but it declined dramati-

cally, by over 70 percent, between Years 1 and 2, and over 80 percent of such use by enrollees occurred in their first three months in the program. At the same time, the number of office or walk-in clinic visits rose by 2 percent, suggesting that Florida Healthy Kids participants were substituting visits to their primary care physician or clinic for more costly emergency room care. The providers worked actively to educate participants about these alternatives, which were at once more accessible, less time-consuming, and more convenient for parents. It seems clear that program participation encouraged parents to take their children to see a physician at an earlier, less acute stage of illness.

For the longer term, Florida Healthy Kids enrollees were expected to be a riskier, somewhat sicker group than children with prior insurance. These expectations proved to be too conservative. There was no evidence that these poor and near-poor children used services in unusual or particularly intensive ways; their utilization patterns were somewhat lower than those of Florida Health Care Plan's commercial enrollees. There are a number of possible explanations—for instance, that demonstration participants had a lesser propensity to use care (but in fact, they used primary care services about as much as commercial enrollees did). It is possible that demonstration participants were somewhat better educated about cost-effective use of services; both the HMO and Florida Healthy Kids mounted intensive patient information programs, and a school district may be a more effective setting than dispersed places of business for educating parents and children about their health care.

As utilization of medical services by participants continued to be lower than predicted, Florida Health Care Plan and Florida Healthy Kids negotiated three reductions in monthly charges. Over a two-year period, costs declined over 20 percent, from \$58.98 per month to \$46.50 per month; demonstration planners had originally assumed a 24 percent increase. Once premiums dropped below \$50 per month, the program reported many more enrollees paying the full premium.

The role of Florida Healthy Kids Corporation

Florida Healthy Kids Corporation was set up as a private, nonprofit corporation with a substantial public representation on its board. It was designed to be small and flexible, without extensive and legalistic formal procedures. The virtues of this quickly became apparent. The project was more visible than if it had been part of the state Medicaid bureaucracy, where this particular approach had a low priority. Its status as a private corporation freed it from both the state personnel system and state procurement rules. The most important consequence was the willingness of Florida Health Care Plan, the only HMO in Volusia County when the demonstration began, to bid on the contract, because it would not

thereby have to deal with state procurement rules that it considered inflexible and complex. In fact, ordinary problems between the program administrators and the HMO tended to be quickly and informally resolved, to the benefit of the program. Evaluators pointed out, however, that the state procurement rules might look less wooden and uncomprehending if one of their ultimate concerns—fraud or self-interest in the management of the program—were to surface.

The small size and flexibility of the Florida Healthy Kids Corporation did exact a price, particularly as the program expanded into new counties, and staff were stretched very thin. Difficulties arose with local officials in Volusia County when the demonstration ended and it became necessary to seek local funding to replace federal demonstration funds. In a sense, Florida Healthy Kids Corporation was neither a representative of the state, speaking with the weight of the state's authority behind it, nor a legitimate local voice, from the point of view of Volusia County officials. This intermediate position allowed it to be a buffer between public and private organizations, but it did distance the program from state and local agencies, like the Medicaid program or county units of government, which would ideally develop a vested interest if the Healthy Kids program were to succeed.

How successful was Florida Healthy Kids?

As with other such state programs, lack of funding has limited the reach of Florida Healthy Kids. The program was never open-ended—the budget was set—and it is currently available in only 7 counties; 13 others are waiting to join. Demonstration grant funding from the federal Health Care Financing Administration ended in February 1995, and the program is currently funded by a complex mix of state general revenue funds, and county, health district, school district funds, and premium payments.

Nevertheless, as a county-level, school-based program, Florida Healthy Kids has established a substantial role for local initiative in bringing “retail” health care reform, county by county, school district by school district. It thus contrasts with “wholesale” reform strategies that attempt to secure the same objectives of coverage for uninsured children through more centralized programs and financing mechanisms. It has been successful in reaching, enrolling, and providing health care to children in low-income families efficiently and at reasonable cost. It has been generally popular: providers like the administrative simplicity, compared with Medicaid, and people enrolled in the program express greater satisfaction with the care provided their children than do families in any of the comparison groups studied, including people with private insurance. The Health Care Financing Agency found that the program substantially reduced the incidence of unmet medical needs

among enrolled children: only 1 percent of Healthy Kids respondents said they were deterred from seeking medical care for their children by the cost of the doctor's visit, compared to 17 percent of respondents not enrolled in the program. The Abt evaluation found that enrollees were also significantly less likely to seek emergency room care. But use of preventive care among the very poorest is still lagging: a study by the Institute for Child Health Policy in Florida found that 32 percent of children in the program had never had a doctor's examination, and the poorest enrolled children and African-American and Hispanic enrollees were more likely never to have used program services. ■

¹R. F. Coulam, N. Cole, C. V. Irvin, and others, *Final Report of the Evaluation of the Medicare Catastrophic Care Act: Impacts on Maternal and Child Health Programs and Beneficiaries*, Report by Abt Associates Inc. for the Health Care Financing Administration, 1995.

²Abt Associates, *Evaluation of the Medicaid Extension Demonstrations: Final Report*, Report by Abt Associates Inc. for the Health Care Financing Administration, 1995.

³The states are Hawaii, Minnesota, Oregon, Rhode Island, Tennessee, and South Carolina. Demonstrations were scheduled to begin in Delaware, Massachusetts, and Vermont in January 1996. By November 1995, 11 states had received approvals and 11 more were pending. See U.S. General Accounting Office, *Medicaid Section 1115 Waivers*, GAO/HEHS-96-44, Washington, D.C., November 1995. On the Arizona plan, which has drawn wide public attention, see, for a recent summary, U.S. General Accounting Office, *Arizona Medicaid*, GAO/HEHS-96-2, Washington, D.C., October 1995.

⁴Evaluations will be conducted by Mathematica Policy Research.

⁵Material in this section of the article is drawn from Coulam et al., *Final Report*, and from evaluations of the effects of the Medicaid expansions of 1988 on maternal and child health in Missouri. See C. V. Irvin, D. Kidder, and K. A. Calore, *The 1988 Expansion of Medicaid Eligibility for Pregnant Women in Missouri: Effects on Medicaid Enrollment, Prenatal Care Access, and Birth Outcomes*, Report by Abt Associates Inc. for the Health Care Financing Administration, 1995; C. V. Irwin, *Missouri Infants: Utilization and Reimbursements of Medicaid Financed Health Services after the Expansion of 1988*, Report by Abt Associates Inc. for the Health Care Financing Administration, 1995.

⁶From 1969 to 1980, the proportion of women receiving prenatal care in the first trimester improved steadily. Thereafter it remained stable or decreased. In 1988, approximately 25 percent of pregnant women were reported to receive late or inadequate prenatal care. Institute of Medicine, *Prenatal Care: Reaching Mothers Reaching Infants* (Washington, D.C.: National Academy Press, 1988).

⁷For example, in Missouri, total federal and state Medicaid expenditures on women made eligible by the expansion of 1988 stood at \$31.8 million, compared to an initial prediction of \$15.5 million. By 1992, Missouri had paid over \$100 million to cover pregnant women made eligible under the expansions.

⁸Missouri was chosen in part because in January 1988 the state had implemented an MCCA-like expansion to include women up to 100 percent of the federal poverty line, though it did not streamline enrollment procedures. The state had also been actively collecting the kinds of linked vital statistics and Medicaid claims data that would be particularly helpful for the analysis.

⁹The 10 states were Arkansas, California, Georgia, Iowa, Michigan, Montana, Tennessee, Utah, Washington, and Wisconsin. See N. Cole, *Increasing Access to Health Care: The Effects of Medicaid Expansions*

for *Pregnant Women*, Report by Abt Associates Inc. for the Health Care Financing Administration, 1995.

¹⁰Effective care for mothers involves more than just being sure that women seek early and timely care. Leaving aside issues of access, there appears to be no simple, purposeful link between the riskiness of the pregnancy, the level of utilization, and the content of services. For instance, in a related study of the 1988 NMIHS data, Carol Irvin explored the content of prenatal care. She found: (1) women with risky pregnancies were no more likely to receive most services than women with low-risk, normal pregnancies; (2) utilization is closely associated with the mother's demographic characteristics, regardless of the level of risk—women who started care early were characteristically white, had 12 years or more of education, were married, used a private doctor, and were covered by private insurance; (3) rates of inadequate care for mothers enrolled in Medicaid were three to four times higher than rates for mothers with private insurance—yet among mothers at low risk, Medicaid rates of better than average care were higher than rates for the privately insured. *The Receipt of Prenatal Care Services across Different Medical Risks and Levels of Utilization: Evidence from the 1988 National Maternal and Infant Health Survey*, Report by Abt Associates Inc. for the Health Care Financing Administration, 1995.

¹¹R. J. Schmitz, *Payer Source and the Use of Prenatal Care: An Analysis of the 1988 National Maternal and Infant Health Survey*, Report by Abt Associates Inc. for the Health Care Financing Administration, 1995.

¹²For the case-control study, researchers drew a random sample from among all cases with adverse birth outcomes (e.g., low birthweight, neonatal or infant death). Controls were selected from a combined sample that included both those that did not have adverse birth out-

comes and those that did, but that did not make it into the case sample. Two controls were matched to each case, using the following criteria: woman's age, race, education, and place of residence.

¹³See R. F. Coulam, *The Expansion of Medicaid Eligibility for Pregnant Women in Missouri: Case Study*, Report by Abt Associates Inc. for the Health Care Financing Administration, 1995.

¹⁴Caution is necessary, because of the generally unadjusted estimates of incidence and frequency of prenatal care and birth outcomes, and because of possible selection bias. Similar findings have been reached by, e.g., P. A. Braveman, T. Bennet, C. Lewis, and others, "Access to Prenatal Care Following Major Medicaid Eligibility Expansions," *Journal of American Medicine* 266, no. 23: 3300-8.

¹⁵Information in this section is drawn from two main sources: Abt Associates, *Evaluation of the Medicaid Extension Demonstrations: Final Report*, Report by Abt Associates for the Health Care Financing Administration, 1995; and U.S. General Accounting Office, *Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children*, GAO/HEHS-96-35, Washington, D.C., January 1996.

¹⁶There were no provisions for determining the eligibility of children in public or private schools that had no free lunch program.

¹⁷Outreach efforts included public service advertising, much of which was donated. However, FHK also made effective use of existing school and community networks. For instance, when it became clear that teenagers and children of migrant workers were not joining the program at expected rates, FHK worked through high school coaches, shop teachers, churches, and migrant crew chiefs to reach parents of these children.

Access to IRP information via computer: the new World Wide Web site

IRP now has a World Wide Web site in addition to its existing gopher site. The Web site offers much easier access to Institute publications than does the gopher, which will eventually be phased out. The Institute site also includes the publications indexes already available on the gopher, information on IRP publications, and ordering information. It provides basic information about the Institute's staff, research interests, and activities such as working groups, conferences, workshops, and seminars. The Web site also includes an annotated list of affiliates, with their particular areas of expertise.

IRP staff are developing plans to create "virtual Green Books" of poverty-related data on the Web site; we are also creating an extensive set of links to poverty-related sites and data elsewhere.

Publications available on the Web site include files of formatted text of *Focus* articles, issues of *Insights*, and selected Discussion Papers and Special Reports in both unformatted (ASCII) versions and formatted (Adobe Acrobat or Postscript) files. From the Web site, charts and graphs are available for immediate viewing and for downloading and printing.

Future plans include the establishment of electronic (hypertext) links between the existing subject index and those IRP publications that are listed or reproduced in full on the Web site. The subject, author, and database indexes will be updated quarterly. The site will also include descriptions of recent books by affiliated faculty.

IRP's home page on the Web can be found at: <http://www.ssc.wisc.edu/irp/>. The gopher site can be found by running your gopher client with the hostname "eunice.ssc.wisc.edu" and selecting the item "IRP Gopher/"

Child support and children's well-being

Judith A. Seltzer and Daniel R. Meyer

Judith A. Seltzer is Professor of Sociology and Daniel R. Meyer is Assistant Professor of Social Work at the University of Wisconsin–Madison. Both are affiliates of IRP.

How do parents who live apart from their children divide the responsibility for taking care of them? What are the economic and noneconomic effects of these arrangements, particularly for the children? Judith A. Seltzer and Daniel R. Meyer review the current research on child support, custody, and visitation in a new report by the Wisconsin Family Impact Seminars.¹ Because the effects of child support are sometimes different for children than they are for either of their parents, and because children are the weakest party among those with competing interests when families come apart, children and their economic needs are the primary focus of the report. The emphasis on children's needs follows from a strong, substantive rationale. It also reflects a general lack of research on the effects of child support on fathers' lives, compared to research on child support and mothers' lives. IRP affiliates Irwin Garfinkel and Sarah McLanahan are working with Seltzer and Meyer to address this gap. To generate new research on fathers' economic and family circumstances, they hosted a conference at Princeton University in September 1995, on "The Effects of Child Support Enforcement on Nonresident Fathers," with funding from the Ford, Russell Sage, and Annie E. Casey foundations. Findings from the conference will be published by Russell Sage and will be summarized in a future issue of *Focus*.

The statistics are by now unpleasantly familiar. Over the past 30 years, the percentage of children who live in single-parent households has approximately tripled. Over one-quarter of children live in a household maintained by one parent—almost all of them because their parents have divorced or separated, or because the children were born outside of marriage. Further, demographic estimates suggest that about half of children born today will spend time in a single-parent household; these children are about evenly split between those who will do so because of separation or divorce and those whose parents were unmarried.²

As recently as fifty years ago, most children in single-parent families had lost a parent to death.³ As a result, programs to help single mothers were originally designed to help widows. Most children today who live in single-parent households have another parent living

elsewhere who may be able to help pay for their living expenses. Recognition of this reality has fueled the drive for reform of the child support system.

The legal basis of child support policy: The Family Support Act of 1988

The Family Support Act, among the most recent in a series of federal laws passed over the last 20 years to strengthen child support enforcement, has two major purposes:

1. To improve the system for administering private child support transfers between parents to help support their children;
2. To establish work programs and work provisions for parents who participate in Aid to Families with Dependent Children.

The report by Seltzer and Meyer focuses on the first of these goals: the reforms that address private responsibilities.

Child support reforms aim to make child support orders—the legal obligation to pay child support—more universal, more equitable, and more strictly enforced.⁴ Because family law governing marriage, divorce, and nonmarital childbearing is made and administered primarily by the states, many requirements in the federal act encourage states to change their administration of child support.

The act has three major provisions regarding child support orders:

1. States must strengthen paternity establishment for children born outside of marriage.
2. States must establish presumptive guidelines for child support orders.
3. Cases that go through the Office of Child Support Enforcement (OCSE) must be reviewed every three years, so that child support orders may be adjusted to reflect changes in families' circumstances.

The act also provided that child support payments be withheld from the nonresident parent's earnings, in the same way that income tax is. This requirement went into effect for cases in OCSE in 1990, and for all new cases in 1994.

Children's living arrangements

Where children live and who lives with them indicate the physical setting and material resources to which children have access. The U.S. Census shows that the vast majority of children (87 percent) who live with a single parent live with their mother.⁵ Most research reflects this by focusing on children who live with their mother.⁶ Census data do not provide direct information about the complexity of children's living arrangements after divorce. Even in California, which has more liberal laws than many other states, a recent study found that primary physical custody of children was assigned to the mother in about two out of three families; only one out of six families in the study had children living in both parents' households (dual residence). Recent evidence from Wisconsin, however, suggests that the number of children who spend significant amounts of time in both parents' households may be rising rapidly.⁷ Evidence from California shows that children who start out with their fathers or in dual residence are somewhat more likely to move in the first few years after the divorce.⁸ Children who relocate more often have more adjustment problems and problems in school.⁹

After their parents separate, about half of children in single-mother families acquire a stepfather through remarriage or cohabitation within five years.¹⁰ The non-economic effects of remarriage vary considerably, but acquiring a stepparent boosts the economic resources available to children. Yet compared to biological or adoptive fathers who live with their children, stepfathers are less socially and emotionally engaged. Nor does simply acquiring a stepparent lessen the chance that a child will drop out of school or become a teen parent, although a good relationship with a stepparent does appear to enhance a child's emotional, social, and academic achievement.¹¹

About a fifth of children who have lived in a single-parent household also spend time living in a grandparent's home with their mother. This is more common for children born out of wedlock than children of divorce.¹²

Contact between nonresident parents and children

When parents separate, many children lose the companionship and emotional support of one of their parents. About 40 percent of nonresident fathers see their children not at all, or only once a year. The longer fathers and children have lived apart, the less involved fathers are. Fathers of children born outside marriage are twice as likely to lose touch with their children as divorced

fathers. Yet among fathers who see their children at least once a week—and about a quarter of all nonresident fathers do—there is little difference between divorced and unmarried fathers.¹³ From the children's point of view, the relationship with their nonresident parent may be viewed as close even where there is little contact.¹⁴

National survey data show no evidence of an association between the amount of time that nonresident parents spend with children and children's well-being.¹⁵ However, the effects on children of the amount of contact they have with their nonresident father depend on how much conflict their parents have with each other. When conflict is high, contact is associated with behavior problems. When conflict is low or controlled so that children are not exposed to it, they appear to benefit from contact with the nonresident father.¹⁶

Legal parenthood

Joint legal custody

At least until very recently, legal and physical custody coincided. In 1987–1988, only about 11 percent of all resident mothers nationwide shared joint legal custody with the children's father.¹⁷ The percentage appears to be rising rapidly: since the late 1980s, both parents have shared joint legal custody in over two-thirds of Wisconsin divorces.¹⁸ One rationale for joint custody is to make children's lives after divorce as similar as possible to the lives of children who live with both parents. In fact, nonresident fathers who have joint legal custody spend more time with their children and may be more likely to comply with child support orders, although the evidence on compliance is mixed. Families with joint legal custody are less likely to return to court for disputes about child support than are families with sole legal custody; they are more likely to return for disputes about access to the children. Overall, however, regardless of the legal custody arrangement, there are more disputes about child support than about access.¹⁹

Parents with higher incomes and education are more likely to acquire joint legal custody. Their greater resources may explain, in part, their greater involvement with their children after separation. Social researchers have also commonly expected that men who took an active role in taking care of children before a divorce would be likely to do so afterwards, but the evidence on this has been inconsistent. Active fathers' involvement may be higher in the short term, soon after the divorce; but as time passes and fathers acquire new relationships or relocate, they may become less involved with their children. This topic is an area of continued research as better data become available.

Paternity

For children born outside of marriage, rates of legal paternity establishment have historically been low, and the mechanisms that states and counties use to determine a child's legal father have varied widely. The 1988 act emphasized more uniform state establishment of paternity as part of the reform of child support procedures. Yet little is known about the effects of legal paternity on children's well-being. Economically, legal paternity increases children's access to child support and to their biological father's health insurance and social security benefits. It may increase contact between the nonresident father and the child. But more rigorous attempts to establish legal paternity may also increase conflict between parents who would otherwise avoid one another, offsetting some of the economic benefits to children.

Economic disadvantages of children who live apart from a parent

Children who live with single mothers are five times more likely to be poor than children who live with both parents.²⁰ When fathers leave the household, family income declines by about one-third—and parents who separate or divorce have lower incomes, even before separation, than do parents who stay together.²¹ Children born to unmarried parents suffer even more severe economic disadvantages. In 1993, about 66 percent of children who lived with never-married mothers were below the poverty line, compared to 38 percent of children who lived with divorced mothers.²² Poverty rates for single-parent families have remained stubbornly high and remarkably stable (Figure 1). These economic differences explain some, but not all, of the educational disadvantages of children in single-parent households.²³ Economic insecurity also creates stress and anxiety, affecting both child-rearing practices and the relationship between parent and child.²⁴

Economic resources and children's needs

Children who live with single mothers rely primarily on their mothers' earnings for economic support. Compared to married fathers, single mothers earn considerably less. They have more child care responsibilities, less training and education, and greater disadvantages in the labor market. For mothers who have not remarried, average annual income is about \$18,000 (1993 dollars). The largest share, about 61 percent, comes from earnings. Child support provides about 7 percent, AFDC another 9 percent. Other income, including help from grandparents or other income transfers, provides about

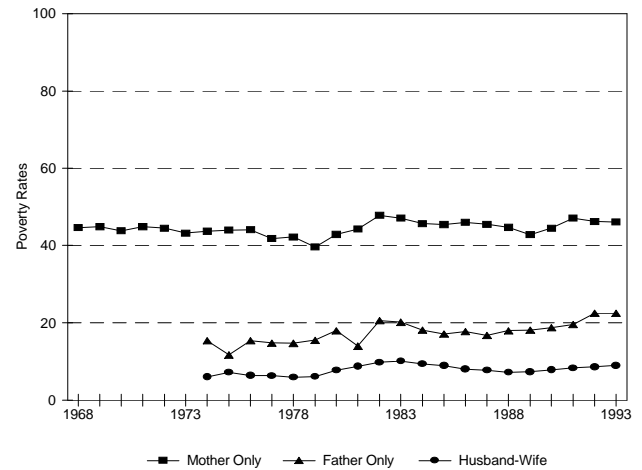


Figure 1. Poverty among families with children, 1968–1993.

Source: U.S. Bureau of the Census, 1995, *Income, Poverty, and Valuation of Noncash Benefits, 1993*, Current Population Report Series P-60, no. 188 (Washington, D.C.: U.S. Government Printing Office).

21.5 percent.²⁵ These lower earnings are not offset by child support payments or public transfers such as AFDC. For remarried mothers, in contrast, family income averages over \$45,000 (1993 dollars).²⁶ Over 75 percent of that is classified as “other income”—usually the husband's earnings. The mother's own earnings provide almost 22 percent, child support less than 2 percent, and AFDC less than half a percent.

Nonresident fathers' contributions

Formal child support. In 1992, 10 million women were eligible for child support—that is, they had a child whose father was living elsewhere. About half of these mothers were legally due child support. Only about half of these got all of the support owed them; one-quarter received nothing. The average yearly payment for those who did get support was \$3,000; for poor families it was notably lower, about \$2,000.²⁷

Do informal payments help? Information from the 1987–88 National Survey of Families and Households shows that about 80 percent of mothers without a formal child support order receive no informal support. Of the remainder, about half receive at least \$80 a month (\$960 a year). These informal transfers are no trivial amount for mothers without formal orders, whose average annual family income in 1987 was about \$9,200.²⁸ Although informal payments are important for some families, they do not compensate for low levels of formal child support payments. Fathers who already pay formal child support are also more likely to make informal transfers than are fathers who do not pay support.²⁹ Efforts to increase formal orders have clear potential for improving children's economic well-being.

Who pays support? Economic and noneconomic factors affect whether fathers pay support. Employment, income, and education obviously affect payments and compliance with support orders. For example, only about one-fifth of divorced fathers in Wisconsin with annual incomes below \$10,000 paid their full child support order, compared to two-thirds of those with incomes over \$30,000. The size of the order affects compliance: Wisconsin data show that fathers of nonmarital children who owe more than 20 percent of their income and divorced fathers who owe more than 35 percent of their income have lower compliance rates.³⁰ Fathers who live apart from their children enjoy fewer of the benefits of being a father and have little ability to monitor how child support payments are spent; for both reasons, they may be reluctant payers. The longer parents are separated, the less child support fathers pay, and the less likely they are to pay any support at all. Finally, when payment is withheld from fathers' earnings, compliance with child support orders is higher.³¹ This circumstance motivated the withholding provisions in the Family Support Act of 1988.

Divorced mothers are more likely to have child support orders than mothers who have never been married. When there is an order, Wisconsin data show that divorced fathers are twice as likely to pay support as fathers of children born out of marriage. However, much of this difference is due to the lower incomes of nonmarital fathers.³²

Fathers who have more contact with their children pay more support. Contact and child support payment may be causally related. Or perhaps both visiting and paying support are explained by some other characteristic of the family, such as the father's commitment to his children or how well the separated parents get along.³³ Even though child support and visitation go together in practice, these matters are often handled separately in family law.

Child support and reductions in poverty

Child support payments by themselves remove only one out of 20 single-mother families from poverty. Payments do fill about 8 percent of the "poverty gap" (the distance between the income of a poor family and the official poverty line).³⁴ There are several possible explanations for this meager result. Many single-mother families have no child support order, and others have one that is lower than what could be paid. Another reason is that many of the policy changes mandated by the Family Support Act still affect only a small portion of the child support caseload. Perhaps, too, the types of families in the child support system are changing, so that the caseload is increasingly made up of cases in which support is difficult to collect. Most importantly, child support will never be enough to lift many single-

mother families out of poverty, because the fathers associated with many low-income mothers are poor themselves.³⁵

Can fathers afford to pay child support?

The economic status of nonresident fathers varies greatly. National data from 1986 show that between 15 and 25 percent have annual incomes below \$5,000, but 40–50 percent have incomes above \$20,000, and 10–15 percent incomes above \$40,000.³⁶ Unmarried fathers have lower incomes than divorced fathers. For example, in Wisconsin those unmarried fathers for whom paternity is established average about \$10,000, compared to over \$20,000 for divorced men (1988 dollars). But over time, income grows substantially, especially for the unmarried fathers. Wisconsin statistics show a \$3,500 median increase (1988 dollars) in fathers' incomes in the three years after paternity is established. One consistent finding, therefore, is that, while there is a great deal of diversity in the economic situations of fathers, most nonresident fathers can afford to pay more child support than they are currently paying.³⁷

Does it matter for children who provides for their economic needs?

A growing number of studies show a positive association between the amount of child support that nonresident fathers pay and their children's behavior and school achievement. A dollar of child support, in other words, has a greater effect on outcomes for children than does a dollar from other sources, such as earnings or AFDC. Child support may have a symbolic value for children, indicating their father's concern and reinforcing the beneficial effects of the greater amount of time that fathers who pay support spend with their children. In addition, fathers who pay support more regularly may get along better with their children's mother. The absence of conflict may explain the better adjustment of children whose fathers pay support. Child support has a positive effect on children's well-being, even when differences in visiting and conflict are controlled statistically. This preliminary evidence suggests that more universal and rigorous child support enforcement may enhance the well-being of children whose parents divorce. However children born outside of marriage may not experience a net benefit, according to one study.³⁸

Efforts to anticipate the effects on children of child support reforms, such as increased paternity establishment and rigorous enforcement of child support orders, must consider that the reforms may push separated families into closer contact. In particular, the reforms encourage contact between parents who, under other circumstances, would avoid each other because they do not get along. Conflict between parents harms children. However, children who are protected from their parents' hostile relationship are better adjusted than those who are drawn into their parents' disagreements.³⁹ The ef-

fects on children of the reforms in the Family Support Act and subsequent legislation will depend heavily on how parents manage their conflict.

Child support policy and children's future

Federal and state reforms are trying to strengthen men's ties to their children: their legal and social rights to access and custody, and their financial ties through more effective establishment and enforcement of child support orders. Yet many nonresident parents may need help in learning how to manage their child-rearing responsibilities, and poverty among children will persist even in a system of perfect child support enforcement. The welfare of children requires that government continue to play a role in this private arena. Unresolved questions are: What role should it play, and how should it play that role? One answer to this conundrum has been given by researchers at IRP and elsewhere: implement a child support assurance policy. Two variants of such a policy, one currently under way in the state of New York and one designed for the state of Minnesota, are described in the next article. ■

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Postdoctoral Position Available

The School of Social Work at the University of Michigan has established a Research and Development Center on Poverty, Risk, and Mental Health. The Center is seeking applicants for one-year and two-year postdoctoral Research Associate positions. Associates will attend seminars, have the opportunity to collaborate with Center Faculty, and conduct their own research. Applicants should send a curriculum vitae and letter of inquiry describing their research interests to the Center at 540 E. Liberty, Ann Arbor, MI 48104. Deadline for the 1997-1998 year is January 10, 1997.

Developing a child support assurance program: New York and Minnesota

Confronted with high and persistent rates of child poverty, states now urgently need policies that can mount an effective response. The federal government—long the primary policy maker and banker for welfare programs—is considering waiving much of its responsibility for policy in favor of state governments and will almost certainly reduce its financial contributions to state programs. Under these circumstances, income support programs are likely to move in different directions and to undergo modification or even replacement. Among the possibilities is one for which early results seem quite promising: child support assurance.

The idea of child support assurance was first actively propounded by Irwin Garfinkel and colleagues at IRP and elsewhere in the late 1970s. Child support assurance is, in essence, a publicly guaranteed minimum child support payment. In any month in which the child support paid by a noncustodial parent is less than the assured level, a public subsidy will be paid to families with current child support orders. Originally, child support assurance was viewed as a nonwelfare alternative to AFDC, though not necessarily a substitute for it. At present it offers intriguing potential rather than solid evidence of success, for it has been investigated or implemented in only a handful of states. New York and Virginia have active projects; Wisconsin, Iowa, and most recently Minnesota have designed, but not yet implemented, a child support assurance program. California, New Jersey, and Connecticut are considering one. The New York program is the only one for which we have even preliminary evidence. This article reports upon that evidence and upon the proposed Minnesota program, which was designed by IRP researchers Daniel Meyer, Thomas Kaplan, and Thomas Corbett, with IRP affiliate Irwin Garfinkel.

What are the possible advantages of a child support assurance program, especially when compared with welfare programs such as AFDC?

1. *It provides support to some economically vulnerable children in single-parent families.* Each month, child support assurance will provide assistance to families who have very low child support orders because the noncustodial parent has low earnings. If the family's order is larger than the public guarantee, child support assurance will provide economic support in months in which the noncustodial parent is unable or unwilling to

pay child support. Thus the assured benefit may enable families with low earnings ability or low child support entitlements to escape poverty. And by guaranteeing that income will not fluctuate wildly from month to month, it may provide greater economic security to children living with only one parent.

2. *Some single-parent families are not poor but are at risk of becoming poor, through illness or unexpected events such as job layoff or housing problems. If child support assurance is available to custodial-parent families without regard to the income of the custodial parent—that is, if it is not income-tested, or is only lightly income-tested—it can provide enough economic support to keep the family's income above the poverty line.* It represents a step toward dismantling a welfare approach to providing economic help to children, for it supplements earnings and avoids much of the stigma attached to programs targeted to the poor.

3. *If child support assurance is available only to those with court orders, it provides an incentive for the custodial parent to establish paternity and seek an order.*

4. *Child support assurance is an effective means of reinvesting the savings from increased child support collections in poor custodial-parent families who have child support orders.* Currently, much of the increased child support collected by states for poor children goes to offset AFDC costs; AFDC families do not get the entire amount paid on their behalf by the father. In effect, such a policy takes money from poor absent fathers to reduce the burden on middle- and upper-income taxpayers.

A publicly guaranteed minimal child support benefit is, however, open to some legitimate criticisms.

1. It may encourage family breakup and/or discourage family formation. The larger the guaranteed payment, the greater the financial advantage to marital separation or feigned separation.

2. It may reduce the incentive for noncustodial parents, particularly low-income parents, to pay child support.

Note that these two criticisms are also criticisms of the AFDC program: AFDC may encourage family breakup and discourages noncustodial parents from paying child support in that the bulk of the payments goes to offset AFDC costs rather than being transferred to the chil-

dren. The extent to which these incentives result in problems for an assured benefit is unknown, and only a careful evaluation of a pilot program will tell.

3. If child support assurance benefits are not income-tested, recipients will include a small number of those with higher incomes. Offsetting this disadvantage, however, is the elimination of the strong work disincentives created by benefits targeted only upon low-income recipients.

4. It will expand the role of government. However, the government already has a substantial role in child support, particularly in establishing paternity, setting child support orders, mandating that child support amounts be withheld from income, and collecting and disbursing child support. An assured benefit is not a large expansion in the type of activity required by the government.

How, in practice, might child assurance work? Below, two different approaches are discussed, one for which eligibility was limited to the AFDC-eligible, the other for which it was not.

New York State: The Child Assistance Program (CAP)

The Child Assistance Program was implemented in October 1988 in seven New York counties, and has since been extended to an additional seven counties, including one in New York City.¹ CAP is a voluntary, income-tested program that was developed by the New York State Department of Social Services specifically as an alternative to AFDC. It is the only child assurance program that has so far been studied in any detail. In three of the original seven counties, eligible families were assigned randomly to treatment groups and allowed, though not required, to participate in CAP. In the remaining four counties (“saturation counties”), and in all the counties added later, enrollment was open to 90 percent of all eligible AFDC families (a 10 percent control group was held out).

Although resembling AFDC in its means-testing, CAP was structured so as to overcome the obstacles to long-term self-sufficiency perceived in AFDC. Earnings disregards were much more generous and there were no limits on the resources that participating families could accumulate (AFDC has a \$1,000 limit). CAP participants were expected to manage their own household budgets: food stamp benefits were paid in cash; child care stipends were paid in advance; and vendor payments—e.g., for shelter and energy bills—were eliminated. CAP’s administrative structure was also designed to provide support for a transition to independence; for instance, CAP managers’ caseloads were barely one-third the size of AFDC caseloads, to allow managers time to provide individual assistance to families. Thus

in some ways CAP closely resembled a traditional welfare-to-work program.

Employment was not a prerequisite, but the basic CAP benefit was about two-thirds the size of the AFDC grant.² This, together with the generous earnings disregards, was intended to encourage participants either to begin working or to increase their existing earnings. CAP offered participants substantial help in establishing or upgrading child support orders, although it did not offer help in collecting monthly payments. Early assessments by the New York Department of Social Services found that requiring a custodial parent to obtain a support order for at least one child limited participation. A positive effect of CAP was that families who entered the treatment group secured more child support orders: there was about a 25 percent increase in the chance that a family would obtain support orders for all children lacking them. Disappointingly, the increase in support orders did not lead to a statistically significant increase in support payments.

Approximately 10 percent of the eligible treatment group members in the experimental counties participated in CAP.³ Over the first two years, participants earned \$37 more per month, on average, than did members of the control group, and they worked about 25 percent more hours (about five additional hours per month). These gains equal or surpass gains documented with employment and training programs, the most widely tested approach of the past decade. CAP also helped some families achieve incomes substantially above the poverty level: families in the treatment group were 18 percent more likely than those in the control group to have incomes exceeding 125 percent of the poverty line.

The net result of all CAP’s costs and benefits for the first two years was an average income gain of \$36 a month to families in the treatment group. This income gain was the result of average increases in family earnings of \$41, in child support of \$3, and an average reduction of \$8 a month per family in government benefits. The program appeared to have no statistically significant effect, either positive or negative, upon families’ receipt of public assistance; thus its long-term effects on self-sufficiency cannot yet be determined. Evaluators found substantial differences across the experimental counties both in the way CAP was implemented and in its impact, suggesting that problems in implementation may have contributed to the modest findings reported thus far. Cost-benefit analysis found a small net savings to government, about \$2 per month per family in the treatment group. This is a promising result, as welfare-to-work programs more commonly have generated net costs to government in their initial years. A five-year followup analysis, currently nearing completion, will determine whether more substantial savings emerge over time.

Minnesota: Design for a universal child support assurance system

The Minnesota budget act of 1994 required the Commissioner of Human Services to report to the legislature on the planning and design of a child support assurance program. The Institute for Research on Poverty was selected to assist the Department of Human Services in this endeavor. The report was issued in January 1995.⁴

From the beginning, Minnesota officials took a different path from that followed by the New York Child Assistance Program. Weighing the relative advantages of efficiently targeting benefits upon an already identified set of poor families against the belief that AFDC both encourages and perpetuates dependency, they chose not to limit eligibility for the program to AFDC recipients. They did, however, impose one important limitation: The program would be available only to custodial parents with a current child support order, even if for a token amount. The AFDC program, in contrast, requires only “cooperation” in establishing paternity and securing orders. Experience has shown that AFDC requirements can easily slip into no enforceable requirement at all.

Minnesota child support policy analysts and IRP researchers established the following general goals for the Minnesota program. The program should: (1) assure a “reasonable and reliable” level of child support; (2) encourage custodial parents to obtain current child support orders; (3) encourage work among single-parent families; (4) encourage (or at least not discourage) child support payments by noncustodial parents. They did not seek to create a program that would provide an income floor to low-income families or a replacement for welfare, believing that AFDC already accomplished this goal.

Assuring a “reasonable and reliable” level of support

Three possible benefit levels for one child were suggested:

Plan 1. The median child support order level among families with one child in Minnesota (\$200/month),

Plan 2. The amount of child support that would be ordered for a man earning the median income (in 1990, the median income of a Minnesota male age 15 or over with income was \$20,913, according to the U.S. Census Bureau; with standard deductions, this translates into an order of about \$300/month),

Plan 3. The estimated cost of raising children in Minnesota (\$389/month for one child).⁵

For families with more than one child, researchers recommended that the benefit increase by the same percentage currently used in the Minnesota guidelines for

private child support: that is, the benefit for two children should be 120 percent of the one-child benefit; for three children, 140 percent; for four or more children, 156 percent. They did so believing that the guidelines are reasonable, that they may reflect a consensus among Minnesota policy makers, and that clear connections with other child support policies would strengthen the assured benefit.

Researchers recommended evaluating two kinds of benefits in a pilot program: a flat guarantee (the type of guarantee envisioned in the original proposals from the late 1970s) and a benefit that rewarded payments. Under the flat guarantee, the custodial parent would receive either the amount paid by the other parent or, if it fell short, the guaranteed amount. This is both easy to understand and simple to administer. However, the flat guarantee used in New York did not increase child support collections, perhaps because some noncustodial parents lowered their payments since their children would be covered anyway. Thus a benefit that varied with the amount paid might increase the incentive to pay more child support. Under such a benefit, for every dollar of child support paid beyond a minimum guaranteed level, the amount of public support might decrease by less than a dollar, in a structure similar to that of the successful Earned Income Tax Credit. A variable benefit does, however, have disadvantages. For costs between the two benefit structures to be comparable, a variable benefit must be lower than a flat guarantee. Family income will be less predictable, and the benefit is complicated to administer and to explain.⁶

Researchers recommended that benefits not be means-tested (as noted earlier, state officials agreed), and that they remain constant as earnings rose but be considered as taxable income. Taxing benefits reduces the cost of the program without harming poor parents, who are already exempted from income taxes, and further differentiates the assured child benefit from welfare.

Modeling consequences and costs

No comparable program has been implemented anywhere in the country. Thus IRP researchers used adjusted data from the 1990 Census to estimate caseloads and costs. They established a representative sample of 6,183 Minnesota families who were either single-parent families with one child under 18 at home or husband-wife families with one stepchild under 18 at home and weighted them to represent the total number of Minnesota families demographically eligible for child support. In the final sample, 89 percent of the custodial parents are mothers. Reflecting the racial composition of Minnesota, 86 percent are non-Hispanic whites, 7 percent non-Hispanic blacks, 2 percent Hispanic, and 4 percent of other racial groups. The researchers estimated that the average amount of child support received by families with child support orders was \$152/month.

Table 1
Estimates for a Statewide Assured Benefit in Minnesota

	Plan 1: \$200	Plan 2: \$300	Plan 3: Cost of Children	Plan 4: \$167; 50% BRR ^a	Plan 5: \$250; 50% BRR
Recipients					
No. of families receiving the assured benefit	68,421	77,552	83,549	79,167	84,076
% of all custodial-parent families	42.3%	48.0%	51.7%	49.0%	52.0%
% recipients who are:					
Remarried custodial mothers	30.2%	30.9%	30.6%	30.9%	30.9%
Divorced custodial mothers	36.6%	37.2%	38.3%	37.4%	38.2%
Separated custodial mothers	9.2%	9.4%	9.4%	9.3%	9.2%
Never-married custodial mothers	16.0%	15.5%	15.1%	15.4%	15.2%
Custodial fathers	8.0%	7.1%	6.6%	6.9%	6.5%
Effects on Welfare, Income, and Poverty					
AFDC:					
Reduction in families receiving benefits	3.3%	6.9%	32.8%	3.1%	6.6%
Reduction in benefits paid	14.0%	24.0%	42.1%	14.5%	23.8%
Food Stamps:					
Reduction in families receiving benefits	0.8%	1.5%	7.0%	0.8%	1.6%
Reduction in benefits paid	1.6%	3.4%	21.4%	1.7%	3.3%
Effects on Poverty:					
Using net income					
Reduction in families in poverty ^b	4.4%	6.5%	27.1%	4.3%	6.3%
Reduction in poverty gap	5.3%	7.8%	29.2%	5.2%	7.5%
Estimated Annual Costs and Savings of a Statewide Assured Benefit (\$ million)					
Costs:					
Maximum public benefits	\$434.4	\$651.7	\$1,128.6	\$362.0	\$543.0
Subtracting \$ for families without orders	198.9	298.4	509.6	165.8	248.6
Subtracting \$ for families who receive more than AB amount	50.7	38.6	20.9	17.9	10.4
Subtracting \$ received among families receiving less than full AB amount	64.8	95.0	127.4	50.8	64.0
Gross Costs	\$120.0	\$219.7	\$470.6	\$127.5	\$220.0
Savings:					
State AFDC	16.8	28.7	50.3	17.3	28.4
Federal AFDC	20.2	34.6	60.6	20.9	34.2
Food stamps	1.3	2.9	18.3	1.4	2.8
State income taxes	3.4	6.7	15.5	3.6	6.8
Federal income taxes	11.6	21.9	48.8	12.5	21.9
State EITC	0.3	0.6	1.1	0.3	0.6
Federal EITC	2.1	3.8	7.5	2.3	3.9
Total savings	55.8	99.2	203.2	58.3	98.4
Net Costs	\$64.2	\$120.5	\$267.4	\$69.2	\$121.6

^aBenefit reduction rate.

^bCash value of food stamps and predicted child care subsidies are added to gross income, and payroll taxes, income taxes, and estimated child care expenditures are subtracted.

Table 1 summarizes the estimated effects and costs of implementing a statewide child assurance benefit, for five possible benefit plans. In all plans, the government pays the guarantee if nothing is paid privately. In Plans 1, 2, and 3 (see earlier), the government benefit decreases by a dollar for every dollar of private support paid (i.e., the benefit reduction rate [BRR] is 100 percent). In Plans 4 and 5, the government benefit decreases by 50 cents for every dollar of private support paid. Plan 4 (\$167) is comparable in cost to Plan 1, with

a lower guarantee and BRR. Similarly, Plan 5 (\$250) is comparable to Plan 2.⁷

From Table 1, it can be seen that each plan reduces welfare use and poverty among custodial-parent families and provides almost two-thirds of its benefits to poor and near-poor custodial-parent families. AFDC caseload declines range from 3.1 percent (Plan 4) to 32.8 percent (Plan 3); using net income, the numbers of families in poverty decline by 4.3 percent under Plan 4,

by 27.1 percent under Plan 3. Table 1 also shows large savings in AFDC outlays, and large gains in state and federal income taxes. All plans are, however, projected to incur net costs, which range from \$64.2 million (Plan 1) to \$267.4 million (Plan 3).⁸ Balancing costs and benefits, IRP researchers recommended that the state test both Plan 1 (\$200/month benefit for one child; 100 percent benefit reduction rate) and the comparable Plan 4 (\$167 month benefit for one child, 50 percent benefit reduction rate). These plans were less costly and affected fewer people, limiting the extent of any adverse consequences and making any midcourse corrections easier. They also recommended a thorough evaluation of the demonstration program before any statewide extensions were to be considered.

No action has yet been taken to implement the recommendations of the report. It remains unclear whether the Minnesota proposal will be implemented or will remain an intriguing, but untested possibility. ■

¹T. M. Perry, *Child Support Assurance: Pilots and Proposals* (Washington, D.C.: Center for Law and Social Policy, 1995); W. L. Hamilton, N. R. Burstein, M. Hargreaves, D. A. Moss, and M. Walker, *The New York State Child Assistance Program: Program Impacts, Costs, and Benefits* (Cambridge, MA: Abt Associates Inc., 1993).

²For a single parent with no earnings and two children, both with support orders, the monthly AFDC benefit in Monroe County was \$634, the CAP benefit was \$443 (if only one child had a support order, the CAP benefit dropped to \$350). For a single parent with two children, both with support orders, and monthly earnings of \$500, the

AFDC benefit was \$224, the CAP benefit \$393 (dropping to \$300 if only one child had a support order). In all cases the family would be eligible for food stamp benefits ranging from \$148 to \$253 a month depending on income.

³In three of the four “saturation” counties, participation ranged from 12 to 20 percent at the end of two years. In the fourth county, it was 4 percent. The rates are not strictly comparable to the rates for the experimental counties because of measurement differences.

⁴D. R. Meyer, T. Kaplan, T. Corbett, with I. Garfinkel, *Developing a Child Support Assurance Program for Minnesota*, IRP Special Report 66 (Madison, WI: Institute for Research on Poverty, University of Wisconsin–Madison, 1995).

⁵D. Betson, *Estimates of the Minimum Consumption Needs of Children* (Denver, CO: Policy Studies, Inc., 1994).

⁶The Minnesota Child Support Enforcement Division ultimately opted to test a variable benefit that guaranteed a custodial parent \$250 a month and reduced the amount of public support by 50 cents for every dollar of private child support paid.

⁷Amounts are for one child. As noted earlier, the increment for additional children is based on the percentages implicit in Minnesota’s child support guidelines. Some simplifications and limitations are inherent in the model. First, child support status must be estimated from national data, and if support orders and payments are higher in Minnesota, the model will underestimate the amount of child support collected and so overestimate costs. Second, tax and welfare program conditions used are from 1989 and do not reflect later changes. Third, the model used to estimate potential changes in labor supply employs many assumptions. Fourth, the assured benefit itself may cause other changes in addition to welfare use and labor supply, and these have not been considered.

⁸If award levels and collections are higher than estimated, or can be increased further, net costs will be lower than estimated.

Kinship foster care and children's welfare: The California experience

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The noisy public debate about the growth of single-parent families in the United States has deflected attention from the fact that a significant number of children are not living with *either* parent.¹ In 1992, according to U.S. Census Bureau figures, approximately 1.3 million children were living apart from their parents in their grandparents' or other relatives' homes.² In March 1991, over 9 percent of African-American families and 2 percent of Caucasian families were composed of children living with relatives who were not their own parents.³ Most of these arrangements were informal—decisions made within the confines of the extended family. This family structure is not new, and has occurred in many parts of the world.⁴ In particular, it is widely recognized that parenting by kin has historically been a survival strategy employed by many African-American families.⁵

If parenting of children by their grandparents and other kin has until recently been ignored, so too has the degree to which the child welfare system has turned to kin in the search for foster homes. Kinship care has traditionally been viewed as an alternative to the child welfare system; it is now also the fastest growing sector in out-of-home placement funded by the child welfare agencies themselves.⁶

Foster care and welfare

To set the growth of kinship foster care in context, we must look to the role of the federal government in supporting substitute care of abused and neglected children. In essence, federally supported foster care is a program whereby government takes over primary child-rearing responsibilities from poor parents on the assumption that it can and must do better. Federal assistance to help states pay for care of children placed away from their parents by a child welfare agency was first provided in 1961, under the old Aid to Dependent Children (ADC) program. The federal role grew from a recognition that some states were denying ADC payments to children when the agency determined that the child's home was

“unfit.” The 1961 regulations required that states either continue ADC payments while making efforts to improve conditions in the home or provide out-of-home care for the child. But the federal government would only contribute to the cost of placing the children if the family had been receiving ADC in the month preceding foster care placement. Later amendments made the program mandatory for the states; they also expanded eligibility to include children from families who were eligible for ADC when the children were removed, regardless of whether they were actually receiving ADC at the time. Children placed in foster care may remain there until age 18—or age 19, if they are near completion of a high school diploma. At that point, foster care funding ends.

How does foster care relate to poverty policy? Comparing the size of foster care relative to its “mother” program, Aid to Families with Dependent Children (AFDC), gives some perspective.⁷ The number of child recipients of AFDC increased by 29 percent over a recent seven-year period, from approximately seven million in 1985 to about nine million in 1992. Over the same period of time, the foster care population grew by 60 percent—twice the rate of AFDC growth—from around 276,000 in 1985 to about 442,000 in 1992.⁸ The relative growth in the federal costs of both programs provides an even more striking contrast. Federal expenditures on AFDC benefits and administration grew from \$7.76 billion in 1981 to \$13.79 billion in 1993. In contrast, federal expenditures for foster care maintenance payments and administration leapt from \$309 million to \$2.55 billion over the same period (see Figure 1). Thus in 1981 the ratio of federal AFDC costs to foster care costs was only 25:1; under current law, it may well decline to less than 4:1 by 1999.

It is much more expensive to supervise the care of children than to distribute AFDC checks, and the cost of enticing foster care providers to raise children greatly outweighs current payments to AFDC recipients. Per capita costs are very high: the federal government spent about \$975 for each child receiving AFDC in 1993, but \$10,945 per child on foster care maintenance and administration—over 11 times as much. Note that these foster care costs are for AFDC-eligible children only—about half of all children in foster care. Although there are no reliable national figures on the total cost (including state and local expenditures) of the foster care program, an American Public Welfare Association analysis of 31 state child welfare plans in 1990 found that states

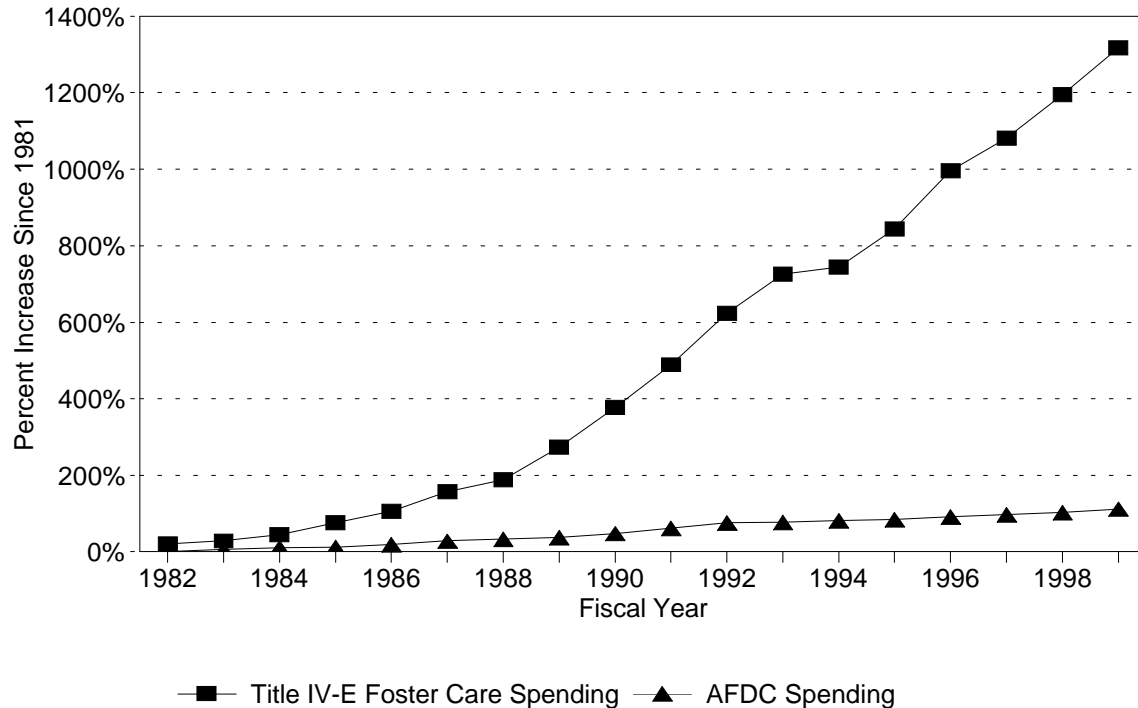


Figure 1. Percentage growth in federal spending on Title IV-E foster care and AFDC compared, fiscal years 1982–1999.

Source: U.S. House of Representatives, Committee on Ways and Means, *Overview of Entitlement Programs: 1994 Green Book* (Washington, D.C.: U.S. Government Printing Office, 1994).

Note: Figures for 1994 through 1999 are U.S. Department of Health and Human Services projections.

expected to provide 68.1 percent of foster care maintenance payments and 57.2 percent of the cost of administering foster care in that year.

The growth of kinship foster care

The growth in formal kinship care can be attributed to a number of factors. First, the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) calls for placement of children in the most family-like setting available, close to their birth families, and with extended family if possible. Many child welfare agencies have taken explicit steps to follow this policy mandate by making greater use of kin as foster parents. Second, as mentioned above, the number of children in out-of-home care has grown rapidly during the past several years. This increase has been linked to a number of factors, including substance abuse, poverty, HIV infection, and homelessness.⁹ By itself, the growth in the numbers of children in care puts pressure on existing placement resources and makes kinship care an attractive option. Third, the declining number of unrelated foster families has led many child welfare agencies to scramble for other placement resources.¹⁰ Last, the U.S.

Supreme Court decision in *Miller v. Youakim* (1979) provided a legal basis for federal reimbursement of foster care payments made by states and localities to kin, when a child being placed came from an AFDC-eligible family and the home of the kin met other state regulations (e.g., licensing standards) regarding foster homes.¹¹ In practice, at least 16 states now make foster care payments to kin regardless of the AFDC eligibility of children in kinship care.¹²

Since the adoption of P.L. 96-272, and especially during the recent period of rapid growth in foster care caseloads, a growing number of children in state legal custody have been placed in the care of relatives, particularly in urban communities. In the 29 states where we can identify kinship care placements, almost 80,000 children, or 31 percent of foster children in the legal custody of the states, were placed with relatives in 1991.¹³ Sixty-five percent of these placements were in New York, Illinois, and California. Between 1987 and 1989, the period of most rapid caseload growth in New York City and Cook County, Illinois, the number of children placed in kinship foster care increased by 63 percent in New York City and 24 percent in Cook County.¹⁴ Although some of the growth in the foster care

caseload is due to a shift from informal to formal kinship foster care, most of it appears to be due to rapid increases in the overall number of entries to foster care.¹⁵

A child in kinship foster care has been placed in state custody in response to substantiated charges of parental abuse and/or neglect. The child is placed with a relative, or an already existing informal placement with a relative is officially sanctioned. Whether or not the state pays foster care funds to the kinship caregiver, the permanency planning protections of P.L. 96-272, including court review of the appropriateness of placements, apply. Thus, though kinship care may not appear on the surface to be “out-of-home” care since children remain with family, the involvement of the public child welfare system in the lives of these children and their families makes this a qualitatively different arrangement from traditional informal caregiving by kin.

Kinship care in California

California has the largest substitute care population of any state, accounting for approximately 18 percent of the total U.S. substitute care population.¹⁶ It has also made increasing use of kinship care. In 1984, 17 percent of children in foster care in California were placed with kin, 65 percent in foster family homes, and 14 percent in congregate care settings. By 1994, 45 percent of California’s child welfare caseload were placed with kin, 39 percent were in foster family homes, 13 percent in group care facilities, and the remaining few percent in hospitals or shelters.

Studies of kinship care and other out-of-home care arrangements conducted in California using state administrative data shed light on some of the outcomes of kinship foster care.¹⁷

Family reunification

Even though children are considered to be “in the family” when placed in kinship care, the permanency plan for most of these children—the ultimate goal of the child welfare service—remains reunification with their biological parent(s). A sizable proportion of children leave the foster care system in California by this route, but there are clear differences: for example, 44.8 percent of children placed in kinship care during the first six months of 1988 had returned to their biological parents’ homes by the end of 1992, in contrast to the 54.2 percent of children who were reunited with parents after being initially placed in foster family homes.¹⁸ This difference appears to derive almost exclusively from the difference in rates over the first few months that the children were in care: during that period, children in kinship care were much less likely to return home than were children in non-kin foster care.¹⁹

Interestingly, even after controlling for a child’s race or ethnicity, gender, age, and family structure (single vs. two-parent families), children in kinship care who come from AFDC-eligible families are about 30 percent less likely to be reunited with their biological parents than are similarly placed children from better-off families.²⁰ This may well be due to the barriers that poverty poses to creating a safe home environment for children,²¹ particularly given that a parent’s access to public assistance is reduced or eliminated if the children are placed in foster care. Financial incentives to keep children in care may also play a role in the lower reunification rates for children in kinship care. Kin who provide foster care to AFDC-eligible children receive boarding rates which are higher than regular AFDC payments. Furthermore, foster care rates increase proportionally to the number of foster children in a family (e.g., two children generally draw twice as much reimbursement as one child), whereas AFDC rates grow only incrementally with each additional child. In many cases, family reunification means a net loss of income for the extended family of a child in kinship foster care.

Adoption

Surveys of kinship care providers have indicated that, for a number of reasons, the vast majority of kin are not interested in adopting the children in their care.²² Most notably, adoption requires the total termination of all parental rights and is culturally unacceptable to many kin. Yet until permanency planning philosophy changes to take into account the unique situation of children in long-term kinship foster care, adoption remains the ultimate agency goal for many children in kinship care.

In California, children placed with kin are much less likely than other children to be adopted. For example, among children placed in out-of-home care during the first half of 1988, 9.4 percent who were initially placed in foster family homes had been adopted by the end of 1992, whereas only 3.3 percent placed with kin had been adopted.²³ Multivariate analysis of placement outcomes has shown that initial placement with kin halves the odds of later adoption, even after controlling for age at entry to care, race/ethnicity, the AFDC eligibility of the child’s family, and preventive services provided to the family before the child was removed for placement elsewhere.²⁴

Finances may play a role in the lower likelihood of adoption for children placed with kin. AFDC eligibility of the child is associated with a one-third decrease in the odds of adoption for children placed with kin.²⁵ The kin of poor children are perhaps more likely than other kin to be poor themselves, thus increasing the financial burden of adoption. In fact, survey research has shown that kinship care providers are significantly poorer than providers of traditional foster family care, and express

the belief that they cannot afford to adopt.²⁶ Although Adoption Assistance Payments under Title IV-E of the Social Security Act may in some cases be available for kinship adoptions, many families may fear the potential financial loss involved in changing from formal foster care to adoption.

Placement stability

The number of changes in placement that a child undergoes while in foster care is an important measure of the “permanence” of the child’s circumstances. Social workers’ experience and child development research both suggest that the fewer the number of out-of-home placements, the better for the child’s long-term development.

For children who entered substitute care in California in 1988, and whose progress was followed through 1992, kinship care proved to be a relatively stable environment.²⁷ Among both “open” cases (i.e., those in which a child remained continuously in care through the end of 1992) and “closed” cases (i.e., those where a child had left care for one reason or another), children in kinship care moved around less than children placed in unrelated foster family homes. Among closed cases, children placed initially in foster family homes averaged 2.01 placements, compared to 1.45 placements for children first placed with relatives—this despite the fact that children placed with kin stay in care longer, on average, and therefore have a longer “exposure” to care than children placed in non-kin foster homes. Among open cases, children who were first placed in foster homes had averaged 2.98 placements by the end of 1992, those placed with kin only 1.85. Among closed cases, only about 22 percent of children placed with kin had more than one placement, whereas about 53 percent of children placed initially in foster family homes had experienced two or more placements and nearly 23 percent three or more. Most strikingly, even among cases that remained open for the entire 3–4-year study period, about 63 percent of children placed initially with kin remained with the same caretaker, and 80 percent had no more than two caretakers. In contrast, among children placed in foster homes, almost 79 percent of open cases had experienced at least two and 49 percent at least three placements by the end of four years.

Clearly, the longer stays in the foster care system that are associated with kin placement do not imply “foster care bounce”—greater placement instability. And even when children in kinship care move to a new placement, the majority remain within the extended family. Approximately 85 percent of children in the 1988 California group who were initially placed in kinship care remained with kin through at least four years or until they were discharged earlier.

Reentry to substitute care

Another measure of permanence is the stability of children’s living arrangements when they are returned to their family after a stay in foster care. In general, a high rate of reentry to foster care for children is a cause for concern. It is clear that children in kinship care in California have very stable placements while in care and stay in care longer than children in other settings. Do they remain out of the substitute care system once they leave?

A three-year analysis of children who had returned to their families in 1989 showed a striking difference in reentry rates, depending on how the child had been placed.²⁸ On the one hand, 22.2 percent of children discharged from foster homes and 24.3 percent of children discharged from group care facilities reentered care. On the other hand, only 13.2 percent of children discharged from kinship care had a second spell in foster care over the study period. The strong association between kinship placement and a lower hazard of reentry holds after controlling for the child’s age, race/ethnicity, health problems, AFDC eligibility, number of placements, and time in care before discharge. Interestingly, one of the strongest predictors of reentry to out-of-home care is the AFDC eligibility of a child’s family: children from AFDC-eligible families were about two-thirds more likely to reenter care than children from better-off families.²⁹

Kinship care and the child welfare system

Is there a need for explicit policies that address the placement of children within their extended families? Some may see the issue as moot. Why subject children to the potential trauma of placement with strangers when the extended family is an option? Given the emphasis on family preservation evident in permanency planning philosophy, the growth of kinship care might be seen as something that should have happened long ago. Indeed, past reluctance to use kin as a placement resource surely in part reflected an ambivalent attitude about the desirability, let alone feasibility, of preserving some families.

At the same time, the arrival of kinship care has not been greeted unanimously with cheers, and it does raise questions about the current permanency planning framework. Some recent critics have derided kinship care as a means for “unfit” kin to be financially supported in taking over child care from “unfit” parents and as a barrier to “permanence”—particularly adoption—for children removed from their birth families.³⁰ There are, after all, many unanswered questions about the quality of kinship care versus non-kin foster care.³¹

Is kinship care a positive contributor to the long-term well-being of children who are placed in such settings? This question can only be answered indirectly from California's administrative data, because information on "well-being" is not collected in such data systems. Furthermore, little is known about the process leading to the decision to place with kin as opposed to non-kin; unexamined differences between these populations may explain much of the difference in outcomes. Nevertheless, some of the indirect measures discussed above paint a relatively bright picture of the outcome for children who enter kinship foster care; they should be taken into account in discussions of the future of the child welfare system.

If one assumes that long-term foster care placement with kin is an appropriate "permanent" arrangement, then at least in California it is associated with a very high likelihood of permanence. Four years after placement, about 83 percent of all children originally placed in kinship care in California in 1988 had experienced a positive outcome: discharge to a parent, kin, or guardian; adoption; or long-term placement with kin. If long-term foster care by kin is not seen as a desirable goal, then such placement is a poor predictor of favorable, long-term, permanent outcomes: four years later, only about 55 percent of children placed in kinship care were discharged to family or to a guardian or were adopted.

These outcomes for children in the care of kin provide an interesting contrast to those children who spent the bulk of their time in foster family care or some form of congregate care. Only about two-thirds of these children reached some kind of permanent placement after four years, taking into account their higher rates of reentry to foster care and the greater instability of placement they experienced. Even this number assumes that long-term foster care or congregate care placement are acceptable forms of permanence. In California, only about 56 percent of the children placed in non-kin foster homes were successfully discharged to family or a guardian (i.e., left care and did not return) or were adopted within four years.

If the public and child welfare policy makers are content that a large proportion of children receiving state supervision and financial support are being placed indefinitely with relatives—that state-supported kinship care itself is an appropriate permanent living arrangement—then kinship care appears to be an ideal permanent placement option. If kinship care is intended to be a waystation to other more traditional child welfare options for permanent placement—discharge from the system to families, guardians, or adoptive parents—then the overall stability of kinship care may be a cause for concern.

Kinship care and welfare reform

It appears very likely that significant changes will be made in the near future in federal funding and regulation of public assistance and child welfare programs, and that there will be a significant devolution of control from the federal to state and local governments. But the specifics of these reforms are far from settled, and it is likely to be some time after federal legislation is signed into law before the consequences of reform become at all clear. Interstate variation between programs will also, inevitably, complicate outcomes. Whatever happens, the central role now played by kinship care in the out-of-home care system has implications for welfare reform.

Cutbacks in economic support for poor families may lead to an increase in child maltreatment, and a corresponding increase in demand for child welfare services, including substitute care.³² The vast majority of children in substitute care come from single-parent homes and about half come from AFDC-eligible families. Poverty is the strongest predictor of child neglect, and a strong predictor of other forms of child maltreatment.³³ Most children placed in foster care today are there because of neglect or parental incapacity (e.g., chronic substance abuse) rather than physical or sexual abuse. Thus, many of the families who are most likely to be unable or unwilling to find work or make use of education and training are, by and large, the types of families already at relatively high risk of neglecting or abusing their children. That risk is likely to grow if benefits to such families are eliminated, reduced, or time-limited, and work requirements are expanded but child care resources are not.

It remains unclear exactly how much the demand for out-of-home care will increase in the wake of welfare reform, but it is likely that at least some of that demand will be met by increased use of kinship care. The phenomena that have led states and localities to turn to kinship care over the past several years will not go away. The primary alternative to kinship care, given the continuing difficulty in recruiting foster parents, is congregate care—an expensive option in an era of fiscal restraint. In fact, some state welfare reform plans call for the development of kinship care programs to provide homes for children displaced by program changes.³⁴

Present interstate variation in the use of kinship care will contribute to the effects of state welfare reforms. Current kinship care funding arrangements create the probability that welfare reform may lead to confusion and fiscal shell games at the state level. Some states make significant use of both federal foster care funds and AFDC funds to support kinship foster care, through

payments to non-legally-responsible relatives (NLRR payments). Other states rely almost exclusively on NLRR payments to fund kinship care. In effect, they have been financing a large part of their foster care system using AFDC funds. Still others appear to discourage the use of kin, though every state makes some use of this placement resource. Depending on the nature of public assistance and child welfare funding in the future, some states may gain funding whereas others will almost certainly lose. For example, states that make high use of kinship care supported by NLRR payments may be hard-pressed to continue doing so if AFDC is converted to block grants to the states. Yet these states may end up with a relatively larger proportion of the AFDC block grant than states that made little use of NLRR payments to support kinship care. If federal foster care funding is left uncapped—a likely scenario—then states with large NLRR foster care caseloads may simply figure out a way to shift kinship care funding from AFDC to the federal foster care funding stream, thus realizing a significant windfall.

Eligibility restrictions imposed by federal or state governments could complicate efforts by child welfare officials to use kinship care. For example, current federal law calls for the reimbursement of costs associated with out-of-home care for AFDC-eligible children, including those in kinship foster care. If the federal foster care program remains an uncapped entitlement, how will eligibility be determined when the AFDC program no longer exists? States now often rely on information from public assistance administrative data systems to establish whether a child is eligible for federal reimbursement of foster care costs. Determining eligibility for public assistance could be very different under a block grant, and state data systems may become largely obsolete. Will federal reimbursement be available for kinship care of children whose parents might no longer be eligible for public assistance (e.g., children born to teen mothers)?

Other questions arise about the impact of changes in federal law on the conditions under which kin may provide state-supported care; will they, for instance, affect the supply of kinship care? Will kin be able to participate in so-called workfare programs and provide kinship foster care at the same time? Will Medicaid be available to kinship care providers if a Medicaid block grant is created or states are otherwise given increased flexibility in providing medical services to the poor?

Kinship foster care has come to play a central role in out-of-home care in recent years and is likely to continue to do so. The available evidence suggests that it provides a relatively stable form of placement for abused and neglected children who have been removed from the care of their parents. Still, little is known about its long-term effect on child well-being. One may also

question the consequences of a policy by which the state pays considerably more for kinship care of poor children than it pays to support poor parents in caring for their own children.

Our ignorance about kinship care poses problems for efforts to reform public assistance and child welfare programs. Existing kinship care policies and utilization patterns complicate attempts to predict the consequences of program changes. Conversely, welfare and child welfare reform will affect out-of-home care, including kinship care, in ways that are difficult to anticipate. As legislators and policy makers seek to implement reform at the state level, it will be imperative for them to deal explicitly with the role of kinship care under the new social contract, and to soundly evaluate the consequences of their decisions. ■

¹Parts of this article were adapted from M. E. Courtney, "The Foster Care Crisis," IRP Discussion Paper no. 1048-94, and M. E. Courtney and B. Needell, "Outcomes of Kinship Foster Care: Lessons from California," in *Child Welfare Research Review*, Vol. 2, ed. R. P. Barth, J. D. Berrick, and N. Gilbert (New York: Columbia University Press, in press).

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²⁶Barth et al., "A Comparison of Kinship Homes and Foster Family Homes."

²⁷Courtney and Needell, "Outcomes of Kinship Care."

²⁸Courtney, "Reentry to Foster Care."

²⁹Courtney, "Reentry to Foster Care."

³⁰R. Kramer, "Adoption in Black and White," *Wall Street Journal*, October 24, 1994; J. B. Sheindlin, "Paying Grandmas to Keep Kids in Limbo," *New York Times*, August 29, 1994.

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Reducing unemployment is the most urgent economic issue for Germany. The connection between unemployment and social costs is a spiral into fiscal calamity: social welfare payments increase business costs, leading to unemployment, and unemployment requires increased contributions to let the social fund bear the costs of joblessness. — *Frankfurter Allgemeine Zeitung*, January 2, 1996

Corporate Germany has been producing a drumbeat of layoffs, downsizings, bankruptcies, and the flight of jobs abroad. . . . Taken together they are producing the grimmest employment prospects in Europe's largest economy since the end of World War II. . . . Nearly four million people—the Government figure is 3.965 million—were unemployed in February, the highest in the postwar period. — *The New York Times*, March 7, 1996

Poverty and social policy in unified Germany

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The Berlin wall fell on November 9, 1989. Almost exactly one year later, the former German Democratic Republic (GDR, or East Germany) ceased to exist, having joined the Federal Republic of Germany (FRG, or West Germany). The integration of two German states with contrasting economic and social systems is a unique historical experiment. Five years after unification, that integration has only just begun; it will be more complicated and time-consuming than most Germans had expected. In these unprecedented circumstances, the task of social policy is not only to protect citizens against economic and social risks but also to develop a strategy for the “inner integration” of the new nation.

In this essay I outline some aspects of poverty and social policy in Germany after unification, including (1) economic and social change, especially in the eastern states; (2) the definition and measurement of poverty in Germany and its extent in western Germany for the last decade and in the newly unified Germany; (3) the reaction of the German welfare state to the challenges of unification, and the potential consequences of that reaction for poverty and public welfare in Germany.

Structural change in the unification process

The new Germany is one state with two societies that differ greatly in living conditions and social structures. In the first phase of unification, the labor market became deeply polarized. In west Germany, production and employment rapidly increased because of the exploding east German demand for its products. People in the west profited from unification through additional jobs and rising income, although that situation changed

after the worldwide economic recession reached Germany in 1992. In the east German transition to a capitalist market economy, the eastern production and employment system broke down. For east Germans, the risk and the reality of job and income losses increased dramatically. Economic potential in the two parts of the new Germany is growing further apart, rather than drawing closer. A primary reason is the political decision, made as unification began, to bring the eastern standard of living close to the western standard within a short period of time. Labor unions and employers' associations based their wage negotiations on this policy; thus wages have risen faster than labor productivity in the east.¹

Economic disruption made it essential that there be a flow of financial transfers from the west to the east, either as a wage subsidy to enable firms to compete in national or international markets, or as unemployment relief, early retirement benefits, or welfare benefits for the newly unemployed. Because the federal government did not adopt the wage-subsidy alternative, there was a net loss of more than one-third of all jobs in east Germany, and the number of employed declined from about 9.8 million in 1989 to 6.3 million in 1994. At the same time, the number of officially unemployed people in the east increased from zero to “only” 1.1 million people (in 1994, the unemployment rate was 16 percent in the east, 9.2 percent in the west).

Not included in this official unemployment figure are the hidden unemployed in east Germany, where the federal government, for political reasons, tried to limit manifest unemployment by using all available instruments of labor market policy. By sending one-third of the unemployed into early retirement and another third into vocational and job-training programs, the federal government prevented an explosion of official unemployment and eased the social consequences of the collapse of the east German labor market. Yet never in German postwar history has the number of registered unemployed been as high as it is now. Nor have there ever been so many people—about 2 million—participating in labor market programs, ranging from training to subsidized early retirement.²

This policy has been of great value in maintaining an acceptable social climate in the eastern states. But these programs cannot by themselves produce fundamental change in labor market conditions. Whereas the conservative government rests its expectations upon the self-help potential of the market system, the parliamentary opposition (the Social Democrats and the Green Party) and the trade unions call for employment programs in the Keynesian tradition. At present, economic recovery has not yet begun in east Germany. And the longer that recovery takes, the greater the risk that the financial cost of public interventions in the labor market will become too high for the federal government.

These dramatic changes in the political and economic structure of east Germany have had decisive consequences for its social structure. The former GDR was characterized by a comparatively egalitarian society based on a quite modest standard of living, but the road to a capitalist economy leads to economic and social differentiation. West Germany, the model for east German development, is a society with a distinctly higher standard of living but much greater inequality in the distribution of economic resources, opportunities, and risks. There has been much public discussion about whether the living standards of the different social classes are becoming increasingly unequal in the former Federal Republic. Many people have not shared in the growing prosperity; their lives are characterized by low income, unemployment, lack of vocational training, and insufficient housing. In the future, these divisions within the Federal Republic will be complicated not only by a welfare gap between west and east but by increasing differentiation and inequality within the eastern states themselves.

Poverty in unified Germany

Scientific discussion of poverty did not begin in Germany until the mid-1970s; in contrast with advances in the United States over the last 30 years, it is still quite a new field of research.³ Nor has poverty become a main issue of social policy. No official definition of poverty exists, hence no official poverty line nor an official statistical measurement of poverty.

In academic discussion, poverty is usually defined as relative income poverty, based on two different poverty lines.⁴

1. First, relative income poverty is usually measured on the basis of a threshold that is 50 percent of the average (mean) disposable household equivalence income. The equivalence scale, which also underlies the structure of current subsistence benefits (*Hilfe zum Lebensunterhalt*) that are available for the different members of a household under the German Social Assistance Act (*Bundessozialhilfegesetz*) of 1961 assigns the first adult over 18

a value of 1.0 and all other adults, 0.8; a child younger than 8 years is valued at 0.5 (0.55 in a single-parent household), a child 8–14 years old, 0.65, and a youth 15–17 years old, 0.9.

2. The second measure is based on the level of public subsistence benefits paid to people without income or with insufficient income and assets. The number of people in poverty is thus defined by national public welfare statistics for the “provided-for poor” (*bekämpfte Armut*). These data supply no information about those whose incomes are below the subsistence-benefit level but who are not registered recipients—the hidden poor (*verdeckte Armut*).

There is a broad consensus that use of this second poverty line is hardly acceptable, because under it the extent of poverty is largely determined by political decisions. When benefit levels or income levels that qualify people for benefits are reduced, the number of poor appears to be declining; when it is raised, the number of poor automatically increases. This measure of poverty is used mainly because comprehensive income data are not readily available in Germany. There are no annual income statistics to provide up-to-date income data at a personal or household level. The only database available for analysis of annual income is the Socio-Economic Panel, a continuing panel survey conducted by the German Economic Research Institute, a private research institute in Berlin. This rather small panel was not designed for poverty research; people and households with very low and very high incomes are not adequately represented and it does not include the homeless, people in institutions, and certain groups of immigrants.

Relative income poverty (the first measure) declined slightly in west Germany from 1984 to 1992, dropping from 12.6 to 9.9 percent.⁵ Despite the relative stability of these numbers, there was considerable fluctuation within the poor population. The majority of those who were poor remained so for only a short period: 17.8 percent were poor for one or two years only, 13.6 percent were poor for three years or more, but only 2.4 percent were poor for eight or nine years. Nearly 70 percent of west Germans never experienced income poverty at all in that nine-year period. But 30 percent were poor in at least one year, showing that this extreme degree of income risk was not limited to the permanently marginalized. And the risk of long-term or permanent poverty is higher among those who have experienced poverty at least once.⁶

How should one measure poverty in a country undergoing such transitions?

1. If Germany is regarded as a politically unified country that consists of two economically and socially separated regions, poverty can be measured on the basis of a

Table 1
Income Poverty Rates in Germany, 1990–1992^a

Threshold	1990	1991	1992
Commonly Calculated			
East	21.1	16.2	14.8
West	7.3	7.3	7.5
All Germany	10.2	9.3	9.1
Separately Calculated			
East	3.3	4.3	5.8
West	10.3	9.7	9.9

Source: German Economic Research Institute, Socio-Economic Panel; author's computations.

^aPercentage of total population, using as poverty line 50 percent of average disposable household equivalence income.

poverty line that is calculated separately for the west and the east. By this criterion, the poverty rate in west Germany is declining somewhat, from 10.3 percent in 1990 to 9.9 percent in 1992. But east Germany shows a dramatic increase in the percentage of poor: the poverty rate nearly doubled in two years, from 3.3 percent in 1990 to 5.8 percent in 1992 (a rate still only half that of west Germany).

2. If Germany is considered as a unified country with a poverty line based on all households, east and west, the level of poverty in west Germany is stable (between 7.3 and 7.5 percent) whereas the level in the east is much higher but is, at the same time, substantially declining (from 21.1 percent in 1990 to 14.8 percent in 1992). (See Table 1.)

The development of income poverty in east Germany is, under the first measure, primarily determined by rising inequality in the east German income distribution; under the second measure, that rising inequality is more than offset by the reduction in the income gap between west and east Germany. Even if use of two different measurements is somewhat confusing, nevertheless they clarify different aspects of poverty in a Germany in transition to one integrated nation.

Poor families in both east and west are predominantly single-person and single-parent households. Children under 16 have the highest poverty rate, nearly twice that of adults: using the commonly calculated poverty threshold, every fifth child in east Germany was living in a poor household in 1992 (Table 2). Above all, children in single-parent households and in families with more than two children are at high risk of poverty. Table 3 shows the instability of the poverty population and the high degree of mobility into and out of poverty in west and especially in east Germany. These results are the same whether east and west are measured against a common poverty threshold or treated as separate income regions with separately calculated poverty lines.

Table 2
Income Poverty Rates in Germany, on the Basis of a Common Threshold, 1990–1992^a

Year	East	West	Germany
Adults (16 and older)			
1990	20.3	6.7	9.5
1991	14.5	6.2	8.0
1992	12.7	6.5	7.8
Children			
1990	23.9	10.1	13.5
1991	22.4	12.0	14.6
1992	21.9	11.8	14.2
All			
1990	21.1	7.3	10.2
1991	16.2	7.3	9.3
1992	14.8	7.5	9.1

Source: German Economic Research Institute, Socio-Economic Panel; author's computations.

^aPercentage of total population, using as poverty line 50 percent of average disposable household equivalence income.

Although the percentage of people in poverty, using the 50 percent threshold, declined slightly over the 1970s and 1980s, the numbers of people receiving public subsistence benefits rose dramatically, from 749,000 in 1970 to 3,405,000 in 1993, 4.5 times higher. The increase in the 1980s was greater than in the 1970s.⁷ It is not clear why the two indicators present such different pictures of income poverty. The relative level of subsistence benefits has not changed, nor is there any sign that the hidden poor, those who were entitled but had not applied, have suddenly become benefit recipients. One answer may be the inadequacy of the Socio-Economic Panel in capturing the lowest income groups.

The West German Social Assistance Act of 1961 was introduced into east Germany in mid-1990; the number of recipients has sharply increased, from 364,000 in 1991 to 545,000 in 1993—a figure that confirms the increase in income poverty shown in Table 2. Even if

Table 3
Dynamics of Income Poverty^a in East and West Germany
(% of total population)

1990 → 1992	West	East
Not poor → Not poor	87.9	73.7
Not poor → Poor	4.5	8.2
Poor → Not poor	3.8	11.9
Poor → Poor	3.8	6.1

Source: German Economic Research Institute, Socio-Economic Panel.
^aUsing the official poverty line of the Commission of the European Union, 50 percent of average disposable household equivalence income.

the number of recipients, considered as a percentage of the total population, is still considerably lower in the east than it is in the west, it is only a matter of time until the poverty rate in the east reaches the level in the west. In the east even more than in the west, unemployment has become the main reason for welfare dependency. And recipients of subsistence benefits, like the poverty population as defined by the 50 percent level, include above-average proportions of households with children.

Social policy after unification: The German welfare state on probation

Theoretically, unification was an opportunity for fundamental reform of the welfare state in the “new” Germany. It opened up the possibility of creating a new, integrated system of social services and social benefits, combining the positive features of both systems. Economic and political pressures did not permit this to happen: in the unification treaties it was established that the welfare state of the FRG should be exported to the former GDR. The underlying assumption was that the West German system was well adapted to a capitalist market economy, whereas the social system of the GDR was discredited by the collapse of *real existierende Sozialismus* (“socialism in practice”). Discussions of the weaknesses and structural defects of the West German welfare state did not enter into this decision.

As a result, the level of services provided to residents of the former GDR improved in many but not in all social sectors. Some negative consequences have occurred. For example, parents lost guaranteed preschool or kindergarten places for their children; the disabled lost a guaranteed minimum income and assured integration into the employment system. Many social supports and services in the former GDR had been linked to the workplace and were organized by enterprise. With the introduction of a market economy and the consequent pressure upon enterprises to become profitable, facilities such as workplace nurseries, kindergartens, and medical outpatient clinics were dropped. Lacking fiscal resources, experience, and qualified staff, local authorities have had great difficulty in building new and improved infrastructures.

In addition to wage income policy and labor market policy, the introduction of the west German social insurance and income maintenance system has been the third factor determining current living conditions in east Germany. An unemployment insurance program—not necessary in the former GDR, where employment was guaranteed by the state—had to be created, and the existing social insurance schemes had to be reconstructed on new principles. The west German social security system is centered on the core institutions of the employment contract and the family; one must be a wage earner, or a dependent of a wage earner, to have access to social

insurance benefits. In this system, the preservation of status differentials is central, and rights and entitlements are related to class and professional status. As a consequence, a very complex set of social insurance schemes has developed in the areas of health care (since 1995), accident, unemployment, and retirement, financed through contributions evenly shared between employers and employees in proportion to earnings. The system guarantees the maintenance of relative status, so that benefit levels are tied to wage levels. Thus, the social security system declares that labor based on a standard employment relationship (*Normalarbeitsverhältnis*) is a prerequisite of a respectable and dignified social existence.

It is questionable whether this insurance system is appropriate to address the particular risks arising from structural change in the former GDR. East German wages are still relatively low, and so are unemployment benefits and pensions calculated on the basis of those wages. Nor is the whole population protected by the work-centered west German insurance system. In particular, new entrants into the workforce or women returning to work after raising their children normally receive no unemployment benefits. Moreover, the switch from unemployment pay to unemployment support, which usually occurs after twelve months, involves means testing. Most married women, therefore, do not receive support because family income is above the minimum by virtue of the husband’s employment. Last but not least, this system has no integrated minimum income scheme, so that poverty cannot always be avoided by wage earners at the bottom of the income hierarchy.

In addition to the social insurance system and other income maintenance benefits, public welfare under the Federal Social Assistance Act of 1961 is the lowest safety net in the German social security system. Its main purpose is to guarantee every citizen a minimum level of subsistence—to serve as a safety net that not only provides economic support but also maintains the social and cultural integration of the recipient into the community. Public welfare is a universal entitlement of citizenship (except that students and certain groups of foreign refugees draw upon other benefit systems). The prerequisites for entitlement include absence of income and/or assets and of family members responsible for and able to support the recipient. Recipients must demonstrate readiness to provide for themselves and their families by their own efforts (especially through work); it must be clear that unemployment is truly involuntary.

Public welfare provides two kinds of allowances: special one-time benefits and a subsistence benefit for all people in need.⁸ The standard rate is periodically reset to accord with growth in the real national standard of living and is annually adjusted by each state according to its cost-of-living index. Amounts for the one-time payments are established and adjusted by the local au-

thorities. Public welfare is financed by tax revenues. The fiscal burden of public welfare is borne primarily by the local communities, who pay about 80 percent of the total; state governments pay the remainder. This “net below the net” has been heavily criticized for many years, because its level is very low and the conditions of receipt too stringent to eliminate poverty.⁹

In the former GDR, a social assistance scheme did not exist; it had to be constructed from the ground up. Because this process was expected to take a long time, a special minimum income scheme, an income supplement (*Sozialzuschlag*), was established for recipients of unemployment benefits and pensions. The income supplement ended in 1995 for those receiving unemployment insurance; for new recipients of old age pensions it ended in 1993, and for those already receiving pensions it will end in 1996. At present, the majority of east German households depend upon social benefits to maintain their standard of living. The social expenditure ratio in east Germany consequently stands at 70 percent of gross national product, compared to 30 percent in west Germany. Because only a small part of public expenditures can be defrayed by taxes and social insurance contributions in the east, a constant flow of transfers from the west has been necessary to close the gap between production and spending and to finance these compensatory payments. Since 1990, these transfers have amounted to about DM 150 billion (net) annually.

Labor market and social policy interventions had great importance in limiting the expansion of income poverty in east Germany in the first years after unification, and living standards in east Germany are still extremely dependent upon them. Yet precisely because of this integration strategy, social policy is rapidly being overloaded. Economic recovery that would reduce the necessity of income transfers or job creation programs has barely begun, while the German welfare state is confronting ever greater economic and political limitations.

Beginning in 1992, the federal government curbed the expansion of public debt by increasing taxes and reducing social benefits. But instead of even-handedly distributing the economic and fiscal burden of the costs of unification, the government has favored a strategy that has placed the main burden upon wage earners and benefit recipients. Enterprise profits and self-employment earnings are to a large extent exempted from additional taxes, because they are regarded as necessary for international competitiveness and continued growth rates in a capitalist economy. In the first phase, through 1992, the German parliament increased taxes and social insurance contributions. In the second phase (1993 on), fiscal priorities shifted toward cuts in the social security system that were justified not only as fiscally necessary but also as a first step to a more fundamental reconstruction of the German welfare state. Compounding the absence of labor market opportunities and the long-

standing deficiencies in the social insurance and income maintenance system, the reduction in social insurance benefits since 1993 has increased the need for subsistence benefits. For many years this lowest safety net played only a marginal role in the German social security system and in social and political discussion. In the last decade, however, and especially since unification, it has become increasingly important; the number of people dependent upon public welfare is rising dramatically and spending in this sector of public finance has exploded.¹⁰ This development prompted the federal government, in 1995, to propose a welfare reform bill in which the level of subsistence benefits was reduced and the conditions of entitlement were made more restrictive. The intent was to provide relief for local government budgets and to put pressure on welfare recipients. There is no doubt that the increasing difficulties of public welfare are above all produced by structural change—economic, social, and political. And there is no evidence that welfare abuse has increased. Nevertheless, the rising number of recipients is primarily interpreted by the federal government as indicating insufficient motivation to work and lack of interest in self-sufficiency. Thus the reform was legitimated by arguments about recipients’ behavior. Its main goals are:

1. To reduce the relative level of subsistence benefits by limiting annual adjustments at least until 1999.
2. To introduce a legally fixed gap between lower wages and subsistence benefits; this is also intended to limit the growth of the benefit level.
3. To strengthen the obligation requiring unemployed welfare recipients to take any kind of work, whether or not conditions are less favorable than in their former occupations, or to attend job training and job creation programs.

Current welfare reform in Germany cannot be compared with the welfare revolution in the United States because it is still conceived as a reform within the existing welfare system.¹¹ Yet this reform bill could be a first step to more fundamental changes in public welfare and could lead to a redesign of the lowest safety net to accord with neoliberal demands. Instead of providing a socially acceptable minimum income, its primary function would be to strengthen work incentives and to support the development of a low-wage employment sector.¹² Because public welfare has always been an important element of the German welfare state, such a transformation could be interpreted as at least a partial erosion of the welfare state. In contrast are a broad range of proposals emphasizing the social protection function of public welfare. They urge, first, that subsistence benefits be transformed into a more standardized national minimum income with an adequate, need-oriented benefit level and, secondly, that a minimum in-

come scheme should be integrated into the existing social insurance systems to reduce the pressure on the lowest safety net.¹³

There is fear that increasing social problems following unification could erode social and political stability in Germany, if policy cannot compensate for economic marginalization and social exclusion. The economic and social consequences of unification have become a far-reaching challenge to the German welfare state. The coming years will show whether that state can be maintained after unification. ■

¹For contributions to the controversial discussions of the unification strategy, see, e.g., Rudolf Hickel and Jan Prieue, *Nach dem Fehlstart: Ökonomische Perspektiven der Deutschen Einigung* [After the False Start: Economic Perspectives on German Unification] (Frankfurt: S. Fischer Verlag, 1994); Gerlinde Sinn and Hans-Werner Sinn, *Kaltstart: Volkswirtschaftliche Aspekte der Deutschen Vereinigung* [Cold Start: Political and Economic Aspects of German Reunification] (Tübingen: Mohr Verlag, 1991).

²*Amtliche Nachrichten der Bundesanstalt für Arbeit, Arbeitsmarkt 1994* [Official Reports of the Federal Bureau of Labor, Labor Market 1994], Special Issue, Nürnberg, 1995.

³See Richard Hauser and Udo Neuman, "Armut in der Bundesrepublik Deutschland: Die sozialwissenschaftliche Thematisierung nach dem zweiten Weltkrieg [Poverty in the Federal Republic of Germany: Social Scientific Discussion since World War II]," in *Armut in Modernen Wohlfahrtsstaat* [Poverty in the Modern Welfare State], ed. Stephan Leibfried and Wolfgang Voges (Opladen: Westdeutscher Verlag, 1992).

⁴See, e.g., Richard Hauser, Helga Cremer-Schefer, and Udo Nouvertne, *Armut, Niedrigeinkommen und Unterversorgung in der Bundesrepublik Deutschland: Bestandsaufnahme und Sozialpolitische Perspektiven* [Poverty, Low Income, and Lack of Provision in the Federal Republic of Germany: Inventory and Sociopolitical Perspectives] (Frankfurt and New York: Campus Verlag, 1981); Richard Hauser, "Armut in Wohlfahrtsstaat [Poverty in the Welfare State]," in *Das Sozialsystem in der Bundesrepublik Deutschland: Bilanz und Perspektiven* [The Social System in the Federal Republic of Germany: Outcomes and Perspectives], Beiträge aus der Arbeitsmarkt- und Berufsforschung (Nürnberg, 1984); Diether Döring, Walter Hanesch, and Ernst-Ulrich Huster, eds., *Armut in Wohlstand* [Poverty amid Wealth] (Frankfurt: Suhrkamp Verlag, 1990).

⁵Using the official poverty line of the Commission of the European Union (50 percent of average disposable household equivalence income), percentages of the population in poverty were: 1984:12.6; 1985 and 1986, 11.9; 1987, 10.7; 1988, 11.0; 1989 and 1990, 10.3; 1991, 9.7; and 1992, 9.9. The data presented in this article are cited from Walter Hanesch et al., *Armut in Deutschland* [Poverty in Germany] (Reinbek bei Hamburg: Rohwohlt Verlag, 1994)

⁶Studies of the dynamic aspects of income poverty in Germany include: Roland Borntson and Ulrich Rendtel, *Zur Stabilität von Einkommensarmut in Längsschnitt* [The Stability of Income Poverty in Longitudinal Analysis] and Roland Habich, Bruce Heady, and Peter Krause, "Armut im Reichum: Ist die Bundesrepublik eine Zweidrittel Gesellschaft? [Poverty in the State: Is the Federal Republic a Two-Thirds Company?]" both in *Zur Einkommensdynamik in Deutschland seit 1984* [Income Dynamics in Germany since 1984], ed. Ulrich Rendtel and Gerd Wagner (Frankfurt and New York: Campus Verlag, 1991); Richard Hauser and Roland Berntsen, "Einkommensarmut—Determinanten von Aufstiegen und Abstiegen [Income Poverty—Determinants of Entry and Exit]," in *Herausforderungen an den Wohlfahrtsstaat im strukturellen Wandel* [Challenges to the Welfare

State in Structural Difficulties], ed. Reinhard Hujer and Hilmar Schneider (Frankfurt, 1992); Stefan Leibfried and Lutz Leisering, eds., *Zeit der Armut: Lebensläufe im Sozialstaat* [Time of Poverty: Life Careers in the Welfare State] (Frankfurt: Suhrkamp, 1992); Michael M. Zwick, ed., *Einmal arm, immer arm? Neue Befunde zur Armut in Deutschland* [Once Poor, Always Poor? New Findings on Poverty in Germany] (Frankfurt and New York: Campus Verlag, 1994).

⁷Data are from the Statistisches Bundesamt [National Bureau of Statistics], *Statistik der Sozialhilfe, Teil II, Nachweis der Empfänger von Sozialhilfe* [Welfare Statistics, Part II, Verification of Welfare Recipients], Fachserie 13, Reihe 2 (Wiesbaden, 1995); Walter Hanesch, *Reform der Sozialhilfe: Eine kritische Würdigung des Gesetzesentwurfs der Bundesregierung zur Reform der Sozialhilferechts* [Reform of Welfare: A Critical Appreciation of the Federal Government's Bill for the Reform of the Social Welfare Law] (Düsseldorf: Grauer Reine der Hans Böckler Stiftung, 1996). The volume of hidden poverty, at least in west Germany, is estimated to be in the same range, so that the total number below this poverty threshold should be about 7 million people. See, e.g., Richard Hauser and Werner Hübing, *Arme unter uns, Teil 1: Ergebnisse und Konsequenzen der Caritas-Armutsuntersuchung* [The Poor Below Us, Part 1: Outcomes and Consequences of the Caritas Poverty Investigation] (Freiburg: Lambertus, 1993).

⁸The subsistence benefit includes a standard rate for expenses for food, clothing, and everyday personal needs (its amount depends on the size and composition of the household); actual costs for accommodation and heating allowances; supplementary benefits for particular groups with special needs; and one-time payments for particular, legally defined noncurrent expenses (winter overcoats, house repairs, furniture, special needs at Christmas, weddings, births, etc.).

⁹See, e.g., Klaus-Jürgen Bieback and Gunther Stahlmann, "Existenzminimum und Grundgesetz [Minimum Income and Constitutional Act]," *Sozialer Fortschritt* 36, no. 1–2 (1987); Johannes Minder, ed., *Zukunft der Sozialhilfe* [Future Perspectives on Public Welfare] (Münster: Votum Verlag, 1988); Arbeitsgruppe BSHG-Reform, *Vorschläge zur Fortentwicklung des Sozialhilferechts* [Proposals for the Improvement of the Public Welfare Law] (Baden Baden: Nomos Verlag, 1991).

¹⁰For a further discussion of the reconstruction of the welfare state in Germany and its impact on poverty see, e.g., Walter Hanesch, ed., *Sozialpolitische Strategien gegen Armut* [Sociopolitical Strategies against Poverty] (Opladen: Westdeutscher Verlag, 1995)

¹¹See, e.g., Hanesch, *Reform der Sozialhilfe*; Stephan Leibfried and Michael Wiseman, "Sozialhilfereform in den USA: Ein Überblick - Zu Nutzen und Frommen der Deutschen [Welfare Reform in the United States: An Overview—for German Use and Contemplation]," *Zeitschrift für Sozialreform*, 7 (1995).

¹²See, e.g., Albert Seffen, "Zur Kritik an der Sozialhilfe in der alten Bundesrepublik [A Critical Review of Public Welfare in the Old Federal Republic of Germany]," *Beiträge zur Wirtschafts- und Sozialpolitik* 195 (1992); Horst Siebert, *Geht den Deutschen die Arbeit aus?* [Are the Germans Running Out of Work?] (München: Bertelsman Verlag, 1994).

¹³See, e.g., Hauser, *Armut in Wohlfahrtsstaat*; Michael Opielka and Margerita Zander, eds., *Freiheit von Armut* [Freedom from Poverty] (Essen: Klartext Verlag, 1988); Paritätischer Wohlfahrtsverband [German Nondenominational Welfare Association], "Bedarfsorientierte Grundsicherung [Need-oriented Basic Income]," *Blätter der Wohlfahrtspflege* 140, no. 7–8 (1993); Walter Hanesch, "Armut in Deutschland: Eine Herausforderung für die Sozialstaat [Poverty in Germany: A Challenge to the Welfare State]," *Nachrichtendienst des Deutschen Vereins* 2 (1995).

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