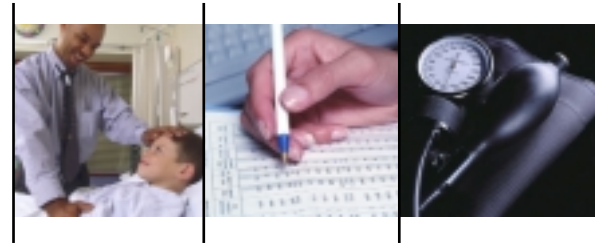


Issue Brief

Findings from HSC



RECENT TRENDS IN CHILDREN'S HEALTH INSURANCE COVERAGE:

No Gains for Low-Income Children

by Peter J. Cunningham
and Michael H. Park

The percentage of low-income children who have health insurance has not changed over the last few years, despite expansions in public coverage through Medicaid and the State Children's Health Insurance Program (SCHIP). Data from 1996-1997 and 1998-1999 from the Center for Studying Health System Change (HSC) find that while the proportion of low-income children with public coverage has increased, the percentage with private insurance coverage has decreased sharply, resulting in no net change in the percentage who are uninsured. This Issue Brief describes these recent changes in public and private coverage. Possible factors that may explain these changes are discussed, including increases in private insurance premiums, substitution of public for private coverage and changes in the characteristics of low-income persons. The study did not determine conclusively the causes of the changes in coverage.

Changes May Affect Children's Coverage

Recent policy changes are likely to have a substantial effect on the health insurance coverage of low-income children. Most prominent among these was the passage of SCHIP in 1997, designed primarily to reach low-income children living above the poverty level who were previously ineligible for Medicaid. At the same time, however, state and federal welfare reform efforts are believed to have led to a significant decline in the percentage of poor children covered by Medicaid. And these policy changes are occurring at a time when private insurance costs have started to increase,

which threatens to erode private insurance coverage further among low-income children.

The 1996-1997 and 1998-1999 Community Tracking Study (CTS) Household Surveys include the most up-to-date estimates of children's health insurance coverage and allow for an examination of children's coverage during a period of significant changes. In addition to continued welfare reform efforts and an increase in private insurance premiums, implementation of SCHIP began in 33 states between the first and second HSC surveys.

Documenting Changes in Coverage

Data from the 1996-1997 and 1998-1999 Household Surveys show gains in public coverage among low-income children and a substantial decline in private insurance coverage, resulting in no significant change in the uninsurance rate (see Figure 1).

For children in families with incomes below 200 percent of the federal poverty level, Medicaid and other state coverage increased from 29 percent to 33 percent between the first and second survey, while private

Data Sources

This Issue Brief presents findings from surveys that are part of HSC's Community Tracking Study. The Household Survey, conducted in 1996-1997 and in 1998-1999, is a nationally representative telephone survey of the civilian, noninstitutionalized population. Data were supplemented by in-person interviews of households without telephones to ensure proper representation. The 1996-1997 survey contains observations on nearly 33,000 families and 60,000 individuals, while the 1998-1999 survey includes about 32,000 families and 59,000 individuals. The overall response rate was 65 percent for families. Each survey includes data on about 10,000 children, defined as individuals younger than 18 years old.

Health insurance coverage was estimated based on the day of the interview. Coverage is defined in the following mutually exclusive categories: employer-sponsored coverage; other forms of private insurance; Medicaid and other state insurance programs, including SCHIP; other forms of public coverage, including Medicare, military coverage and the Indian Health Service; and uninsured.

Figure 1
Health Insurance Coverage of Children

INSURANCE TYPE	1996-1997	1998-1999
LESS THAN 200 PERCENT OF POVERTY		
PRIVATE INSURANCE	47%	42%*
EMPLOYER-SPONSORED	38	34*
OTHER PRIVATE ¹	9	7
MEDICAID AND OTHER STATE COVERAGE	29	33*
OTHER PUBLIC ²	5	6
UNINSURED	19	20
200 PERCENT OF POVERTY AND HIGHER		
PRIVATE INSURANCE	89%	89%
EMPLOYER-SPONSORED	80	81
OTHER PRIVATE ¹	9	8**
MEDICAID AND OTHER STATE COVERAGE	3	3
OTHER PUBLIC ²	3	3
UNINSURED	5	5

* Difference from 1996-1997 estimate is statistically significant at p<.05 level.

** Difference from 1996-1997 estimate is statistically significant at p<.10 level.

¹ Includes nongroup private insurance and private insurance obtained through someone outside of the household.

² Includes Medicare, CHAMPUS, Indian Health Service and any other unspecified coverage.

Source: Community Tracking Study Household Survey, 1996-1997 and 1998-1999

insurance coverage fell from 47 percent to 42 percent (see Figure 1A). Most of the decrease in private insurance coverage was the result of a decrease in employer-sponsored coverage among low-income children. In contrast, coverage for children in families with incomes of 200 percent of poverty and higher was virtually unchanged.

In addition, HSC data show that increases in public coverage and decreases in private coverage occurred largely in families whose children are the primary targets for SCHIP and other recent Medicaid expansions—those earning between 100 and 199 percent above the poverty line. For children below the poverty line, there was no change in public

coverage, and the decreases in private insurance coverage were smaller than those for low-income children above the poverty line.

Private insurance for the parents of low-income children also decreased between 1996-1997 and 1998-1999 (see Figure 2). However, because low-income parents have fewer alternatives for public coverage than children, their rates of uninsurance rose from 31 percent to 35 percent between the two surveys. Moreover, this erosion of private coverage was observed only for low-income parents with children. In fact, there were no changes in private or public coverage or uninsurance rates for low-income adults with no children.

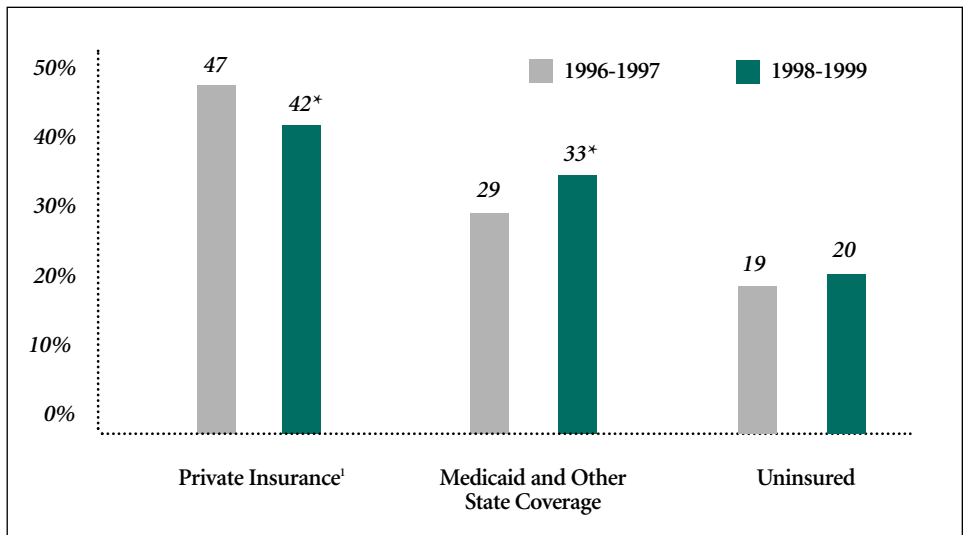
Declines in Offer and Take-Up Rates

The decline in employer-sponsored coverage among low-income children stems from two factors: fewer children with access to such coverage and fewer parents enrolling in, or taking up, that coverage when it is offered. The percent of all low-income children with access to employer-sponsored coverage (i.e., offered coverage through a parent's employer) decreased slightly between the two surveys, from 48 percent to 46 percent (see Figure 3). This resulted not from fewer low-income parents being in the workforce, but from fewer employed parents being offered coverage by their employer.

Even among children whose parents were offered coverage through an employer, fewer low-income children were being enrolled in that coverage and more were opting instead for Medicaid and other state coverage. Among low-income children whose parents were offered and eligible for employer-sponsored coverage, 72 percent were enrolled in that coverage in 1996-1997, compared with 66 percent in 1998-1999 (see Figure 4). Conversely, the proportion of low-income children with access to employer-sponsored coverage who were enrolled in Medicaid or other state coverage increased from 10 percent in 1996-1997 to 14 percent in 1998-1999. About 11 percent of children with access to employer-sponsored coverage went without any insurance, with that number holding steady across both time periods.

In addition, further analysis reveals that about two-thirds of the decrease in employer-sponsored coverage among low-income children is accounted for by fewer children being enrolled in coverage when it is offered to a parent, while one-third of the decrease is the result of fewer children with access to employer-sponsored coverage through a parent (see *Research Report Number 4* for details of this analysis).

Figure 1A
Changes in Coverage of Children (less than 200 percent of poverty)



* Difference from 1996-1997 estimate is statistically significant at $p < .05$ level.

¹ Includes employer-sponsored insurance, nongroup private insurance and private insurance obtained through someone outside of the household.

Source: *Community Tracking Study Household Survey, 1996-1997 and 1998-1999*

Factors Affecting Offer and Take-Up Rates

Changes in the relative number of low-income children who have access to and are enrolled in employer-sponsored coverage may be attributed to a number of factors, including labor market shifts, changes in other key sociodemographic characteristics or changes in the costs associated with coverage, among others.

Although the percentage of low-income children with employed parents held steady between the two surveys, fewer low-income children would have access to employer-sponsored coverage if there were a shift from large to small firms in the employment of low-income parents, since smaller firms are much less likely to offer coverage. Indeed, CTS data indicate that there was a decrease in the percentage of low-income children with parents employed in the public sector or in firms with 100 or more workers (from 62 percent to 58 percent), and an increase in the percentage with parents employed in firms with between

10 and 50 workers (from 14 percent to 18 percent). However, these changes in the size of the firm did not account for most of the decreases in offer and take-up rates among parents of low-income children.

The effects of welfare reform or strong economic growth may have shifted some children's income status and, consequently, their eligibility for public programs and access to private insurance. Similarly, rates of private and public health insurance coverage vary by race and age, and any changes in these factors between the two surveys could result in a change in coverage for all low-income children. However, only small changes in these factors were found between the two surveys.

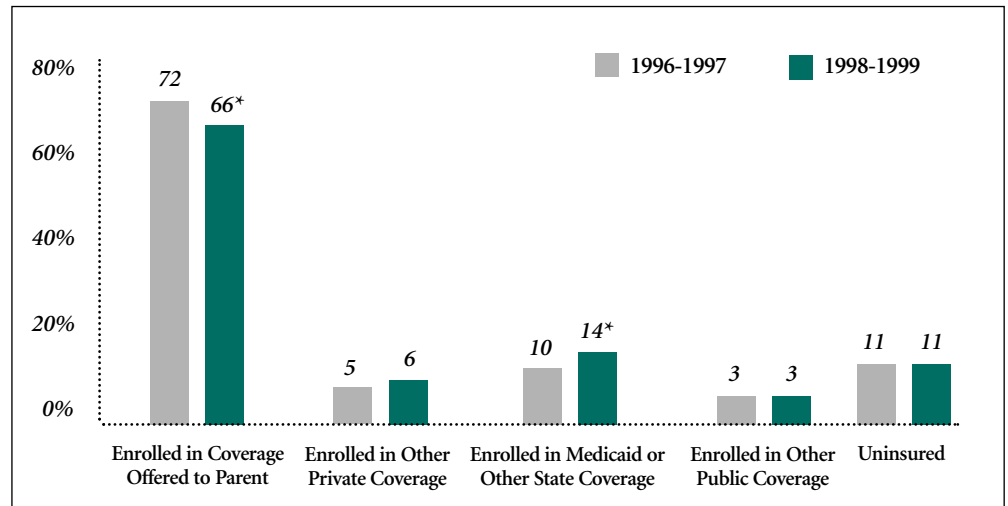
More important, further analysis revealed that the sizable changes in private and public coverage for low-income children would have occurred even if there had been no change in these sociodemographic characteristics.

Increases in health insurance costs may account, in part, for decreases in access to and enrollment in employer-sponsored



**The rate of
uninsurance
among low-
income parents
rose significantly,
from 31 percent
to 35 percent,
while it
remained virtually
unchanged for
low-income
adults without
children.**

Figure 4
Health Insurance Coverage of Low-Income Children with Access to Employer-Sponsored Coverage¹



* Difference from 1996-1997 estimate is statistically significant at $p < 0.05$ level.

¹ Sample includes low-income children (less than 200 percent of poverty) with at least one parent who is offered and eligible for employer-sponsored coverage.

Source: Community Tracking Study Household Survey, 1996-1997 and 1998-1999

This substitution can manifest itself in a number of different ways. Wider availability of public coverage may influence employers to drop coverage altogether, increase the employee share of the premium or change benefits in a way that makes the offered plans less attractive to workers. The presence of new public programs may also induce eligible, lower-income families to forgo costly private family coverage and opt for public coverage for their children. Finally, such programs may also influence some low-income workers to seek higher-paying jobs without health benefits, so they can trade private coverage for higher wages and the promise of subsidized or free public health insurance coverage for their children.

If there is greater substitution of public coverage for private—regardless of how it occurs—one might expect to see an increase between the two surveys in the percentage of low-income children switching from private to public coverage. However, an analysis of CTS data shows that of low-income children enrolled in Medicaid and other state coverage, only about 2 percent had switched into that coverage directly from private insurance at some time during the year prior to the

interview. More important, the rate of switching from private coverage to public did not change between the two surveys. In both surveys, almost all of the low-income children covered by Medicaid or other state coverage were either enrolled in that coverage for the entire year preceding the interview (85 percent), or they were uninsured immediately prior to enrolling in Medicaid or other state coverage (13 percent).

Still, movement from private coverage to public may be more complex and may play out over an extended period of time during which children may be uninsured for a brief period. This longer time frame may result, in part, because states are required by the SCHIP legislation to prevent or reduce the potential for substitution through such measures as mandatory waiting periods. On the other hand, because the time between SCHIP implementation and the survey interviews was generally less than a year, it is unlikely that substitution taking place over a more prolonged period would be reflected in these results. More lead time would be required, especially if substitution were to occur through changes in employer health plan offerings or by low-income parents

Figure 2
Health Insurance Coverage of Adults (age 21-64)

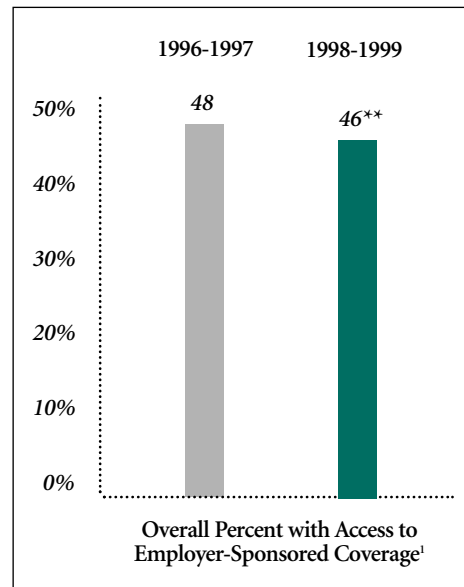
	1996-1997	1998-1999
LOW-INCOME ADULTS WITH CHILDREN		
PRIVATE INSURANCE ¹	51%	46%*
PUBLIC COVERAGE ²	19	19
UNINSURED	31	35*
LOW-INCOME ADULTS WITH NO CHILDREN		
PRIVATE INSURANCE ¹	39	38
PUBLIC COVERAGE ²	26	27
UNINSURED	35	34

* Difference from 1996-1997 estimate is statistically significant at $p < .05$ level.
¹ Includes employer-sponsored insurance, nongroup private insurance and private insurance obtained through someone outside of the household.
² Includes Medicaid, other state coverage, Medicare, CHAMPUS, Indian Health Service and any other unspecified coverage.
 Source: Community Tracking Study Household Survey, 1996-1997 and 1998-1999

coverage. Premiums for employer-sponsored insurance rose 3.3 percent in 1998 and 4.8 percent in 1999.¹ Increases in premiums among small firms were even higher (5.2 percent in 1998 and 6.9 percent in 1999). Moreover, the employee's share of the premium has been increasing for family coverage in recent years—from an average of \$122 per month in 1996 to \$145 in 1999—while the employee share for single coverage decreased slightly, from an average of \$37 per month in 1996 to \$35 per month in 1999. It was not possible to explicitly test the impact of these premium changes on rates of private coverage, but they may explain in part why private coverage decreased for low-income families with children but not for low-income adults without children (who are more likely to have single coverage).

The Issue of Substitution. Another possible explanation for the decrease in private insurance coverage and the increase in public coverage among low-income children is that expanded eligibility for public coverage through SCHIP and Medicaid expansions has resulted in greater substitution of public coverage for private.

Figure 3
Access to Employer-Sponsored Coverage among Low-Income Children



** Difference from 1996-1997 estimate is statistically significant at $p < 0.10$ level.
¹ Sample includes low-income children. Access to employer-sponsored coverage defined as having one or both parents offered and eligible for employer-sponsored coverage.

Source: Community Tracking Study Household Survey, 1996-1997 and 1998-1999



There have
 been no recent,
 net gains in
 coverage for
 low-income
 children, with
 private insurance
 coverage
 decreasing sharply
 and public
 insurance
 increasing.

Notes

1. Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits: 1999 Annual Survey*, Menlo Park, CA, and Chicago, IL, 1999; Ginsburg, Paul, "Tracking Health Care Costs: Long-Predicted Upturn Appears," *Issue Brief* No. 23, November 1999. Center for Studying Health System Change, Washington, DC.
2. Cunningham, Peter, et al., "Who Declines Employer-Sponsored Health Insurance and Is Uninsured?" *Issue Brief* No. 22, October 1999. Center for Studying Health System Change, Washington, DC.

This Issue Brief is adapted from "Tracking Recent Changes in Health Coverage for Low-Income Children with the Community Tracking Study, 1996-1997 and 1998-1999" by Peter J. Cunningham and Michael H. Park, *Research Report* No. 4, April 2000.

ISSUE BRIEFS are published by the Center for Studying Health System Change.

President: Paul B. Ginsburg
Director of Public Affairs: Ann C. Greiner
Editor: The Stein Group

For additional copies or to be added to the mailing list, contact HSC at:
600 Maryland Avenue, SW
Suite 550
Washington, DC 20024-2512
Tel: (202) 554-7549
Fax: (202) 484-9258
www.hschange.org

Update your address for the mailing list at
www.hschange.org/Guestbk.html

switching to jobs with no health benefits to get higher wages. If the increases in public coverage and decreases in private coverage are the result of substitution, it is likely that this substitution would reflect expansions in public coverage that occurred prior to SCHIP.

Policy Implications

During the period between the two surveys, there have been no gains in coverage for low-income children, despite targeted efforts to expand coverage. And during this same period the parents of these children have lost ground, experiencing an increase in uninsurance rates from 31 percent to 35 percent between 1996-1997 and 1998-1999. Nevertheless, these findings capture only the early stages of SCHIP implementation. As more children are enrolled in the program, the number of uninsured may decline.

Perhaps the key policy question is whether the decrease in private insurance coverage among low-income families was a *result* of expanded eligibility for public programs (i.e., substituting public for private coverage), or whether it occurred *independently* of public coverage expansions. If the decrease in private insurance was largely due to substitution of public for private insurance, it would suggest that public coverage expansions have benefited primarily children who already had private insurance by providing them with a lower-cost alternative. This explanation would also imply that the public dollars required to reduce the number of uninsured children through these programs are considerably higher than expected.

However, if the decrease in private insurance coverage occurred independently of public coverage expansions (e.g., as a result of health insurance premium increases), it would imply that expansions in public coverage have provided an important safety net to many low-income children whose parents can no longer afford private insurance coverage. In other words, there

would have been a substantial increase in uninsurance rates among low-income children (as has happened with their parents) if not for these expansions in public coverage.

It is beyond the scope of the analysis described in this report to determine which of these two alternative interpretations is more appropriate. Some amount of substitution of public for private coverage is to be expected in any type of incremental health insurance expansion that targets the uninsured. On the other hand, since these findings reflect the early stages of SCHIP implementation, it is probably too early for a substantial amount of substitution to have taken place, especially given the fact that the vast majority of new enrollees in Medicaid and other state coverage were previously uninsured.

In addition, there are certainly pressures on low-income families to discontinue private insurance coverage that are independent of public coverage expansions; these pressures are likely to increase in the future. Paying for health insurance—even if it is partially subsidized by employers—is a major financial burden for many low-income families. Other HSC research has shown that low-income persons are five to ten times more likely to decline employer-sponsored coverage than higher-income persons, and lower-wage workers often have to pay more for health insurance than higher-wage workers.²

Further increases in health insurance costs—as many predict will happen—will only increase the financial burden and, therefore, the pressure on low-income families to find alternatives to private insurance or do without insurance entirely. This will make it even more difficult to determine in the future whether the primary effect of public coverage expansions is to draw low-income persons away from private coverage, or whether these programs act as a safety net for families who can no longer afford private insurance. ●