



Changes in
HEALTH CARE
FINANCING &
ORGANIZATION

findings brief

The Dynamics of Health Insurance Coverage: 1996 to 2000

In an effort to curb the rising tide of uninsured children, Congress passed the State Children's Health Insurance Program (SCHIP) in August of 1997. SCHIP, authorized by a new Title XXI in the Social Security Act, was a federal-state partnership intended to offer health coverage to nearly 40 percent of the then-estimated 10 million children without insurance¹. With the federal government promising to match state contributions at an additional 30 percent above prevailing Medicaid matching levels, states moved quickly to create coverage programs, extending benefits to the first enrollees as early as January 1998.

The SCHIP legislation explicitly defined the target population as low-income uninsured children, and included provisions requiring states to maintain pre-SCHIP eligibility levels for their Medicaid enrollees. Given the fact that many of the newly eligible children had private insurance coverage, Congress wanted to prevent the substitution of this new public insurance for pre-existing private coverage, requiring States to create mechanisms ensuring against potential crowd-out.

With the SCHIP program enrolling 897,000 children in its first year of operation, questions remained: Did SCHIP

reach its target population? What proportion of new enrollees were the previously uninsured versus those who substituted prior private coverage or Medicaid benefits? While previous literature suggests that Medicaid expansions have led to reductions in both uninsurance and private coverage (based on varying state requirements and household income levels), no studies had used longitudinal data to assess this SCHIP infancy period.²

Nearly a decade after the program's inception, researchers Lisa Dubay, Ph.D., and Linda Blumberg, Ph.D., of the Urban Institute, sought to answer these questions by analyzing whether the increases in program participation were reflective of low-income uninsured children having gained access to new coverage, or whether families had substituted public coverage for private.

Under a recently completed HCFO grant, they looked at SCHIP enrollment patterns between 1996 and 2000 in an attempt to differentiate reductions in uninsurance and crowd-out as components of the increase in public coverage that resulted from the implementation of the SCHIP program. Determining the effect of expanded SCHIP eligibility on public coverage, private coverage, and uninsurance in the low-income population informs the



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ongoing debate about more effective approaches to increase or maintain health insurance levels.

Adding to SCHIP enrollment statistics that document the large number of low-income uninsured children who gained access to public health insurance coverage during SCHIP's infancy, this analysis offers an unprecedented look at how SCHIP implementation had a more pronounced affect on uninsurance levels versus on the substitution rates of public coverage for private. In fact, Dubay and Blumberg's research found the greatest increases in SCHIP participation among children who had low levels of private coverage and high levels of uninsurance.

Background

With a commitment to enrolling children who lacked insurance, states were given considerable flexibility in designing their SCHIP programs. States were given the option to enhance their Medicaid program, create or expand upon an existing state program, or create a stand-alone approach. They were authorized to use various design and financing mechanisms, including alternative benefit packages, premiums, and cost sharing provisions, subject to predetermined limits. States could also initiate waiting periods for coverage in order to help prevent the likelihood of new enrollees abandoning employer-sponsored insurance (ESI).

By July 2000, all 51 states had developed a SCHIP program; 35 creating a new program or using a combination strategy and 16 expanding their Medicaid enrollments³. Three years after inception, half of all children in the United States were income-eligible for public insurance coverage. Among all uninsured children, 57 percent were eligible for Medicaid and 26 percent were eligible for SCHIP. For low-income uninsured children, only 8 percent were ineligible for either Medicaid or the SCHIP program⁴.

In an effort to enroll more low-income children in SCHIP, states also expanded their program eligibility requirements in a number of ways. States utilized continuous and presumptive eligibility to ensure a more stream-

lined process for increasing enrollment and improving retention. With continuous eligibility rules, nearly one-third of Medicaid-eligible and two-thirds of SCHIP-eligible children were allowed to enroll for a 12-month period without being subject to redetermination procedures (eliminating the fear that family income changes would disrupt coverage). Presumptive eligibility was used to establish short-term, temporary eligibility based on declaration of family income. Under these provisions, 15 percent of all SCHIP-eligible children were also allowed to receive coverage prior to the completion of their paperwork, guaranteeing payment to providers who rendered these services.

In an attempt to reduce the potential substitution of public for private insurance, states also instituted waiting periods for children who were previously covered by private insurance. Seventy-four percent of SCHIP-eligible children were subject to waiting periods of one month to more than a year before receiving coverage. Most children were required to wait three to four months after their private insurance ended before they were deemed eligible. For states that created separate SCHIP programs, the majority of children also faced minimal premiums (74 percent of SCHIP-eligible children)⁵.

Methodology and Data

Dubay and Blumberg analyzed the first and last wave of the 1996 panel of the Survey of Income and Program Participation (SIPP). The 1996 SIPP panel gathered information on labor force participation, income levels, public program participation, and health insurance coverage from a nationally representative sample of the U.S. civilian, non-institutionalized population. Participants were observed every four months, from December 1995 to February 2000, for a total of 12 waves. They were asked to report whether their health coverage status was Medicaid or SCHIP, employer-sponsored insurance (ESI) or military coverage, private non-group, private coverage of an unknown type, or uninsured.

While numerous prior studies have documented the expansion of childhood eligibility for public assistance during this time period, Dubay and Blumberg were the first to use lon-

gitudinal data to analyze the impact of SCHIP implementation on individual children over time. Their research draws upon population-based longitudinal surveys to capture the changing dynamics in health insurance coverage for the low-income population.

The researchers used a difference-in-difference approach and divided SIPP individuals into treatment and control groups. The treatment group was composed of all children eligible for SCHIP in the last wave of SIPP. The three comparison groups were:

- 1) children whose family income was 50 to 100 percentage points above the SCHIP eligibility thresholds in their state;
- 2) parents of SCHIP-eligible children; and
- 3) near eligible parents and children whose household income was 50 to 100 percentage points above state eligibility thresholds.

In the first phase of their two-part analysis, Dubai and Blumberg identified children who were eligible for SCHIP in the last wave of SIPP to observe changes in their health insurance status from the first wave. They documented whether increases in coverage attributable to implementation of the SCHIP were due to the substitution of public for private coverage or reductions in uninsurance.

The second phase of the study examined the influence of the SCHIP program on changes in the distribution of insurance coverage for children eligible for SCHIP in the last panel of the SIPP in terms of the shifts between private coverage, public coverage, and uninsurance. Dubai and Blumberg conducted this analysis for all children eligible for SCHIP in the last wave of the SIPP panel and separately for those who were eligible in the first wave.

Findings

Over the study period, Dubai and Blumberg found minimal evidence that public insurance coverage eligibility produced substantial reductions in private coverage and com-

elling evidence of decreases in uninsurance. In their first analysis, Dubai and Blumberg attribute nearly three-fourths of enrollment increases to a reduction in uninsurance, while a quarter of recipients substituted public insurance for private insurance. In the second analysis, they find virtually no evidence of crowd-out. Their findings also highlight that the greatest increases in SCHIP coverage were found among children who had the lowest incomes at the beginning of the panel, suggesting that the program was appropriately used by those with few other options for coverage.

Utilizing a difference-in-difference approach to capture only the changes in health insurance status attributable to enhanced SCHIP eligibility—while isolating other external market factors, such as the economic expansion and welfare reform changes that defined this period—Dubai and Blumberg reported on the extent to which SCHIP coverage increases are due to reductions in uninsurance or due to crowd-out. The longitudinal nature of the SIPP data allowed the research team to focus on whether and how the substitution was occurring.

The first analysis found relative increases in public health insurance coverage for children starting in each insurance group, but with large relative increases for those who entered the panel with public coverage or uninsured.

During the study period,

- ◆ SCHIP had virtually no effect on children's movement from private to public coverage. In fact, rates of private coverage actually increased. Private coverage among SCHIP-eligible children rose by 8 percent, to 69 percent.
- ◆ The likelihood of SCHIP-eligible children remaining covered by public insurance increased by 14 percentage points. Importantly, almost all of the increase in public coverage was due to relative decreases in private coverage.

- ◆ Children who were uninsured at the beginning of the survey, but gained public insurance eligibility through SCHIP, were likely to have remained uninsured if not for SCHIP implementation. As compared to the near eligible group, uninsured SCHIP-eligible children were 10 percentage points more likely to have public coverage and 9.6 percentage points less likely to remain uninsured by 2000.

Dubay and Blumberg estimated that of the 6.2 percentage point increase in public coverage attributable to implementation of the program, the only traces of the crowd-out effect were isolated to children who began the panel with Medicaid coverage. Dubay suggests that this substitution may be due to the fact that “parents are quite satisfied with their public insurance coverage and, once enrolled, are likely to stay enrolled [rather] than face high premiums and co-payments under an employer-sponsored plan.”

Importantly, since only a small share of the increase in coverage was attributable to children who began the panel with Medicaid coverage, the overall estimate of the extent of substitution was 25 percent, with fully 75 percent due to reductions in uninsurance.

Dubay and Blumberg also examined changes in the distribution of health insurance coverage by eligibility category in the first wave. The findings illustrate that children with Medicaid eligibility pre-SCHIP, had the largest increases in public coverage and most significant reductions in uninsurance.

Specifically,

- ◆ Children eligible for Medicaid under AFDC rules in the first wave of the panel, though not statistically significant, had:
 - a 7 percentage point increase in public coverage; and
 - an 11 percentage point reduction in uninsurance.
- ◆ Children eligible for Medicaid based on poverty-related expansions in the first wave of the panel saw the largest increase in public coverage combined with greatest reduction in uninsurance, highlighting:
 - a 12 percentage point increase in public coverage; and
 - an 11 percentage point reduction in uninsurance.
- ◆ Children who would have been SCHIP-eligible at the beginning of the panel had the program been in place recorded the fewest changes in coverage status, with:
 - a 4 percentage point increase in public coverage; and
 - a 3 percentage point reduction in uninsurance.

Noting the economic surpluses of the time, in combination with the introduction of SCHIP programs in every state, low-income children were presented with unparalleled opportunities to secure both public and private health insurance between 1996 and 2000. Among children who gained public insurance coverage, the largest increases in SCHIP coverage were found among those children who had lower incomes in the beginning of the panel. Low-income children also acquired increased access to private coverage, likely attributable to market factors beyond the SCHIP implementation. Blumberg notes, “The expansion in private coverage reflects, at least in part, the strengthening of the economy and improved access to employment with health insurance offers attached.” The Dubay and Blumberg findings attempted to capture all these changing distributions of coverage among the newly eligible.

“It is important to recognize,” adds Dubay, “that this is a very early look at impacts of the SCHIP program on insurance coverage.”

This analysis is unique in that children were followed from a pre-SCHIP to a post-SCHIP period. However, tremendous increases in SCHIP enrollment occurred after the end of the SIPP panel, therefore, these results likely understate the influence of SCHIP on insurance coverage of eligible children in the full implementation period.

For more information, contact Lisa Dubay, Ph.D., at LDubay@ui.urban.org or Linda Blumberg, Ph.D., at LBlumber@ui.urban.org.

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End Notes

- 1 Wooldridge, J. et al. "Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program." Submitted to the Dept. of Health and Human Services Office of the Secretary for Planning and Evaluation by Mathematica Policy Research, Inc. and the Urban Institute. Contract No.: HHS-100-01-0002. February 2003.
- 2 Dubay, L. and L.Blumberg. "The Impact of SCHIP on Insurance Coverage In its Infancy: An Analysis Using the SIPP." Working paper.
- 3 Smith, V. and D. Rousseau. "SCHIP Program Enrollment: December 2002 Update." The Kaiser Commission on Medicaid and the Uninsured. July 2003.
- 4 Dubay, L., J. Haley, and G. Kenney. "Children's Eligibility for Medicaid and SCHIP: A View from 2000." *New Federalism: National Survey of America's Families*. The Urban Institute. Series B, No. B-41, March 2002.
5. Ibid.