Shifting Health Insurance Coverage, 1997–1999

Economic expansion, welfare reform, and SCHIP have changed who has insurance coverage, but not across the board.

BY STEPHEN ZUCKERMAN, GENEVIEVE M. KENNEY, LISA DUBAY, JENNIFER HALEY, AND JOHN HOLAHAN

The forces that affect private and public health insurance coverage have been shifting over the past several years. During the 1990s unprecedented economic expansion brought increased employment and higher incomes, which should have raised access to job-based coverage. Nevertheless, evidence on how employer offer rates have been changing is mixed. There is consistent evidence, however, that employee take-up rates have been falling, and the costs of coverage may be changing differently for different types of coverage.

Public health insurance programs also have been in transition. Federal welfare reform may have had the unintended side effect of reducing Medicaid participation among eligible children and adults. At the same time, the State Children’s Health Insurance Program (SCHIP) has expanded coverage to children with higher family incomes than traditionally covered under public programs. However, most states’ SCHIP programs were not yet mature in 1999. A few states have taken advantage of new policy options to expand Medicaid coverage to low-income parents and other nonelderly adults.

This paper uses the National Survey of America’s Families (NSAF) to assess how health insurance coverage is changing for children and adults in various income groups and states. This analysis was done as part of the Urban Institute’s Assessing the New Federalism (ANF) project.

Data And Methods

We used the 1997 and 1999 rounds of NSAF to examine changes in insurance coverage over those two years. NSAF is a household survey that provides information on more than 100,000 children and nonelderly adults in each round and is representative of the noninstitutionalized civilian population under age sixty-five. Interviews were conducted in households with and without telephones using computer-assisted telephone interviewing technology. NSAF oversamples low-income families (defined as having incomes below 200 percent of the federal poverty level, $33,400 for a family of four in 1999). In addition, it has large enough samples to provide reliable estimates for each of thirteen states intensively studied as part of the ANF project and an additional sample drawn from the other states to make estimates that are representative of the nation as a whole. The data are weighted to provide reliable national and state estimates.

Detailed information was collected on up to two children in each family from the adult who knew the most about the child’s education and health care. The response rates for the 1997 and 1999 rounds were about 70 and 64 percent, respectively. Standard errors...
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used to conduct the tests of statistical significance on changes over time and differences across subgroups are based on the balanced repeated replication method to account for the complex nature of the sample design.12

Categorization. Respondents were asked about their family's health insurance coverage at the time of the survey, including a question that confirmed the absence of coverage for household members who were not originally identified as having any type of coverage.13 Responses were categorized into one of the following groups: (1) employer coverage (includes coverage from a current or former employer or union or under a military program); (2) Medicaid/SCHIP/state; (3) other (includes Medicare, private coverage, and other coverage that is not classifiable elsewhere); and (4) uninsured.14 Health insurance is defined using a hierarchy; persons with both employer coverage and some other form of coverage were classified as having employer coverage.15

NSAF versus CPS. The approach to measuring insurance coverage in NSAF differs from that used in the Current Population Survey (CPS)—the most widely cited source of health insurance information—in several important ways. These differences were designed to address some of the concerns that have been expressed about the CPS related to potential recall problems, the treatment of uninsurance as a residual, and identification of coverage through state programs.16 First, we measured insurance coverage at the time of the survey as opposed to the CPS approach of asking about coverage from the previous calendar year. Second, we used a question to confirm that people for whom no coverage has been reported during the main battery of questions were actually uninsured.17 Finally, we included separate questions that asked about coverage related to SCHIP or state programs.18 All of these features are designed to avoid missing insurance coverage.

Although national trends covering a period comparable to, and much longer than, NSAF could be derived from the CPS, we feel that it is still appropriate to consider the national estimates of change based on NSAF in this paper. These estimates provide a consistent context for considering the NSAF state estimates, which are, with the exception of California, based on much larger samples than are available from the CPS.

Population groups. We present separate analyses for children (age eighteen and under) and nonelderly adults (ages nineteen to sixty-four) nationally and by state.19 We also examine national patterns of change for low-income adults by race/ethnicity, self-reported health status, and parental status. Parents are defined as adults who live in a household with their biological, step, or adoptive child under age eighteen; all other adults are classified as nonparents.

Findings

Levels of and changes in insurance coverage. Nationally, 96 million children and 26.5 million adults—13 percent of all children and 16 percent of all adults—lacked health insurance coverage in 1999 (Exhibit 1). Overall, rates of uninsurance did not change significantly between 1997 and 1999 for either adults or children, but trends did differ between income groups.

Higher-income children experienced a one-percentage-point increase in their uninsurance rate, while rates remained steady for low-income children.22 In contrast, uninsurance rates for higher-income adults did not change. The uninsurance rate of low-income adults decreased by almost two percentage points (from 37 percent to 35 percent) but this change was not statistically significant. While the disparity between the uninsurance rates of the lower and higher income groups narrowed slightly for both adults and children between 1997 and 1999, the low-income population remained much more likely than the higher-income population was to lack insurance coverage.

Patterns of coverage varied widely by fam-
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EXHIBIT 1
Changes in Health Insurance Coverage of U.S. Children and Adults, By Poverty Level, 1997–1999

<table>
<thead>
<tr>
<th></th>
<th>Employer</th>
<th>Medicaid/SCHIP/state</th>
<th>Other</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (ages 0–18)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>66.7%</td>
<td>-0.1%</td>
<td>16.4%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>&lt; 200% of poverty</td>
<td>58.7%</td>
<td>0.9%</td>
<td>35.2%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>&gt; 200% of poverty</td>
<td>85.3%</td>
<td>-2.8***</td>
<td>3.5%</td>
<td>1.0***</td>
</tr>
<tr>
<td>Adults (ages 19–64)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>72.3%</td>
<td>1.2**</td>
<td>4.8%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>&lt; 200% of poverty</td>
<td>41.7%</td>
<td>3.2***</td>
<td>14.7%</td>
<td>0.6%</td>
</tr>
<tr>
<td>&gt; 200% of poverty</td>
<td>83.7%</td>
<td>-0.8%</td>
<td>1.1%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>


NOTES: Changes between 1997 and 1999 are presented in percentage points. SCHIP is State Children’s Health Insurance Program.

* p < .10  ** p < .05  *** p < .01

ily income for both children and adults. More than 80 percent of children and adults with family incomes above 200 percent of poverty had employer coverage, compared with 39 percent of low-income children and 42 percent of low-income adults. At the same time, 33 percent of low-income children and 15 percent of low-income adults received coverage through Medicaid/SCHIP/state programs, compared with 4 percent of children and about 1 percent of adults with family incomes above 200 percent of poverty.

Over this period, changes in types of coverage among children differed across income groups, which may partially reflect the effects of federal welfare reform and SCHIP. Although Medicaid/SCHIP/state coverage did not change significantly across all low-income children, it fell for poor children relative to other children (data not shown), a likely consequence of welfare reform.22 At the same time, Medicaid/SCHIP/state coverage increased for children with family incomes between 100 and 200 percent of poverty—the group primarily targeted by SCHIP during the period. In addition, children with family incomes between 200 and 300 percent of poverty also gained Medicaid/SCHIP/state coverage, but still only 7 percent relied on this source.

Changes in employer coverage varied between adults and children and across income groups. Among children, those in families with incomes above 200 percent of poverty lost employer coverage; these children were 2.8 percentage points less likely to rely on employer coverage in 1999 than they were in 1997. These declines appear to be responsible for the rising rates of uninsurance among these children. Over this same period, the rate of employer coverage increased by 3.2 percentage points among low-income adults. However, this did not translate into a significant decrease in uninsurance because of small and statistically insignificant decreases in Medicaid/state and other coverage.

Insurance Coverage Among Low-Income Adults

Although the uninsurance rate for low-income adults was not significantly lower in 1999 than in 1997, there were significant gains in coverage for certain subgroups of low-income adults (Exhibit 2). Similar analysis was also performed for different subgroups of low-income children, but very little change was found, and the results are not reported here.23

- Race and ethnicity. Across racial/ethnic groups, the gain in employer coverage for low-income adults in 1997–1999 seems to be concentrated among whites.24 They started out with a higher rate of employer coverage in 1997 than either blacks or Hispanics, and the coverage gap between whites and Hispanics
EXHIBIT 2
Changes in Health Insurance Coverage Of Low-Income Adults, By Selected Characteristics, 1997–1999

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All low-income adults</td>
<td>41.7%</td>
<td>3.2%</td>
<td>14.7%</td>
<td>-0.6%</td>
<td>8.8%</td>
<td>-1.0%</td>
<td>34.9%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Race/ethnicity*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>48.2</td>
<td>4.5***</td>
<td>12.4</td>
<td>-0.9</td>
<td>10.7</td>
<td>-1.4</td>
<td>28.7</td>
<td>-2.8*</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>36.0</td>
<td>1.2</td>
<td>24.1</td>
<td>-0.4</td>
<td>6.8</td>
<td>-0.7</td>
<td>33.2</td>
<td>-0.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29.6</td>
<td>-0.4</td>
<td>18.2</td>
<td>-0.6</td>
<td>3.2</td>
<td>-0.9</td>
<td>64.1</td>
<td>1.6</td>
</tr>
<tr>
<td>Fair/poor health</td>
<td>28.1</td>
<td>5.6***</td>
<td>25.8</td>
<td>0.2</td>
<td>10.8</td>
<td>-0.7</td>
<td>35.3</td>
<td>-5.2***</td>
</tr>
<tr>
<td>Excellent/very good/h</td>
<td>44.0</td>
<td>2.5**</td>
<td>11.2</td>
<td>-0.9</td>
<td>8.1</td>
<td>-1.1*</td>
<td>34.7</td>
<td>-0.8</td>
</tr>
<tr>
<td>Parent</td>
<td>43.2</td>
<td>2.0</td>
<td>15.8</td>
<td>-3.6***</td>
<td>6.0</td>
<td>0.3</td>
<td>36.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Nonparent</td>
<td>40.4</td>
<td>4.3***</td>
<td>13.8</td>
<td>1.8</td>
<td>12.2</td>
<td>-2.0*</td>
<td>33.8</td>
<td>-4.0**</td>
</tr>
</tbody>
</table>

SOURCE: Urban Institute tabulations from the 1997 and 1999 National Survey of America’s Families (NSAF). * Those classified in “other” race/ethnicity groups were excluded from this exhibit, because of insufficient sample size.

* p<.10 ** p<.05 *** p<.01

appears to have expanded by 1999. Almost half of white low-income adults had employer coverage in 1999, up from 43 percent in 1997.

In comparison, the employer coverage rate in 1999 for blacks was 36 percent and for Hispanics, almost 30 percent. The gains among low-income whites were sufficient to lead to a significant reduction in their uninsurance rate, from 31 percent to 29 percent.

Health status. Employer coverage rates among low-income adults increased over the period, regardless of health status. For those in fair or poor health, the coverage rate increased from 23 percent to 28 percent, resulting in a reduction in their uninsurance rate from 41 percent to 35 percent. This suggests that the expansion in employer coverage among low-income adults was helping persons for whom nongroup coverage might be expensive and possibly unavailable. Nevertheless, low-income adults in fair or poor health remained much more dependent on coverage through Medicaid or a state program than did other low-income adults. The gains in employer coverage were not large enough to lower the uninsurance rate of healthier low-income adults, because of small reductions in other types of health insurance.

Parents and nonparents. The national patterns of change in insurance coverage are quite different for low-income parents than for other low-income adults. Low-income parents did not see a significant gain in employer coverage, but Medicaid/state coverage declined significantly, from 19 percent to 16 percent. Despite this loss, the small but statistically insignificant gains in employer coverage resulted in a fairly stable uninsurance rate for parents (36 percent). Data not shown indicate that most of this statistically significant loss in Medicaid/state coverage was concentrated among parents with incomes below the poverty level and occurred in seven of the thirteen ANF states. This is consistent with other studies showing that adults leaving welfare have lost Medicaid coverage, possibly due to welfare reform.26

As a result of gains in employer and public coverage, uninsurance rates for low-income nonparents fell from 38 percent to 34 percent. Thus, low-income nonparents moved from being slightly worse off than low-income parents in 1997 to being slightly better off in 1999.

Variation Across States

As shown in Exhibit 3, there was substantial cross-state variation in the 1999 uninsurance rates for both children and adults, a pattern similar to that observed in 1997.26 Among children and adults at all income levels, uninsurance rates were well below average in Massachusetts and Minnesota and well above
average in California and Texas. Among low-income children, uninsurance rates ranged from 7 percent in Massachusetts to 57 percent in Texas. For low-income adults, uninsurance rates ranged from 19 percent in Massachusetts to 20 percent in Minnesota to 41 percent in California and 47 percent in Texas.

States with uninsurance declines. Alabama, Colorado, and Massachusetts were the only states in Exhibit 3 that had significant declines in uninsurance rates for all children and adults as well as for those in low-income families.21 Focusing on low-income adults and children (Exhibit 4), we see that the reasons for the decrease in uninsurance rates varied across the three states. For the discussion of changes in types of insurance coverage at the state level, we combined the employer and other coverage categories.

In Colorado and Alabama, the gains in employer/other coverage were sufficient to lower uninsurance rates by between five and ten percentage points. In fact, for low-income adults in Colorado—the group with the smallest improvement—the gains were large enough to overcome a small but significant decrease in Medicaid/state coverage. In Alabama, low-income children gained both employer/other coverage and Medicaid/SCHIP state coverage, which together led to a 9.7 percentage-point reduction in their uninsurance rate. The gains in public coverage among low-income children in Alabama may be traced to the implementation of ALL Kids, one of the first SCHIP programs in the nation to be approved. Alabama’s separate SCHIP program was layered on top of a limited Medicaid program. The ALL Kids launch was accompanied by broad-based outreach and a simplified joint Medicaid/SCHIP application.22

In contrast to Colorado and Alabama, there were three states—Michigan, Texas, and Washington—in which low-income adults or children, or both, experienced statistically significant gains in employer/other coverage without a reduction in uninsurance rates (data not shown).23 In each of these cases, a decrease in public coverage (sometimes not statistically significant) offset the employer/other gains. In Colorado and Alabama, on the other hand, public coverage held steady, declined, by much less than the gains in employer/other coverage, or actually increased (Exhibit 4).
In Massachusetts, low-income children experienced a 7.3-percentage-point reduction in the rate of uninsurance, while low-income adults experienced a 10.7-percentage-point reduction (Exhibit 4). This growth in coverage appears to be associated with a substantial expansion of the Massachusetts Medicaid program and the consolidation of its other state health insurance programs into a single seamless system called MassHealth. The increases in Medicaid/SCHIP/state coverage in 1997–1999 were fourteen percentage points for children and 7.9 percentage points for adults. Public coverage in Massachusetts expanded among both low-income parents and nonparents (data not shown). These increases were all occurring at a time when Medicaid/SCHIP/state coverage was flat for the nation as a whole. The expansion of public coverage to nonparents is particularly notable because typically this group is excluded from public programs unless they are disabled.

While the increase in public coverage in Massachusetts seemed to lower the rate of uninsurance, it is possible that these expansions reduced the rate of employer coverage. To address this policy concern, we conducted a separate analysis (not shown in the exhibits) of changes in employer coverage in Massachusetts and the rest of the nation. The data present a mixed picture on this issue. On the one hand, the rate of employer coverage for low-income children fell in Massachusetts while increasing in the rest of the United States. However, significant declines in employer coverage were also experienced by children with family incomes between 200 and 300 percent of poverty in Massachusetts, which suggests that there may have been forces at work, other than MassHealth, that led to this erosion in employer coverage. In addition, for low-income adults the changes in employer coverage were not statistically different from those in the rest of the nation. Thus, while some drop in employer coverage because of the MassHealth expansions cannot be ruled out completely, the predominant effect of MassHealth appears to have been to reduce dramatically the number of uninsured persons in the state.

**Discussion**

This paper shows that even over a period as short as two years, the ongoing economic expansion, welfare reform, and SCHIP have been changing who has insurance coverage as well as the relative importance of various types of coverage. However, the influence of these forces is not being felt uniformly among all adults and children or across all states.

The economic expansion, for example, seems to be associated with increased employer coverage among low-income adults but not among higher-income adults or chil-
dren. In fact, the gains were not experienced by all low-income adults. Significant gains among whites are widening the coverage gap between them and Hispanics. For higher-income children, employer coverage actually decreased. Although higher-income children are about half as likely to be uninsured as low-income children are, they may become more of a policy concern than they are now if this downward trend continues.

Variations in the apparent influence of policy changes are more predictable, given that many policies are targeted at specific types of persons. Reductions in Medicaid coverage resulting from welfare reform should have affected poor children and parents, because families with children were much more likely to receive cash assistance and be covered by Medicaid before reform. This is precisely the pattern observed in this study. In fact, the reduction in Medicaid coverage among parents increased their risk of being uninsured in 1999 to a level above that of nonparents. In terms of SCHIP, the recent experiences in Massachusetts and Alabama—two states that implemented the program relatively quickly—suggests that SCHIP may be starting to expand coverage among low-income children.

Despite these positive signs, SCHIP does not appear to be lowering uninsurance rates for low-income children in other states or nationally. However, it would be premature to judge SCHIP on that basis. Given the time it takes to implement major new programs, large declines in uninsurance rates for low-income children should not have been expected by 1999. Within the next few years, SCHIP programs will mature. Ultimately, the program’s success will depend upon its ability to make large inroads into the population of low-income uninsured children over time.

MassHealth’s apparent success in increasing coverage may be a signal that a broad-based seamless approach that covers whole families is more likely to succeed than programs that only cover children. Future research should explore whether the success of this approach is limited to Massachusetts or if other states with similar approaches, such as Wisconsin, also have large reductions in uninsured.

Despite the changes we observe in insurance coverage, large differences persist between low-income and higher-income groups and across states. In 1999 low-income children and adults were more than three times more likely than their higher-income counterparts to lack health insurance. In addition, the states that had low rates of employer coverage and high rates of uninsurance in 1997 remained the same in 1999.

Over time, as the full effects of SCHIP are felt and if more policies that extend eligibility to parents of already-eligible children are adopted, some of these coverage gaps could narrow. States now have the flexibility to cover low-income parents under Medicaid, but these new provisions still leave many uninsured parents ineligible for coverage. In addition, finding the appropriate incentives to encourage states to cover parents and getting them to enroll in the programs may be difficult. Moreover, current Medicaid rules constrain states in their options for covering nonparents. Overlaid on these policy challenges is the sobering reality that the economic expansion that appears to have helped some subgroups of the population has not really changed the overall patterns of coverage and cannot be expected to continue indefinitely.

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NOTES
9. In the ANF project, thirteen states were selected for intensive study because they represented a mixture of approaches to health and social policy and because they were diverse geographically and economically. These thirteen states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.
14. To have clearly delineated employer and Medicaid state categories of insurance coverage, we included Medicare coverage with “other coverage.” Recall that Medicare is not a major source of coverage among the nonelderly population.
15. The impact of this hierarchy on our results should be minimal, only approximately 2 percent of the weighted sample in both years reported coverage in more than one of these four insurance categories.
17. Rajan et al., “Confirming Insurance Coverage,” The CPS added a question to confirm lack of insurance coverage in the March 2000 survey. Results based on this new question are expected by the time of this publication.
18. In these questions, we used state specific program names to enhance respondents’ recognition. The CPS is planning to move to a separate question related to SCHIP in its March 2001 survey.