Analysis of Children's Health Insurance Patterns: Findings from the SIPP

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EXECUTIVE SUMMARY

This paper summarizes work using the 1992 panel of the Survey of Income and Program Participation (SIPP) to provide the most detailed look yet at the dynamics of health insurance coverage among children and the relationship between Medicaid eligibility and insurance coverage. We summarize what our technical work (contained in companion technical appendices A-D) says on five broad questions:

1. How many children lack insurance?
2. How long do children remain uninsured?
3. What are the patterns of movement between spells with and without insurance?
4. What are the characteristics of children by type of health insurance coverage?
5. How many fewer uninsured children would there be if participation in Medicaid were more complete?

We find that from October 1992 to September 1994, between 12.4 and 13.3 percent of children under 19 were uninsured at any one point in time, with one in four children (27.1 percent) uninsured for some period of time over the two years. About half of all spells without insurance last less than six months, but a quarter last 12 months or more. Further, nearly half of all children uninsured at any one time were already uninsured for 12 months or more.

Among children becoming uninsured, 52 percent were covered by employer-sponsored coverage in the previous month, 39 percent by Medicaid, and 9 percent by other sources or were newborns. More than half of the 550,000 children leaving Medicaid each month (56 percent) became uninsured. But loss of Medicaid eligibility explains fewer than half these transitions. While reporting error may explain some of this, our findings highlight the importance of shifting some attention from studying why children do not enroll in Medicaid to the question of why children lose Medicaid coverage when they may still be eligible. This is particularly relevant as our findings highlight the sensitivity of insurance coverage rates to Medicaid enrollment patterns.

The 1992 SIPP data support previous research on the relationship between children's insurance status and various demographic and socio-economic characteristics. The findings highlight how Medicaid eligibility policy affects the relationships among income, child age, and coverage. They also highlight the periodic discrepancy between a child's coverage and that of the parents. About one-fifth of uninsured children appear to have at least one insured parent, although some of this may be reporting errors. Children who experience long spells without insurance do not appear strikingly different from those who experience relatively brief spells, contrary to what some may expect.

Our data suggest that Medicaid participation rates by children range from 65 percent to 79 percent, depending on how they are calculated. Simulations indicate that about one third of the 8.9 million uninsured children in September 1994 were eligible for Medicaid; some of this group is in transition to Medicaid, however, and many more were enrolled previously. The findings also highlight the substantially lower participation rates for children who are *not* cash assistance participants. This reinforces the importance of strong outreach to achieving high levels of CHIP participation and highlights ways of targeting outreach to reach diverse subsets of children.

In sum, our work suggests that the number of children with some spell without insurance over time greatly exceeds the number uninsured at any point in time. The findings highlight the importance of not just enrolling children in Medicaid or CHIP but also retaining them in the programs. They also show that, contrary to common perception, Medicaid participation by eligible children with no other coverage was relatively high before welfare reform. These rates were lifted by the high proportion of children covered through cash assistance programs, reinforcing the concern over the potentially adverse effects of TANF on Medicaid coverage for children.

ANALYSIS OF CHILDREN'S HEALTH INSURANCE PATTERNS: FINDINGS FROM THE SIPP

INTRODUCTION

Purpose of This Report

The passage of the legislation establishing the Children's Health Insurance Program (CHIP) has turned the policy spotlight on the number and characteristics of children without health insurance. In fact, many more children go without health insurance than the number who are uninsured at any one time. The research reported here was conducted to explore the dynamics of health insurance coverage among children and to tell us more about the relationship between Medicaid eligibility and insurance coverage. The unique contribution of this research is that it provides the most detailed picture yet of the dynamics of health insurance coverage among children by addressing five broad questions:

1. How many children lack insurance?

2. How long do children remain uninsured?

3. What are the patterns of movement between spells with and without insurance?

4. What are the characteristics of children by type of health insurance coverage?

5. How many fewer uninsured children would there be if participation in Medicaid were more complete?

This report summarizes the key findings in each of these areas and interprets them against the backdrop of current policy discussions.

Source of Data

This analysis is based on the 1992 panel of the Survey of Income and Program Participation (SIPP), a longitudinal survey that provides extensive monthly data on a large sample of children (and adults) from 1992 through 1994. These are the latest data with which we could construct the multi-year longitudinal measures presented in this report. The 1993 SIPP panel would have given us data through 1995, but our work with these data raised concerns that the number of poor children was overstated. The Census Bureau started another SIPP panel in 1996, but until recently, only the first wave of data, covering a four-month reference period, had been released.

Given that readers will want to apply the findings presented here to the present, an important caveat is that the data on which this analysis is based precede welfare reform. Clearly, point estimates of uninsured children and Medicaid participants in 1994 will differ from today's figures, but the underlying dynamics on which this report focuses remain relevant even though some of the particulars may have changed.

HOW MANY CHILDREN LACK INSURANCE?

In the two years from October 1992 through September 1994, between 12.4 and 13.3 percent of children under 19 were reported to have been uninsured at any one time. Over the course of each fiscal year, however, 21.5 percent of children went at least one full month without insurance, and over the two-year period, 27.1 percent--more than one in four children--were uninsured for some period of time. Policymakers tend to focus on the point-in-time estimates, but figures representing periods of a year or more are at least as important because they tell us the full extent to which children are exposed to spells without insurance. Annual data from the Current Population Survey (CPS) suggest that before the widespread implementation of CHIP

this exposure was increasing. Indeed, both the number and percentage of children who were without insurance rose after 1995 (Fronstin 1997a, 1997b).

HOW LONG DO CHILDREN REMAIN UNINSURED?

About half of all spells without insurance end in less than six months, but a quarter last for 12 months or more. By examining all spells that started in 1993 and following them to their conclusion or to the end of 1994, whichever came first, we could identify spells that continued for at least 12 months and those that ended in any number of months up to 12. More than 9 million new spells began in 1993 (including multiple spells experienced by the same children). So the number of new spells is comparable to the number of children who were without insurance at any one time. That half of these new spells ended in less than six months helps to explain why the number of children who were uninsured for any part of 1993 is so much higher than the number who were uninsured at any one time during the year. Nevertheless, a significant fraction of the new spells--about 24 percent--did last for 12 months or more. Therefore, new spells that started in 1993 added more than 2.3 million children, ultimately, to the number of long-term uninsured (based on a common 12-month definition of long-term).

Nearly half of the children who are without insurance at any one time have already been uninsured for 12 months or more. Of the more than 9 million children who were uninsured in September 1993, 47 percent had been uninsured for at least 12 months, while only 37 percent had been uninsured for less than 6 months. We projected that fewer than 20 percent of these 9 million children would end their spells (become insured) in less than six months and that nearly two-thirds would be uninsured for 12 months or more. Essentially, long spells are more likely to be ongoing at any one time than short spells, so the uninsured population at a point in time, includes a higher proportion of long-term uninsured than we find among all new spells.

The distribution of spell durations is important because brief spells, moderate spells, and long spells without insurance carry very different policy implications. By definition, very short spells are transitional. That is, with no intervention, these spells will end quickly, the assumption being that these uninsured children are in transition from one source of insurance to another (perhaps because of a waiting period for private insurance). These transitional periods, or short spells, demand a different policy response, if any, than periods in which the near-term availability of coverage may be uncertain. Even spells of six months or so may require a different policy approach than much longer spells--both from the standpoint of program efficiency and potential clients' perceived needs for coverage.

When a spell starts, how do we determine if it is going to be a short spell or a long spell? The surest approach is to wait. The CHIP regulations explicitly address the differential treatment of short-term and long-term spells, and the federal guidelines allow waiting periods as a device for countering the potential crowd-out of private insurance.

WHAT ARE THE PATTERNS OF MOVEMENT BETWEEN SPELLS WITH AND WITHOUT INSURANCE?

What Precedes Spells without Insurance?

Between October 1992 and September 1994, children started nearly 19 million new spells without insurance. Each month, on average, about 800,000 children became uninsured. In the month preceding each new spell, 52 percent of these children were reported to have been covered by employer-sponsored insurance, 39 percent by Medicaid, and 6 percent by another source of insurance. The remaining 3 percent were born uninsured.

Altogether, more than 550,000 children left Medicaid each month, on average. More than half of this group--56 percent--started new spells without insurance. Just over one-third, or 34

percent, gained employer-sponsored coverage, 2 percent obtained coverage from another source, and 7 percent turned 19 or became ineligible for the SIPP.[1]

These findings beg the question: why do so many children leave Medicaid only to become uninsured? Loss of Medicaid eligibility appears to explain fewer than half of these transitions from Medicaid to uninsured. That is, more than half of the children who left Medicaid and became uninsured still appeared to be eligible for Medicaid, according to a state by state simulation of the Medicaid eligibility rules. It is possible that reporting error may account for some of these apparent departures from Medicaid by eligible children, contributing to the recognized undercount of Medicaid enrollment.[2] Research in progress will shed light on the potential role of reporting error in particular, and on the circumstances surrounding these changes in Medicaid enrollment and insurance coverage more generally. Even if the number of children moving from Medicaid to uninsured proves to be fewer than the estimate reported here, policymakers need to shift some attention from the question of why children are not enrolling in Medicaid to the question of why they are losing coverage, especially when many of them may still be eligible.

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[1]Children leave the SIPP population by moving out of the country, becoming institutionalized, moving into military barracks, or dying.

[2]Surveys report fewer children enrolled in Medicaid than the statistics compiled by the Health Care Financing Administration (HCFA) indicate. This finding is typical of comparisons between survey data and program administrative statistics for means-tested entitlement programs. Some researchers adjust their estimates of uninsured children to compensate for Medicaid underreporting (Ullman et al. 1998). Others caution that we know too little about the sources of the Medicaid undercount to reliably attribute a large portion of it to children who are misreported as uninsured. In our case, adjusting reported insurance coverage to compensate for a Medicaid undercount was not practical, for the most part, because there is no evidence on how Medicaid underreporting might be correlated with the complex dynamics and the many characteristics we examined. Nevertheless, it is important to recognize when we and other researchers examine Medicaid eligibility among uninsured children that the survey data on which we base our estimates fail to account for all children who are counted in the Medicaid program statistics.

What Follows Spells without Insurance?

Of the more than 9 million children who were uninsured in any one month, about 8 percent, or 750,000 children on average, became insured in the next month, and another 60,000 simply aged out of the population of children (turned 19) or left the SIPP universe. Medicaid had a disproportionate impact on these transitions. Of the children who became insured each month, 41 percent enrolled in Medicaid, 52 percent obtained coverage from their parents' employers, and 7 percent gained coverage from another type of plan. Thus, while Medicaid was reported to insure only 19 percent of all children under 19 at any one time in 1993 or 1994, it accounted for 41 percent of the uninsured children who gained coverage. This suggests that the number of uninsured children will be particularly sensitive to changes in Medicaid enrollment patterns. Indeed, the decline in the Medicaid caseload that followed the introduction of welfare reform appeared to produce a full percentage-point increase in the proportion of children who were without health insurance, as measured in the CPS (Fronstin, 1997b).

How Much Churning Is There among Uninsured Children and Medicaid Participants?

"Churning" in a population consists of exits and re-entries by the same group of people over a relatively short period, whereas "turnover" more literally involves exits and entries by *different* people. The frequency of churning and turnover among uninsured children and Medicaid participants influences the magnitude of the task of insuring the uninsured and the efficiency with which it may be possible to do so. For example, churning in the Medicaid population has come to be viewed as a serious problem by Medicaid managed care organizations.

As we noted, 12 million children started nearly 19 million new spells without insurance between October 1992 and September 1994. In other words, more than one-third of the new spells that began during this two-year period were the second or third spells of children who had

become uninsured earlier in the period. In each year alone, 20 to 23 percent of the new spells were additional spells of children becoming uninsured for at least the second time in the year. The magnitude of this churning among the uninsured raises questions that must be addressed if we are to make significant progress in permanently reducing the number of uninsured children. Why do so many children regain coverage only to lose it again within a year or two? What are the roles of public and private sources of insurance in accounting for this phenomenon?

If we look at who is uninsured from one year to the next, we find less turnover than we might imagine, given the sizable numbers of children entering and leaving the uninsured population each month. While 800,000 children regained insurance coverage each month over the study period, only to be replaced by another 800,000 who lost coverage, and while 12 million different children became uninsured over the two-year period, we find that 62 percent of the 9.5 million children who were uninsured in October 1992 were still uninsured in September 1993, and 52 percent were still uninsured a year later. In other words, after two years, only about half of the uninsured children or between four and five million had been replaced by children who became uninsured during the intervening period. Some of the children who were still uninsured had undoubtedly remained uninsured continuously over the two-year period, but the estimates of churning suggest that children who gained insurance coverage and then lost it again may account for a significant proportion of the children who were uninsured at both the beginning and end of the period.

While the turnover in the population of uninsured children over one or two years may appear small, we would underscore two aspects of these findings:

- The turnover is not small in terms of actual numbers of children. If the federal government and the states could *immediately and permanently* insure the estimated

11 million children who are currently uninsured, these findings suggest that a year later, an additional 4 to 5 million children would be uninsured.

- The figures on year-to-year turnover hide the many children who go without insurance for some period during the intervening 12 months--losing but regaining coverage before the end of the year. Again, in the scenario that we described, with current estimates of the uninsured, more than 4 million additional children would go without insurance for some period during the year.

Relative to the number of new enrollments, the amount of churning in the Medicaid program is on a par with what we see among uninsured children. Specifically, 9.0 million children initiated the 13.4 million new spells of Medicaid participation in FY93 or FY94. That is, one-third of the new spells were second or third spells by children who had enrolled in Medicaid earlier in the period. Each year, about one in five new spells included children who were enrolling in Medicaid for at least the second time during the year.

Both in absolute number and as a proportion of the total caseload, however, new spells on Medicaid were less common than new spells without insurance. The 13.4 million new spells on Medicaid that started between October 1992 and September 1994 contrast with the 19 million new spells without insurance initiated over the same period. The month-to-month turnover in the Medicaid child population, at 4 percent of the caseload, was only half the monthly turnover in the uninsured. Further, 80 percent of the children who were enrolled in Medicaid in October 1992 were still enrolled in Medicaid in September 1993 and, a year later, 76 percent.   Again, some portion of the children who were enrolled in Medicaid at the beginning and end of the period actually left the program and returned, but given the lower exit rates from Medicaid than from the uninsured, we would expect a larger share to have been continuously enrolled in Medicaid than the fraction of uninsured children who were continuously uninsured over the same period.

In sum, while churning has attracted interest in studies of the Medicaid population, we find more churning and substantially more turnover among uninsured children than among children enrolled in Medicaid. However, we must recognize that changes in the Medicaid caseload that are developing post-welfare reform could begin to alter the Medicaid dynamics as well.

WHAT ARE THE CHARACTERISTICS OF CHILDREN BY HEALTH INSURANCE COVERAGE?

How Does Insurance Coverage Vary among Subgroups of Children?

Other research has established that uninsured children differ from insured children in terms of a variety of demographic and economic characteristics (Fronstin 1997b, Lewis et al. 1997). In our analysis, insurance coverage varied with nearly every characteristic that we examined and in ways that largely replicated earlier findings. For example, Hispanic children were more than twice as likely to be uninsured as black children, who were only marginally more likely to be uninsured than white children. Nearly three-quarters of children whose parents did not work were enrolled in Medicaid compared to about half that percentage among children whose parents were employed part-time. This latter group along with children with no parent in the household were the most likely to be uninsured, but together, they accounted for only 13 percent of all uninsured children.

While employer-sponsored insurance was the most common source of coverage, subgroups of children with comparatively low rates of employer-sponsored coverage were not necessarily more likely to be uninsured. Medicaid accounts for this situation but fills the gap more completely for some groups than others. Children in families below 50 percent of poverty, for example, have only one-fifth the employer-sponsored coverage that children between 100 and 200 percent of poverty have, but they are less likely to be uninsured. Indeed, uninsured children in families between 100 and 200 percent of poverty account for nearly 40 percent of all children

without insurance, while those below 100 percent of poverty account for one-third of all children without insurance. This pattern is evidence of the need for the broad coverage that states are allowed to provide through CHIP.

How Does a Child's Insurance Coverage Compare to That of His or Her Parents?

Children's coverage tends to mirror that of their parents, but the exceptions to this rule pose interesting questions for policymakers and analysts. About one-fifth of uninsured children appear to have at least one insured parent--a situation that merits further research to establish if and why it is true. Between 7 and 8 percent of uninsured children, for example, have a parent who reports being covered by Medicaid--a fraction that appears much too high and suggests that many of these children may in fact be covered by Medicaid, contributing to the aforementioned Medicaid undercount . At the same time, between 10 and 13 percent of the children who were reported to have been covered by Medicaid in the study period appeared to have an uninsured parent. This finding is very plausible in light of the opportunity for many children to be enrolled in Medicaid under child-only provisions. In fact, we would very likely find an even greater proportion of Medicaid children with uninsured parents if the Medicaid participation rates of children eligible under the various child-only provisions were as high as they are in the eligibility categories with the greatest participation. This situation raises the policy question--to which we will return--of whether the Medicaid enrollment of children could be increased by extending eligibility to parents as well.

How Does a Child's Age Influence the Chances of Being Uninsured or on Medicaid?

It is important to measure the relationship between age and health insurance coverage because age differences in coverage reflect experiences over the life cycle. Both the probability

of being uninsured and the average time without insurance increase with age--a finding

established by longitudinal analysis. To generate findings like this, we followed children over

the entire year at a given age. Between infancy and late adolescence, the probability of being

uninsured during a year rose from 16 percent to 27 percent. Among those who were uninsured

for any length of time, only 10 percent of infants versus 38 percent of 18-year-olds were

uninsured for the entire year.

The likelihood of being both uninsured and *ineligible* for Medicaid increases even more

sharply with age than does being uninsured alone. Only 6 percent of infants compared with a full

24 percent of 18-year-olds were ever uninsured and ineligible for Medicaid during the year.

Furthermore, while only 5 percent of those infants who were ever uninsured and Medicaid-

ineligible remained so for the entire year, nearly one-third of the 18-year-olds in the same

situation remained so for the entire year.

Medicaid coverage declines sharply with age. Age differences in Medicaid participation are

to a large degree a reflection of eligibility criteria that progressively favor younger children.[3] Our

findings highlight the very prominent role of Medicaid among infants and how that role

diminishes as children grow older. Nearly 40 percent of all infants were covered by Medicaid

for some part of their infancy, and nearly two-thirds of them, or 25 percent of all infants, were

covered for the entire year. With increasing age, the probability that a child was ever covered by

Medicaid during the year declined gradually to about 15 percent or less, while the proportion of

Medicaid children who were covered for the entire year fell to about one-third. In contrast to the

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[3]For example, under provisions included in the Omnibus Budget Reconciliation Act, states were required to cover infants and children under age 6 in families with incomes below 133 percent of the federal poverty level and to cover older children born after September 30, 1983 in families below 100 percent of poverty. Many states exercised an option to cover infants up to higher income levels, and a smaller number extended the income limits for older children as well. In addition, families with younger children were more likely than families with older children to have an income below the levels that qualified them for Aid to Families with Dependent Children (AFDC) and thus were more likely to obtain Medicaid coverage through that route.

25 percent of all infants who were covered by Medicaid for the entire year, only 10 percent of 10-year-olds and less than 5 percent of 18-year-olds were enrolled for the entire year. This latter differential is likely to diminish over time as Medicaid eligibility under the poverty-related criteria is phased in and Medicaid expansions are introduced under CHIP.

What Characteristics Distinguish Uninsured Children Who Are Medicaid-Eligible?

In general, uninsured children who are Medicaid-eligible resemble Medicaid participants, which supports the contention that many of these children are either in transition to Medicaid or are enrolled but have not reported their coverage. However, these two groups of people differ notably from each other in four areas:

- *Racial Composition*. Uninsured Medicaid-eligible children are twice as likely to be white as black, whereas the proportions among Medicaid participants are nearly equal. Hispanic children are only slightly more represented among the uninsured Medicaid-eligibles than among Medicaid participants.

- *Family Structure*. Children from two-parent families account for more than half of the Medicaid-eligible uninsured whereas they are one-third of Medicaid participants.

- *Poverty Status*.   Children in families between 100 and 200 percent of poverty make up one-third of the Medicaid-eligible uninsured compared to one-fourth of Medicaid participants.

- *Parents' Employment Status*. Children with a parent employed full-time make up half of the Medicaid-eligible uninsured but only 30 percent of Medicaid participants. The reverse is true of children whose parents are not working.

These findings have direct implications for Medicaid outreach. For instance, the characteristics of eligible children who are less likely to participate can guide decisions about how--and where--to target the outreach and education efforts under both Medicaid and CHIP to achieve higher participation. But what accounts for the lower participation probabilities of these

groups of eligible children? Further research to answer this question could significantly enhance

the design of outreach programs.

Do the Characteristics of Uninsured Children Vary by Spell Duration?

Differences in the characteristics of children with long versus short spells without insurance

are also potentially important to the design of programs as well as targeted outreach. However,

children who experience long spells without insurance do not appear to be strikingly different

from children who experience relatively brief spells without insurance. Researchers have found

very strong differences between children with and without insurance coverage, but once children

lose their coverage, there appears to be little that differentiates between those who remain

uninsured for long periods of time and those who become re-insured fairly quickly. Children

with long spells were somewhat more likely to be Hispanic and to live with both parents, but no

other notable differences emerged. On the whole, these findings give us little information to use

in designing programs or outreach.

**HOW MANY FEWER UNINSURED CHILDREN WOULD THERE BE WITH MORE COMPLETE
PARTICIPATION IN MEDICAID?**

How High Is Medicaid Participation?

With no adjustment for the Medicaid undercount in the SIPP, the reported participation in

Medicaid is 65 percent among children who we simulated to be eligible.[4] If we exclude from the

denominator those eligible nonparticipants who reported some other source of coverage, the

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[4]Our simulation did not encompass all categories of eligibility; nor could it take account of the full range of income
disregards that states might apply to individual cases. For this reason, we do not include in our participation rate those
children who were reported as Medicaid participants but were simulated to be ineligible.

participation rate rises to 79 percent. With an undercount adjustment, the 65 percent figure would rise to about 75 percent.

What Proportion of Uninsured Children Are Eligible for Medicaid?

Our simulation of Medicaid eligibility revealed that 2.9 million, or 33 percent, of the estimated 8.9 million uninsured children in September 1994 were eligible for Medicaid. This is comparable to what other researchers have reported with more limited Medicaid eligibility simulations (Lewis et al. 1997).[5] With longitudinal data, however, we could also address the question of what happens to these Medicaid-eligible uninsured children over time; and what we found suggests that policymakers need to think about the Medicaid-eligible uninsured differently than they may have in the past.

Our findings do not support the inference that all 3 million of these children would be enrolled in Medicaid if only Medicaid outreach were more effective. First, much of this group is in transition--including transition to Medicaid. Between one month and the next about 20 percent of the Medicaid-eligible uninsured children completed the transition, with roughly equal shares enrolling in Medicaid, obtaining employer-sponsored or other coverage, or experiencing a rise in family income that made them ineligible for Medicaid. Within five months, more half of the initial 2.9 million Medicaid-eligible uninsured children had left that state. The mobility among the Medicaid-eligible uninsured suggests that while all of these children could theoretically be brought into Medicaid, or brought into Medicaid more quickly, it is useful to distinguish between those who would remain eligible and otherwise uninsured for only a few months and those who would remain in that state for a much longer period. Second, 25 percent

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[5]While the level of detail in our simulations and the use of monthly income would tend to raise estimates of eligibility relative to many of these other efforts, the SIPP obtains more complete reporting of Medicaid participation than most other surveys, which reduces the number of simulated eligibles who are identified as uninsured.

of the children who transition in and out of Medicaid eligibility and between 40 and 50 percent of those who remain Medicaid-eligible and uninsured for longer periods were actually enrolled in Medicaid previously. Thus, there is a sizable group of uninsured and Medicaid-eligible children for whom it may be more relevant to ask why have they *left* Medicaid than why have they not enrolled. Better Medicaid *outreach* is not the answer to removing them from the uninsured.

In 1994, about one million children remained uninsured for a year or more despite being eligible for Medicaid, and the number is likely to have grown since then. Policymakers would do well to focus on this group, whose persistence in this condition suggests that they are hard to reach and so will require extraordinary outreach techniques if they are to be brought into Medicaid. The demographic and socioeconomic characteristics that we examined shed little light on what differentiates this group of children from those who more quickly become insured or Medicaid-ineligible. Ultimately, understanding why children remain uninsured and Medicaid-eligible for a year or more may require different kinds of data than our surveys can provide, but we have not exhausted what longitudinal surveys like the SIPP can tell us.

What Do Medicaid Participation Rates Tell Us about Strategies for Outreach?

Medicaid participation rates among children vary widely by the basis of eligibility. In September 1994, we observed the following participation rates:

- 100 percent among AFDC participants, who are automatically enrolled

- 75 percent among reported SSI recipients and foster children

- 54 percent among children in families that appeared to be eligible for AFDC but did not report that they were receiving cash assistance

- 37 percent among children eligible under the poverty-related expansions

- 23 percent among other eligibility groups[6]

As the number of families receiving cash assistance diminishes under welfare reform, we would expect the overall Medicaid participation rate to drop significantly unless there is a sizable increase in participation rates among children in these other eligibility categories.

The overall pattern of participation and the nature of changes in the cash assistance caseload post-welfare reform carry implications for CHIP. First, it is clear that outreach efforts will have to be very strong to achieve high participation rates in both the Medicaid expansions and the state programs. In the absence of strong outreach, we might expect to see participation rates that are no better than what we observed in the populations eligible for Medicaid without cash assistance. Second, to the extent that CHIP extends eligibility to families and children who were not eligible previously, participation rates could be even lower than we have seen for non-cash families and their children historically. Many newly eligible families may not perceive that a public program is truly for them; they may not even be aware that they are eligible and, lacking experience with public programs, may not think to inquire. They may also hesitate because of the stigma that they believe accompanies participation in such programs. Third, different outreach strategies may prove to be differentially effective with different eligibility groups and different subgroups of the population. At a minimum, strategies should be designed to deal with three different types of eligibles, who will be found in different proportions in different eligibility groups and population subgroups:

- Children who have been eligible for Medicaid but resisted participation

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[6]This category does not include children whose eligibility depended on their families "spending down" their income to meet thresholds specified in a state medically needy program. We did not simulate this aspect of Medicaid eligibility because data on health care expenditures are very limited in the SIPP.

- Children who have already participated

- Children who are becoming eligible for the first time

It may be relatively easy to enroll children who have already participated, but it is likely to be much more difficult to enroll children who have resisted participation or who have become eligible for the first time. For the newly eligible, outreach will have to communicate basic information about the program and allay the concerns of prospective new clients. For those who have been eligible but have not participated, we may need to understand the reasons for their behavior in order to design effective outreach programs.

Another factor that plays into this issue of outreach is the role of coverage for the parent. The differences in participation by eligibility group provide at least a suggestion that children are more likely to participate if a parent is eligible as well. Some states have begun to consider strategies that would allow them to use CHIP funds to partially fund coverage for the parents of eligible children. Further research into the importance of parents' access to coverage in determining their children's likelihood of participating in public insurance programs is clearly in order and may lend additional support to efforts intended to increase the coverage that is available to parents.

CONCLUSION

Examining the dynamics of health insurance coverage among children tells us much about the magnitude of the task of insuring the uninsured. While policymakers and researchers tend to focus on the number of children who are without insurance at any one time, children who experience one or more months without insurance over the course of a two-year period are more than double this number. Most children who become uninsured remain uninsured for less than

six months at a time, so growth in the number of uninsured children has remained modest. Nevertheless, policymakers' well-warranted concerns about the difficulty of enrolling a high proportion of eligible children--especially those who have not participated in Medicaid previously--bring the problem into focus. Turnover in the population of uninsured children implies that outreach efforts will have to continue at a high level in order to achieve and maintain strong participation in Medicaid and CHIP.

Retention of children who have already enrolled in Medicaid or CHIP emerges as a potentially important policy issue. More than half of the children who leave Medicaid are uninsured the next month, and such children account for two-fifths of the newly uninsured. Why do they leave Medicaid, and if access to insurance continues to be a need, what can be done to keep them enrolled?

Despite a widespread perception to the contrary, participation in Medicaid by eligible children with no other insurance was quite high before welfare reform, and many of those who appeared to be uninsured and eligible for Medicaid were actually in transition--often to Medicaid. But participation rates were lifted by the high proportion of cash assistance recipients. As this group declines in importance the historically much lower participation rates of other groups of eligibles may become more typical. As CHIP extends affordable health insurance coverage to increasingly more children, the greatest challenge for policymakers is to ensure that no child who needs this coverage is denied it.

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