SNAPSHOTS
of America's Families II

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Assessing the New Federalism

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Health Insurance, Access, and Health Status of Children

Findings from the National Survey of America's Families

In recent years, the forces that shape private and public health insurance coverage for children have shifted. Economic growth has brought increased employment and higher incomes (Economic Report of the President 2000), which should provide greater access to private coverage. At the same time, however, employees may be bearing a larger share of premiums for family coverage (Ginsburg 1999). Public coverage has been expanding under the new State Children's Health Insurance Program (SCHIP), but most SCHIP programs were not yet mature in 1999 (Kenney, Ullman, and Weil 2000). Finally, federal welfare reform appears to have resulted in unintended reductions in Medicaid enrollment among children (Garrett and Holahan 2000).

This Snapshot uses data from the National Survey of America's Families (NSAF) to describe insurance coverage for children ages 18 and under in 1999 and how coverage changed between 1997 and 1999.[1] The NSAF asked families a series of questions about their health insurance coverage at the time of the survey, including whether coverage was provided through an employer (employer-sponsored insurance [ESI]); through Medicaid or a separate SCHIP or another state program (Medicaid/SCHIP/State); by some other source (including private nongroup plans and Medicare); or whether they had no coverage. This Snapshot analyzes coverage by income group, age, and state. Low-income children (those living in families with incomes below 200 percent of poverty) are divided into two groups: those with incomes below poverty, who are most likely to be affected by welfare reform, and those with incomes between 100 and 200 percent of poverty, who were the primary target group for SCHIP during this period. Higher-income children (those with family incomes above 200 percent of poverty) are also divided into two groups: those with incomes between 200 and 300 percent of poverty and those with incomes above 300 percent of poverty. This Snapshot also briefly examines changes in access to care and health status, but it does not attempt to link them to changes in insurance coverage.

HIGHLIGHTS

- In 1999, 12.5 percent of all children 18 and under—9.6 million children—lacked health insurance at the time of the survey; this was not a statistically significant change from the 1997 rate.
- Uninsurance rates for low-income children held steady, but higher-income children experienced a statistically significant increase in uninsurance that was driven by declines in employer-sponsored insurance coverage.
- Low-income children in Alabama, Colorado, and Massachusetts experienced the greatest reductions in their uninsurance rates. In Massachusetts, this was due primarily to gains in Medicaid/SCHIP/State coverage; in Colorado, it was due to gains in employer-sponsored insurance and other coverage; and in Alabama, it was due to a combination of both.
- Higher-income children experienced modest declines in health care access while low-income children saw some gains.

Major Findings

Against a backdrop of change in the forces that influence insurance coverage for children, the rate of uninsurance for children between 1997 and 1999 remained virtually the same overall. Nationally, 12.5 percent of all children (9.6 million) lacked health insurance in 1999 (table 1)—an increase of 0.3 percentage points from 1997—but this change was not statistically significant. However, trends in both coverage and access to care diverged for children in different income groups and across states. Uninsurance rates for low-income children held steady, but higher-income children experienced a statistically significant increase in uninsurance. This increase was concentrated among children with family incomes between 200 and 300 percent of poverty, who were 2 percentage points more likely to be uninsured in 1999 than in 1997. During that period, the number of uninsured children with family incomes above 200 percent of poverty rose by 600,000. Higher-income children also experienced modest declines in health care access, while low-income children saw some gains. In sum, while the gaps in coverage rates and access to care between low- and higher-income children narrowed slightly between 1997 and 1999, low-income children remained substantially more likely than higher-income children to lack insurance coverage and to experience access problems.

TABLE 1 **Health Insurance Coverage of Children, by Income, 1997 and 1999**

	Employer-Sponsored (%)		Medicaid/SCHIP/State (%)		Other Coverage (%)		Uninsured (%)		Number of Children in Income Group (millions)	
	97	99	97	99	97	99	97	99	97	99
Below 100% of poverty level	19.3	21.7	55.6	52.2	3.5	3.0	21.7	23.2	15	13
100–199% of poverty level	54.7	51.8	17.8	21.9 ▲	5.2	4.4	22.3	21.8	17	17
200–299% of poverty level	82.3	76.7 ▼	5.3	7.7 ▲	3.5	4.5	8.9	11.2 ▲	15	15
Above 300% of poverty level	91.0	89.4 ▼	1.5	2.0	4.5	5.1	3.0	3.5	29	31
All incomes	66.8	66.7	16.8	16.4	4.2	4.5	12.2	12.5	75	76

Note: The symbols "▲" and "▼" represent statistically significant increases and decreases, respectively, between 1997 and 1999 at the 0.10 confidence level. *Source:* Urban Institute

Coverage Changes, But Similar Patterns Persist

Despite the slight decrease in the gap in insurance coverage, low-income children remained substantially more likely to lack insurance: 22 percent of low-income children were uninsured in 1999, compared with 6 percent of higher-income children (table 2). Of the 9.6 million uninsured children, 6.8 million had incomes below 200 percent of poverty and 2.7 million had higher incomes.

As in 1997, ESI was the most important source of coverage, covering two-thirds of all children. But type of coverage varied substantially by family income. Almost 90 percent of the children with family incomes over 300 percent of poverty had ESI, compared with 22 percent of poor children. In contrast, 52 percent of poor children received coverage through Medicaid/SCHIP/State, compared with 2 percent of children with family incomes above 300 percent of poverty.

Although uninsured children were still concentrated in low-income families, a growing share lived in families with higher incomes; such families are heavily dependent on ESI, with limited access to public coverage in most states. In 1999, 29 percent of all uninsured children lived in higher-income families; in 1997, the figure was 23 percent.

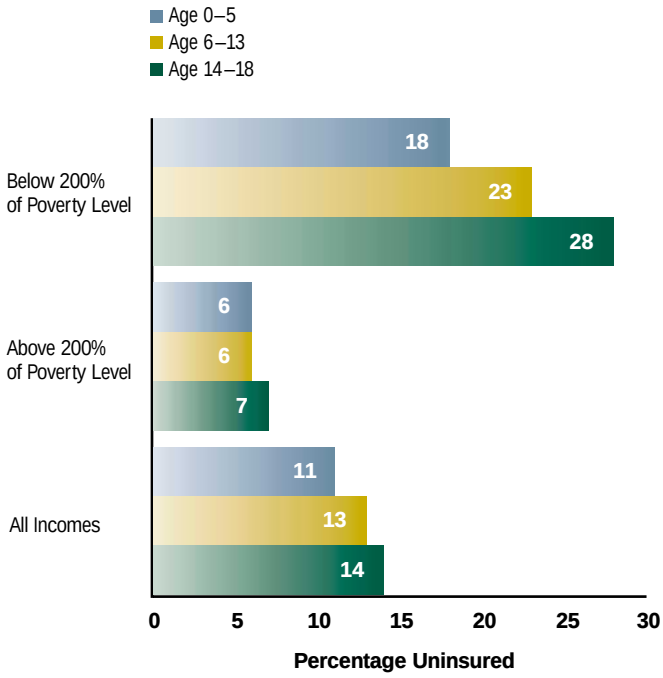
Changes in Coverage by Income Group

Type of insurance coverage shifted between 1997 and 1999 for children in different income groups. Over this period, children below poverty lost Medicaid/SCHIP/State coverage but gained ESI, in contrast to children in the three other income groups.[2] It appears that the combination of federal welfare reform and the strong economy served to shift poor children from Medicaid/SCHIP/State coverage to ESI. Still, more than one in five poor children were uninsured in 1999, although almost all were eligible for Medicaid or SCHIP.

Children with family incomes between 100 and 200 percent of poverty—the group primarily targeted by SCHIP during this period—experienced the greatest gains in Medicaid/SCHIP/State coverage, but the gains were not enough to cause a statistically significant decrease in their uninsurance rate.

Children with family incomes between 200 and 300 percent of poverty—who experienced modest gains in Medicaid/SCHIP/State coverage—experienced the biggest losses in ESI and the largest increases in uninsurance, both of which were statistically significant. Children with family incomes above 300 percent of poverty experienced smaller, but still statistically significant, declines in ESI. The declines in ESI among higher-income children may be a consequence of rising costs for family coverage, or they may reflect that children in the higher income brackets have less access to ESI than in the past.

Figure 1: Uninsured Children, by Family Income and Age, 1999



Source: Urban Institute

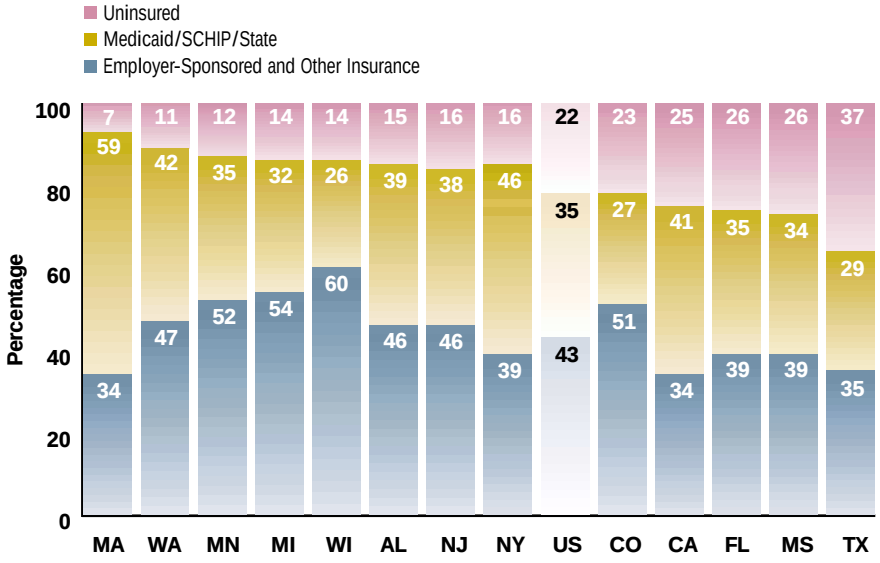
Variation in Coverage among Children in Different Age Groups

Overall, older children continue to have higher uninsurance rates than younger children, as was true in 1997. In 1999, 14 percent of all children ages 14 to 18 were uninsured, compared with 11 percent of all children age 5 and under (figure 1). Higher-income children did not experience significant differences in uninsurance rates between age groups, but low-income children did. Among low-income children, 28 percent of 14- to 18-year-olds, 23 percent of 6- to 13-year-olds, and 18 percent of children under age 5 were uninsured in 1999. Thus, low-income children ages 14 to 18 were 1.6 times as likely as those age 5 and under to lack coverage in 1999. States have moved to equalize eligibility for children of different ages under Medicaid and SCHIP, so uninsurance rates for children of different ages are expected to converge as states' SCHIP programs are fully implemented.

State Variation in Insurance Coverage for Low-Income Children

Insurance coverage for low-income children continues to vary substantially across states (figure 2).[3] Among the states highlighted in the NSAF, the prevalence of ESI/Other coverage varies from 60 percent in Wisconsin and 54 percent in Michigan to about 35 percent in California, Massachusetts, and Texas. Coverage through Medicaid/SCHIP/State programs also varies across states, ranging from 59 percent in Massachusetts to below 30 percent in Colorado, Texas, and Wisconsin. These patterns have created large discrepancies in coverage for low-income children across states: for example, only 7 percent of all low-income children in Massachusetts lacked health insurance coverage in 1999, compared with 37 percent of low-income children in Texas.

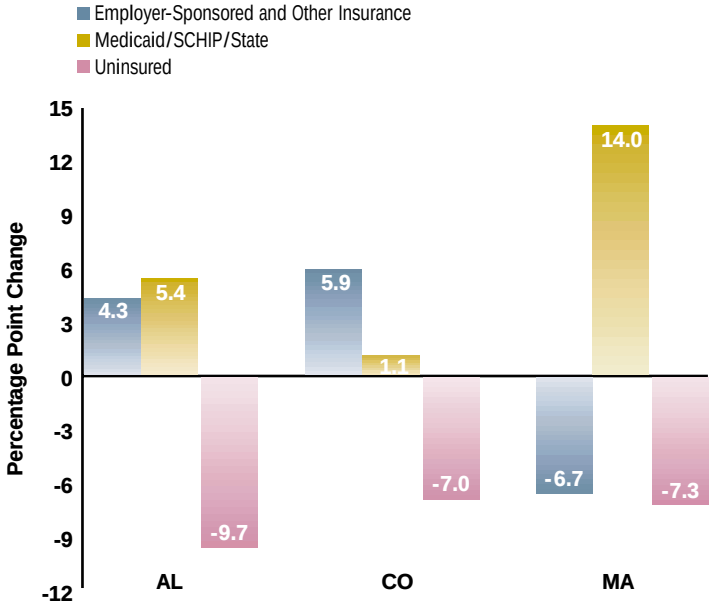
Figure 2: Health Insurance Coverage of Low-Income Children, by State, 1999



Source: Urban Institute

Nationally, there was no statistically significant change between 1997 and 1999 in the proportion of low-income children who lacked health insurance coverage. The national picture, however, masks changes in some of the highlighted states (figure 3).[4] There were statistically significant reductions in the uninsurance rates for low-income children in Alabama, Colorado, and Massachusetts.[5] The underlying explanation for these declines appears different for each state. In Alabama, for example, more low-income children obtained Medicaid/SCHIP/State, ESI, and other coverage, leading to a 10 percentage point reduction in the uninsurance rate. In Massachusetts, low-income children had large gains in Medicaid/SCHIP/State coverage, but were somewhat less likely to have ESI, and on balance were 7 percentage points less likely to be uninsured.[6] In contrast, in Colorado, the increased coverage for low-income children appears to be largely attributable to an increase in ESI.

Figure 3: States with Falling Uninsurance Rates among Low-Income Children, 1997–1999



Source: Urban Institute

Both Alabama and Massachusetts implemented large-scale SCHIP expansions soon after SCHIP was enacted. Alabama's program, ALLKids, built upon a limited Medicaid program and was one of the first to be approved. Its launch was accompanied by a broad-based outreach effort and a simplified joint Medicaid/SCHIP application (Hill and Westpfahl forthcoming).[7] In Massachusetts, the SCHIP program, called MassHealth, was the culmination of the state's efforts to create a single, seamless program that also covers parents. Substantial investments have been made to raise awareness about MassHealth and to streamline the enrollment system (Hill and Westpfahl forthcoming).

Of the other 10 states highlighted in the NSAF, Michigan and Texas exhibited particularly interesting patterns of change in their insurance distributions. In both states, Medicaid/SCHIP/State coverage declined among low-income children while ESI coverage increased, particularly among those below poverty. Although the increases in ESI did not fully offset the Medicaid/SCHIP/State declines, the estimated uninsurance rate increases (2.5 and 3.1 percentage points, respectively) for low-income children in Michigan and Texas were not statistically significant.

Access and Health Status

As was the case for 1997, the NSAF data for 1999 reveal that low-income children are worse off than higher-income children in terms of access to care and health status: Low-income children are more likely to lack a usual source of care (including those who rely only on a hospital emergency room), to have parents who are not confident that family members can get medical care when they need it, and to be in fair or poor health (figure 4 on page 5).

Overall, there was a small decrease in the percentage of children with a usual source of care, an increase in the percentage with confidence in their ability to receive needed medical care, and no change in the percentage reporting fair or poor health (table 2 on page 6). The trends varied by income group, and, to some extent, across states, although there were few significant changes in these indicators among the states highlighted by the NSAF. Interestingly, higher-income children experienced deteriorating status across all three measures: 1 percentage point more lacked a usual source of care, 1 percentage point more had parents who lacked confidence in their ability to get their families needed care, and a larger portion were reported to be in fair or poor health. Children in low-income families experienced a decline (3 percentage points) in the proportion with parents lacking confidence in their family's ability to obtain needed care, but changes in the other measures were not statistically significant.

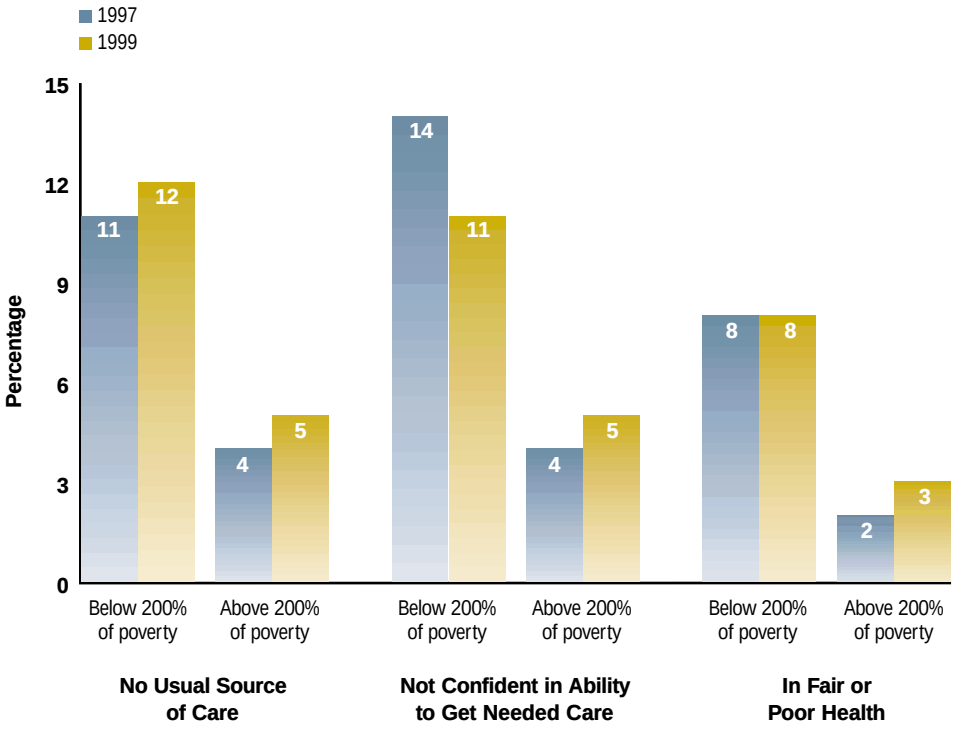
Discussion

Despite the strong economy and expansions in eligibility under the new State Children's Health Insurance Program, the proportion of children lacking health insurance coverage did not decline between 1997 and 1999. In fact, higher-income children were somewhat more likely to be uninsured in 1999 than in 1997, due to declines in ESI that had begun earlier in the 1990s (Holahan and Kim 2000). While some children with family incomes above 200 percent of poverty have become eligible for SCHIP, most higher-income children are not eligible for public coverage (Dubay and Haley forthcoming). It will take more research to understand why higher-income children experienced these reductions in employer-sponsored insurance.

Although uninsurance rates held steady for low-income children, this masks divergent trends within this group. The NSAF shows that poor children lost Medicaid/SCHIP/State coverage and gained ESI, in contrast to other low-income children who experienced significant gains in Medicaid/SCHIP/State coverage. While understanding the influences of federal welfare reform and SCHIP on coverage for low-income children is beyond the scope of this Snapshot, changes may have been caused in part by federal welfare reform. The high uninsurance rate in 1999 for poor children, almost all of whom are eligible for public coverage, also highlights the need for new strategies to enroll these children. These simple descriptive data hint that early SCHIP expansions may be starting to have significant impacts, particularly in Alabama and Massachusetts, where large reductions in uninsurance were accompanied by large increases in Medicaid/SCHIP/State enrollment. Forthcoming analyses will assess the impacts of SCHIP, both in its early stages and in its more mature form, on insurance coverage.

Large differences persist in uninsurance rates between low- and higher-income children, both nationally and across the states examined here. In 1999, low-income children were almost four times as likely as higher-income children to lack insurance coverage; low-income children were also more likely to be in fair or poor health and to experience greater access problems. Substantially higher rates of uninsurance were also experienced by low-income children who are Hispanic (Staveteig and Wigton 2000) or over 13. Uninsurance rates among low-income children across the highlighted states also vary dramatically. In 1999, a low-income child in Texas was more than five times as likely as a low-income child in Massachusetts to be uninsured. As time passes, and the full effects of SCHIP are felt, many of these coverage gaps are expected to shrink, given the expansion in coverage under SCHIP to most low-income children and a move toward greater equalization of eligibility thresholds for low-income children across different age groups and states.

Figure 4: Children's Access to Care and Health Status, 1997–1999



Source: Urban Institute

TABLE 2 **Indicators of Health Insurance, Access and Health Status of Children, by State**

	AL		CA		CO		FL		MA		MI		MN	
	97	99	97	99	97	99	97	99	97	99	97	99	97	99
Health Insurance Coverage of Children (%), by Family Income and Type of Insurance, 1997–1999														
Below 200% of poverty level														
Employer-sponsored	37.7	40.8	28.6	**29.0**	39.1	**45.5** ▲	33.2	34.8	36.8	**32.2**	44.7	**50.4** ▲	41.7	**45.5**
Medicaid/SCHIP/State	33.9	**39.4** ▲	44.4	**40.8**	25.7	**26.8**	33.1	35.3	45.2	**59.2** ▲	40.4	**31.6** ▼	39.9	35.4
Other coverage	3.9	5.1	4.0	5.1	5.4	4.8	5.8	4.4	4.1	**2.1** ▼	3.1	3.6	6.3	**7.2**
Uninsured	24.4	**14.7** ▼	23.0	25.1	29.9	**22.9** ▼	28.0	25.5	13.8	**6.5** ▼	11.9	**14.4**	12.1	**12.0**
Above 200% of poverty level														
Employer-sponsored	90.8	**88.6**	85.6	**82.0** ▼	84.8	85.3	81.9	**76.4** ▼	90.0	**89.0**	92.8	**89.8** ▼	89.7	**88.7**
Medicaid/SCHIP/State	1.8	3.6 ▲	3.0	4.5	3.3	**2.6**	3.8	**6.5** ▲	3.2	**5.6** ▲	2.5	**2.6**	2.8	4.2 ▲
Other coverage	2.1	4.1	6.4	**7.7**	6.7	**6.8**	6.7	**8.2**	4.0	**3.2**	2.5	4.2	4.7	4.5
Uninsured	5.3	**3.7**	5.0	5.8	5.2	5.3	7.6	**8.9**	2.9	**2.2**	2.3	**3.4**	2.7	**2.6**
All incomes														
Employer-sponsored	65.0	65.7	57.2	**59.6**	69.0	**72.1** ▲	58.1	**57.9**	73.8	**72.9**	76.7	**76.4**	75.7	**76.9**
Medicaid/SCHIP/State	17.4	**20.8** ▲	23.6	**19.8** ▼	11.0	**10.7**	18.1	**19.3**	16.0	**20.8** ▲	15.2	**12.5** ▼	13.7	**12.7**
Other coverage	3.0	4.6 ▲	5.2	**6.6**	6.2	**6.1**	6.3	**6.5**	4.0	**2.9** ▼	2.7	4.0	5.2	5.2
Uninsured	14.6	**9.0** ▼	14.0	14.0	13.7	11.1 ▼	17.5	**16.3**	6.2	**3.4** ▼	5.5	**7.2** ▲	5.5	**5.2**
Children's Access to Health Care (%), by Family Income, 1997–1999														
Below 200% of poverty level														
No usual source of care	16.2	13.9	15.8	**16.6**	10.5	10.5	15.1	12.2	4.5	**5.6**	7.9	10.7	3.8	**4.5**
Not confident in ability to get needed care	14.3	10.5	18.0	15.9	15.3	13.0	14.6	14.1	10.2	8.9	10.1	11.6	6.7	5.8
Above 200% of poverty level														
No usual source of care	4.5	5.0	4.4	6.9	4.4	**3.8**	3.8	**8.3** ▲	3.0	**3.0**	3.6	4.6	2.4	**3.0**
Not confident in ability to get needed care	3.5	2.4	4.6	6.2	4.4	4.2	8.1	7.0	3.4	3.2	3.4	3.8	2.5	2.5
All incomes														
No usual source of care	10.2	9.3	10.1	**11.0**	6.5	**6.0**	9.3	**10.0**	3.4	**3.7**	5.0	6.7	2.8	**3.4**
Not confident in ability to get needed care	8.7	6.3 ▼	11.3	10.4	8.1	7.1	11.3	10.2	5.4	4.8	5.7	6.5	3.8	3.4
Children (%) in Fair or Poor Health, by Family Income, 1997–1999														
Below 200% of poverty level	8.5	8.3	11.8	**11.0**	9.2	9.4	7.9	7.7	6.6	7.0	7.3	7.6	5.1	**4.5**
Above 200% of poverty level	3.0	**1.6**	2.5	3.6	1.7	2.0	3.2	3.2	1.5	2.1	1.6	2.6	2.0	2.2
All incomes	5.6	4.8	7.1	**6.7**	4.3	4.5	5.5	5.2	3.0	**3.5**	3.5	4.3	2.9	**2.8**

Note: Figures in color represent values that are statistically significantly different from the 1999 national average at the 0.10 confidence level.
The symbols "▲" and "▼" represent statistically significant increases and decreases, respectively, between 1997 and 1999 at the 0.10 confidence level.

MS		NJ		NY		TX		WA		WI		US	
97	99	97	99	97	99	97	99	97	99	97	99	97	99
34.2	35.4	41.1	41.7	33.1	**34.6**	27.6	**32.7** ▲	36.2	40.1	54.0	**55.4**	37.8	38.7
32.7	34.3	36.6	38.1	45.5	**45.9**	36.3	**28.7** ▼	47.0	**42.2**	27.0	**25.6**	35.9	35.2
3.4	4.3	2.9	3.9	2.7	3.5	2.5	**2.0**	3.2	**6.5** ▲	4.3	**5.4**	4.3	3.8
29.7	**26.1**	19.5	**16.3**	18.7	**16.1**	33.6	**36.7**	13.6	**11.2**	14.7	**13.7**	22.0	22.4
82.6	**81.9**	89.6	**89.2**	89.1	86.5	79.6	**82.2**	86.6	83.5 ▼	91.5	**89.6**	88.1	85.3 ▼
2.2	3.7	2.3	3.1	3.1	**5.4** ▲	3.2	3.7	4.5	**6.0**	1.4	**2.2** ▲	2.8	3.8 ▲
8.9	5.6 ▼	3.5	**2.9**	2.7	**3.3**	6.4	4.6	4.9	6.2	4.5	**3.5**	4.2	4.9 ▲
6.2	**8.8**	4.5	**4.8**	5.3	4.8	10.8	**9.6**	4.0	**4.3**	2.6	4.7 ▲	5.0	6.0 ▲
54.5	**57.3**	75.5	**75.9**	64.3	**64.0**	54.0	**57.6** ▲	68.4	**69.9**	79.5	**79.4**	66.8	66.7
19.9	**19.9**	12.3	**12.9**	21.8	**23.0**	19.6	16.1 ▼	19.8	17.3 ▼	9.6	**9.1**	16.8	16.4
5.7	4.9	3.3	**3.1**	2.7	**3.4**	4.5	**3.3**	4.3	**6.3** ▲	4.5	4.1	4.2	4.5
19.9	**18.0**	8.9	**8.0**	11.2	**9.7**	22.0	**23.0**	7.5	**6.5**	6.4	**7.4**	12.2	12.5
12.3	**16.1** ▲	11.1	10.3	8.6	**9.0**	20.1	**17.4**	8.3	**9.0**	5.7	**7.8**	10.9	11.7
11.5	13.0	14.2	12.0	14.4	11.9	17.1	13.3	11.8	11.2	10.1	9.8	14.1	11.4 ▼
6.8	**8.6**	4.3	**3.4**	3.9	3.9	6.5	6.0	2.7	5.0 ▲	2.9	**2.8**	4.2	5.2 ▲
4.4	4.7	4.3	4.2	5.3	4.5	5.0	4.8	3.8	3.8	2.1	2.9	3.8	4.6 ▲
10.0	**12.6** ▲	6.2	**5.3**	6.0	**6.1**	13.2	**11.7**	4.7	**6.2**	3.8	**4.3**	7.1	7.8 ▲
8.5	9.1	7.2	6.4	9.3	7.8	11.0	9.0	6.7	6.1	4.7	5.0	8.2	7.3 ▼
9.3	**12.9** ▲	7.4	**11.0** ▲	7.9	**9.8**	12.0	**11.8**	6.9	7.8	5.6	**6.0**	8.3	7.9
2.0	3.3	2.6	**2.0**	2.4	1.8	2.9	2.7	2.0	2.2	2.0	1.9	1.9	2.5 ▲
6.2	**8.4** ▲	4.0	4.5	4.8	5.3	7.4	**7.2**	3.8	4.0	3.1	**3.2**	4.6	4.7

Source: Urban Institute

SNAPSHOTS
of America's Families II

This Snapshot presents findings from the 1997 and 1999 rounds of the National Survey of America's Families (NSAF). Information on more than 100,000 people was gathered in each round from more than 42,000 households with and without telephones that are representative of the nation as a whole and of 13 selected states. As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on NSAF methods can be obtained at http://newfederalism.urban.org/nsaf/methodology.html.

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Endnotes

1 We include 18-year-olds as children in this Snapshot because they are eligible as children under both Medicaid and SCHIP.

2 The changes between 1997 and 1999 in Medicaid/SCHIP/State and ESI coverage for poor children were statistically significantly different from the changes for children in the other income groups.

3 For ease of presentation, figures 2 and 3 combine the Employer-Sponsored and Other categories.

4 In only one state, Wisconsin, was there a significant change in the uninsurance rate for higher-income children.

5 These three states also experienced statistically significant declines in uninsurance rates for all children.

6 This was consistent with large reported increases between 1997 and 1999 in Medicaid enrollment for families, adults, and children in Massachusetts relative to other states for which comparable administrative data were available (Kaiser 2000).

7 The increases in Medicaid/SCHIP/State coverage in Alabama may be related to eligibility expansions under SCHIP, but they may also reflect rising enrollment in Medicaid among poor children (Smith 1999). Alabama's ALLKids program expanded coverage to 200 percent of poverty; prior to SCHIP, Medicaid covered younger children at federally mandated minimums and older children at just 15 percent of poverty. ALLKids's use of the state's Blue Cross/Blue Shield organization for service delivery seems to be very popular among both consumers and providers (Hill and Westpfahl forthcoming).

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