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SCHIP
State Children's Health Insurance Program Evaluation

# Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era

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*It is clear that some states have been able to achieve very high Medicaid coverage rates for eligible children, indicating that success is possible.*

Following the creation of Title XXI—the State Children's Health Insurance Program (SCHIP)—in 1997, all states expanded public health insurance coverage for low-income children. SCHIP gave states the option of using either Medicaid or separate state programs to expand children's eligibility. By September 2000, 33 states had increased their eligibility thresholds for children of all ages to at least 200 percent of the federal poverty level (FPL) (Health Care Financing Administration [HCFA] 2000). With the expansions in Medicaid eligibility for children that began in the late 1980s and the more recent expansions under SCHIP, more than three-quarters of all uninsured children are now eligible for coverage under either Title XIX or Title XXI (Dubay, Haley, and Kenney 2001).

In part because so many uninsured children are now eligible for public coverage, current policy debates are focusing on how to reach these children and enroll them in Medicaid and SCHIP. Historically, participation in Medicaid has been low, particularly for children ineligible for any type of cash assistance (Selden, Banthin, and Cohen 1998; Dubay and Kenney 1996). In addition, the federal welfare reform law enacted in 1996 may have exacerbated these problems, with the unintended effect of reducing Medicaid participation (Garrett and Holahan 2000; Families USA 1999; Davidoff, Garrett, and Yemane 2001). Before SCHIP, it appeared that 70 percent of eligible children were participating in Medicaid[1] and that millions of children were uninsured despite being eligible for the program (Selden et al. 1998).

In this brief, the 1999 National Survey of America's Families (NSAF) is used to examine participation in both Medicaid and SCHIP—nationally and for the 13 *Assessing the New Federalism* (ANF) project study states[2]—among children who are citizens and who do not have private insurance coverage. The analysis builds on a model that simulates eligibility for Medicaid and SCHIP for each state. In 1999, 45 percent of SCHIP-eligible children were participating in SCHIP and 72 percent of Medicaid-eligible children were participating in Medicaid. It is not surprising that participation rates were higher for Medicaid than for SCHIP, given how new the SCHIP expansions were in 1999; in fact, these early SCHIP participation rates are an encouraging sign that SCHIP programs were already taking root. The research also points to large differentials in both Medicaid and SCHIP participation across the 13 study states. For example, Medicaid participation ranged from a high of 93 percent in Massachusetts to a low of 59 percent in Texas. Massachusetts, one of the earliest states to expand coverage under SCHIP, also achieved high participation (90 percent) among SCHIP-eligible children by 1999. This suggests that states can achieve high participation rates in both Medicaid and SCHIP.

## The NSAF: Data and Methods

The NSAF is a nationally representative household survey that oversamples low-income households (less than 200 percent of FPL) and households in 13 states. Detailed information was collected on up

to two sampled children ages 17 and under per household from the adult who knew the most about the child's education and health care.

The analyses presented herein rely on a detailed Medicaid and SCHIP eligibility simulation model.[3] This model attempts to mimic the eligibility determination process faced by families applying for Medicaid or SCHIP. First, eligibility units were created from the household survey data. (Only individuals who would be considered in the eligibility determination process are included in this unit.[4]) Second, Medicaid and SCHIP eligibility rules in place in August 1999 were applied to these units regarding eligibility thresholds (which vary by the age of the child), family composition, and work status of the parents; how income is counted, including whose income and what types of unearned income are counted; work, earned income, child care, and child-support disregards; asset limits; and deeming of stepparent and grandparent income. Third, children were categorized hierarchically into three eligibility groups: those who are eligible for both Medicaid and Temporary Assistance for Needy Families (TANF) according to the 1997 TANF rules (TANF-related);[5, 6] those who are eligible for Medicaid on the basis of the poverty-related expansions, both federally mandated and those allowed under §1902(r)(2) provisions (poverty-related);[7] and those who are eligible for SCHIP, including children in states that expanded Medicaid or created separate programs under SCHIP (SCHIP-eligible).

This analysis focuses on children who are either U.S.-born citizens or naturalized U.S. citizens. Noncitizen children born outside the United States (3.4 percent of all children, or a total of 2.4 million children) are excluded from this analysis because their Medicaid and SCHIP eligibility could not be accurately determined (Dubay et al. 2002).[8]

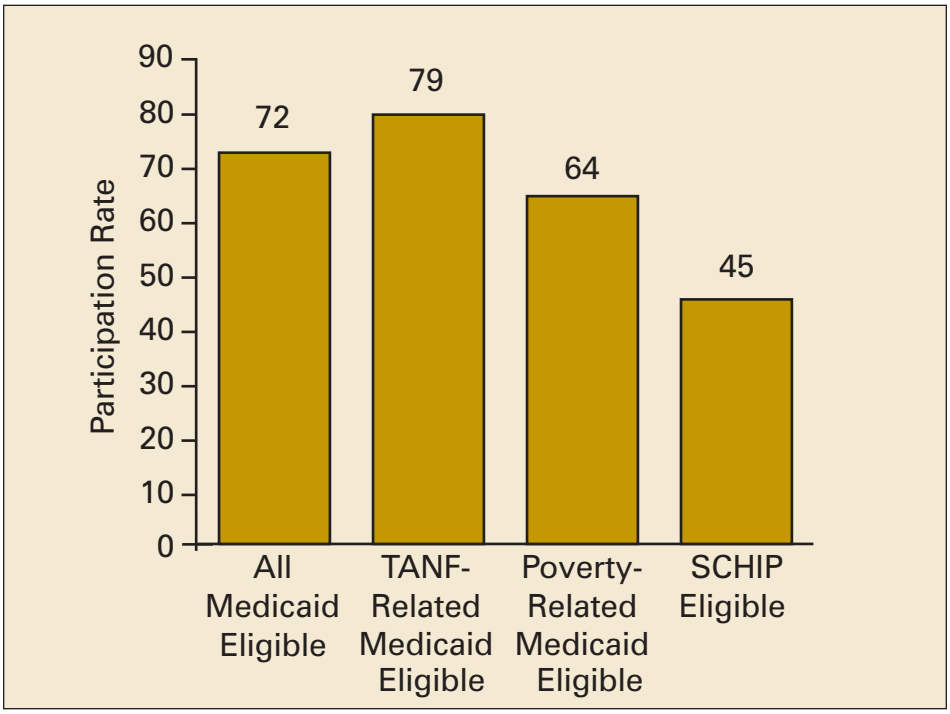
To illustrate the extent to which these programs fill the gap left by the lack of private coverage, this analysis also excludes children with private coverage. The focus is on these children because their participation in Medicaid and SCHIP is the best indicator of the degree to which Medicaid and SCHIP are reaching the target population of uninsured children (Spillman 2000).[9, 10, 11, 12] Data are first presented on participation rates in Medicaid and SCHIP among eligible children nationally. Patterns of participation are then presented by the age, race / ethnicity, health status, and the presence of an activity limitation of the child; the birthplace of the parents; and the family's experiences with and opinions about welfare. Finally, participation rates are presented for the 13 ANF study states. Five states were excluded from the analysis of SCHIP participation: Minnesota was excluded because its SCHIP expansion was very small and as a consequence so was the size of the SCHIP-eligible population, and Mississippi, Texas, Washington, and Wisconsin were excluded because their SCHIP programs were not fully implemented by the time the 1999 NSAF was fielded.[13]

## Findings

### *National Estimates of Participation in Medicaid and SCHIP*

Figure 1 presents participation rates among eligible children when children with private coverage are excluded. In 1999, 72 percent of children eligible for Medicaid who did not have private coverage were participating in Medicaid. Consistent with historic patterns, children eligible for Medicaid in the TANF-related group participated at much higher rates (79 percent) than children eligible in the poverty-related group (64 percent). In 1999, very early in the implementation of most SCHIP expansions, almost half (45 percent) of all children eligible for coverage under SCHIP were participating.

*FIGURE 1. Participation in Public Health Insurance Programs, Excluding Children with Private Coverage, U.S. Citizen Children 0–17, 1999*




*Source:* 1999 National Survey of America's Families.

### *Patterns of Participation for Children in Different Subgroups*

**Age.** The extent to which Medicaid and SCHIP programs reach uninsured children appears to vary systematically with the characteristics of the child (table 1). Younger children participated in Medicaid and SCHIP at significantly higher rates than older children: Children five and under were 9 percentage points more likely to participate in Medicaid or SCHIP when eligible than children ages 6 to 12, and almost 17 percentage points more likely than children ages 13 to 17. These patterns hold for children in all three eligibility groups and are not surprising, given that younger children tend to have greater contact with the health care system.

**Health Status and Activity Limitations.** SCHIP-eligible children in poor health were much more likely to participate than other SCHIP-eligible children, but this finding did not hold for children in the other eligibility groups.

Overall, children with activity limitations tended to participate in Medicaid and SCHIP at higher rates than other children. Children with some sort of activity limitation were about 12 percentage points more likely to participate in Medicaid or SCHIP than children with no reported activity limitation; this finding held for the TANF-related eligibility group but not for the other two groups.

**Race/Ethnicity and Birthplace of Parents.** Black non-Hispanic children were about 11 percentage points more likely than white non-Hispanic children overall—and specifically the TANF-related eligible group—to participate in Medicaid or SCHIP. On the whole, it appeared that children with at least one foreign-born parent were about 8 percentage points less likely than children with no foreign-born parents to be covered by Medicaid or SCHIP; however, this difference was not statistically significant when each eligibility group was considered separately.

**Welfare Participation and Opinions.** Children in families that had participated in the TANF program in the past two years and whose parents had more positive views about welfare were more likely to participate in Medicaid or SCHIP than other children (table 2). Overall, children whose families left welfare during the two years before the survey were 15 percentage points more likely to participate in Medicaid or SCHIP than children whose families had not participated in the welfare program over that same period. Participation rates were higher when the parent had more positive and less negative views about welfare. Children were about 7 to 10 percentage points more likely to have Medicaid or SCHIP coverage when parents did not think that welfare makes people work less or that it encourages babies before marriage, or when they believed that welfare helps people get on their feet.

**Familiarity with Programs.** Much higher rates of participation were found among children whose parents understood the basic eligibility rules for Medicaid or SCHIP. Children were about 20 percentage points more likely to be covered by Medicaid or SCHIP when their parents knew that participation in welfare was not required in order to be covered by Medicaid or SCHIP than those whose parents believed it was required or did not know whether welfare participation was necessary. The participation differential between those whose parents understood the basic rules and those whose parents did not was greatest

*TABLE 1. Medicaid and SCHIP Participation Rates by Characteristics of Child and Parents, U.S. Citizen Children 0–17, 1999*

| | TANF-Related Eligible | Poverty-Related Eligible | SCHIP-Eligible | All Eligible Children |
|---|---|---|---|---|
| **Age of Child** | | | | |
| 0–5 ^ | 84.2 | 69.7 | 56.8 | 74.8 |
| 6–12 | 78.5** | 59.1*** | 45.0** | 65.4*** |
| 13–17 | 70.4*** | 56.7*** | 39.0*** | 58.3*** |
| **Health Status of Child** | | | | |
| Excellent/Very Good/Good | 78.7 | 63.6 | 45.3*** | 67.2 |
| Fair | 78.5 | 67.0 | 46.2*** | 70.2 |
| Poor ^ | 88.0 | 56.3 | 92.8 | 80.2 |
| **Activity Limitations of Child** [a] | | | | |
| Has activity limitation ^ | 86.6 | 66.7 | 55.4 | 77.4 |
| No activity limitation | 76.9*** | 63.4 | 44.1 | 65.8*** |
| **Race/Ethnicity of Child** | | | | |
| White, Non-Hispanic ^ | 74.0 | 63.6 | 42.8 | 63.3 |
| Black, Non-Hispanic | 83.1*** | 67.1 | 48.3 | 74.0*** |
| Hispanic | 81.4* | 59.0 | 48.9 | 67.5 |
| Other, Non-Hispanic | 67.7 | 76.0* | 51.5 | 67.7 |
| **Birthplace of Parents** | | | | |
| No foreign-born parents | 79.5 | 65.3* | 45.7 | 68.9*** |
| One or both parents foreign-born ^ | 74.6 | 57.6 | 44.4 | 60.7 |

*Source:* 1999 National Survey of America's Families (NSAF).
*Notes:*
^ indicates reference category for tests of statistical significance.
* indicates participation rate is significantly different than the reference category at the 0.10 level.
** indicates participation rate is significantly different than the reference category at the 0.05 level.
*** indicates participation rate is significantly different than the reference category at the 0.01 level.
a. Indicates whether child has a physical, learning, or mental health condition that limits his or her participation in the usual kinds of activities done by most children his/her age or ability to do regular school work.

TABLE 2. *Medicaid and SCHIP Participation Rates by Families' Participation in and Opinions about Welfare, U.S. Citizen Children 0–17, 1999*

| | TANF-Related Eligible | Poverty-Related Eligible | SCHIP-Eligible | All Eligible Children |
|---|---|---|---|---|
| **Welfare Participation (Past 2 Years)** | | | | |
| Welfare leaver in past 2 years | 73.0 | 74.7*** | 86.3*** | 74.5*** |
| No welfare participation in past 2 years ^ | 69.4 | 58.9 | 42.9 | 59.4 |
| **Opinions about Welfare** | | | | |
| *Believes welfare encourages babies before marriage* | | | | |
| Strongly agree or agree ^ | 72.3 | 61.8 | 45.3 | 63.5 |
| Strongly disagree or disagree | 82.1*** | 66.0 | 45.5 | 70.1** |
| *Believes welfare helps people get on their feet* | | | | |
| Strongly agree or agree ^ | 80.6 | 66.0 | 47.3 | 69.4 |
| Strongly disagree or disagree | 73.5** | 57.0* | 41.2 | 62.1** |
| *Believes welfare makes people work less* | | | | |
| Strongly agree or agree ^ | 76.3 | 63.5 | 43.0 | 65.1 |
| Strongly disagree or disagree | 84.4*** | 67.8 | 54.2* | 74.5*** |
| **Familiarity with Medicaid/ SCHIP Programs** | | | | |
| Heard of program but do not understand basic rules ^[a] | 79.5 | 52.5 | 27.8 | 59.3 |
| Heard of program and understand basic rules[b] | 74.6 | 77.2*** | 62.4*** | 79.1*** |

*Source:* 1999 National Survey of America's Families (NSAF).
*Notes:*
^ indicates reference category for tests of statistical significance.
* indicates participation rate is significantly different than the reference category at the 0.10 level.
** indicates participation rate is significantly different than the reference category at the 0.05 level.
*** indicates participation rate is significantly different than the reference category at the 0.01 level.
a. Indicates parent has heard of the Medicaid or SCHIP program in their state but did not know that families do not have to participate in welfare programs in order for children to enroll.
b. Indicates parent has heard of the Medicaid or SCHIP program in their state and understands that families do not have to participate in welfare programs in order for children to enroll.

among SCHIP-eligible children and smallest among children in the TANF-related category.

### Medicaid Participation Rates in 13 States

Participation in Medicaid among children without private coverage appears to vary substantially for children in different states—from 59 percent in Texas to 93 percent in Massachusetts (figure 2). Among the 13 states, six (Alabama, California, Massachusetts, New Jersey, New York, and Washington) had participation rates that were statistically significantly above the national level, and two (Mississippi and Texas) had rates that were below. The fact that three states—Massachusetts, New York, and Washington—achieved participation rates in Medicaid of over 80 percent and that Massachusetts appears to be reaching more than 9 in 10 eligible children demonstrates that states can make significant inroads with their Medicaid programs in covering eligible children who otherwise might be uninsured. Other analysis suggests that the coverage of parents under Medicaid in Massachusetts may contribute to the higher participation rates observed among Medicaid-eligible children there (Dubay and Kenney 2001). It is interesting to note that the two states that had not fully implemented their SCHIP expansions by 1999—Texas and Mississippi—had the lowest Medicaid participation rates among the 13 studied and also had the lowest levels of awareness of public programs (Kenney, Haley, and Dubay 2001).

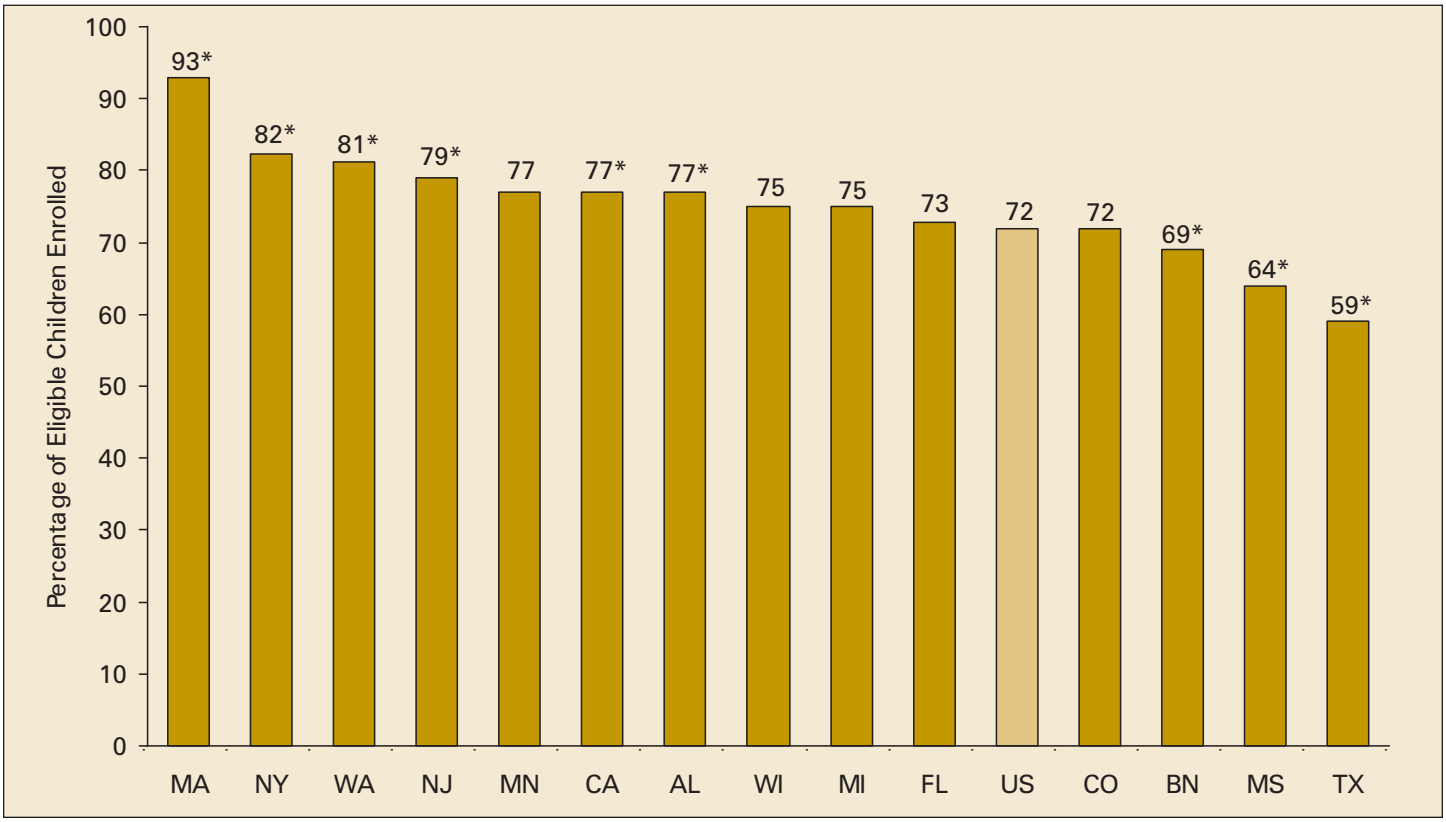
### SCHIP Participation Rates in Eight States

As with Medicaid, there appears to have been substantial variation across states in rates of SCHIP participation in 1999 (figure 3). Again, Massachusetts was at the high end of the spectrum, with participation of an estimated 90 percent of SCHIP-eligible children. Both Alabama and New York also achieved SCHIP participation rates significantly above the national average, but their SCHIP participation rates were about 25 percentage points lower than the rate for Massachusetts. The higher rates of SCHIP participation in Alabama, Massachusetts, and New York may be due in part to the fact that Alabama and Massachusetts were among the earliest to implement SCHIP expansions and that the New York program dates to 1991, before the federal legislation that created SCHIP. Among the eight states examined here, Florida had the lowest SCHIP participation rate (33 percent). There are several possible reasons for the low participation rate in Florida's SCHIP program, Healthy Kids, in 1999. In Florida, counties must provide a local match for the Healthy Kids program. Although all counties currently participate in the program, 7 of Florida's 67 counties were not participating in 1999 because of the local match requirement. In addition, Florida had a backlog of applications and waiting lists in some counties in the early years of the program that have since been resolved.[14] Thus, participation rates in Florida have probably risen since 1999.

## Policy Implications

These new data indicate that 72 percent of eligible children without any other coverage were covered by Medicaid in 1999. This leaves more than 4 million Medicaid-eligible citizen children uninsured (data not shown). In 1999, many states were still trying to reverse losses of

*FIGURE 2. Medicaid Participation, U.S. Citizen Children Ages 0–17, by State, 1999*




*Source:* 1999 National Survey of America's Families.
*Note:* Excludes those with private coverage.
*Statistically different from the rest of the nation at the 10 percent level or lower.
BN = balance of nation

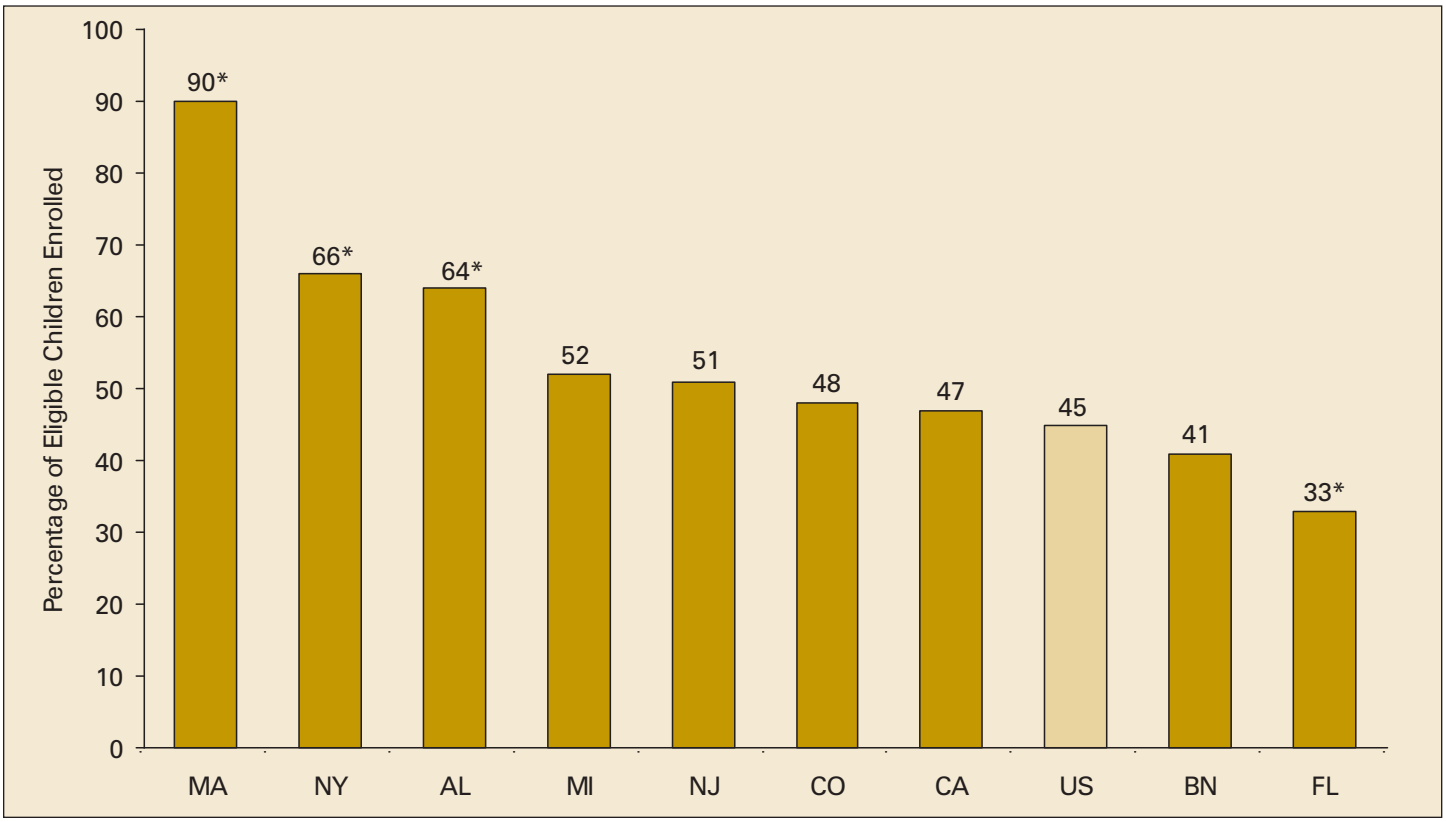
Medicaid coverage related to the implementation of federal welfare reform, and many were in the process of launching new initiatives for outreach and streamlining enrollment and redetermination processes. Therefore, participation rates in Medicaid may have grown since these data were collected. Moreover, it is clear that some states have been able to achieve very high Medicaid coverage rates for eligible children, indicating that success is possible. It will be important to understand how programs achieve these high participation rates and whether their successes can be replicated elsewhere. Reducing uninsurance among children hinges on further increasing participation in Medicaid, as the majority of low-income uninsured children are eligible for Medicaid (Dubay et al. 2001).

These findings show that children with greater health services needs (i.e., those who are very young or who have a functional limitation) tend to participate in Medicaid/SCHIP at higher rates than other children. These patterns suggest that parents may more aggressively seek out and obtain public coverage for their children when the expected benefits of health insurance coverage and the downsides of lacking coverage are greatest. It is also possible that these children more frequently come into contact with providers who are actively identifying and enrolling eligible uninsured children. Nevertheless, many children who are in poor health or who have activity limitations remain uninsured. Moreover, the low participation rates among teenage children may be cause for concern, indicating that some of the health needs of teenage children are not being met.

Variation in Medicaid and SCHIP participation among children in different racial and ethnic subgroups calls for a better understanding of why such differentials exist. For example, the lower participation of citizen children with foreign-born parents may indicate that fears about public charge issues are acting as a deterrent to applying for Medicaid and SCHIP to which the children are entitled (Lake Snell Perry and Associates 1998).

The fact that children were less likely to participate in Medicaid or SCHIP when their families had not previously been enrolled in welfare suggests that, if welfare programs continue to shrink, Medicaid and SCHIP programs may face greater challenges in reaching uninsured children. Thus, further declines in welfare participation may make uninsured children even harder to reach. In addition, because more positive opinions about welfare seem to be associated with greater participation in both Medicaid and SCHIP, it appears that improvements in the image of welfare

*FIGURE 3. SCHIP Participation, U.S. Citizen Children Ages 0–17, by State, 1999*




*Source:* 1999 National Survey of America's Families.
*Notes:* Excludes those with private coverage.
* Statistically different from the rest of the nation at the 10 percent level or lower.
BN = balance of nation

programs may have positive spillover effects on participation in Medicaid and SCHIP. It also appears that welfare and Medicaid / SCHIP programs remain connected in many people's minds (Kenney et al. 2001) and that raising understanding about the true nature of the Medicaid / welfare link could reduce uninsurance among eligible children.

These new data offer promising evidence that, as early as 1999, SCHIP was making important inroads in covering children. Although fewer than half of all SCHIP-eligible children were participating in SCHIP at that time, it is encouraging that even this many children were participating in such a new program. Participation in SCHIP is likely to have improved since the time period of this analysis, given that the programs have become more established. Clearly, however, for both Medicaid and SCHIP programs to achieve their objectives, they will have to enroll even more uninsured children. A full assessment of SCHIP's ability to enroll and retain eligible children will be possible as the program matures. It is important that such an assessment also explore whether children who enroll in Medicaid and SCHIP obtain access to timely, comprehensive, and high-quality care.

## Endnotes

1. This participation rate and all others reported in this brief exclude children with private insurance coverage.

2. The 13 ANF states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.

3. For a complete discussion of the simulation model, see Dubay and Haley (forthcoming).

4. These units vary across states and within states across programs.

5. This group also includes children eligible for Medicaid because of their receipt of Supplemental Security Income (SSI) and being in foster care.

6. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created a new category of Medicaid eligibility for families in Section 1931 of the Social Security Act. We use the TANF rules in place in 1997 to identify the TANF-related group in 1999 because SCHIP locked in Medicaid eligibility rules for children as of June 1997.

7. This group also includes children eligible for Medicaid under Ribicoff, medically needy, and transitional medical assistance provisions.

8. This group will be analyzed separately in forthcoming work.

9. Children with Medicare coverage only are also excluded; they represent a very small share of low-income children.

10. As in all household surveys, the possibility exists that public insurance coverage is underreported in NSAF. Thus, the participation rates reported herein may underestimate the actual participation rates if some

respondents have not reported their children's participation in these programs.

11. NSAF respondents were asked separately about their children's participation in Medicaid and SCHIP using state-specific program names. However, Medicaid and SCHIP enrollees cannot always be distinguished from each other (for example, in states with the same name for Medicaid and SCHIP). Thus, enrollment in either Medicaid or SCHIP was used to indicate participation in Title XIX or Title XXI, depending on the program for which the child was determined to be eligible on the basis of the simulation model.

12. Children with private insurance coverage are, by law, excluded from enrolling in SCHIP, but they may be eligible for Medicaid. While these participation rates are the best available measure of participation, they assume that public coverage is being provided to children who would otherwise be uninsured. To the extent that public coverage is substituting for private coverage, these participation rates may overstate the extent to which public programs are filling in gaps.

13. By 1999, Mississippi and Texas were using SCHIP funds only to phase in coverage of older children with incomes up to 100 percent of FPL; their larger expansions to children with incomes up to 200 percent of FPL took place in 2001. Washington did not implement its SCHIP program until January 2001, and Wisconsin started its program in April 1999, in the middle of the survey's fielding period. Minnesota's SCHIP program, while fully implemented at the time of the survey, covered only children under age 2 with incomes between 275 and 280 percent of FPL, a group too small for which to obtain precise estimates of participation.

14. From an interview conducted by Ian Hill with Rose Naff, Director, Healthy Kids Corporation, December 17, 1999, as part of the Urban Institute's SCHIP Evaluation.

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This series 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 (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on the NSAF can be obtained at **http://newfederalism.urban.org**.

The NSAF is part of ***Assessing the New Federalism,*** a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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