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Children Eligible for Medicaid but Not Enrolled: How Great a Policy Concern?

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In the mid-1990s, children eligible for, but not insured by, Medicaid were almost four times more likely than Medicaid-enrolled children to lack a regular source of health care.

Approximately one of every five children eligible for Medicaid coverage is medically uninsured, despite great interest in reducing the number of children without health insurance. Since these Medicaid-eligible children account for up to a quarter of all uninsured children (Lewis, Ellwood, and Czakja 1997; Selden, Banthin, and Cohen 1998), many states have launched outreach and enrollment initiatives to attract them. But is underenrollment really a public policy concern? If these children have sufficient access to primary care and can enroll in Medicaid when serious health problems strike, for example, does further outreach represent a cost-effective use of public funds?

Children who are eligible for but not enrolled in Medicaid do, in fact, encounter greater obstacles to care than their Medicaid-covered counterparts, according to National Health Interview Survey (NHIS) data.[1] Medicaid-eligible uninsured children are somewhat healthier than enrolled children, but not all are healthy. If uninsured Medicaid-eligible children are compared with Medicaid-covered children with the same health status, family income, and other characteristics, the uninsured are more likely to report unmet medical need and less likely to use health care services. Also, their families are more likely to be burdened with out-of-pocket health costs.

Medicaid-eligible children with *private* health insurance also face barriers to access. When health status and other non–insurance-related differences are taken into account, these children are more likely than Medicaid-enrolled children to have a regular source of care. However, they are also more likely to report financial barriers (out-of-pocket expenses) to seeking care. Furthermore, those who saw a provider in the past year had fewer visits, on average, than Medicaid-enrolled children. For these reasons, the public interest in enrolling more Medicaid-eligible children is justified.

Differences between Eligible Uninsured and Medicaid-Enrolled Children

A nationally representative sample of 18,462 Medicaid-eligible children ages 0 to 17 in the 1994 and 1995 NHIS forms the basis for

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the analysis reported here.[2] This group represents 32 percent of U.S. children nationwide. Of these Medicaid-eligible children, 56 percent were enrolled in Medicaid, 27 percent had private insurance, and 17 percent were uninsured.[3]

The uninsured and Medicaid-enrolled groups of Medicaid-eligible children differ demographically, socially, and economically (table 1). The uninsured are slightly older than the Medicaid-covered group, more likely to be white non-Hispanic, and less likely to be African American non-Hispanic. Their families are better educated on average than their Medicaid-covered counterparts, less likely to be very poor (below 50 percent of the federal poverty level [FPL]), more likely to have two resident parents, more likely to have resident parents working full-time, and less likely to have at least one parent out of the labor force (neither working nor looking for work).

What about their relative health? Most children in both groups are healthy (table 2). More than 9 out of 10 reported no activity limitations, and less than 6 percent reported fair or poor health. The typically small health differences between the groups are statistically significant, however, with Medicaid-covered children slightly less healthy than the uninsured. This is to be expected because eligible children often are enrolled in Medicaid when they seek care for a health problem. Both providers and parents are strongly motivated to enroll eligible uninsured children in such circumstances. Still, it is conspicuous that about 4 percent of the uninsured were limited in a major activity, and 11 percent had some chronic health condition. Thus, it is not uni-

TABLE 1: Characteristics of Medicaid-Eligible Children: Uninsured versus Enrolled (Percent Distribution)

	Uninsured	Enrolled
Age		
0–6 years	51.0***	54.9
7–13 years	36.9***	32.9
14–17 years	12.0	12.2
Race/Ethnicity		
White, non-Hispanic	48.3***	38.8
African American, non-Hispanic	17.4***	31.5
Hispanic	28.7***	24.9
Other	6.0	4.9
Family Type		
Two parents	60.9***	42.2
Single parent, female	35.3***	55.2
Single parent, male	3.8**	2.6
Parental Education[a]		
Less than high school	29.3***	34.2
High school graduate	45.9**	42.4
Some college	18.0	18.3
College graduate or more	7.8***	5.0
Family Income (% FPL)[b]		
<50	42.0***	63.1
50–100	41.4***	20.6
100–150	14.4***	9.3
150–200	2.1**	3.2
>200	0.1***	3.7
Parental Work Activity[c]		
Full-time (one or both as relevant)	31.9***	20.1
Part-time (at least one)	17.0	15.9
Not in labor force (at least one)	50.7***	64.0

Source: Urban Institute tabulations of NHIS data, 1994 and 1995.

a. Of responsible adult.

b. In previous month.

c. Resident parent(s) in previous two weeks.

*** Different from Medicaid enrollees at the 99 percent level of statistical significance.

** Different from Medicaid enrollees at the 95 percent level of statistical significance.

* Different from Medicaid enrollees at the 90 percent level of statistical significance.

TABLE 2: Health Status of Medicaid-Eligible Children: Uninsured versus Enrolled

	Uninsured	Enrolled
Fair or Poor Health (%, self-reported)	3.5***	5.6
Activity Limitations (% distribution)		
None	95.2***	91.3
In a major activity	3.5***	6.8
In other activity	1.4**	2.0
Restricted Activity Days (number in a year)[a]	7.9***	11.3
Bed Days (in a year)[b]		
Any (%)	38.6*	40.9
Number (if at least one)	5.3***	6.6
Chronic Conditions		
Any (%)	10.7***	15.4
Number (if at least one)	1.3***	1.4

For source and statistical significance notes, see table 1.

a. As reflected in a two-week recall.

b. As reflected in a 12-month recall.

versally true that Medicaid-eligible children are enrolled if they have health needs.

Access to care is clearly more of a problem for eligible uninsured than for Medicaid-covered children (table 3). Almost one-quarter (23 percent) of these uninsured children lacked a regular source of care, compared with about 6 percent of the Medicaid-enrolled. In fact, only 28 percent of the uninsured reported lack of need as their main reason for not having a regular source of care, while 56 percent cited lack of insurance. For those *with* a regular source of care, the type of provider used for that care was similar for both groups. However, the eligible uninsured were less likely to see a specific provider or to be satisfied with how long they had to wait to be seen—suggesting that the perceived quality of care they get from their regular source may be lower. Finally, Medicaid-eligible uninsured children were almost three times as likely to have an unmet health care need during the year as Medicaid-enrolled children—and more than four times as likely to delay care due to cost.

Consistent with their better health and more limited access to providers, health care use by eligible uninsured children was lower than use by Medicaid-enrolled children (table 4). Uninsured children were less likely to have seen a provider in the past 12 months, for example, and less likely to have been hospitalized. If they had a provider visit, the eligible uninsured children were less likely to have had it in a physician's office. They were more likely than Medicaid-enrolled children to have had a telephone contact, however, suggesting that the parents of uninsured children may be substituting free telephone consultations for physician visits (this is particularly likely for those who do have a regular source of care). About one-third of both groups reported less-than-adequate immunization,[4] suggesting that the preventive care delivery system may be failing some low-income children, even those with health insurance. Finally, families of the uninsured children spent substantially more out-of-pocket on medical care, with almost 30 percent spending over $500 a year, while only 13 percent of the families of Medicaid-enrolled children spent this much.

TABLE 3: Health Care Access for Medicaid-Eligible Children: Uninsured versus Enrolled

	Uninsured	Enrolled
No Regular Source of Care (%)	23.0***	5.6
Main Reason for No Regular Source (% of total without)		
No need	28.0***	40.7
Moved, don't know where to go	9.7***	22.5
No insurance	56.2***	18.6
Other	6.1***	18.2
Regular Source of Care (% of total with)		
Physician's office	73.0	75.7
Outpatient	21.2	22.0
Hospital emergency room	2.6*	1.4
Military/VA	1.7***	0.1
Other	1.6*	0.7
Characteristics of Regular Source (%)		
Satisfied with wait time for appointment	87.1	90.9
Satisfied with wait time to be seen	79.6**	85.3
Evening/weekend availability	82.5	86.1
Specific provider seen	68.2***	77.2
Unmet Need in a Year (%)[a]		
Any	17.9***	6.2
Medical	5.9***	1.5
Dental	13.5***	3.7
Other	5.6***	2.4
Delayed Seeking Care Due to Cost	11.3***	2.5

For source and statistical significance notes, see table 1.

a. As reflected in 12-month recall.

TABLE 4: Health Care Used by Medicaid-Eligible Children: Uninsured versus Enrolled

	Uninsured	Enrolled
Use in a Year[a]		
Any provider (%)	69.2***	84.1
Number of visits (if at least one)	3.2***	4.5
Any acute hospital stay (%)	2.3***	4.5
Family Out-of-Pocket Spending in a Year (%)		
None	15.2***	41.5
$1–500	55.8***	45.6
Over $500	28.9***	12.9
Visits to Primary Care Provider (% of total visits)[b]	77.3	70.7
Provider Location (% of total visits)[b]		
Physician's office	48.1*	55.0
Nonhospital outpatient	19.6	18.6
Hospital outpatient	9.9	8.7
Hospital emergency room	9.1	8.7
Home	0.0**	0.4
Telephone	13.3*	8.6
Adequacy of Immunizations (%)[c]	64.8	70.0

For source and statistical significance notes, see table 1.

a. As reflected in 12-month recall.

b. If any visits in previous two weeks.

c. For children ages 19 to 35 months.

Changes since the mid-1990s may have narrowed access gaps. For example, CHIP requires states to inform potentially eligible families about coverage availability.

Effects of Medicaid Coverage on Health Care Access and Use

These differences between eligible uninsured and Medicaid-enrolled children provide a useful measure of how much greater the unmet need for care is among uninsured Medicaid-eligibles. However, these differences do not reflect how much of that unmet need could be eliminated if all Medicaid-eligible uninsured children were enrolled. Many factors affect access and use, irrespective of insurance coverage.

Estimating the effect of lack of Medicaid coverage per se requires statistical adjustment for demographic, social, economic, and health differences between the two groups, the results of which are shown in table 5. The first column of the table shows the observed differences between eligible uninsured and Medicaid-covered children on a range of health care access and use measures. The second column shows how much of the differences are attributable to lack of Medicaid coverage. For example, Medicaid-eligible uninsured children were 17.4 percent more likely than Medicaid-covered children to have no regular source of care. Yet, when health and other differences are eliminated from the comparison, the uninsured group was just 7.7 percent more likely to have no regular source of care—this is the gap that Medicaid coverage could close. Similarly, Medicaid-eligible uninsured children were 11.7 percent more likely to have had an unmet health need in the previous year. When health and other differences are taken into account, however, those without insurance were only 7.0 percent more likely to have had an unmet health need—again, the gap Medicaid could fill.

All the observed differences in health care access and use are smaller but remain statistically significant when the effect of Medicaid enrollment per se is the focus. Therefore, expanding Medicaid enrollment could reduce but not totally eliminate the health care access and use gaps between the two groups. Interestingly, there is no statistically significant difference in immunization adequacy overall. When the effects of health and other differences between the two groups are taken into account, however, lack of insurance has a significant negative impact on immunization adequacy. The Medicaid-enrolled population is more likely to have very low income and less family education, reducing the likelihood of adequate immunization, other things being equal. The lack of statistical significance for the observed difference results from the positive impact of Medicaid counteracted by the negative impact of low income and less education. Removing the effect of these other factors reveals the benefits of Medicaid coverage.

TABLE 5: Effect of Being Uninsured on Health Care Access and Use by Medicaid-Eligible Children

	Difference between Uninsured and Enrolled	
	Unadjusted Difference[a] (Uninsured vs. Medicaid)	Effect of Being Uninsured (Adjusted Difference)[b]
No Regular Source of Care (%)	17.4***	7.7***
Unmet Need in a Year (%)[c]		
Any	11.7***	7.0***
Medical	4.4***	2.1***
Dental	9.8***	4.6***
Other	3.2***	1.9***
Delayed Seeking Care Due to Cost (%)	8.8***	4.7***
Use in a Year[c]		
Any provider(%)	–14.9***	–9.2***
Number of visits (if at least one)	–1.24***	–1.16***
Received Adequate Immunizations (%)[d]	–5.2	–6.2*
Family Out-of-Pocket Spending in a Year More Than $500 (%)	16.0***	12.4***

For source, see table 1.

a. First column minus second column of tables 3 or 4.

b. Group difference adjusted for a variety of noninsurance factors affecting access and use (see text note 5.)

c. As reflected in 12-month recall.

d. For children ages 19 to 35 months.

*** Difference statistically significant at the 99 percent level.

** Difference statistically significant at the 95 percent level.

* Difference statistically significant at the 90 percent level.

Medicaid-Eligible Children with Private Insurance

Medicaid-eligible children with private coverage are not generally the focus of

public policy concerns except for the concern that Medicaid expansions, rather than attracting the uninsured, may be attracting enrollees who otherwise would have private insurance. In addition, privately insured Medicaid-eligible children may be relevant to policy in the context of access barriers, especially if the copayments and deductibles associated with private coverage reduce children's use of care. This may be an issue particularly for preventive or other services less likely to be covered by private insurance plans than by Medicaid.

Privately insured Medicaid-eligible children resemble their uninsured counterparts: they have better health, higher family incomes and education levels, and a greater likelihood of having two resident and employed parents than Medicaid enrollees. They are also less likely to be Hispanic or African American.

Without adjusting for different characteristics of the two populations, patterns of health care access and use among privately insured Medicaid-eligible children are different from those among the Medicaid-eligible uninsured (table 6). The privately insured were less likely than Medicaid enrollees to lack a regular source of care, slightly less likely to report unmet medical need (although slightly more likely to report unmet dental need), and more likely to report delay in care due to cost. The family spending burdens of privately insured children were very similar to those of the uninsured and significantly greater than for Medicaid enrollees, with an unadjusted difference of 21 percent in the proportion of privately insured and Medicaid enrollees with family out-of-pocket spending over $500.

How much of these access and use variations are due to the difference in insurance coverage? Removing the differences in health and other noninsurance characteristics between the two groups changes the picture in several ways. The privately insured were even less likely to lack a regular source of care, the (small) difference in unmet dental need is reduced, and the difference in unmet medical need loses significance. Additionally, privately insured children who made at least one provider visit in a year made even fewer visits than Medicaid enrollees (from 0.49 fewer to 0.73 fewer visits on average). The difference in family out-of-pocket spending burden was reduced but still was substantially larger than for Medicaid-enrolled children. Because of their private insurance, 11.7 percent more families had out-of-pocket spending burdens of over $500 in a year compared with their Medicaid-covered counterparts.

TABLE 6: Effect of Private Insurance on Health Care Access and Use by Medicaid-Eligible Children

	Difference between Privately Insured and Enrolled	
	Unadjusted Difference[a] (Private vs. Medicaid)	Effect of Being Privately Insured (Adjusted Difference)[b]
No Regular Source of Care (%)	–2.3***	–2.8***
Unmet Need in a Year (%)[a]		
Any	1.2	0.9
Medical	–0.4*	–0.4
Dental	1.8***	1.0*
Other	–0.1	0.3
Delayed Seeking Care Due to Cost (%)	1.0**	0.7***
Use in a Year[c]		
Any provider	–1.3	–1.3
Number of visits (if at least one)	–0.49***	–0.73***
Received Adequate Immunizations (%)[d]	–0.7	–1.5
Family Out-of-Pocket Spending in a Year More Than $500 (%)	21.0***	11.7***

For source, see table 1; for statistical significance notes, see table 5.

a. Difference in group means (privately insured–Medicaid).

b. Group difference adjusted for a variety of noninsurance factors affecting access and use (see text note 5).

c. As reflected in 12-month recall.

d. For children ages 19 to 35 months.

Removing Barriers to Medicaid Enrollment: Next Steps

A useful way to summarize health and health care access differences among the two eligible nonenrolled groups and Medicaid enrollees is to compare the proportions with some health or access problem. Among Medicaid-enrolled children, 40 percent reported at least one of the following: fair or poor health, activity limitations, chronic conditions, no regular source

of care besides an emergency room, unmet care needs or care delays due to cost, and family out-of-pocket health care spending over $500 a year. Among eligible children with private insurance, 49 percent reported at least one problem. Among those with no insurance, 58 percent did.[5]

Parents whose children face health and health care access problems that Medicaid coverage could ease would be expected to enroll their children so long as time, hassle, stigma, or lack of knowledge were not barriers. That almost three out of five Medicaid-eligible children who were uninsured faced at least one health or access problem in 1994 and 1995—problems even when health and other differences are excluded from the comparison—strongly suggests that such barriers exist.

Increasingly older children in poor families have become eligible for Medicaid, and many states have expanded coverage to children higher up the income scale.

Recent policy initiatives have begun to address them. First, the 1997 Balanced Budget Act allows states to implement presumptive eligibility for Medicaid. Under this option, any qualified provider (whether WIC programs, Head Start, or agencies determining eligibility for subsidized child care, in addition to traditional health care providers) may deem children eligible for Medicaid, facilitating temporary enrollment when medical care is needed.[6] Second, Medicaid enrollment has become easier as the Children's Health Insurance Program (CHIP) has been implemented, since CHIP requires states to inform potentially eligible families about coverage availability and enrollment processes. The new emphasis on outreach has affected children who were already eligible for Medicaid prior to CHIP: For all applicants, many states have shortened application forms, dropped asset tests, permitted application by mail, used media outreach, placed eligibility workers in agencies that deal with low-income families with children in other contexts, and involved schools and employers (NGA 1998).

What about Medicaid-eligible children whose families have private insurance? Although private insurance has some advantages over Medicaid—including greater likelihood of full family coverage, a wider range of providers, no stigma, and greater satisfaction with various aspects of care—our results indicate some Medicaid-eligibles with private insurance may not seek care because it is too expensive. To the extent that this is true, choosing Medicaid when both options are available may improve health care access overall (Holahan 1997).

Two other developments since 1994–1995 probably have changed the pool of Medicaid-eligibles and their insurance options. First, increasingly older children in poor families have become eligible for Medicaid. Many states have also expanded coverage to children higher up the income scale, either through Section 1115 waivers or through CHIP. The Medicaid impact results reported here indicate that extending Medicaid coverage to new groups of uninsured children will narrow gaps in access and use. Second, many states have implemented CHIP programs that resemble private insurance more than traditional Medicaid. Such CHIP coverage should enhance access to providers relative to CHIP programs that operate as Medicaid expansions. Indeed, private CHIP programs may have greater positive impacts than private coverage because out-of-pocket expenses—a major access barrier—are far lower.

Have these developments narrowed the access gaps that existed in 1994–1995 between Medicaid-enrolled children as a group and Medicaid-eligible children who were uninsured or privately insured? And if so, to what extent? These pressing questions can be answered as more recent data become available.

Endnotes

1. The NHIS is a large, nationally representative sample of the U.S. noninstitutionalized civilian population. The analysis presented here uses data from the core instrument as well as three supplemental files and a special study of immunization adequacy among 19- to 35-month-olds in the NHIS. This database was supplemented with data on federal and state regulations for the Aid to Families with Dependent Children (AFDC) and Medicaid programs.

2. They were identified as Medicaid-eligible on the basis of family structure, child age, family income, assets, and out-of-pocket medical spending, all compared with age, state, and year-specific thresholds. Children with Medicare or Supplemental Security Income were excluded because they are

likely to have substantial health problems and could skew comparisons across groups.

3. This estimate from 1994–1995 shows a smaller proportion who are uninsured, relative to estimates for 1996 by Selden et al. (1998). Part of the explanation could be that Medicaid enrollment decreased in anticipation of welfare reform, which increased the numbers of Medicaid-eligibles who were uninsured. Dual Medicaid and privately insured children were counted in the privately insured category. Because we suspect the NHIS underreports Medicaid enrollment, we counted all children on AFDC in the Medicaid-covered group. Cash welfare recipients were automatically enrolled in Medicaid until AFDC was replaced by Temporary Assistance for Needy Families (TANF) in 1996.

4. Adequate immunization (for 19- to 35-month-olds) consists of the recommended four diphtheria/polio/tetanus vaccines, three oral polio vaccines, one measles-containing vaccine, and three hemophilus influenza bacteria vaccines.

5. The Medicaid-eligible uninsured children reporting at least one health status or access problem are somewhat different from those without any problem. They are, for example, less likely to be in the youngest age group, less likely to be African American, and more likely to live in two-parent families. The differences are too small to be of much use in targeting outreach efforts, however.

6. The child's parent must submit the completed application by the end of the following month if the child is to continue in enrollment status.

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