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Public Policy and the Dynamics of Children’s Health Insurance, 1986-1999

John C. Ham
Department of Economics
3105 Tydings Hall
University of Maryland
College Park, MD 20742
E-mail: ham@econ.umd.edu
Tel: 301-405-3497
Fax: 202-318-0863

Xianghong Li
Department of Economics
York University
Vari Hall 1068, 4700 Keele St
Toronto, ON, M3J 1P3, Canada
E-mail: xli@econ.yorku.ca
Tel: (416)736-2100, Ext. 77036
Fax: (416) 736-5987

Lara D. Shore-Sheppard (corresponding author)
Department of Economics
Williams College
203 South Academic Building
24 Hopkins Hall Drive
Williamstown, MA 01267
E-mail: lshore@williams.edu
Tel: (413) 597-2226
Fax: (413) 597-4045

Discussant: Kosali Ilayperuma Simon
Public Policy and the Dynamics of Children’s Health Insurance, 1986-1999

By John C. Ham, Xianghong Li, and Lara D. Shore-Sheppard*

The past twenty years have seen important changes in public policy with the potential for significant impacts on health insurance for children. These changes included both those explicitly intended to expand access to public insurance for children, including expansions in eligibility for Medicaid and the introduction of the State Children’s Health Insurance Program (SCHIP), and other changes in anti-poverty policy. Since health insurance coverage among children is entwined with parental welfare participation and employment, shifts in policy designed to encourage work in place of welfare participation—such as welfare reform and the expansion of the Earned Income Tax Credit (EITC)—may have secondary impacts on children's health insurance coverage. As parents leave welfare, with its guaranteed health insurance through Medicaid, for jobs that may or may not have health insurance coverage offered as a benefit, children may experience a change in the source of their health insurance coverage or may become uninsured. Similarly, changes in health care markets and economic conditions such as rising health care prices and cyclicality in the availability of employment may also affect children's coverage.

Despite the potential importance of these factors for coverage, the fraction of children who are uninsured has remained largely constant, particularly through the 1990s. However, this

* Ham, 3105 Tydings Hall, University of Maryland, College Park, MD 20742 (e-mail: ham@econ.umd.edu); Li, 1068 Vari Hall, 4700 Keele St., York University, Toronto, ON, M3J 1P3, Canada (e-mail: xli@econ.yorku.ca); Shore-Sheppard, 24 Hopkins Hall Dr., Williams College, Williamstown, MA 01267 (e-mail: lshore@williams.edu). We gratefully acknowledge the support of the National Science Foundation and the National Institutes of Health (NICHD). We thank Eileen Kopchik and Zhichun Ying for expert research assistance.
relatively constant level of uninsurance may mask changes in the underlying dynamics of health insurance among children. In this paper, we use monthly data from the 1986-1996 panels of the Survey of Income and Program Participation (SIPP) to examine patterns of health insurance coverage among children during the period 1986-1999, focusing on transitions between public coverage, private coverage, and no coverage. Using these data, we find that over the 1990s the rate of transitions between all three insurance states—public insurance, private insurance, and no insurance—increased, with a particular increase in transitions involving public coverage. We investigate whether there is evidence of a relationship between insurance transitions and various policy and economic variables, focusing on the impacts of expansions in public coverage availability, the effects of other policies directed at the poor that affect employment and insurance coverage, and economic conditions. We find that several of the policy changes that took place over the 1990s had important effects on health insurance transitions for children.

I. Policy Changes Affecting Children’s Health Insurance

The 1990s were a period of great policy activity, and many of the policies that were implemented had implications for children's health insurance. Probably the most significant of these policies was the expansion of public health insurance for children whose families did not qualify for cash assistance. Prior to the late 1980s, Medicaid eligibility for children was tied to eligibility for Aid to Families with Dependent Children (AFDC), resulting in stringent eligibility limits. Starting in the late 1980s, a series of federal law changes substantially diminished the link between Medicaid eligibility and AFDC eligibility by extending Medicaid coverage to pregnant women and children with incomes above the AFDC limits. Following the Medicaid expansions, in 1997 the federal government expanded availability of public coverage further,
establishing SCHIP, a block grant program that was designed to give states the means and flexibility to offer insurance coverage to more children. Overall, between the Medicaid expansions and SCHIP implementation, average eligibility limits increased over the period from less than half the federal poverty line to around twice the federal poverty line by the end of the 1990s. This increase in eligibility would be expected to increase the probability a child obtains public coverage, possibly at the expense of private coverage, thereby increasing transition rates.

In addition to policies explicitly focused on health insurance, there was substantial policy activity surrounding work and welfare participation. Welfare reform, implemented by some states beginning in 1993 under waivers of federal requirements for AFDC and then implemented across the country with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996, was generally intended to encourage welfare recipients to leave the welfare rolls and begin to work. One potential effect of welfare reform is to reduce Medicaid coverage for children, since participation in the AFDC program conferred automatic Medicaid coverage. However, to reduce the chance that children lost insurance, PRWORA required states to provide Medicaid coverage to any family that met the pre-PRWORA welfare eligibility limits. The other potential effect is on private coverage—as mothers began to work they increased their chances of obtaining health insurance through an employer. To the extent that former welfare recipients are unable to find jobs offering health insurance benefits, however, the impact on private coverage transitions may be small.

Along with welfare reform, the mid- to late-1990s saw a substantial increase in the EITC. The EITC increases the return to working since only workers are eligible for it, and initially the more the person works the more he or she is allowed to take home. Over the period we study,
the federal government increased the subsidy rate substantially, and many states followed suit with their own earned income credits. As a result of this change and changes in the phase-out rates, the maximum credit also rose, increasing more than six-fold between 1986 and 2000. Expansions of the EITC have ambiguous predicted effects on children’s insurance coverage—they increase the return to working, which may increase transitions into private coverage, but if the jobs obtained do not offer insurance to workers and their families, it is possible that transitions out of public coverage may increase while transitions into private coverage remain unchanged. Also, conditional on working family incomes will be higher, which should raise the demand for private insurance.

II. Data

As noted above, our primary data source is the 1986-1996 SIPP panels, which provide monthly data for October 1985 to February 2000. Our analysis sample is composed of children who are younger than 19 years old, are not the head or spouse of their own family, and live in states that are identified in the SIPP (41 states and the District of Columbia are identified—the others are grouped for confidentiality). To address the possibility that our results may be driven by spurious transitions, we recode the data to eliminate any spells of one month duration except for those occurring at the beginning or end of the sample period.

Using the state of residence information available in the SIPP, we link information from other sources to our data, including the Medicaid or SCHIP eligibility limits applying to each child, welfare and welfare reform variables, state-level Medicare expenditure data as a measure of health care costs, the combined federal and state EITC maximum credit applying to each family, the monthly unemployment rate in the state, and the minimum wage in the state.
(Information about the sources of these variables, their means, and the means of the SIPP data are provided in the online Data Appendix.)

**III. Changing Patterns of Children’s Health Insurance Coverage, 1986-1999**

Figure 1 shows trends in coverage rates by type (public, private, and uninsured) over the period of our data. These trends are estimated from the underlying rates for each month in the SIPP data using a locally weighted regression smoothing method (figures showing the underlying monthly rates are available in the online Appendix).

![Figure 1: Insurance Coverage of Children](image)

Overall uninsurance rates fell slightly in the early part of the period, were flat through the mid-1990s, and then fell again at the end of the period. Examining the changes in the underlying types of coverage illustrated in Figure 1, it appears that the declines in uninsurance occur most noticeably when private insurance coverage is increasing, with public coverage either flat or falling. The relatively flat uninsurance rate in the early 1990s masks significant changes in public and private coverage, with public coverage increasing substantially and private coverage declining. This was the period of the initial Medicaid expansions as well as a recession, and this
The figure shows clearly why researchers of the Medicaid expansions focused on examining whether the expansions led to crowding out of private insurance. A cyclical pattern is evident in insurance coverage, particularly for private coverage, which is not surprising as private coverage is tied so closely to employment.

We next move from examining static coverage rates to investigating transitions. In Figure 2 we graph trends in the rates of transitions into and out of insurance. Over the 1986-1999 period, children appeared to gain and lose insurance at a fairly steady rate, despite the many changes in policy. Though the monthly rates are noisy, the rate at which children gain insurance appears to have fallen slightly at the beginning and the end of the period, indicating that parents had more difficulty obtaining insurance for their children in these years. In contrast, between about 1991 and 1996 the entry rate appeared to rise slightly. Most strikingly, the pattern in transitions out of insurance is very similar to the insurance entry pattern, rather than mirroring it as one might expect if transitions out of insurance increased when transitions into insurance fell. Instead, both sets of transition rates appeared to rise slightly between 1991 and 1996, indicating an overall higher level of turnover in insurance during this period.
To analyze the factors that influence health insurance coverage transitions and determine whether and how they are related to the policy changes that took place during this period, we estimate descriptive models of insurance transition probabilities. Using simple linear probability models for ease of interpretation, we estimate equations of the form:

\[ \text{Transition}_{it} = \text{Policy}_{it}' \cdot \mathbf{B} + \text{Demog}_{it}' \cdot \mathbf{\Gamma} + v_t + \lambda_s + u_{ist}, \]

where Transition is a binary variable indicating the occurrence of a transition (coverage gain or loss, overall and by type of coverage), Policy is a vector of variables measuring changes in the policy and economic variables discussed above, Demog is a vector of demographic variables (age and its square, male, race, Hispanic ethnicity, headship status of the family, and the family head’s education, head’s disability status, and head’s age), \( v_t \) is a set of year dummies, and \( \lambda_s \) is a set of state dummies. These equations are estimated on SIPP monthly data, with a dummy variable for the “seam month” included to account for the fact that transitions are more likely to be reported as occurring between interviews than as occurring during an interview period (in other work we show that this approach produces results roughly comparable to the results from a more complex seam bias correction).

We do not show the coefficients from our estimated models in the interest of space (full results are available in the online Appendix) and instead discuss the conclusions that can be drawn from these results. Keeping in mind that this is a descriptive approach, we find evidence that several of the policy moves pursued over this period are strongly associated with changes in insurance transition probabilities, while others either show no evidence of association or are associated in a counterintuitive way.
Most notably, higher public insurance eligibility limits are associated with increases in both types of transitions involving public coverage. The finding that higher eligibility limits are associated with greater rates of public coverage exit, as well as entry, has interesting implications for the use of income eligibility-based expansions of public coverage to provide insurance coverage to children. For example, it may be due to greater income mobility among the newly eligible, whose families are slightly more well-off and likely to have greater attachment to the labor market. Another possible explanation is that families unaccustomed to obtaining coverage from public sources are more likely to drop public coverage or allow it to lapse.

The implementation of TANF is also associated with public coverage transitions, with more transitions out of public coverage and fewer transitions into public coverage following TANF. Since eligibility for Medicaid continued for most children whose mothers did not participate in welfare due to stricter eligibility rules under TANF, this finding suggests that the mechanism of automatic enrollment via welfare was an important one for Medicaid take-up among eligible children, so that although eligibility continued, enrollment did not. The variable indicating the presence of a major AFDC waiver in a state has coefficients that are more difficult to interpret, however, indicating that a major waiver is associated with fewer transitions out of public coverage. The state’s maximum welfare benefit level shows little evidence of an effect. The results for the EITC are also mixed, as we find that a higher maximum credit is counterintuitively associated with gaining public coverage but is also associated with a more easily explained reduction in the probability of losing coverage overall.

In the case of variables measuring economic conditions, we find that higher unemployment is associated with a reduction in the probability of public coverage loss, perhaps
because a child’s family is less likely to become income-ineligible through employment, while a higher minimum wage is associated with an increase in the probability of private coverage loss. Health care costs are positively associated with transitions involving public coverage and negatively associated with transitions involving private coverage. The demographic variables are almost always statistically significant in all regressions, and interestingly almost always have the same sign regardless of whether the regression is explaining a transition into or out of coverage. These results indicate that children who are minority race, Hispanic, younger, from single parent families, and who have younger, less educated family heads have substantially higher rates of coverage transitions in both directions, indicating a lack of coverage stability for these children. Finally, even after controlling for these individual-level characteristics, state policies, and state fixed effects, we find evidence that national-level trends contributed to coverage dynamics over this time period, particularly during the recession years of 1989-1991 (which saw reductions in all types of transition probabilities except movements into public coverage) and the later years of the sample (which saw increases in all types of transition probabilities). This finding, together with the findings of increases in transitions associated with some policies and a generally higher level of insurance transitions for some types of children, suggests that further research is needed to establish the effects of increased insurance transitions on measures of child well-being such as access to needed health care and health. Moreover, a more formal investigation of children’s insurance dynamics over this period and the ensuing years would be useful in establishing the nature of any causal relationships between children’s health insurance coverage and the policies studied in this paper.