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Health Insurance Trends Point to an Increase in Uninsured Children in New York and New Jersey

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Between 1988 and 1997, the United States saw only a slight percentage increase in the population of children without health insurance. Insurance trends for children in the Second District, however, have not been as positive. In 1988, New York State's and New Jersey's shares of uninsured children aged fourteen and under were significantly below the national average. Yet by 1997, children in the District were as likely to lack health insurance as children in the rest of the country.¹

This edition of *Second District Highlights* seeks to explain these discouraging regional trends in children's health insurance. By examining the changes in insurance status in more detail, we find that the percentage of children in New York and New Jersey receiving public health insurance increased modestly, while the portion of children with private insurance showed a sharp decline.² The net effect of these unequal changes has been a marked rise in the share of Second District children without any health insurance. By contrast, in the country as a whole, the increase in the percentage of children with public insurance was only slightly smaller than the decrease in the portion of children with private insurance, producing a much smaller net increase in the share of uninsured children over the period.

Our analysis also shows that legislative changes to public health insurance, reduced barriers to health care, and altered parental attitudes toward obtaining insurance—what we call structural changes—can help explain why the insurance status of children in New York and New Jersey has shifted. We complete our investigation with a look at the characteristics that heighten a child's likelihood of being uninsured.

Note that this study does not attempt to distinguish children who are not eligible for insurance from children whose parents and guardians have chosen to forgo coverage or are unaware of their children's eligibility. Our statistics on insurance status are based on information reported by parents or guardians who responded to the U.S. Census Bureau's Current Population Survey.³ Thus, we are dependent on respondents' own assessments of their insurance status.

PUBLIC POLICY TOWARD HEALTH INSURANCE

The problem of uninsured children clearly presents a public policy challenge.⁴ These children are less likely than insured children to have the recommended number of well-baby and well-child medical visits and less likely to receive standard immunizations. Children without health insurance also rely more on hospital emergency rooms for basic care and therefore receive this care in the least cost-efficient manner. Prompted by these concerns, many policymakers, health care practitioners, and researchers advocate providing public health insurance to all children who have none.

The majority of children receiving public health insurance are covered by Medicaid.⁵ Medicaid was authorized in 1965 as an amendment to the Social Security Act of 1935 to provide medical assistance to certain low-income individuals, including children. Because Medicaid is a federal-state matching entitlement program, states design their own programs under broad federal guidelines. Historically, a child's eligibility for Medicaid was tied to his or her eligibility for welfare (Aid to Families with Dependent Children), and

only poor children in single-parent families were eligible for welfare. However, beginning in 1986, Medicaid eligibility was gradually expanded to other groups of needy children, and states were given more discretion in determining eligibility and benefits. Under the national guidelines, states are now required to cover all children under age nineteen born after September 1983 in families below the federal poverty line.⁶ Interestingly, the Medicaid expansions have compelled many states to extend their eligibility criteria to the level of New York State’s program, traditionally one of the nation’s more inclusive Medicaid programs.

States are also increasingly using their own funds to design health insurance plans. New York State’s program, Child Health Plus, was introduced in 1991 and expanded in 1995. It covers children with family incomes too high to qualify for Medicaid but still low enough to be eligible for subsidized services. Another program, Health Access New Jersey, began in April 1995 but was cut back substantially in May 1996. Today, it covers only a small number of children. Both programs are targeted to children of the working poor.

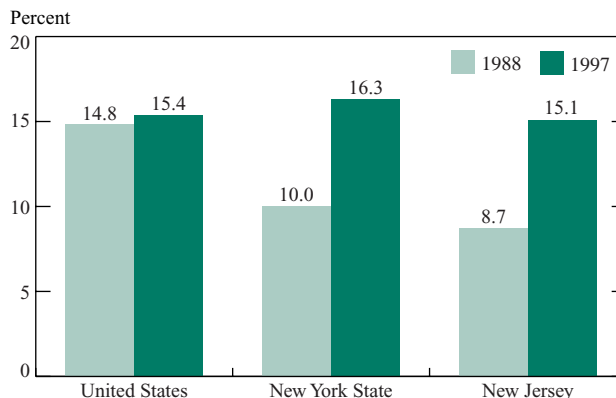
More recently, the Balanced Budget Act of 1997 provides matching funds for states to expand health coverage for uninsured low-income children. As part of this legislation, the Children’s Health Insurance Program (CHIP) covers children of working parents with incomes too high to qualify for Medicaid.⁷ CHIP funding became available in October 1997, but start-up has been slow, despite the great flexibility afforded states in program design. New Jersey developed KidCare in late 1997 in response to the CHIP legislation.

CHANGES IN INSURANCE STATUS, 1988 TO 1997

Despite advances in health care legislation, the Second District experienced a sizable increase in the share of uninsured children from 1988 to 1997. Nationwide, the percentage of uninsured children aged fourteen and under rose a mere 0.6 percentage point (Chart 1). Yet in New York and New Jersey, the shares of these children increased markedly: from about 10 percent to 16 percent in New York and from about 9 percent to 15 percent in New Jersey. By 1997, no significant differences existed between the shares of uninsured children in New York, New Jersey, and the United States as a whole.

To understand these trends, we look at the underlying changes in insurance status over the period. We see that in both the nation and the District, reliance on public coverage increased, while the use of private coverage

Chart 1
Children with No Health Insurance



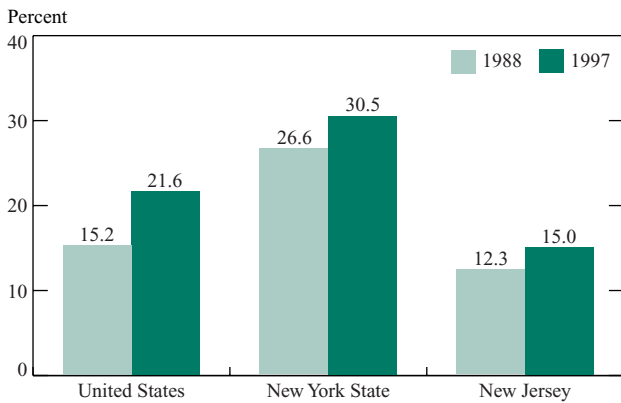
Source: Authors’ calculations, based on respondent-reported data from U.S. Bureau of the Census, Current Population Survey, 1989 and 1998.

decreased (Charts 2 and 3). The share of children covered by public insurance rose almost 6½ percentage points nationally, with increases of just 4 percentage points in New York and 3 in New Jersey. The share of children with private insurance fell 7 percentage points in the United States, with decreases of about 10 percentage points in New York and 9 in New Jersey. At the national level, the roughly equal percentage-point changes in coverage status produced a slight net increase in the overall share of uninsured children between 1988 and 1997. However, the large percentage-point differentials in New York and New Jersey—indicating that many more children were dropped from private insurance than were added to public insurance—led to a considerable rise in the share of uninsured children in these states.⁸

UNDERSTANDING THE CHANGES OVER TIME

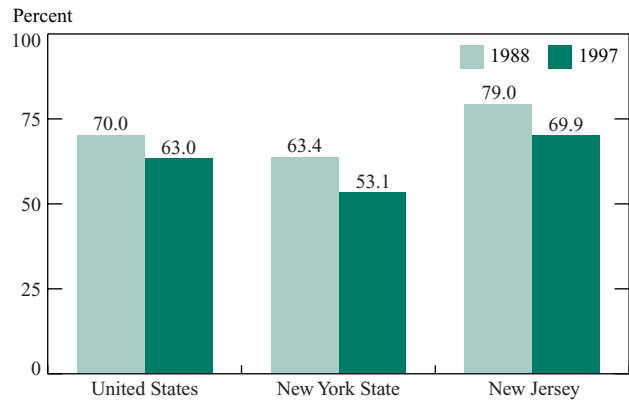
There are two main reasons why the proportion of uninsured children can change over time. First, the characteristics of the children and their households might change. For example, if the share of the population that is poor increases, and if the poor are more likely to be uninsured, the share of uninsured children will also increase. This type of change is known as a *population change*. Second, the relationship between insurance status and the characteristics of a child and his or her household might change. For example, if Medicaid expansions increase eligibility for the poor, the share of those without insurance will decrease, even if the number of poor remains constant. This type of change is known as a *structural change*. Structural changes include changes in the relevant public insurance and other laws,

Chart 2
Children with Public Health Insurance



Source: Authors' calculations, based on respondent-reported data from U.S. Bureau of the Census, Current Population Survey, 1989 and 1998.

Chart 3
Children with Private Health Insurance



Source: Authors' calculations, based on respondent-reported data from U.S. Bureau of the Census, Current Population Survey, 1989 and 1998.

in any barriers to obtaining insurance coverage, and in the decisions of parents regarding insurance.

To determine the relative importance of population and structural changes in bringing about the increased percentage of uninsured children, we compare actual insurance patterns in 1997 with the patterns that would have been observed if the characteristics of the child population remained unchanged from 1988 to 1997. By holding the population factor constant, we can isolate the effects of structural change on insurance status.⁹

Consider first New York State, where the share of children without insurance increased from 10 percent to 16 percent over the period. We calculate that in the absence of any change in the child population, the share of children without insurance would still have risen to 15 percent. This finding suggests that population changes accounted for only 1 percentage point of the rise in the share of uninsured children, while structural changes accounted for the remaining 5 percentage points—clearly, the bulk of the increase. Similar calculations reveal that the increased share of uninsured children in New Jersey (15 percent, up from roughly 9 percent) can also be traced primarily to structural changes in the relationship between characteristics and insurance status, and not to population changes.

Nevertheless, when we break down the changes in insurance status into public and private components, we see that the decrease in private coverage and the increase in public coverage were more evenly split between population changes and structural changes in New York. There, about 40 percent of the decrease in

private coverage was due to population changes while the remaining 60 percent stemmed from structural changes in the relationship between the child's/household's characteristics and the probability of having private coverage. By contrast, in New Jersey, population changes actually led to a small decrease in estimated public insurance coverage. Yet large structural changes overwhelmed these population effects.

Our calculations reveal that structural changes go a long way toward explaining the Second District's increasing share of children with public insurance and its decreasing share of children receiving private insurance—and hence the rising percentage of uninsured children. Although statistical analysis cannot pinpoint the exact sources of the structural changes, several policy and behavioral factors likely contributed to these trends.

Legislative changes, for instance, no doubt caused some of the observed structural changes behind the increased reliance on public insurance in all geographic areas. As part of the Medicaid eligibility expansions of the late 1980s and early 1990s, all states were obligated to cover more children than they did in the past. For example, a ten-year-old living in a poor two-parent household would have been eligible for Medicaid in 1997 but not in 1988. In addition, children on Medicaid today may face fewer barriers to health care coverage than they did in the past. The increased prevalence of managed care, for instance, has generally led to a decline in physician income. It is possible that these shrinking incomes have prompted a growing number of practitioners to accept Medicaid patients.

At the same time, parental attitudes may explain part of the decreased reliance on private coverage for children. Although the number of workers offered employment-based health insurance rose over the decade, the number of workers accepting the offer fell.¹⁰ More employees—especially those with very low incomes—are rejecting the health care coverage provided by their employers (Cooper and Schone 1997). Their decision to forgo coverage probably stems in part from the high cost of employment-based insurance—premiums for which rose by 90 percent between 1987 and 1993.

WHICH CHILDREN ARE AT RISK FOR BEING UNINSURED?

Our examination of insurance trends in the Second District raises a vital question: *Which* children are most likely to lack coverage? Clearly, not all children are at equal risk for being uninsured. To identify those children at greater risk and in need of special attention, we measure the effect of changing one characteristic of the children in our sample while holding other important characteristics constant. This exercise reveals that two characteristics—poverty and race—have an especially notable effect on the probability of uninsurance.

Poverty Status

Not surprisingly, poor children in the United States are more likely to be uninsured than their wealthier counterparts.¹¹ Our analysis of Current Population Survey data indicates that the estimated probability of uninsurance fell dramatically in 1988—from 30 percent to 11 percent—as a child moved from being in a poor family to being in one with at least 50 percent more income.¹²

However, the relationship between uninsurance and poverty weakens over time. In 1988, the wealthier child was 18 percentage points more likely to have health insurance than the poor child. That figure had narrowed to just 11 percentage points by 1997. This improvement in insurance coverage for poor children likely reflects the Medicaid eligibility expansions. By 1997, many states had enabled not only poor children, but also children in somewhat better-off families, to qualify for this program.

Despite these positive trends, all eligible children are apparently not participating in Medicaid. This phenomenon is known as the “take-up” problem in public insurance. Parents may not take advantage of available health services because they are unaware that their children are eligible for public insurance.¹³ Alternatively, some people may associate public insurance with a stigma and choose not to seek coverage. Thus, outreach programs

aimed at solving the take-up problem could focus on identifying children eligible for public insurance who are not enrolled in the relevant program.

In the Second District, changes over time in the probability of not having insurance vary less with poverty status in New York State than in the country as a whole. This difference is not unexpected, considering the greater inclusiveness of New York’s Medicaid program. Children in somewhat better-off families in New York are more likely to be eligible for public insurance than similar children in other states, including New Jersey. For this reason, the link between poverty and insurance status in New Jersey is more in line with that of the nation.

The Race of the Child

Unlike the impact of poverty on insurance status, the effect of racial differences on coverage is notoriously hard to explain. Our statistical analysis of the Current Population Survey data reveals that in the nation as a whole, whites, African-Americans, and members of other races were about as likely to be uninsured in 1997 as they were in 1988. In New York State, however, the picture is somewhat different. There, children in the category of other races—mostly Asian-Americans—were more likely to be uninsured than white or African-American children in both years. Moreover, 22 percent of the state’s other-race children lacked insurance in 1997, compared with only 16 percent of the nation’s other-race children.

What could account for this pattern among New York State’s other-race children? One hypothesis is that the state has a larger share of children of immigrant parents than most other states. Children of immigrants may face barriers to obtaining insurance if their parents work long hours or do not speak English (Currie 1995). In any case, one way to increase the rate of health insurance among other-race children in New York State might be to introduce educational efforts in the relevant neighborhoods and languages.¹⁴

CONCLUSION

Over the past decade, the Second District has seen an escalating share of children with no health insurance. This rise can be traced to shifts in insurance status. Between 1988 and 1997, the decline in the fraction of District children receiving private coverage exceeded the increase in the percentage of those with public coverage, resulting in a net increase in uninsured children. Fundamental changes in the relationship between a

child's or a household's characteristics and insurance status likely contributed to these trends. For example, legislative changes that extended Medicaid eligibility to more children no doubt fueled the increase in public insurance. Conversely, the diminishing number of workers accepting employment-based health insurance surely spurred the decline in private coverage.

In the United States, and in New Jersey, poverty plays a key role in a child's likelihood of being uninsured. In New York State, however, the link is not as strong—arguably because the eligibility criteria of the state's public programs entitle a wider range of families to coverage. Turning to race and insurance status, we find that the relationship is not so clearly defined. Racial differences evidently have little impact on insurance status in the nation as a whole. Yet in New York State, other-race children are at greater risk of being uninsured than white or African-American children sharing broadly comparable characteristics.

NOTES

1. We base our assessments on 1988 and 1997 unweighted data (published in 1989 and 1998) from the Current Population Survey.
2. Most children with private health insurance have dependent coverage under an adult's plan. The plan can be either group coverage (employment-based) or privately purchased. We discuss public health insurance more fully in the next section.
3. The Current Population Survey, a monthly survey of about 50,000 households, is conducted by the U.S. Census Bureau for the U.S. Department of Labor's Bureau of Labor Statistics. It collects considerable information about the child and adult members of each household. The public and private insurance status variables of the survey measure whether a child was covered by one or both types of insurance at any time during 1988 and 1997. Children covered by any type of public insurance are considered to have public insurance even if they also have private coverage.
4. See, for example, Currie and Gruber (1996), Rapaport and Trenholm (2000), and their references.
5. A very small fraction of children are covered by Medicare, the federal program for disabled individuals. In addition, in this article the military insurance program (CHAMPUS) is considered private insurance because it is job-based; public insurance programs are need-based.
6. The federal poverty line reflects the bare-minimum money income needed to support a family of a given size.
7. In fact, New York's Child Health Plus is explicitly mentioned in the CHIP legislation as the type of comprehensive state-based program that CHIP is intended to support. Moreover, in December 1999, New York State enacted the Health Care Reform Act. The main goal of this legislation is to provide greater access to health care coverage to low-income families and the uninsured (City of New York Office of the Comptroller 2000).
8. Increases in the number of children of immigrant parents could also affect the changing mix of insurance coverage. New York City is the only area of the state where a child is more likely to have public insurance than private. Nevertheless, between 1988 and 1997, the probability of a New York City child being on public insurance fell, from 59 percent to 47 percent. Our estimates compare two children with identical values for all measured characteristics except location. They are based on the methodology described in note 9.
9. These calculations come from our estimation of the probability that a child with a given set of characteristics will have private insurance, public insurance, or no insurance. The estimated probabilities sum to 1 and depend on a wide variety of economic and demographic variables.
More formally, we estimate six separate multinomial logits: one each for the United States, New York, and New Jersey in each of two years. The dependent variable is the choice of insurance—public, private, or none. Each set of independent variables is identical, and includes measures of the child's gender, race, ethnicity, and age; measures of the household's size, age composition of children, poverty status, and female headship; measures of the head of the household's marital status, age, and education; measures of the spouse's (if present) age and education; and geographic measures (which vary across the geographic samples). In households with a male present, the household head is defined to be the male.
Changes attributable to population reflect changes in the underlying characteristics of the population, assuming that the structure of insurance choice remains constant.
10. For information on offers and acceptances of employment-based insurance, see Cooper and Schone (1997).
11. Although children in poor and nearly poor families are more likely to be eligible for public health insurance than other children, wealthier children are more apt to have private coverage.
12. A poor family is defined as one earning income below the federal poverty line. Our estimates compare two children with identical values for all measured characteristics except poverty status.
13. The problem of low take-up likely intensified after 1997 because of welfare reform. As individuals leave the welfare rolls—either because they have found jobs or because their welfare eligibility time period has expired—their children may still be eligible for Medicaid or CHIP. Anecdotal evidence suggests that many of these individuals assume that their children are no longer eligible for any public health insurance.
14. Characteristics other than race and poverty status could affect a child's likelihood of receiving health insurance. For example, the marital status of the child's mother has received much attention. We find, however, that children of unmarried mothers are indistinguishable from other children in terms of receiving coverage. Additional characteristics found to have no effect on the probability of lacking health insurance include whether a child is Hispanic, a girl, or the eldest child in the family.

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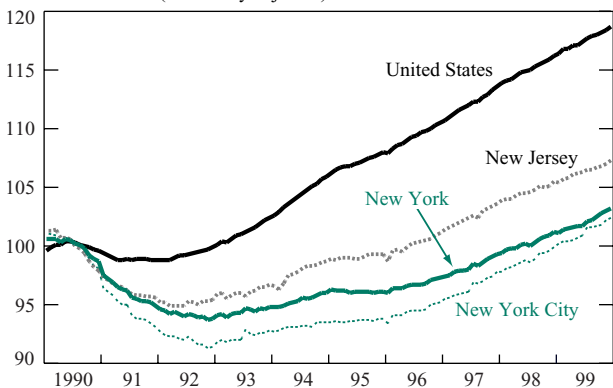
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Economic Trends in the Second District

Payroll Employment

Index: 1990 = 100 (seasonally adjusted)



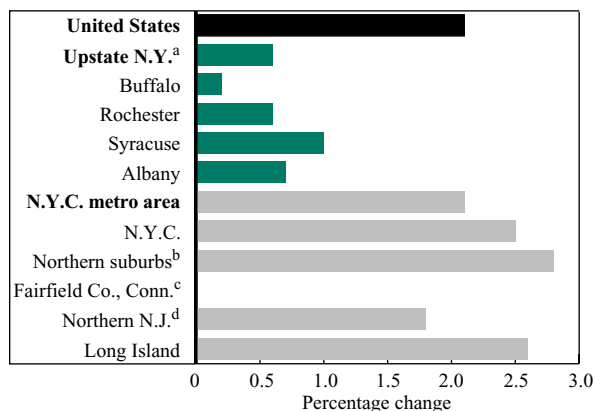
Sources: New York, New Jersey, and Connecticut Departments of Labor; U.S. Department of Labor, Bureau of Labor Statistics; Federal Reserve Bank of New York.

^a Upstate N.Y. comprises the four metropolitan areas listed as well as Binghamton, Elmira, Glens Falls, Jamestown, and Utica-Rome.

^b The northern suburbs of N.Y.C. comprise Dutchess, Orange, Putnam, Rockland, and Westchester Counties, N.Y., and Pike County, Pa.

Job Growth in the Nation and Selected Metropolitan Areas

October-December 1998 to October-December 1999



^c Fairfield Co. had zero job growth.

^d Northern N.J. comprises Bergen, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, and Warren Counties.

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