Children's health insurance, family income, and welfare enrollment

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ABSTRACT

Children from wealthier families are more likely to have health insurance than children from poorer families on average. However, the relationship between family income and health insurance is non-linear, as children near the Federal Poverty Line (FPL) are less likely to be insured than children from both wealthier families (who obtain health insurance from the private market) and poorer families (who obtain government-funded health insurance). This health insurance dip has persisted even as Medicaid has been expanded to cover those above the FPL. One explanation for this is that families who are far below the poverty line are better connected to the welfare system, and consequently, are more likely to enroll in Medicaid. This study uses data from the 2001–2013 Current Population Surveys and finds that (1) controlling for many of the determinants of eligibility, those on other forms of government assistance are more likely to have health insurance, and (2) the relationship between family income and children's health insurance status is strictly increasing after controlling for enrollment in other welfare programs.

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1. Introduction

Children of high-income parents are more likely to have private health insurance than children from lower-income families. However, the relationship between any health insurance coverage, private or public, and family income is more subtle. The U.S. model has been for employers to provide health insurance to most families, and for the government to fund health insurance for children from low-income families who are unlikely to obtain employer-provided health insurance. Because Medicaid used sharp income thresholds at the Federal Poverty Line (FPL) prior to Medicaid expansion, children near the FPL have historically been one of the least likely groups to have health insurance, even when compared to children from families well below the FPL.

This health insurance dip has persisted even as Medicaid has been expanded to cover those above the FPL (Shore-Sheppard, 2000). This can be seen by examining Fig. 1, which non-parametrically graphs health insurance coverage rates (private or public) for children by family income using Current Population Survey data from 1988, 1996, 2004, and 2012.[1] For all of these years, coverage rates reach a local maximum below the poverty line, then decline reaching a local minimum near the FPL, and then increase. It is clear from Fig. 1 that this dip in coverage rates has persisted for at least two decades, but has become less pronounced over time.

One explanation for why this dip has persisted even after the expansion of Medicaid is that families who are far below the poverty line are better connected to the welfare system, and consequently, are more likely to enroll in Medicaid. For example, Currie and Grogger (2002) find that changes in welfare caseloads predict Medicaid caseloads. The administrative barriers to enrolling in Medicaid can be high, and there may be stigma associated with enrolling in publicly funded health insurance (Bansak & Raphael, 2007; Aizer, 2007; Moffitt, 1983). However, both the administrative barriers and the stigma associated with Medicaid may decrease if the family is already enrolled in other welfare programs, such as food stamps or rent subsidies.

This study uses data from the 2001–2013 Current Population Surveys and finds that (1) controlling for Medicaid eligibility, family income, and other determinants of public assistance eligibility, those on other forms of government assistance (food stamps, rent subsidies, public housing, heat subsidies, reduced-price school lunch, or TANF) are more likely to have health insurance, and (2) the relationship between family income and children's health insurance status is monotonic (strictly increasing) after controlling for enrollment in other welfare programs.

These findings are relevant to policymakers for two reasons. First, one of the justifications for the Children's Health Insurance Program was to cover children who were too poor to afford private health insurance, but too wealthy to qualify for Medicaid. The extent to which the health insurance and family income relationship is non-decreasing is one measure of whether the program achieved that goal. Second, policymakers may wish to ensure that families with higher incomes

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[1] Similar graphs appear in Card and Shore-Sheppard (2004), Shore-Sheppard (2000), and Buchmueller, Ham, and Shore-Sheppard (2015).
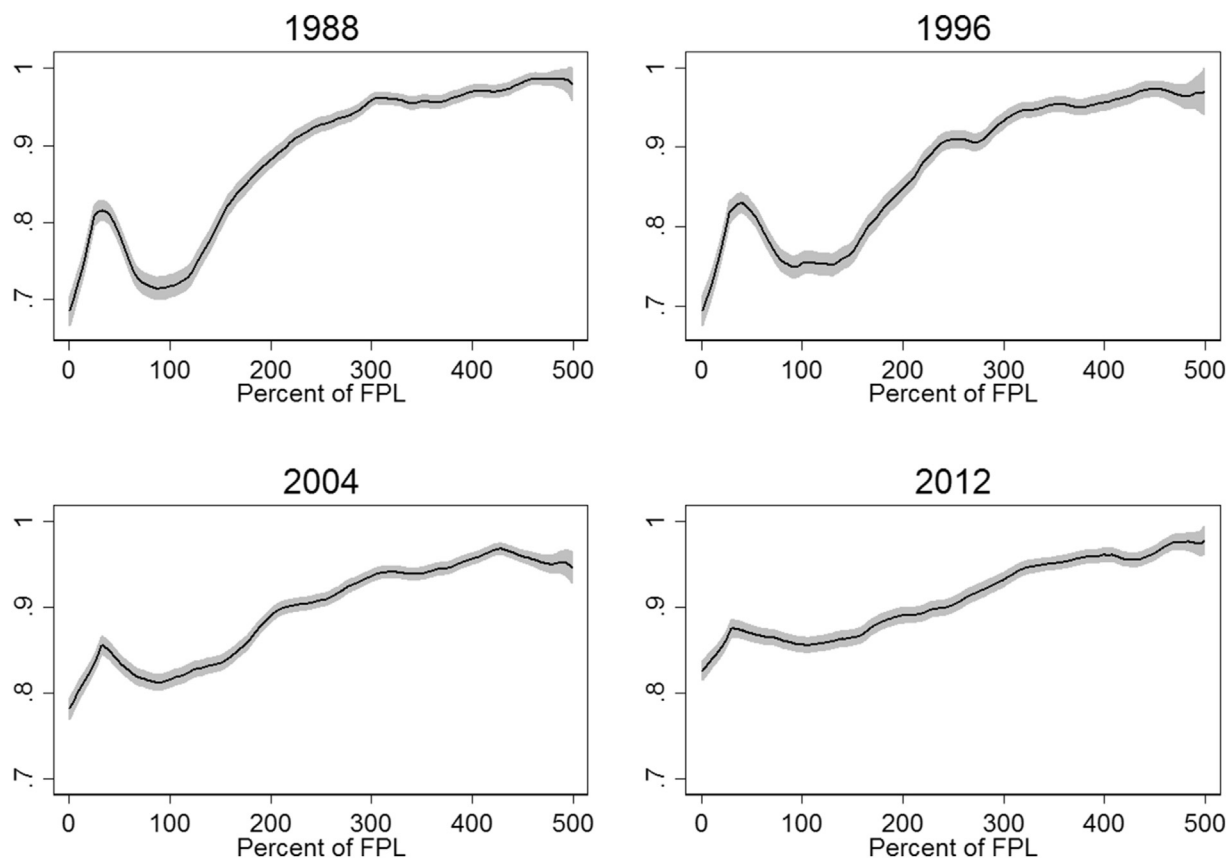
Fig. 1. Percent of children with health insurance coverage Notes: Data come from the March CPS. Each line is a local-mean smooth. The shaded area is the 95% confidence interval. The sample is restricted to individuals under the age of 18.

have at least as much access to health insurance as families in poverty to avoid discouraging work.

2. Background

Before the expansion of Medicaid in the early 1990s, the children of families who were near the Federal Poverty Line (FPL) were one of the least likely groups to have health insurance. The children of wealthier families typically received private insurance through their parents' employers. Single-parent families well below the FPL likely enrolled in Aid to Families with Dependent Children (AFDC) and qualified for Medicaid. To address this dip in coverage near the FPL, federal legislation required states to expand Medicaid coverage starting in the early 1990s. In 1997, the Children's Health Insurance Program (CHIP) further expanded public health insurance for low-income children who were just above the Medicaid threshold by requiring states to either increase the Medicaid income threshold or create an entirely new program. Despite the expansion in public health insurance, children from low-income families still have low coverage rates, because the take-up rate, which is the percent of Medicaid-eligible children who enroll in the program, has been low. Additionally, some families may have dropped privately funded health insurance in hopes of receiving Medicaid. The percent of families who switch from private to public health insurance is known as the crowd-out rate. See Bitler and Zavodny (2014) for a review of this literature.

The social safety net in the United States consists of both cash transfer programs and in-kind benefits. Aid to Families with Dependent Children (AFDC) used to provide cash transfers to single mothers, but the program has now been replaced by Temporary Assistance to Needy Families (TANF). Before the early 1990s, Medicaid was tied to AFDC enrollment. Consequently, single mothers who received AFDC risked also losing health insurance if their income increased above the FPL.

Outside of health insurance, in-kind benefits received by low-income families with children include food subsidies through either the Supplement Nutrition Assistance Program (SNAP), which was previously known as food stamps, or the Women, Infants, and Children (WIC) program. WIC provides referrals for prenatal care, which might increase the probability that a woman enrolls in Medicaid (Hoynes & Schanzenbach, 2015). The National School Lunch Program reimburses schools for providing lunches to low-income children. Because schools are reimbursed, but not families, it is possible that recipients of reduced-price school lunches are less connected to the welfare system than recipients of other public assistance programs. Additionally, low-income families are sometimes eligible for public housing or rent subsidies. Many families also receive heat subsidies through the Low-Income Home Energy Assistance Program. Depending on the state, enrollment in one program may lead to enrollment in others. Slack, Kim, Yang, and Berger (2014) find that low-income families tend to enroll in distinct bundles or packages of public assistance programs. Cancian, Han, and Noyes (2014) estimate that most TANF-enrolled families in Wisconsin participate in three other welfare programs, whereas most SNAP-enrolled families participate in one or two. Consequently, a lack of connectedness to the welfare system may help explain why Medicaid-eligible children do not enroll.

3. Data and sample

This study uses data from the Annual Social and Economic sample from the Current Population Survey (CPS) from 2001 to 2013. The data were downloaded from the Integrated Public Use Microdata Series (Flood, King, Ruggles, & Warren, 2015). This sample includes a variable indicating whether each child has any form of health insurance, and whether that health insurance is public or private. As in Shore-Sheppard (2000), I interpret their answers to these questions as point-