Losing Health Insurance:

The Unintended Consequences of Welfare Reform

A REPORT BY

Families USA Foundation
1334 G Street, NW
Washington, DC 20005
202-628-3030

Support for this report was generously provided by
The W.K. Kellogg Foundation
with additional support from
The George Gund Foundation and The Nathan Cummings Foundation

May 1999

Losing Health Insurance: The Unintended Consequences of Welfare Reform

Families USA Publication No. 99-103

Families USA
1334 G Street, NW
Washington, DC 20005
Phone: (202) 628-3030
Fax: (202) 347-2417
E-mail: info@familiesusa.org
Website: www.familiesusa.org

INTRODUCTION

In the aftermath of the 1996 welfare reform law, welfare rolls have dropped dramatically across the country. While welfare reform has been hailed for decreasing the welfare rolls and moving former recipients to jobs, little attention has been devoted to the health coverage of those who lose welfare benefits. As this report shows, one of the unintended consequences of welfare reform is that many people lose Medicaid coverage and become uninsured. This is the first study to show a direct connection between the loss of welfare benefits and the loss of health insurance coverage.

Using data from the U.S. Census Bureau's Current Population Survey and from the Health Care Financing Administration, we have found that *over two-thirds of a million low-income people—approximately 675,000—lost Medicaid coverage and became uninsured as of 1997 due to welfare reform*. The majority (62 percent) of those who became uninsured due to welfare reform were children, and most of those children were, in all likelihood, still eligible for coverage under Medicaid. Moreover, the number of people who lose health coverage due to welfare reform is certain to grow rather substantially in the years ahead.

Because 1997 was the first year of welfare reform implementation, this study reports only the earliest consequences of welfare reform, before many of the time limits imposed by the new law take effect. This year, more people will be required to work in order to retain their welfare benefits. Most people moving from welfare into jobs wind up in entry-level positions with low salaries and no employer-subsidized health insurance. If, as required by law, they are granted 6 to 12 months of Medicaid coverage during the transition to work, they are then likely to join the ranks of the uninsured when their transitional coverage ends. Similarly, large numbers of people will be dropped from the welfare rolls in the future as they reach the 5-year lifetime limit on welfare benefits. When that happens, we can expect the number of uninsured to swell.

KEY FINDINGS

- *Welfare reform has contributed to the increase in the number of low-income people without health insurance.* In 1997, an estimated 675,000 low-income people became uninsured as a result of welfare reform.
- *Welfare reform has contributed to declining Medicaid enrollment.* As of 1997, 1.25 million people with incomes under 200 percent of the federal poverty level lost their Medicaid coverage as a result of welfare reform.
- *Children under age 19 made up the majority of people who became uninsured as a result of welfare reform.* Of the 675,000 low-income people becoming uninsured as of 1997 as a result of welfare reform, more than three out of five (62 percent) were children. Of the 1.25 million people who lost Medicaid between 1995 and 1997 as a result of welfare reform, almost two-thirds (65 percent) were children.
- *More than half of both children and adults who would have been enrolled in Medicaid absent welfare reform were instead uninsured in 1997.* Fifty-four percent of all people losing Medicaid as a result of welfare reform became uninsured.
- *Most of the children who had lost Medicaid as of 1997 as a result of welfare reform probably were still eligible for Medicaid and should not have lost that coverage.* Considerably more than half of the children who lost Medicaid between 1995 and 1997 as a result of welfare reform were eligible *under federal requirements*.
- *Poor people are more likely than those just above the poverty line to become uninsured as a result of welfare reform.* For people with incomes below the federal poverty level, nearly two out of three adults (62 percent) and over half of the children (57 percent) became uninsured when they lost Medicaid. The impact on those with incomes just over poverty was significant as well: for people with incomes between the federal poverty level and 200 percent of poverty, 45 percent of adults and 42 percent of children became uninsured when they lost Medicaid.
- *Minority children are more likely to go uninsured than white children as a result of welfare reform.* When minority children lost Medicaid, about 58 percent became uninsured, while 41 percent of white children became uninsured when they lost Medicaid.

- *The number of people becoming uninsured as a result of welfare reform is likely to increase considerably in the years following 1997.* These data show only the early-warning signs of welfare reform's impact on health insurance coverage for people with low incomes. As welfare reform is fully implemented over time, there will be large increases in the number of low-income uninsured people.

BREAKING THE LINK BETWEEN WELFARE AND MEDICAID

The 1996 welfare reform law (the Personal Responsibility and Work Opportunity Reconciliation Act) fundamentally altered our system of providing public assistance to poor families. Welfare reform eliminated the entitlement to cash assistance and ended the 60-year-old Aid to Families with Dependent Children (AFDC) program. Congress replaced the AFDC program with the Temporary Assistance to Needy Families (TANF) block grant program. TANF carries new requirements that recipients must meet in order to receive benefits and emphasizes moving welfare recipients off of the welfare rolls as quickly as possible.

Although the welfare law established restrictions and limitations for the receipt of cash welfare benefits, Congress included provisions intended to insulate Medicaid participation from those restrictions and limitations. Prior to welfare reform, most low-income families qualified for Medicaid by first qualifying for welfare. The welfare reform law maintains the Medicaid entitlement and requires Medicaid eligibility to be determined independently from welfare. Despite the effort to ensure that low-income people continue to receive needed Medicaid benefits, hundreds of thousands of people, as of 1997, lost health insurance as an unintended consequence of welfare reform.

HOW PEOPLE LOSE HEALTH COVERAGE BECAUSE OF WELFARE REFORM

There are three ways that low-income people lose health care coverage as a result of welfare reform. ***First***, *people lose health coverage when they or a family member successfully move from welfare to work.* Most people moving from welfare to work wind up in jobs that provide no health care coverage *and*, after they leave welfare for a job, they often remain eligible for Medicaid only during a limited

transition period. ***Second**, termination from welfare for any reason often results in wrongful losses of Medicaid coverage*. Many people dropped from the welfare rolls remain eligible for Medicaid but, because welfare administrators fail to inform people of their continuing eleigbility, many people inappropriately lose their Medicaid coverage. ***Third**, state efforts to deter people from applying for welfare often result in people being denied the opportunity to apply for Medicaid.*

Losing Health Coverage When Moving from Welfare to Work

When families move from welfare to work, they are likely to find jobs that pay very low wages and do not offer benefits such as affordable health insurance. Evidence from a review of state "exit studies" (surveys of people who have left welfare) shows that, typically, only about 25 percent of people who got jobs after leaving welfare reported having employment-based health insurance.[1] (See boxes on pages 12-13 for more information about state exit studies.) A number of studies have shown that people moving from welfare to work tend to find jobs that pay less than $8 an hour and that do not provide benefits such as health insurance or paid sick leave.[2] Most welfare recipients who find jobs work less than full-time, full-year and earn less than the poverty level; however, even such a low-wage, part-time job will make a parent ineligible for Medicaid in most states.

Parents are eligible for Medicaid only if they earn very little money. In nine states, parents become ineligible for Medicaid when they earn more than 40 percent of the federal poverty level ($5,460 for a family of three in 1998). In about half of the states, parents become ineligible if they earn more than 60 percent of the federal poverty level ($8,190 for a family of three in 1998). In all but 11 states, parents become ineligible if they earn more than the federal poverty level ($13,650 for a family of three in 1998).[3] (See Figure 1 for state Medicaid eligibility levels for parents.)

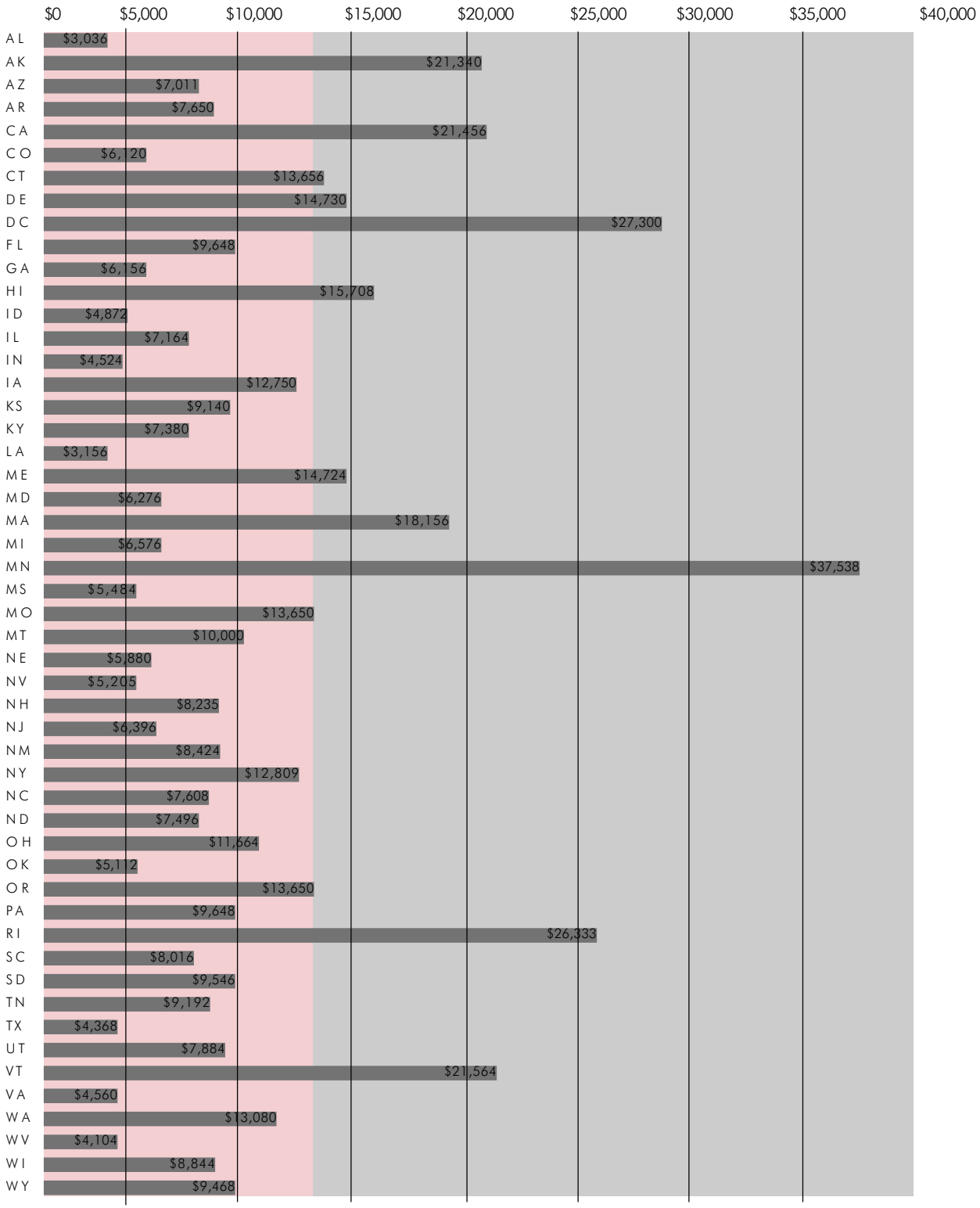
In many cases, children remain eligible for Medicaid even when their parents lose eligiblity because children are eligible for Medicaid at higher income levels (see box on page 15). However, because families are unaware of this and states may fail to reassess the child's eligibility when parents are terminated, many children in working families are eligible but not enrolled in Medicaid.[4]

When low-income families become ineligible for Medicaid, they have very few

Figure 1

Income Eligibility Limits for Parents Receiving Medicaid

(Based on a family of three with one wage earner)



Source: 1998 data reported by Jocelyn Guyer and Cindy Mann, *Employed But Not Insured*, Center on Budget and Policy Priorities, March 1,1999.
Note: Information from a survey of state officials in late 1998/early 1999. These state income limits take into account earnings disregards for parents receiving Medicaid who have worked for 12 months or more. Income limits assume that earnings are the only source of income for the family. These income limits are for single-parent families; limits for two-parent families are lower in many states.

places to turn for health insurance. The vast majority of insured people get their health coverage from their employers, but employer-sponsored coverage has declined significantly since 1987. This decline in employer-sponsored health insurance has hit low-wage workers the hardest: by 1997, only 42 percent of workers in jobs paying less than $7 per hour had employer-sponsored health insurance.[5] Over the past decade, the rising costs of health care led many employers to cut down on the scope of health insurance benefits they offer, to increase the percentage of health insurance costs that employees must pay, and/or to stop providing coverage for employees' spouses and children.[6]

Families who become ineligible for Medicaid because they have increased income from work are entitled to receive extended Medicaid benefits, called "Transitional Medicaid." Families should receive six months of Transitional Medicaid regardless of how much income they earn. They should get a second six months if their incomes (minus childcare expenses) are below 185 percent of the federal poverty level.[7] It is difficult to find data on the availability of Transitional Medicaid: states are not

TRANSITIONAL MEDICAID EXPIRES BEFORE FAMILY HAS INSURANCE OR STABLE EMPLOYMENT

Loretta Trawick and her daughter Ashley left the Georgia welfare rolls when Ms. Trawick obtained temporary employment in March 1998. With a monthly income of $1,510—about 160 percent of the federal poverty level for a family of two—Ms. Trawick and her daughter qualified for one year of Transitional Medicaid benefits. The Trawicks lost their Medicaid in March 1999. Ms. Trawick's employer does not offer her health insurance, and her temporary job is scheduled to end in May 1999.

Ashley needs ongoing treatment for gastroesophageal reflux, a stomach disorder. Ms. Trawick has to pay $100 monthly to fill just one of her daughter's prescriptions. Although her mother hopes that Ashley will eventually be certified for Georgia Peach Care, the state's new child health insurance program, the loss of Medicaid and delays in processing her Georgia Peach Care application will leave Ashley uninsured for a period of time.

Ms. Trawick has recurring bronchial asthma. Purchasing health insurance for herself would cost about $200 a month, which she cannot afford. After paying for groceries and monthly household expenses, Ms. Trawick only has $188 left for gas, car repairs and maintenance, discretionary expenses, and possible health insurance. When her job ends, she will have even fewer resources to purchase coverage.

required to report such data to the federal government and most states do not track Transitional Medicaid in any systematic way. However, two studies have found that very few families who leave welfare actually receive Transitional Medicaid.[8] Those who do get transitional coverage will only have it for a limited time, whether or not they have access to affordable health insurance at their new jobs.

In 1997, the first year of federal welfare reform implementation in the states, only a small percentage of people moving from welfare to work reached the limits of their Transitional Medicaid coverage. As more and more people move from welfare to work, and as the six-month to one-year transition periods expire, increasing numbers of people are likely to lose health insurance coverage.

Losing Health Coverage Due to Termination of Welfare Assistance

Historically, welfare has been the primary pathway to Medicaid for poor families. The two programs were linked so that people who qualified for welfare automatically received Medicaid as well. Although the law now requires Medicaid eligibility to be determined independently from welfare, state administrative systems often continue to treat Medicaid as an extra welfare benefit. This means that when a family is terminated from welfare, its Medicaid case is often closed at the same time. Because the two programs remain connected in the minds of caseworkers and recipients as well as in state computer eligibility systems, the new emphasis on closing welfare cases as quickly as possible is causing many families to be cut off Medicaid, even when they are still eligible.

A number of federal and/or state rules cause people to lose cash welfare assistance. These rules include the following:

- Under federal law, families may only receive cash welfare assistance for a maximum of five years. Many states have established even shorter lifetime caps for welfare.
- Federal law requires non-exempt[9] welfare recipients to be working in jobs after two years of receiving welfare benefits in order to continue receiving cash assistance.

- States may require welfare recipients to begin job search and work or other activities as soon as they are enrolled; failure to do so can result in termination of assistance.

While families may only receive cash welfare assistance for a specified number of years over their lifetime, there is no such time limit for Medicaid benefits. Similarly, none of the penalties for violating welfare rules can be applied to Medicaid participation except in one circumstance: states may opt to terminate an adult welfare recipient's Medicaid if the state cuts that person's welfare benefit for "refusal to work."[10] At no time, however, can a state terminate Medicaid for pregnant women or children because a member of their family has violated a welfare rule. Yet it appears that many people who are losing their cash welfare assistance are automatically losing their Medicaid coverage as well—either because of state administrative errors or because no one is informing low-income families about their continued eligibility for Medicaid.

FAMILY DOESN'T GET TRANSITIONAL MEDICAID BENEFITS WHEN MOTHER GOES TO WORK

Jo (not her real name)and her children left welfare when she got a new temporary job and her earnings increased. Her Medicaid and Food Stamps abruptly ended in the summer of 1998 for "excess income." Like many others in her state, due to problems in the programming of welfare and Medicaid computers, she did not receive the Transitional Medicaid benefits to which she was entitled. Her numerous phone calls and calls from advocates on her behalf failed to correct the problems. Jo requested a fair hearing and finally obtained benefits after four months without insurance.

During their time without coverage, Jo and her children had many medical problems. She and her children all had asthma. In addition, Jo suffered from other allergies, pneumonia, and an illness that results in a lowered immune system and that left her prone to numerous infections. Jo required, but could not afford, medication and ongoing treatment by a physician. She had to borrow money for prescriptions and do without needed care.

By July 1, 1999, current welfare recipients will have reached the two-year

time limit when they must be working in order to keep their welfare benefits. Three years later, by July 1, 2002, individual families will have reached the lifetime limit on receipt of cash welfare. As these limits are reached, it is likely that many families losing welfare will lose their Medicaid coverage as well. Thus, the number of people losing health coverage due to welfare reform is likely to become considerably higher than the 1997 data depicted in this report.

MOVING FROM WELFARE TO WORK AND BECOMING UNINSURED . . .

Terry (not her real name) had been on welfare for about two years when she got a job at McDonald's. Working 30 hours a week, Terry earned $600 a month. When she told her welfare caseworker about her new job, Terry and her 5-year-old son, James, were cut off of cash assistance and Medicaid. Her Food Stamps stopped, too, although she was promised they would continue. When Terry left welfare for work, no one told her that she was eligible for Transitional Medicaid. And her son James should have continued to receive Medicaid until Terry earned at least $1,200 a month—twice as much as she made at her job at McDonald's.

Terry and her son have been uninsured ever since they lost Medicaid. Now Terry works 35 hours a week at Pizza Hut, earning $6.50 an hour. Her employer offers health insurance, but Terry cannot afford to pay for it. Fortunately, Terry and James are both healthy. When James needs a checkup or shots, she takes him to Children's Medical Center and pays cash.

Terry and James live in Washington, DC, which has recently raised Medicaid eligibility for families up to 200 percent of poverty. Terry had not heard about the new program before being contacted for this report, but now she plans to apply for it.

Losses of Health Coverage Due to State Administrators' Diversion of Welfare Applications

Since cash welfare assistance is no longer an entitlement for eligible families, states are under no obligation to provide cash assistance to needy people. States are allowed to "divert" people from completing their welfare applications—by requiring them to undertake job search activities or to seek other forms of private

WELFARE "DIVERSIONS" AND "SANCTIONS" DISCOURAGE MEDICAID APPLICANTS

New York City converted a number of its welfare offices to "Job Centers" following passage of welfare reform. At these Centers, people applied for Medicaid, cash assistance, and Food Stamps, but they were required to search for work before their applications were processed. In 1999, a federal court found that New York City's Job Center staff illegally discouraged and denied needy people from applying for Medicaid. The court barred the city from converting any more welfare offices to Job Centers until they corrected the problems.

People affected by New York's diversion and sanction policies included the following:

- **In October 1998, Ms. C., a pregnant teen, applied for Medicaid and other assistance at a Job Center. She attended high school at night. Job Center personnel told her that she would have to search for work daily and participate in a "work experience" project, sweeping streets for the Department of Sanitation, in order to receive assistance. The next day, Ms. C. went to an obstetric clinic instead of to the Job Center's orientation. Although she explained this to Job Center personnel, her Medicaid was still denied, along with her Food Stamps and cash assistance, for "failure to comply with Employment Center Orientation."**
- **Ms. G., a 39-year-old homeless woman, lost her Medicaid, cash assistance, and Food Stamps in August 1998 when New York's Office of Employment Services alleged that Ms. G. had not reported to a work experience assignment with the Department of Sanitation—an allegation that Ms. G. disputed. She was "sanctioned" for four months and could not receive any assistance during that time. In mid-November, Ms. G. was pregnant with twins and had severe anemia and low blood pressure. She desparately needed blood pressure medication and attempted to reapply for benefits. The Job Center gave her a "Job Profile" form and collected documents that Ms. G. had brought, but did not permit her to file a Medicaid application until the following week. When Ms. G. returned the following week, the Job Center had lost her documents. Ms. G. completed application forms and was required to visit either the Job Center or another welfare office daily. When Ms. G. went to a doctor's appointment, the Job Center would not reschedule her Medicaid and welfare eligibility interview. In early December, for reasons that are not clear, the Job Center denied Ms. G.'s applications for Medicaid, cash assistance, and Food Stamps and told her that she would have to reapply for benefits.**

Source: Reynolds v. Giuliani, 98-Civ-8877(WHP)(S.D.N.Y.)

help before applying for assistance, for example. In some instances, welfare administrators, rather than enrolling families in welfare, may offer them a lump-sum benefit to tide them over temporarily while they seek other help. If families accept this inducement, they also may not be enrolled in Medicaid.

As of August 1998, 31 states had implemented some form of "diversion" in the application process for cash welfare assistance.[11] Although such "diversion" processes are becoming routine in the context of cash welfare assistance, they can improperly divert people from applying for Medicaid as well. As a result, many families entitled to Medicaid are not receiving such coverage, and they remain uninformed about their right to complete Medicaid applications. Since many people cycle in and out of Medicaid each year, these diversionary practices may constitute a barrier to coverage for both new applicants and those who have left the Medicaid rolls but need coverage again.

What Exit Studies and Evaluations Tell US about Employer-Sponsored Coverage

How do we know what is happening to people who leave welfare? Although there has been no national study tracking the health insurance status of people leaving welfare, there have been some state efforts to determine what happened to people who left welfare in their state. These studies all use different survey methods, ask different questions, interview different groups of people, and tend to have relatively low response rates. All of this makes it difficult to draw national conclusions based on the findings. However, despite these differences, the studies show consistently that people who leave welfare lose health insurance.

The surveys described here contained questions about employer-provided health insurance. One review of the exit study and evaluation literature available found that, typically, only one out of four welfare recipients who found jobs reported that they received employer-sponsored insurance.[12] A few of the studies only asked respondents whether their employer *offers* health insurance, not whether they could afford to take that insurance. Many low-income workers cannot afford the insurance offered by their employers, and therefore go uninsured.

- Mathematica Policy Research, Inc. studied families in IOWA temporarily cut off welfare for failing to comply with program rules. They found that only 10 percent of people who had jobs after being terminated from welfare had employer-sponsored insurance.[13]
- A SOUTH CAROLINA study, conducted by the state Department of Social Services Division of Program Quality Assurance, found that 11 percent of children and 36 percent of adults had private health coverage 8 to 12 months after leaving welfare.[14]
- A survey of people who left welfare in NEW MEXICO found that 20 percent of respondents who were working were covered by employer-sponsored insurance. However, 50 percent of respondents who were working indicated that their employers *offered* health insurance. Most people who did not take their employers' insurance said that they could not afford it. The survey was conducted by the Bureau of Business and Economic Research at the University of New Mexico in September 1997.[15]
- A study of people in WASHINGTON state who had left welfare between December 1997 and July 1998, found that about 36 percent of respondents who were currently working or had worked in the previous 12 months had employer-sponsored health insurance at their current or most recent jobs. The study was conducted by the Washington State Department of Social and Health Services Economic Services Administration.[16]
- The Human Resouces Adminstration (HRA) of the City of New York conducted a study of former

welfare recipients in NEW YORK CITY in 1998. HRA found that only 36 percent of respondents who held jobs since leaving welfare received health insurance from their employers.[17]

- The evaluation of FLORIDA's Family Transition Program (FTP), conducted by Manpower Demonstration Research Corporation, found that only 43 percent of recipients who found jobs were *offered* health insurance by their employer.[18] The data do not indicate how many people could afford and actually purchased such coverage.
- A study conducted by the Texas Department of Human Services (DHS) tracked people who left welfare and people who were diverted from applying for welfare in TEXAS. DHS found that, overall, 40 percent of respondents were *offered* health insurance by their employer, but it is unclear how many could actually afford that coverage.[19]

What Exit Studies and Evaluations Tell Us About Medicaid Participation After Welfare

Some people who leave welfare become ineligible for Medicaid because they have higher income levels. Many, however, remain eligible but lose coverage when states improperly terminate their Medicaid coverage. The surveys described below show that people lose Medicaid when they leave welfare, even if they remain eligible.

- A study of former welfare recipients in NEW YORK CITY found that, of respondents working at the time of the survey (about six months after they left welfare), 46 percent were uninsured and only 14 percent were receiving Medicaid. Of those who were uninsured, all were eligible for Transitional Medicaid, but had not received it.[20]
- A study of the employment and earnings of single-parent families on welfare in Milwaukee, WISCONSIN looked at families that had left welfare in September 1996. The researchers found that, three months later, at least 45 percent were no longer receiving Medicaid.[21] The study was conducted by researchers at the University of Wisconsin.
- A study in the state of WASHINGTON found that only about 60 percent of the children had received Medicaid after leaving welfare and only about 40 percent of adults had received Medicaid after leaving welfare.[22]

METHODOLOGY

This report uses data from the U.S. Health Care Financing Administration (HCFA) and from the U.S. Census Bureau's Current Population Survey (CPS) March Supplements for 1996 and 1998 to estimate the loss in Medicaid coverage and growth in the uninsured attributable to welfare reform. HCFA administrative data provide information on the number of people enrolled in the Medicaid program by age each year. The numbers include all people enrolled for any part of the year. The CPS March Supplement provides information on the demographic characteristics of U.S. residents, their source of health insurance during the previous calendar year, and the number who had no health insurance, based on an annual survey.

Information on declining Medicaid coverage alone does not explain whether declines are related to welfare reform or whether people losing Medicaid obtain insurance elsewhere. For example, growth in the economy would probably lead to a decline in Medicaid participation, but such a change should not be—and was not—attributed to welfare reform in our study. Families USA contracted with the Lewin Group, which developed a model to control for variables that might affect Medicaid participation independent of welfare reform. These variables include changes in family composition, the educational status of the household head, the age of the parent or child, race and ethnicity, family earnings as a percentage of poverty, and non-transfer income as a percentage of poverty. Using data from the 1996 CPS March Supplement to estimate the effects of each of these variables on Medicaid enrollment, Lewin then applied the model to the 1998 CPS to estimate the number of people who would have been enrolled in Medicaid in the absence of welfare reform. Finally, Lewin compared this predicted Medicaid enrollment with actual Medicaid administrative data and CPS data to estimate the number of people who lost Medicaid and became uninsured as a result of welfare reform. For a fuller explanation of the methodology, see the Technical Appendix of this report.

Medicaid Eligibility Levels

Each state determines the income limits for its Medicaid program. Eligibility for Medicaid for parents varies from a low of 22 percent of the federal poverty level in Alabama ($3,036 for a family of three in 1998) to a high of 275 percent of poverty in Minnesota ($37,538 for a family of three in 1998) (see Figure 1). However, in all states, children are eligible for Medicaid at higher income levels than their parents. Federal law requires states to provide Medicaid eligibility to children under age 6 up to 133 percent of the poverty level. Federal law also requires phased-in coverage of older children (those age 6 and over) up to 100 percent of poverty.[23] In 1997, states were required to cover children up to age 14 with income below poverty. By 2002, every child under the poverty level age 18 and under will be eligible for Medicaid.

New Children's Health Insurance Program cannot cover children eligible for Medicaid

In 1997, Congress passed the State Children's Health Insurance Program (CHIP), which offers states incentives to expand health coverage for children with family income up to 200 percent of poverty. Most states have taken this option, although few of these programs were up and running before late 1998. CHIP offers health insurance coverage to children whose families earn too much to qualify for Medicaid but too little to afford private health insurance. This program will help many low-income working families, but it cannot cover the majority of children who became uninsured due to welfare reform because most of those children were still eligible for Medicaid, even if they were not receiving it. State administrators, however, expect that outreach efforts for CHIP may help to identify and enroll children who are currently eligible for, but not receiving, Medicaid.

FINDINGS

1. ***Welfare reform has contributed to the increase in the number of low-income people without health insurance.***

As of 1997, approximately 675,000 low-income people became uninsured as a result of welfare reform. This means that more than half (54 percent) of the people who lost Medicaid because of welfare reform became uninsured.

Previous research has found that about two-thirds of women who leave Medicaid become uninsured.[24] This report confirms that Medicaid is an important source of health insurance for low-income people, and, without it, they are likely to join the ranks of the uninsured. Low-wage workers are significantly less likely to have access to employer-sponsored health insurance than higher-wage workers.[25] In 1996, only 42 percent of workers earning less than $7 per hour had employer-sponsored health insurance coverage, while 90 percent of workers earning over $15 per hour had such coverage.[26]

Table 1

People Who Lost Medicaid and Became Uninsured Due to Welfare Reform, in Families Under 200 Percent of Poverty

Number Who Lost Medicaid	Number Uninsured After Losing Medicaid
1,250,000	675,000

2. ***Welfare reform has contributed to declining Medicaid enrollment.***

Between 1995 and 1997, 1,250,000 low-income people lost Medicaid because of welfare reform (see Table 1). These Medicaid declines occurred despite the fact that there were no policy changes intended to constrain enrollment during this period. On the contrary, there was continuing expansion of Medicaid eligibility for adolescent children due to the "phase-in" of 13- and 14-year-olds in 1996 and 1997. [27]

Although federal and state officials tout the early indications of increased work activity among welfare recipients as a welfare reform success, the

Table 2
Characteristics of Children Who Lost Medicaid Coverage and Became Uninsured in Families With Income Below 200% of Poverty, 1995-1997 (in Thousands)

	Individuals Estimated to Have Lost Medicaid Coverage		
	Total	Uninsured	Percentage Uninsured
Overall	807	420	52.1%
INCOME AS A % OF POVERTY			
0-99%	570	322	56.5%
100-199%	238	99	41.7%
AGE			
0-5	373	201	53.9%
6-12	269	131	48.7%
13-18	165	88	53.3%
CHILD <13 AND INCOME <100% OF POVERTY			
No	356	166	46.7%
Yes	452	255	56.4%
NUMBER OF CHILDREN IN FAMILY			
<2 Children	454	247	54.5%
3 or More Children	354	173	48.9%
MARITAL STATUS			
Married-No	571	303	53.0%
Married-Yes	236	118	50.0%
YEARS OF EDUCATION			
Less than 13 Years	618	351	56.7%
13+ Years	190	70	37.1%
RACE			
Non-Minority	274	111	40.6%
Minority	534	310	58.0%
GEOGRAPHIC LOCATION			
Rural	169	87	51.7%
Suburban	340	180	52.9%
Central City	299	153	51.4%
REGION			
North East	106	55	52.1%
Midwest	164	71	43.3%
South	334	194	58.2%
West	203	99	49.0%

Source: The Lewin Group estimates based on U.S. Census Bureau, Current Population Survey, March Supplements for 1996 and 1998. CPS data were adjusted for Medicaid underreporting using U.S. Health Care Financing Administration administrative data.

Note: Due to small sample sizes for those losing Medicaid, the difference in percentage uninsured by characteristics are not statistically significant. Estimates of the overall Medicaid loss and loss for: children under poverty, <2 children in the household, < 12 years of education, and minority children are statistically significant. See Appendix for discussion. Due to rounding, the number uninsured in each category may not add to the total uninsured.

Table 3
Characteristics of Adults Who Lost Medicaid Coverage and Became Uninsured in Families with Income Below 200% of Poverty, 1995-1997 (in Thousands)

	Individuals Estimated to Have Lost Medicaid Coverage		
	Total	**Uninsured**	**Percentage Uninsured**
Overall	443	255	57.5%
INCOME AS A % OF POVERTY			
0-99%	326	203	62.2%
100-199%	117	52	44.9%
AGE			
9-35	260	167	64.5%
36-64	183	87	47.7%
DISABILITY			
Disability - No	284	183	64.4%
Disability - Yes	159	71	44.8%
CHILDREN <6 IN HOUSEHOLD			
Child <6 - No	242	120	49.5%
Child <6 - Yes	201	135	67.1%
MARITAL STATUS			
Married - No	354	205	58.0%
Married - Yes	89	50	55.7%
EDUCATION			
Less than 13 years	335	205	61.4%
13+ Years	108	49	45.6%
RACE			
Non-Minority	248	154	62.3%
Minority	195	100	51.3%
GEOGRAPHIC LOCATION			
Rural	92	57	61.8%
Suburban	175	96	55.1%
Central City	176	102	57.8%
REGION			
North East	84	47	56.2%
Midwest	85	47	55.2%
South	148	91	61.3%

Source: The Lewin Group estimates based on U.S. Census Bureau, Current Population Survey, March Supplements for 1996 and 1998. CPS data were adjusted for Medicaid underreporting using U.S. Health Care Financing Administration administrative data.

Note: Due to small sample sizes for those losing Medicaid, the differences in percent uninsured by characteristics are not statistically significant. Estimates of the overall Medicaid loss are statistically significant. See Appendix for discussion. Due to rounding, the number uninsured in each category may not add to the total number uninsured.

associated decline in Medicaid enrollment is not a welfare reform success story. Families leaving welfare for work should receive Transitional Medicaid for a minimum of six months, regardless of income. They should receive an additional six months of Transitional Medicaid when their incomes (minus childcare expenses) remain below 185 percent of the poverty level. Previous studies have indicated that very few families who leave welfare actually get Transitional Medicaid.

Reports about the earnings of welfare recipients who leave welfare for work indicate that, although more people are working, they rarely earn enough to pull their families out of poverty.[28] With such low incomes, it is likely that their children remain eligible for Medicaid and that very few of those children should have lost Medicaid in the years covered in this study.

3. ***Children under age 19 make up nearly two-thirds of the people who lost Medicaid as a result of welfare reform and over 60 percent of the people who became uninsured as a result of welfare reform. Most of the children who lost Medicaid as a result of welfare reform were still eligible for Medicaid and should not have lost coverage.***

More than three-quarters of a million (807,000) children lost Medicaid between 1995 and 1997 as a result of welfare reform. More than half of them (52 percent) became uninsured after losing Medicaid (see Table 2 and Figures 2 and 3).

Perhaps one of the most troubling findings of this report is that most of the children who lost Medicaid, in all likelihood, were still eligible for the program. Our data show that more than half of the children who lost Medicaid (56 percent) were eligible because they were age 12 or under and lived in families with income sbelow poverty. Many of the remaining 44 percent of children who lost Medicaid were also eligible for coverage, including the following:

- children under age 6 in families with incomes between poverty and 133 percent of the federal poverty level;
- children ages 13 and 14 in families with incomes below the poverty level;
- children living in states that expanded Medicaid beyond federal minimum requirements. As of October 1997, 41 states had some expansion of Medicaid coverage for children above the federal minimum requirements.[29]

Figure 2

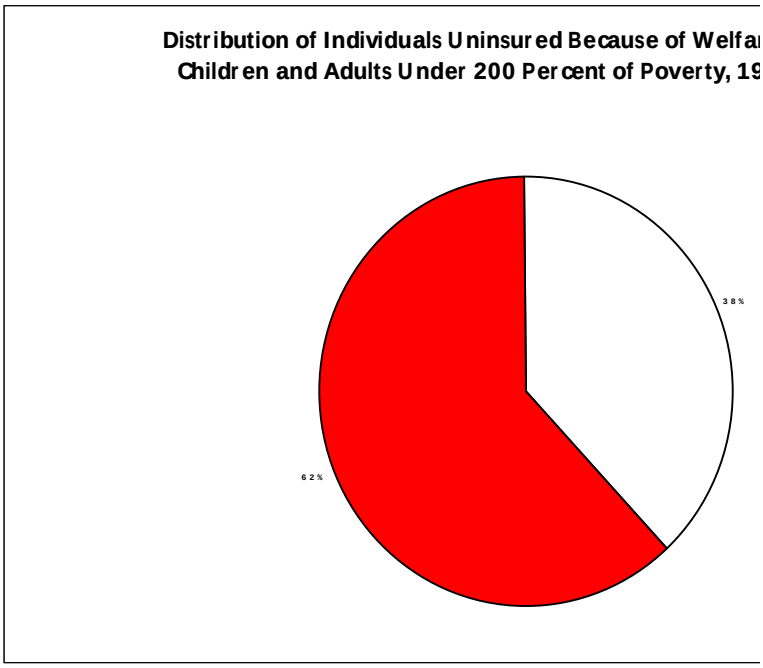
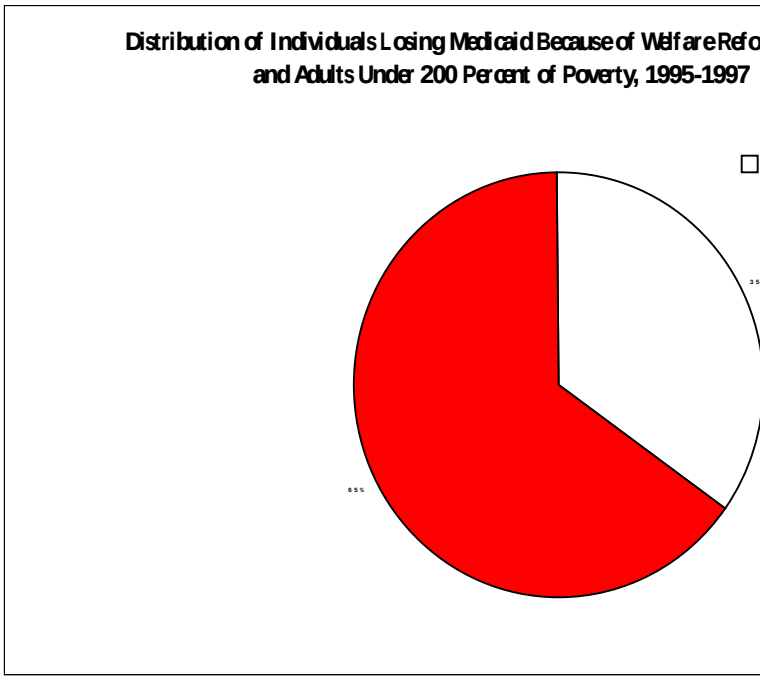


Figure 3



(See box on page 15 for more explanation of federal minimum coverage requirements for Medicaid.)

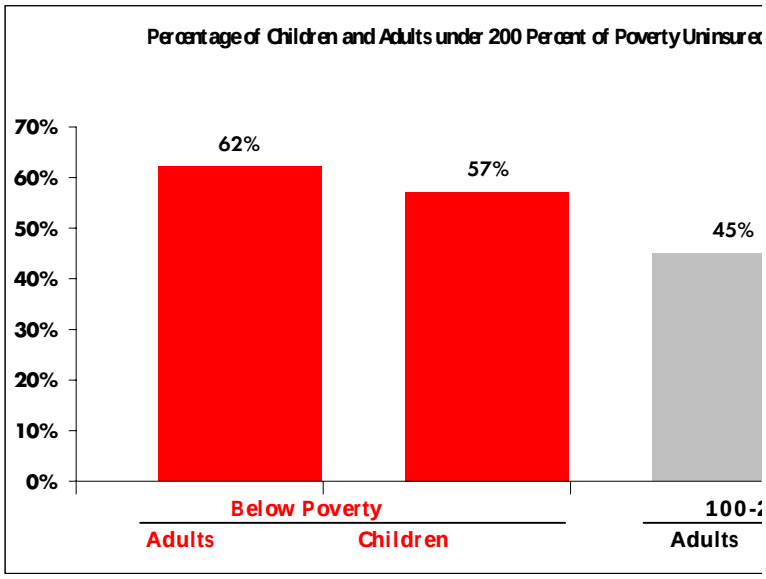
The State Children's Health Insurance Program (CHIP), enacted in 1997, was intended to encourage states to establish health insurance programs for children in low-income families in order to reduce the number of uninsured children. The CHIP statute, however, specifically bars states from using the new funds to cover children who were already eligible for Medicaid. The majority of children who became uninsured due to welfare reform were almost certainly eligible for Medicaid, which means that they could not be helped by CHIP. Of the children who lost Medicaid coverage and became uninsured, only those whose family income rose above the Medicaid eligibility level but not above the state's CHIP eligibility level could regain coverage through CHIP.

4. ***People with incomes below poverty are more likely than those living just above the poverty level to become uninsured as a result of welfare reform.***

Of the 675,000 people who became uninsured when they lost Medicaid, more than 78 percent lived in families with incomes below the poverty level. Three out of five adults (62 percent) with below-poverty incomes became uninsured, while 57 percent of below-poverty children became uninsured, after they lost Medicaid coverage due to welfare reform. The impact on people living in families earning between 100 and 200 percent of poverty was significant as well, with 45 percent of adults and 42 percent of children becoming uninsured when they lost Medicaid. (See Tables 2 and 3 and Figure 4).

Medicaid eligibility levels for parents in most states are so low that a minimum-wage or part-time job can lead to loss of health insurance (see Figure 1). Studies of the work experiences of welfare beneficiaries have found that, even when they get jobs, welfare recipients rarely earn enough to bring their family over the poverty level.[30] Without Medicaid, low-income families often have nowhere else to turn for health insurance because so few entry-level jobs offer affordable employer-sponsored insurance.

Figure 4



5. ***Minority children are more likely than white children to go uninsured as a result of welfare reform.***

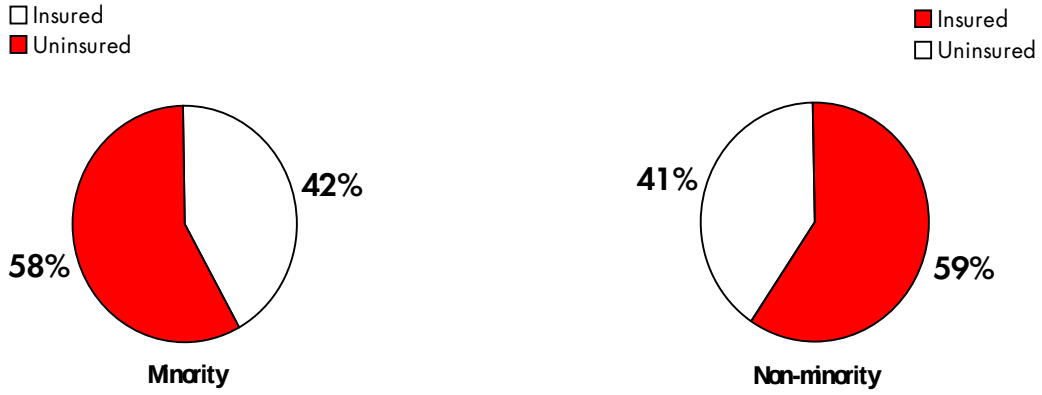
When minority children lost Medicaid, 58 percent became uninsured. By contrast, 41 percent of white children who lost Medicaid became uninsured (see Tables 2 and 3 and Figure 5).

Recent studies have shown that race and ethnicity are significant factors in determining insurance status and access to health care. Two recent studies found that Medicaid-eligible Hispanic children are more likely to be uninsured than Medicaid-eligible white non-Hispanic children.[31] When they lose Medicaid, minority children are more likely to go uninsured than white children. Other analyses of Census Bureau data confirm that the same trend is true for minority adults.[32]

A separate study by the Commonwealth Fund found that minority workers have less access to employer-sponsored coverage than white workers. Among full-time workers, 37 percent of Hispanics were uninsured, 20 percent of blacks were uninsured, and 12 percent of whites were uninsured.[33] Among workers earning less than $7 per hour, the study found, only 35 percent of Hispanics had employer-sponsored insurance, 47 percent of blacks had employer-sponsored insurance, and 56 percent of whites had such coverage.

Research has shown that poverty and minority status both pose significant barriers to accessing health care, although lack of health insurance is the most important barrier.[34] As more low-income people become uninsured because of welfare reform, they will have less access to health care.

Figure 5
Percentage of Children and Adults under 200 Percent of Poverty Uninsured After Losing Medicaid



Options for States to Reach More Families

The welfare reform law gave states new flexibility, in effect, to raise Medicaid eligibility levels for families without first getting a waiver from the federal government. Under this provision, states have the ability to provide Medicaid coverage to more working families. Only a few states—Rhode Island and the District of Columbia, for example—have taken advantage of this option to significantly raise Medicaid eligibility levels for families.

Because of concerns about the administrative complexities of determining Medicaid eligibility separately from welfare, Congress allotted $500 million in federal funding to states to ease this burden. Most of this money remains unspent today.

CONCLUSION

The data presented in this report demonstrate that welfare reform has been a significant factor in the decline in Medicaid enrollment and the increase in the number of low-income people who are uninsured. Because this report is based on data from 1997, it captures only the earliest effects of welfare reform. Since the welfare rolls dropped even more rapidly in 1998 and 1999, it is likely that the loss of health coverage described in this report has also accelerated. Thus, as welfare reform unfolds, changes in federal and state laws and administrative practices are needed to stanch the growing health coverage losses that are an unintended consequence of welfare reform.

ENDNOTES

[1] Greenberg, Mark, *Participation in Welfare and Medicaid Enrollment* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 1998).

[2] Parrot, Sharon, *Welfare Recipients Who Find Jobs: What Do We Know About Their Employment and Earnings?* (Washington, DC: Center on Budget and Policy Priorities, November 1998).

[3] Guyer, Jocelyn, and Cindy Mann, *Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance* (Washington, DC: Center on Budget and Policy Priorities, February 1999).

[4] Health Management Associates, *The Dynamics of Current Medicaid Enrollment Changes* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 1998), p.13; T. Seldon, et al. "Medicaid's Problem Children: Eligible But Not Enrolled," *Health Affairs*, May/June 1998 (vol. 13, #3), pp. 192-200.

[5] O'Brien, Ellen, and Judith Feder, *How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 1998).

[6] U.S. General Accounting Office, *Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases*, GAO/HEHS-97-35 (Washington, DC: U.S. General Accounting Office, February 1997).

[7] Nine states have waivers from federal law that allow them to provide Transitional Medicaid to families for longer than 12 months. These states are: AZ, CT, DE, NE, SC, TN, TX, UT, and VT. Of these, two states provide an extra six months of transitional coverage, six offer an extra 12 months, and one (VT) provides an additional 24 months. Kaplan, Jan, *Transitional Medicaid Assistance* (Washington, DC: Welfare Information Network, December 1997); *Section 1115 Waivers Affecting Transitional Child Care and Medicaid* (Washington, DC: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, October 1997); Peller, John, and Heidi Shaner, *Medicaid Eligibility Standards for Low-Income Families and Children: State Implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996* (Washington, DC: National Association of State Medicaid Directors, American Public Welfare Association, May 1998).

[8] Kaplan, op. cit.; *Fact Sheet: Transitional Medi-Cal*, Medi-Cal Policy Institute, www.medi-cal.org/publications/factsheets/transmedical.html [Dec. 1998]. Studies of Medicaid receipt three months after leaving welfare show that approximately 17 to 29 percent of former welfare recipients received Transitional Medicaid. Johnson, Amy, and Alicia Meckstroth, *Ancillary Services to Support Welfare to Work: Lack of Health Insurance* (Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, June 1998).

[9] States may exempt up to 20 percent of their average monthly caseload from federal time limits and work requirements.

[10] Medicaid law allows non-pregnant adults in a family to be sanctioned if they refuse to cooperate with efforts to get medical support from a non-custodial parent. States may now impose a TANF sanction for refusal to cooperate with getting cash child support from non-custodial parents; they may also sanction Medicaid (for the parent only) if the child support includes a medical support award for the child.

[11] Maloy, Kathleen A., LaDonna A. Pavetti, Peter Shin, Julie Darnell, and Lea Scarpulla-Nolan, *A Description and Assessment of State Approaches to Diversion Programs and Activities Under Welfare Reform* (Washington, DC: The George Washington University, Center for Health Policy Research, August 1998).

[12] Greenberg, Mark, op. cit.

[13] Fraker, Thomas M., Lucia A. Nixon, Jan L. Losby, Carol S. Prindle, and John F. Else, *Iowa's Limited Benefit Plan: Summary Report* (Princeton, NJ: Mathematica Policy Research, Inc. and the Institute for Social and Economic Development, May 1997).

[14] South Carolina Department of Social Services, Division of Program Quality Assurance, *Survey of Former Family Independence Clients: Cases Closed During April through June 1997*, June 1998, p. 11, as reported in Greenberg, Mark, op. cit.

[15] Bureau of Business and Economic Research, *Survey of the New Mexico Closed-Case AFDC Recipients: July 1996-June 1997, Final Report* (Albuquerque, NM: University of New Mexico, September 1997), pp. 12-13.

[16] DSHS Economic Services Administration, *Washington's Single Parent Families After Welfare* (Olympia, WA: Department of Social and Health Services, February 1998), p.6

[17] Bush, Andrew S., Swati Desai, and Lawrence M. Mead, *Leaving Welfare: Findings from a Survey of Former New York City Welfare Recipients*, HRA Working Paper 98-01 (New York: Office of Policy and Program Analysis, Human Resources Administration, City of New York, September 1998).

[18] Dan Bloom, et al., *The Family Transition Program: Implementation and Interim Impacts of Florida's Initial Time-Limited Welfare Program*, Manpower Demonstration Research Corporation, March 1998, as reported in Parrott, Sharon, *Welfare Recipients Who Find Jobs: What Do We Know about Their Employment and Earnings?* (Washington, DC: Center on Budget and Policy Priorities, November 1998).

[19] Program Analysis and Evaluation Office, Executive Office of Planning, Evaluation, and Project Management, *Texas Families in Transition: The Impacts of Welfare Reform Changes in Texas: Early Findings* (Austin, TX: Texas Department of Human Services, December 1998).

[20] Bush, Andrew S., *Leaving Welfare: Findings from a Survey of Former New York City Welfare Recipients*, op. cit.

[21] Pawasarat, John, *Employment and Earnings of Milwaukee County Single Parent AFDC Families: Establishing Benchmarks for Measuring Employment Outcomes Under 'W-2'"* (Milwaukee, WI: University of Wisconsin Employment and Training Institute, 1998).

[22]The report shows that, for families who left welfare between December 1997 and March 1998, 57 percent of children and 36 percent of adults received Medicaid after leaving welfare. For families who left welfare between April and July 1998, 64 percent of children and 44 percent of adults received Medicaid after leaving welfare. DSHs Economic Services Administration, op. cit., p. 3.

[23] Children born on or after October 1, 1983 up through the age of 18 were gradually made eligible for Medicaid if they live in families earning no more than the federal poverty level. This "phase-in" of Medicaid eligibility for adolescents means that children born after October 1, 1983 who live in poor families will not lose eligibility for Medicaid until they turn 19. Because of this phase-in, more children are eligible for Medicaid every year until 2002.

[24] Farley-Short, Pamela, *Medicaid's Role in Insuring Low-Income Women* (New York: The Commonwealth Fund, May 1996).

[25] O'Brien, op. cit.

[26] Ibid.

[27] Our predictions for 1997 Medicaid enrollment do not take into account the "phase-in" of 13- and 14-year-olds in families earning less than 100 poverty of the federal poverty level. Therefore, our estimation of the decline in Medicaid coverage is very conservative; an even larger decline for this age group is likely.

[28] Parrot, Sharon, *Welfare Recipients Who Find Jobs*, op. cit.

[29] National Governor's Association, *Issue Brief: State Medicaid Coverage of Pregnant Women and Children* (Washington, DC: National Governor's Association, September 30, 1997).

[30] Parrot, Sharon, *Welfare Recipients Who Find Jobs*, op. cit.

[31] U.S. General Accounting Office, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*, GAO/HEHS-98-93 (Washington, DC: U.S. General Accounting Office, March 1998); Reschovsky, James D., and Peter J. Cunningham, *CHIPing Away at the Problem of Uninsured Children*, Issue Brief Number 14 (Washington, DC: Center for Studying Health System Change, August 1998).

[32] Fronstin, Paul, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey*, EBRI Issue Brief Number 204 (Washington, DC: Employment Benefit Research Institute, December 1998), pp. 11-12; Carrasquillo, Olveen, MD, MPH, David U. Himmelstein, MD, Steffie Woolhandler, MD, MPH, and David H. Bor, MD, "Going Bare: Trends in Health Insurance Coverage, 1989 Through 1996," *American Journal of Public Health*, Vol. 89, No. 1 (January 1999).

[33] Hall, Allyson, Karen Scott Collins, and Sherry Glied, *Employer-Sponsored Health Insurance: Implications for Minority Workers* (New York: The Commonwealth Fund, February 1999).

[34] Newacheck, Paul W., Jeffrey J. Stoddard, Dana C. Hughes, and Michelle Pearl, "Children's Access to Health Care: The Role of Social and Economic Factors," in Ruth E. K. Stein, editor, *Health Care for Children: What's Right, What's Wrong, What's Next* (New York: United Hospital Fund, 1997).

[35] Rhode Island raised Medicaid eligibility levels for parents to 185 percent of poverty under the new Section 1931, and the District of Columbia expanded Medicaid for parents and children to 200 percent of poverty.

Appendix

Change in Welfare Caseloads January 1995-December 1998

State	Jan-95	Jan-96	Jan-97	Jan-98	Change Jan 1995 Jan 1998	% Change Jan 1995 - Jan 1998	Dec-98	Change Jan 1998- Dec 1998	%Change 1998
NATIONAL	**13,930,953**	**12,876,661**	**11,423,007**	**9,131,716**	**-4,799,237**	**-34%**	**7,912,941**	**-1,218,775**	**-13%**
Alabama	121,837	108,269	91,723	61,809	-60,028	-49%	49,461	-12,348	-20%
Alaska	35,432	36,189	31,689	31,689	-3,743	-11%	25,472	-6,217	-20%
Arizona	195,082	171,617	151,526	113,209	-81,873	-42%	96,298	-16,911	-15%
Arkansas	65,325	59,223	54,879	36,704	-28,621	-44%	30,606	-6,098	-17%
California	2,692,202	2,648,772	2,476,564	2,144,495	-547,707	-20%	1,850,898	-293,597	-14%
Colorado	110,742	99,739	87,434	55,352	-55,390	-50%	41,674	-13,678	-25%
Connecticut	170,719	161,736	155,701	138,666	-32,053	-19%	97,600	-41,066	-30%
Delaware	26,314	23,153	23,141	18,504	-7,810	-30%	12,316	-6,188	-33%
Dist. of Col.	72,330	70,082	67,871	56,128	-16,202	-22%	53,455	-2,673	-5%
Florida	657,313	575,553	478,329	320,886	-336,427	-51%	227,156	-93,730	-29%
Georgia	388,913	367,656	306,625	220,070	-168,843	-43%	154,900	-65,170	-30%
Guam	7,630	7,634	7,370	7,461	-169	-2%	8,083	622	8%
Hawaii	65,207	66,690	65,312	75,817	10,610	16%	45,452	-30,365	-40%
Idaho	24,050	23,547	19,812	4,446	-19,604	-82%	3,128	-1,318	-30%
Illinois	710,032	663,212	601,854	526,851	-183,181	-26%	414,872	-111,979	-21%
Indiana	197,225	147,083	121,974	95,665	-101,560	-51%	113,680	18,015	19%
Iowa	103,108	91,727	78,275	69,504	-33,604	-33%	59,945	-9,559	-14%
Kansas	81,504	70,758	57,528	38,462	-43,042	-53%	32,436	-6,026	-16%
Kentucky	193,722	176,601	162,730	132,388	-61,334	-32%	104,683	-27,705	-21%
Louisiana	258,180	239,247	206,582	118,404	-139,776	-54%	128,016	9,612	8%
Maine	60,973	56,319	51,178	41,265	-19,708	-32%	36,870	-4,395	-11%
Maryland	227,887	207,800	169,723	130,196	-97,691	-43%	99,852	-30,344	-23%
Massachusetts	286,175	242,572	214,014	181,729	-104,446	-36%	150,641	-31,088	-17%
Michigan	612,224	535,704	462,291	376,985	-235,239	-38%	279,245	-97,740	-26%
Minnesota	180,490	171,916	160,167	141,064	-39,426	-22%	138,030	-3,034	-2%
Mississippi	146,319	133,029	109,097	66,030	-80,289	-55%	43,499	-22,531	-34%
Missouri	259,595	238,052	208,132	162,950	-96,645	-37%	137,954	-24,996	-15%
Montana	34,313	32,557	28,138	20,137	-14,176	-41%	16,133	-4,004	-20%
Nebraska	42,038	38,653	36,535	38,090	-3,948	-9%	34,809	-3,281	-9%
Nevada	41,846	40,491	28,973	29,262	-12,584	-30%	23,108	-6,154	-21%
New Hampshire	28,671	24,519	20,627	15,947	-12,724	-44%	15,893	-54	0%
New Jersey	321,151	293,833	256,064	217,320	-103,831	-32%	179,910	-37,410	-17%
New Mexico	105,114	102,648	89,814	64,759	-40,355	-38%	80,583	15,824	24%
New York	1,266,350	1,200,847	1,074,189	941,714	-324,636	-26%	833,045	-108,669	-12%
North Carolina	317,836	282,086	253,286	192,172	-125,664	-40%	148,782	-43,390	-23%
North Dakota	14,920	13,652	11,964	8,884	-6,036	-40%	8,359	-525	-6%
Ohio	629,719	552,304	518,595	386,239	-243,480	-39%	319,912	-66,327	-17%
Oklahoma	127,336	110,498	87,312	69,630	-57,706	-45%	55,531	-14,099	-20%
Oregon	107,610	92,182	66,919	48,561	-59,049	-55%	44,126	-4,435	-9%
Pennsylvania	611,215	553,148	484,321	395,107	-216,108	-35%	325,546	-69,561	-18%
Puerto Rico	171,932	156,805	145,749	130,283	-41,649	-24%	113,007	-17,276	-13%
Rhode Island	62,407	60,654	54,809	54,537	-7,870	-13%	54,175	-362	-1%
South Carolina	133,567	121,703	98,077	73,179	-60,388	-45%	49,383	-23,796	-33%
South Dakota	17,652	16,821	14,091	10,514	-7,138	-40%	8,945	-1,569	-15%
Tennessee	281,982	265,320	195,891	139,022	-142,960	-51%	149,138	10,116	7%
Texas	765,460	714,523	626,617	439,824	-325,636	-43%	330,616	-109,208	-25%
Utah	47,472	41,145	35,493	29,868	-17,604	-37%	27,526	-2,342	-8%
Vermont	27,716	25,865	23,570	21,013	-6,703	-24%	18,260	-2,753	-13%
Virgin Islands	4,345	5,075	4,712	4,129	-216	-5%	3,967	-162	-4%
Virginia	189,493	166,012	136,053	107,192	-82,301	-43%	94,383	-12,809	-12%
Washington	290,940	276,018	263,792	228,723	-62,217	-21%	178,333	-50,390	-22%
West Virginia	107,668	98,439	98,690	51,348	-56,320	-52%	27,529	-23,819	-46%
Wisconsin	214,404	184,209	132,383	44,630	-169,774	-79%	33,807	-10,823	-24%
Wyoming	15,434	13,531	10,322	2,903	-12,531	-81%	1,913	-990	-34%

SOURCE: US Department of Health and Human Sevices, Administration for Children and Families, April 1999 (www.acf.dhhs/gov/news/stats/caseload.htm).

TECHNICAL APPENDIX

by

David Stapleton, Ph.D
Ellen Englert, M.S.
The Lewin Group

Technical Description

Data

The data for this study are drawn from the 1996 and 1998 March Supplements of the Current Population Survey (CPS). The CPS data provide information about socioeconomic characteristics, including Medicaid enrollment and other health insurance coverage, for a national sample of individuals. While the variables in the CPS are well-tailored to the needs of this study, there are several limitations to the data. In particular, there are two issues with the Medicaid participation variable.

First, Medicaid participation is generally underreported in the CPS survey. For 1997 there were 31.2 and 25.3 percent more child and adult Medicaid enrollees, respectively, reported in the Health Care Financing Administration (HCFA) administrative data than estimated based on the CPS survey.[1] The underreporting may result from respondents' failure to accurately report or recall Medicaid enrollment. The underreporting might also result from respondents misinterpreting the Medicaid enrollment question on the CPS. The CPS Medicaid enrollment question refers to any time in the previous calendar year (CY), but there is reason to believe that many respondents answer this question with respect to their current enrollment status. If substantial numbers of individuals left Medicaid from CY 1997 to March 1998, then enrollment reported for CY 1997 in the March 1998 survey would understate actual Medicaid enrollment in CY 1997 by a greater degree than the March 1996 survey understates actual CY 1995 enrollment because Medicaid enrollment was fairly constant between CY 1995 and March 1996.

Indeed the degree of underreporting in the CPS relative to the HCFA administrative data increased between the 1996 and 1998 March Supplements. Relative to the CPS data the HCFA administrative data had 25.5 and 28.8 percent more Medicaid enrollees reported for 1995 and 1997, respectively.[2] The degree of underreporting and the change in underreporting varied by age and state. There

[1] The Medicaid enrollment data available from HCFA reflect federal fiscal years. In order to compare these numbers to the CPS data, we develop trending adjustments to move these data forward three months to the calendar year. These data are in Table 1-E, which is available from Families USA upon request.

[2] Medicaid enrollment data for Hawaii are not available from HCFA. Thus, Hawaii is excluded from the comparison of Medicaid enrollment estimates. Data from Hawaii are included in our study, however. These data are in Table 1-E, which is available from Families USA upon request.

was a greater change in the degree of underreporting for children. Among children the HCFA data had 26.3 and 31.2 percent more Medicaid enrollees than the CPS. Among adults the HCFA data had 24.4 and 25.3 percent more Medicaid enrollees. In particular, in several areas the degree of underreporting increased more than 24 percentage points between the 1996 and 1998 surveys. Among children these areas were Alabama, Connecticut, Florida, Louisiana, Mississippi, Oregon, South Carolina, Wisconsin, and the District of Columbia. Among adults these areas were Alabama, Louisiana, Ohio, South Carolina, and the District of Columbia. We refer to remaining states for children and adults as our analysis states. If these areas are excluded from both the CPS and the HCFA Medicaid enrollee counts, then the degree of underreporting in the CPS is constant or declining between the 1996 and 1998 March Supplements. Therefore, in order to assure that we do not overestimate the impact of welfare reform on Medicaid enrollment because of increased underreporting in the CPS, we exclude these areas from our analysis. If increases in underreporting are associated with declines in a state's Medicaid caseload, as hypothesized, then excluding these states from our analysis should result in more conservative estimates of Medicaid enrollment declines related to welfare reform. Table 1 below shows the percentage declines in AFDC/TANF enrollment that occurred in these areas between January 1995 and September 1998.

Table 1
Percentage Decline in AFDC/TANF Enrollment in Areas Excluded from Analysis

	Jan 1995	Jan 1997	Sept 1997	% Change Jan 1995 to Jan 1997	% Change Jan 1997 to Sept 1997
Alabama	121,837	91,723	52,076	-24.7%	-43.2%
Connecticut	170,719	155,701	118,066	-8.8%	-24.2%
District of Columbia	72,330	67,871	53,727	-6.2%	-20.8%
Florida	657,313	478,329	246,191	-27.2%	-48.5%
Louisiana	258,180	206,582	121,772	-20.0%	-41.1%
Mississippi	146,319	109,097	45,009	-25.4%	-58.7%
Ohio	629,719	518,595	319,912	-17.6%	-38.3%
Oregon	107,610	66,919	44,235	-37.8%	-33.9%
South Carolina	133,567	98,077	52,280	-26.6%	-46.7%
Wisconsin	214,404	132,383	34,031	-38.3%	-74.3%

Source: The Administration for Children and Families, DHHS.

Each of the states excluded saw substantial declines in AFDC/TANF enrollment in the period between January 1995 and September 1998.[3]

A second limitation to the CPS data is that the Medicaid variable is imputed for about 28 percent of individuals with Medicaid coverage indicated. For approximately 16 percent of the individuals with Medicaid coverage indicated, Medicaid enrollment was logically imputed because the individual was enrolled in SSI or the family reported AFDC/TANF participation. If AFDC/TANF enrollment declined between the March 1996 and 1998 CPS Supplements, then Medicaid enrollment as indicated by the CPS might decline as a result of the imputation method, even though actual Medicaid enrollment remained unchanged. As fewer people report AFDC/TANF enrollment, fewer people will have Medicaid participation logically imputed based on their participation in AFDC/TANF, even if Medicaid enrollment does not fall with the decline in AFDC/TANF participation. This leads us to expect that the number of non-SSI logically imputed Medicaid enrollees would fall more rapidly than the number of reported enrollees as AFDC/TANF participation declines, resulting in an upward bias in the estimated impact on Medicaid enrollment if no correction were made. In fact, however, the share of logically imputed cases among non-SSI Medicaid participants with family incomes under 200 percent of poverty in the 1998 CPS is similar to the 1996 CPS among both adults and children. For adults, 16.8 and 16.7 percent of cases were logically imputed in 1996 and 1998, respectively. For children, the percentages were 14.6 and 14.9 percent, respectively. Hence, we make no adjustment in our analysis for the CPS imputation method.

Methodological Approach

Estimation of the Number of Individuals Losing Medicaid

We develop a binomial model of Medicaid participation based on the demographic and socio-economic characteristics available in the CPS March Supplement. The basis for the model is the linear equation (1) listed below:

$$(1) \qquad Y_i^* = x_i \beta + \varepsilon_i$$

Y_i^* in this equation is an unobserved variable measuring an individual's

[3] In order to test the effect of excluding states that appeared to have had increases in Medicaid underreporting we estimated our model including these states. If we include these states in our analysis, we find a 5.4 and 5.1 percentage reduction in Medicaid enrollment resulting from welfare reform for children and adults, respectively. These declines are greater than the percentage declines reported below when these areas are excluded.

likelihood of Medicaid enrollment. We observe Y_i, an indicator variable for whether an individual is enrolled in Medicaid. If Y_i^* is greater than zero, then Y_i is equal to one and the individual is Medicaid enrolled. If Y_i^* is less than or equal to zero, then Y_i is equal to zero and the individual is not Medicaid enrolled. The vector x_i is a set of demographic, socio-economic characteristics, and state dummy variables. There was little change between 1995 and 1997 in the distribution of the population under 200 percent of poverty by age, marital status, presence of children, disability status, race, years of education, non-transfer income as a percentage of poverty, and earnings as a percentage of poverty.[4]

We were concerned about including earnings in the model, because earnings are likely to have been affected by welfare reform. However, we decided the benefit of including earnings as a control for changes in the economy outweighed the risk of correlation between this variable and welfare reform. If welfare reform has increased earnings, then our estimates of the number of people who would have been enrolled in Medicaid in absence of welfare reform is biased downward. *Thus, our estimate of the number of people not participating in Medicaid due to welfare reform is conservative.*

Our model does not control for the increases in Medicaid enrollment expected annually as a result of the phase-in of the expansion of eligibility for children through age 18 born after September 30, 1983 in families with income up to 100 percent of the federal poverty line. Coverage for children in families with income below 100 percent of the poverty level is being phased-in to cover older children through September 30, 2001. *Since our model does not control for these expected increases, our estimate of the reduction in the number of children on Medicaid that resulted from welfare reform is slightly understated.*

With the added assumption that ε_i in equation (1) is a random error term drawn from a standard normal distribution the Medicaid enrollment equation takes the form of a standard probit model:

$$(2) \qquad P(Y_i = 1) = \Phi(x_i \beta)$$

Where $\Phi(\ )$ is the standard normal distribution function. We estimate this model separately for three groups in the CPS survey: children <19, males 19-64, and females 19-64. Individuals over 64 are not included in our analysis. While Medicaid is an important secondary insurance source for the low-income elderly,

[4] These data are in Tables 2-E and 3-E, which are available from Families USA upon request.

these individuals were not targeted by welfare reform initiatives. When we estimate the model we include only individuals below 200 percent of poverty, because most Medicaid recipients are included in this income range.[5]

To assess the mean prediction error in the model for each of the subgroups included in our analysis we compared the actual number of individuals on Medicaid in 1995 to the number predicted by the model. For the majority of the subgroups the predicted value is within one percent of the actual value.[6] While we believe it is important to include citizenship in our model of Medicaid enrollment, we do not believe the sample size for the non-citizen subpopulation in the CPS is large enough to report findings for this subpopulation.

Once the parameter estimates for these models were obtained, we applied them to data from the 1998 CPS March Supplement to estimate the probability of enrollment in Medicaid in the absence of the reforms. Based on these probability estimates, we compute the number of individuals expected to be enrolled in Medicaid in the absence of welfare reform for each of the three subpopulations. The difference between this number and the actual number of individuals who report or were imputed to be Medicaid enrolled in 1997 is our base estimate of the number of individuals disenrolled from Medicaid as a result of welfare reform. These numbers are reported in Table 2 below for children and adults.

Table 2
Comparison of Actual and Predicted Medicaid Enrollment, 1997 Without Adjustment for CPS Underreporting - Analysis States (in Thousands)

	Predicted 1997 Enrollment In Absence of Reform	Actual 1997 Medicaid Enrollment	Estimated Number of Individuals Losing Medicaid Coverage Due to Reform	Estimated Percentage Decline
Children, less than 19	11,635	11,145	489	4.2%
Adults, 19-64	8,102	7,796	306	3.8%

These estimates represent only the states included in our analysis, and they reflect only those individuals who report or who are imputed to be Medicaid

[5] These parameter estimates for children and adults are in Tables 4-E and 5-E, which are available from Families USA upon request.
[6] This comparison is presented for children and adults, respectively, in Tables 6-E and 7-E, which are available from Families USA upon request. In addition, Tables 8E and 9E present the number of CPS March Supplement observations represented by each of the subpopulations discussed in our results. Tables 8E and 9E are available from Families USA upon request.

enrolled based on the CPS survey and imputation method. Below, we report estimates increased to adjust for the difference in Medicaid enrollment as reported in the CPS and HCFA administrative data. The HCFA administrative data show Medicaid enrollment for children and adults fell 3.3 and 3.6 percent, respectively, between 1995 and 1997. Thus, the overall declines observed in the HCFA administrative data are similar in magnitude to our estimates of the declines resulting from welfare reform.

Characteristics of Individuals Losing Medicaid

After estimating the number of individuals losing Medicaid, we examined the characteristics of those individuals most likely to have been removed from the Medicaid rolls due to welfare reform. In order to do this, in each of our 1998 CPS subsamples we first identify those individuals who did not report enrollment and who were not imputed to be enrolled in Medicaid. Then, from among these individuals, we select a sample of the same size as the number of individuals estimated to have been removed from the Medicaid rolls due to welfare reform. We select these individuals based on predicted Y_i^* values based on equation (1) above. The Y_i^* value is computed based on the estimated coefficients, the individuals' personal demographic and socio-economic characteristics, and a randomly drawn value for the error term. The random value for the error term is a draw from a standard normal distribution. Once the Y_i^* value has been derived for each individual, the individuals with the highest Y_i^* values are selected until the number of individuals estimated to have lost their Medicaid enrollment is reached. To reduce sampling error, this process of drawing values for the error term and selecting the set of non-Medicaid enrollees in the subsample with the highest Y_i^* values was repeated 100 times.

Each of the statistics reported is based on the average value across the 100 samples.[8]

---

[7] Because of extreme increases in Medicaid underreporting relative to HCFA administrative data, children in Alabama, Connecticut, Florida, Louisiana, Mississippi, Oregon, South Carolina, Wisconsin, and the District of Columbia were excluded from our analysis. Similarly adults in Alabama, Ohio, South Carolina, Louisiana, and the District of Columbia were excluded.

[8] Once individuals enrolled or imputed to be enrolled in Medicaid are excluded, an alternative method of deriving the estimated characteristics of the individuals most likely not to be participating in Medicaid due to welfare reform would be to use the probability of Medicaid participation assigned by the model as a weight and compute the weighted average insurance status among subgroups of the remaining individuals. As the number of samples we draw in the method above increases, the results of these two methods will converge.

This analysis of the insurance status of individuals who were estimated to have lost Medicaid due to welfare reform is limited by the quality of the insurance information reported in the CPS. We exclude from this analysis individuals who reported Medicaid enrollment in 1997 or who were imputed to be Medicaid enrolled in 1997. We know, however, that the number of individuals we exclude is substantially lower than the number of people enrolled in Medicaid based on HCFA administrative data. Thus, some of the individuals included in the analysis are Medicaid enrolled although they are neither reported nor imputed to be. If these individuals are disproportionately reported to be uninsured in the CPS data, then their presence in our analysis is likely to result in higher estimates of the number of individuals losing Medicaid coverage who become uninsured. Symmetrically, if these individuals are disproportionately individuals who report private insurance even though they are actually covered by Medicaid[9] or who have private or other insurance coverage for part of the year and Medicaid for another part, then the number of people losing Medicaid who gain private or other insurance is likely to be overstated. Based on estimates from other researchers, there is reason to believe that these individuals are more likely to be in the uninsured group. Below we describe how we adjust our estimates to account for the likelihood that these individuals are disproportionately uninsured.

To estimate the number of people losing Medicaid as a result of welfare reform and the insurance status of those individuals after welfare reform, we considered as an alternative method using a multinomial model to predict the probability of Medicaid enrollment, private insurance, or uninsured simultaneously. Then, the number and characteristics of the uninsured would be derived based on the predicted probabilities. We chose not to use this method, since this method does not use information available in the 1998 CPS about who is actually enrolled in Medicaid. That is, an individual who is observed in the CPS to have been enrolled in Medicaid in 1997 may be assigned a high probability of being uninsured based on the model. However, we observe that this individual is on Medicaid in 1997 and we believe that welfare reform deterred individuals from enrolling or continuing to participate in Medicaid rather than encouraging increased participation. Based on this information, we do not include this

[9] The degree of Medicaid underreporting in the CPS has increased over time. This may result from Medicaid enrollees who are enrolled in commercial managed care plans reporting that they have private insurance.

individual in the group of individuals who may potentially not be participating in Medicaid due to the effects of welfare reform.

Approximation of the Standard Errors

Standard errors for the estimates were approximated based on parameters and formulas provided by the Bureau of the Census. State-specific factors are provided by the Bureau of the Census. These factors are used for regional estimates and to adjust for the exclusion of the areas with extreme increases in underreporting. The significance levels reported are based on approximated standard errors for the CPS survey adjusted for sample design and random sample variability. The standard error estimates generally do not account for nonsampling variability, such as errors in imputing values for missing data, respondent failure to report accurate information, and errors made in data collection and processing. The errors also do not account for random error associated with the simulation procedures that we use to estimate the characteristics of individuals predicted to have lost their Medicaid coverage. Finally, the standard errors do not account for error in our correction for the underreporting of Medicaid enrollment in the CPS relative to the HCFA administrative data.

Adjustment for Underreporting

The estimates presented above do not explicitly adjust for underreporting of Medicaid enrollment in the CPS relative to HCFA administrative data. Other authors[10] have explicitly accounted for the underreporting of Medicaid enrollment in the CPS by selecting individuals whose coverage was not reported or imputed by the CPS and assigning Medicaid participation for these individuals. If we assume that individuals who participated in Medicaid, but who are not identified by the CPS as Medicaid enrollees, were as likely to lose Medicaid as individuals identified by the CPS, then the aggregate number of individuals losing Medicaid as a result of the reforms would be substantially higher than the numbers in Table 2 above. Table 3 reports estimates of the number of individuals affected by welfare reform adjusted for CPS underreporting of Medicaid enrollment, based on this assumption.

[10] *The Insurance Status of Medicaid Eligible Persons Not Participating in the Program: Estimates for Children and Other Eligibility Groups*, The Lewin Group, November 21, 1997 *and Counting the Uninsured: A Review of the Literature,* The Urban Institute, July 20, 1998.

Table 3
Comparison of Actual and Predicted Medicaid Enrollment, 1997 Adjusted for CPS Underreporting of Medicaid Enrollment Individuals in Families with Income Below 200% of Poverty Analysis States (in Thousands)

	Predicted 1997 Enrollment In Absence of Reform	Actual 1997 Medicaid Enrollment	Estimated Number of Individuals Losing Medicaid Coverage Due to Reform	Estimated Percentage Decline
Children, less than 19	16,387	15,698	689	4.2%
Adults, 19-64	10,948	10,535	413	3.8%

We compare the number of people who became uninsured to the number of individuals uninsured overall. CPS counts of the number of people uninsured must also be adjusted for the underreporting of Medicaid enrollment. We base our adjustment on a comparison of Urban Institute and Bureau of the Census estimates of the number of people on Medicaid and uninsured in 1995 based on the 1996 March Supplement of the CPS. The major difference between the Urban Institute and Bureau of the Census estimates is that the Urban Institute adjusted its estimates for Medicaid underreporting in the CPS. Table 4 below compares these two sets of estimates.

Table 4
Derivation of Percentage Reduction in Uninsured Related to Adjustment for CPS Underreporting of Medicaid Enrollment (in Millions)

	Children 0-18	Adult 19-64	All Non-Elderly 0-64
Medicaid Enrollment			
CPS Reported	16.9	12.1	29.0
HCFA Reported	21.9	14.8	36.7
Adjustment for CPS Underreporting			
Increase in Medicaid	5.0	2.7	7.7
Decrease in Uninsured	2.9	1.7	4.6
Percentage Reduction to Uninsured	58.7%	61.7%	59.7%

The Urban Institute estimated that 7.7 million more people age less than 65 were enrolled in Medicaid and 4.6 million fewer were uninsured relative to the Bureau of the Census estimates.[11] Thus, 59.7 percent of individuals who

[11] *Counting the Uninsured: A Review of the Literature,* The Urban Institute, July 20, 1998.

were imputed to be enrolled in Medicaid had reported no other health insurance in the CPS survey. When the percentage of individuals who were imputed to be enrolled in Medicaid is assessed separately for adults and children, we find that 58.7 and 61.7 percent of children and adults with imputed Medicaid enrollment, respectively, reported no other health insurance in the CPS survey. Reductions to the number of uninsured people for 1995 and 1997 are reported in Table 5 below.

Table 5
Reductions to the Numbers of Uninsured Individuals Related to the Medicaid Underreporting Adjustment Individuals in Families with Income Below 200% of Poverty Analysis States (in Thousands)

	Children		Adults	
	1995	1997	1995	1997
CPS Estimate of Medicaid Enrolled	11,549	11,145	8,078	7,796
Medicaid Enrollment Estimate Adjusted for Underreporting	16,266	15,698	10,917	10,535
Increase in Medicaid Related to Underreporting	4,717	4,552	2,838	2,739
Reduction to Number Uninsured	2,769	2,672	1,751	1,690

Finally, the estimates of the number of individuals who became uninsured as a result of no longer being enrolled in Medicaid must be adjusted for the effects of underreporting. As noted above when we estimated the number of people becoming uninsured as a result of no longer being covered under Medicaid, we excluded individuals who reported Medicaid enrollment in 1997 or who were imputed to be Medicaid enrolled in 1997. We know, however, that the number of individuals we excluded is substantially lower than the number of people enrolled in Medicaid based on HCFA administrative data, and that these individuals are disproportionately uninsured. Table 6 below reports the number of non-Medicaid enrolled individuals who are uninsured and insured with and without adjustment for Medicaid underreporting in the CPS. The percentage of non-Medicaid enrolled individuals who are uninsured decreases by 6.4 and 1.1 percentage points for children and adults, respectively, as a result of adjusting for Medicaid underreporting in the CPS. Therefore, we use a ratio of the percentage uninsured after adjustment over the percentage uninsured before adjustment to decrease our estimates of the number of individuals who became uninsured as a result of no longer being enrolled in Medicaid for the effects of underreporting.

Table 6
Health Insurance Status of Non-Medicaid Enrolled Individuals Unadjusted and Adjusted for CPS Underreporting of Medicaid

	Unadjusted	Adjusted	Adjustment Factor
Child, less than 19			
Private/Other	**9,015**	**7,135**	
Uninsured	6,731	4,059	
Percentage Uninsured	42.7%	36.3%	84.8%
Adult, 19-64			
Private/Other	16,000	14,951	
Uninsured	15,575	13,885	
Percentage Uninsured	49.3%	48.2%	97.6%

Development of National Estimates

Once we derived estimates of the percentage and number of individuals losing Medicaid coverage due to welfare reform in our analysis states, we extended the analysis to produce national estimates. We derived two sets of national estimates. For the first set of national estimates, we assumed that individuals in the excluded states would have lost Medicaid at the same rate we estimated for individuals in the non-analysis states. These estimates are presented in Table 7 below. The estimates are presented by subgroups of the

Table 7
Comparison of Actual and Predicted Medicaid Enrollment, 1997 Adjusted for CPS Underreporting of Medicaid Enrollment, Individuals in Families with Income Below 200% of Poverty All States (in Thousands)

	Actual 1997 Medicaid Enrollment	Predicted 1997 Medicaid Enrollment In Absence of Reform	Estimated Number of Individuals Losing Medicaid Coverage Due to Reform	Estimated Percentage Decline
Unadjusted for Underreporting				
Children, less than 19	12,660	13,216	556	4.2%
Adults, 19-64	8,436	8,767	331	3.8%
Adjusted for Underreporting*				
Children, less than 19	18,394	19,202	807	4.2%
Adults, 19-64	11,289	11,732	443	3.8%

* The adjustment corrects for the difference between the CPS estimate of the number of Medicaid enrollees in 1997, nationally, and the corresponding HCFA administrative estimate, separately for children and adults.

population in Tables 10 and 11 at the end of this report. Table 10 presents estimates adjusted for Medicaid underreporting for children and Table 11 presents the same for adults.

By excluding states that had sharp declines in Medicaid underreporting we believe we have developed conservative estimates of the impact of welfare reform on Medicaid enrollment. This is because we hypothesize that increases in underreporting are most likely associated with declines in a state's Medicaid caseload. To demonstrate the impact of excluding these states and to provide a less conservative estimate of Medicaid enrollment declines related to underreporting, we provide a second set of national estimates in Table 8 below. To calculate these estimates we include all states and reestimate our model.

Table 8
Comparison of Actual and Predicted Medicaid Enrollment, 1997 Adjusted for CPS Underreporting of Medicaid Enrollment Individuals in Families with Income Below 200% of Poverty Without Correction for Underreporting Changes All States (in Thousands)

	Actual 1997 Medicaid Enrollment	Predicted 1997 Medicaid Enrollment In Absence of Reform	Estimated Number of Individuals Losing Medicaid Coverage Due to Reform	Estimated Percentage Decline
Unadjusted for Underreporting				
Children, less than 19	12,660	13,388	728	5.4%
Adults, 19-64	8,436	8,893	457	5.1%
Adjusted for Underreporting*				
Children, less than 19	17,178	18,159	981	5.4%
Adults, 19-64	11,159	11,759	600	5.1%

* The adjustment correct for the difference between the CPS estimate of the number of Medicaid enrollees in 1997, nationally, and the corresponding HCFA administrative estimate, separately for children and adults. The 1995 relationship between the CPS and HCFA estimates was used for this set of estimates, because this set of estimates assumes that the change in the relationship between the CPS and HCFA estimates that occured between 1995 and 1997 is likely to be due to factors other than increased underreporting of Medicaid enrollment among CPS respondents.

The estimates produced when all states are included in the model show larger declines in Medicaid enrollment resulting from welfare reform. When all states were included in our analysis, we estimated slightly different adjustment factors for CPS underreporting of Medicaid enrollment for the percentage of individuals who became uninsured after losing Medicaid as a result of welfare reform. The changes in these factors results from differences between the distribution of insurance status in our original analysis states and the

distribution for all states. The national adjustment factors are reported in Table 9 below.

Table 9
Health Insurance Status of Non-Medicaid Enrolled Individuals Unadjusted and Adjusted for CPS Underreporting of Medicaid Enrollment (in Thousands)

	Unadjusted	Adjusted	Adjustment Factor
Child, less than 19			
Private/Other	10,660	8,930	
Uninsured	7,985	5,198	
Percentage Uninsured	42.8%	36.8%	85.9%
Adult, 19-64			
Private/Other	16,970	15,845	
Uninsured	15,575	17,758	16,160
Percentage Uninsured	51.1%	50.5%	98.7%

NOTE: Researchers who would like more information about our estimation methodology or to order copies of Tables 1E-9E should contact Rachel Klein at Families USA, (202) 628-3030 or rklein@familiesusa.org.

Table 10
Confidence Intervals for Estimates of Uninsured Due to Welfare Reform: Children; Characteristics of Individuals Estimated to Have Lost Medicaid Coverage; Children Less Than 19 in Families Below 200% of Poverty - All States, Estimates Adjusted for CPS Underreporting of Medicaid Enrollment (in Thousands)

	Number of Individuals Estimated to Have Lost Medicaid Coverage		5th Percentile Percentage Uninsured	Percentage Uninsured	95th Percentage Uninsured
	Total	Uninsured			
Overall	807	420	40.8%	52.1%	63.3%
INCOME AS A % OF POVERTY					
0-99%	570	322	42.4%	56.5%	70.5%
100-199%	238	99	23.2%	41.7%	60.2%
AGE					
0-5	373	201	37.0%	53.9%	70.8%
6-12	269	131	29.7%	48.7%	67.7%
13-18	165	88	28.2%	53.3%	78.3%
CHILD <13 AND INCOME <100% OF POVERTY					
No	356	166	30.7%	46.7%	62.7%
Yes	452	255	40.6%	56.4%	72.1%
NUMBER OF CHILDREN IN FAMILY					
<2 Children	454	247	39.1%	54.5%	70.0%
3 or More Children	354	173	32.5%	48.9%	65.4%
MARITAL STATUS					
Married-No	571	303	39.4%	53.0%	66.6%
Married-Yes	236	118	29.8%	50.0%	70.1%
YEARS OF EDUCATION					
>=12 Years	618	351	43.3%	56.7%	70.2%
13+ Years	190	70	17.6%	37.1%	56.6%
RACE					
Non-Minority	274	111	23.5%	40.6%	57.6%
Minority	534	310	43.3%	58.0%	72.7%
GEOGRAPHIC LOCATION					
Rural	169	87	26.6%	51.7%	76.8%
Suburban	340	180	35.3%	52.9%	70.5%
Central City	299	153	33.2%	51.4%	69.5%
REGION					
North East	106	55	25.9%	52.1%	79.6%
Midwest	164	71	21.9%	43.3%	65.7%
South	334	194	37.4%	58.2%	80.2%
West	203	99	28.4%	49.0%	70.8%

Table 11

Confidence Intervals for Estimates of Uninsured Due to Welfare Reform: Adults Characteristics of Individuals Estimated to Have Lost Medicaid Coverage Adults 19-64 in Families Below 200% of Poverty —All States Estimates Adjusted for CPS Underreporting of Medicaid Enrollment (in Thousands)

	Number of Individuals Estimated to Have Lost Medicaid Coverage		5th Percentile Percentage	Percentage	95th Percentage
	Total	Unisured	Uninsured	Uninsured	Uninsured
Overall	443	255	41.5%	57.5%	73.6%
INCOME AS A % OF POVERTY					
<100%	326	203	42.7%	62.2%	81.8%
100%+	117	52	17.7%	44.9%	72.1%
AGE					
19-35	260	167	42.3%	64.5%	86.7%
36-64	183	87	25.0%	47.7%	70.4%
DISABILITY					
Disability - No	284	183	43.3%	64.4%	85.5%
Disability - Yes	159	71	20.9%	44.8%	68.7%
CHILDREN <6 IN HOUSEHOLD					
Child <6 - No	242	120	29.3%	49.5%	69.6%
Child <6 - Yes	201	135	41.5%	67.1%	92.8%
MARITAL STATUS					
Married - No	354	205	40.0%	58.0%	76.0%
Married - Yes	89	50	20.6%	55.7%	90.7%
EDUCATION					
<=12 Years	335	205	42.3%	61.4%	80.4%
13+ Years	108	49	16.6%	45.6%	74.5%
RACE					
Non-Minority	248	154	40.1%	62.3%	84.6%
Minority	195	100	28.4%	51.3%	74.2%
GEOGRAPHIC LOCATION					
Rural	92	57	24.8%	61.8%	97.6%
Suburban	175	96	30.2%	55.1%	79.9%
Central City	176	102	32.4%	57.8%	83.3%
REGION					
North East	84	47	21.1%	56.2%	91.3%
Midwest	85	47	17.4%	55.2%	93.0%
South	148	91	31.8%	61.3%	90.8%
West	126	71	27.4%	55.9%	84.4%

CREDITS

This report was written by:

Rachel Klein, Health Policy Analyst, Families USA

With assistance from:

Cheryl Fish-Parcham, Associate Director of Health Policy, Families USA

The following Families USA Foundation staff contributed to the preparation of this report:

Ron Pollack, Executive Director

Kathleen Haddad, Director Health Policy

Peggy Denker, Director of Publications

Nefretiri Cooley, Press Secretary

Justine Zabala, Administrative Assistant

Vyda Stewart, Administrative Assistant

Jennipher Johnston, Media Associate

Jeremy Dadzie, Intern

Patricia Myung, Intern

Data development and technical appendix by:

David Stapleton, Ph.D.
Ellen Englert, M.S.
The Lewin Group

The cover was designed by:

Gallagher Wood Design

Families USA thanks the following for their contributions:

Leighton Ku, The Urban Institute

Please visit our website at:
www.familiesusa.org

FAMILIES USA

Families USA is a national, nonprofit organization dedicated to the achievement of high-quality, affordable health and long-term care for all Americans. You can help promote Families USA's goals by becoming a member of Families USA today.

Yes, I want to add my voice in support of affordable, high-quality health care for all.

☐ Enclosed is my contribution:

_____ $25 _____ $50 _____ $100 _____ $250 _____ Other

☐ Please send me information about the following **Families USA's** grassroots advocacy networks:

- ☐ ***asap!***
- ☐ Medicaid Advocacy Network
- ☐ Medicare Network
- ☐ Children's Health Campaign

☐ Enclosed is my check to cover the costs of the following publications (from list on next page): **(DC residents add 5.75% sales tax.)**

Pub. Code	**Title**	**Quantity**	**Price**

Name: _____

Organization: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (Day) _____ (Evening) _____ (Fax) _____

E-mail: _____

Contributions to Families USA Foundation are tax-deductible. Please make your check payable to Families USA Foundation.

Families USA Foundation receives no financing from the health or insurance industries. We rely on funding from individuals and private foundations.

Families USA Foundation • 1334 G Street, NW, 3rd Floor • Washington, DC 20005 • 202-628-3030

PUBLICATIONS AVAILABLE FROM FAMILIES USA FOUNDATION

Publication Code	Title	Price
PS-101	***Families USA Publications Service.*** Reports, issue briefs, and other publications.	$70.00
99-102	***The Impact of Medicare Reform on Low-Income Beneficiaries*** (3/99)	$10.00
99-101	***Deep in the Heart of Texas: Unisured Children in the Lone Star State*** (2/99)	$10.00
99-100	***Consumer Health Action '99 Toolkit*** (1/99)	$35.00
98-107	***The Quality of Maryland and District of Columbia Medicaid Managed Care Plans: External Reviews*** (12/98)	$10.00
98-106	***The Best From the States II: The Text of Key State HMO Consumer Protection Provisions*** (10/98)	$10.00
98-105	***Premium Pay II: Corporate Compensation in America*** (9/98)	$15.00
98-104	***Hit and Miss: State Managed Care Laws*** (7/98)	$15.00
98-103	***Shortchanged: Billions Withheld From Medicare Beneficiaries*** (7/98)	$15.00
98-102	***Monitoring Medicare HMOs: A Guide to Collecting and Interpreting Available Data*** (5/98)	$20.00
98a-101	***A Guide to Access to Providers in Medicaid Managed Care*** (4/98)	$20.00
98a-100	***A Guide to Meeting the Needs of People with Chronic and Disabling Conditions in Medicaid Managed Care*** (1/98)	$20.00
98-100	***Consumer Health Action '98 Toolkit*** (1/98)	$35.00
97a-102	***A Guide to Complaints, Grievances, and Hearings under Medicaid Managed Care*** (1/98)	$20.00
97-109	***Comparing Medicare HMO's: Do They Keep Their Members?*** (12/97)	$15.00
97b-101	***A Guide to Cost-Sharing and Low-Income People*** (10/97)	$20.00
97-108	***A Preliminary Guide to Expansion of Children's Health Coverage*** (9/97)	$15.00
97a-101	***A Guide to Marketing and Enrollment in Medicaid Managed Care*** (6/97)	$15.00