# The Dynamics of Coverage Status

**Speaker:**

- Linda Bilheimer, Senior Economist, The Robert Wood Johnson Foundation

Moderator: Edward Neuschler, Institute for Health Policy Solutions

(Additional information about the speaker appears at the end of this section.)

**Transcript:**

MR. NEUSCHLER: We're very pleased to have Linda Bilheimer with us this afternoon to talk about an issue that has been mentioned somewhat already today. I think a lot of state program people are well aware of how people's status changes over time. But I think a lot of folks, when talking about the uninsured, tend to speak of them as if they're this block of people who are static, in one place, and the fact that that's not the case is very important for designing policies, for covering the uninsured and coordinating with employer coverage.

So we're very pleased that Linda Bilheimer is with us this afternoon. I think most of you know her. She's now been with the Robert Wood Johnson Foundation for over a year. Before that she was with the Congressional Budget Office for several years and became quite well known to the Washington policy community through that job. She's also been with Mathematica Policy Research and the Arkansas Department of Health, and many other illustrious assignments. Se we're very glad to have her with us.

MS. BILHEIMER: It's a good thing that there isn't a platform here because I do walk around when I talk. On one occasion I got very carried away with my slide and just went on walking and disappeared off the end of the platform, and there was this gasp in the middle of the room. There was just total silence, and then everybody burst out laughing. It's very difficult to carry on with a talk after that has happened.

But I am delighted to be here and I'm delighted that there is no platform for me to fall off. And with that, I will begin. Rick asked me to come this afternoon to discuss the issue of the dynamics of insurance coverage because, as has just been said, it has profound implications for strategies to expand coverage, particularly strategies to expand coverage building on an employer base.

Changes in coverage, as you all well know, occur far more frequently than annual changes in the number of the uninsured indicate. For example, the CPS reduction in the number of uninsured between 1999 and 2000 from 44 million to 42 million did not represent a pool of 44 million people, two million of whom gained insurance. Rather, it represented the net effect of many millions of changes in people's health insurance status.

Our problem is that people with unstable employment situations, who include many of those in the target populations for the expansions that we're considering, have inherently unstable coverage. Many of them have employer-sponsored insurance some of the time, which they lose when they become unemployed, have to cut back their work hours, get switched to contract status or have to change jobs.

Many people with public coverage also have unstable coverage. Volatility used to be associated with gaining or losing AFDC. In the aftermath of welfare reform, and more recently with SCHIP, we've been dealing with confusion about eligibility, problems with states' administrative data systems, and the complexities of staying enrolled in Medicaid and SCHIP.

To illustrate what this means I'm going to cheat and use some old data—and I apologize for its age—which predates welfare reform. Unfortunately, these types of longitudinal survey data are costly and take a long time to produce. The data, which were compiled by Mathematica Policy Research for ASPE, are from the 1992 to 1994 panel of the Survey of Income and Program Participation, sponsored by the Census Bureau.

## Children's Health Insurance Transitions

**July 1993 - June 1994**

**(Millions)**

| | Average Number of Children | Transitions Out | Transitions In |
|---|---|---|---|
| Employer-Sponsored | 42 | 7 | 7 |
| Medicaid | 13 | 6 | 5 |
| Other Insurance | 3 | 2 | 3 |
| Uninsured | 9 | 8 | 8 |
| Unknown | 4 | - | - |
| Total | 71 | 23 | 23 |

Source: Czajka and Olsen, Mathematica Policy Research

The 1996 to 1999 panel is now complete and the Census Bureau hopes to have those data available this fall. So we hope to be able to update what I am now about to show you. But I

think the basic point carries over. And the data really demonstrate the complexity of these issues relating to people moving in and out of coverage.

These data show changes in the insurance status of children from July '93 through June 1994. In that year, there were 23 million changes in children's coverage status, which means there was one change for every three children in the country.

Notice that I didn't say 23 million children changed their status, because the transitions shown include multiple changes by the same children who moved in and out of coverage during that year. The reason that we don't notice these numbers from the aggregate annual data is because movements in and out are very close to each other. So, for example, there were 42 million children with employer-sponsored coverage during that year, but there were seven million transitions into employer-sponsored coverage and about seven million transitions out of employer-sponsored coverage. And you can see the same pattern with other changes in insurance status—transitions in and out parallel each other, and the net effect is small. Hence, we observe only small changes in the number of uninsured from year to year.

Many children who changed insurance status during that year moved back again into the same coverage that they had before. The next chart shows the percentage of changes that were reversed within a four-month period. So if we look at employer-sponsored coverage, for example, 55 percent of children's transitions from employer-sponsored to Medicaid were reversed within four months.

Similarly, if we look at the uninsured, 19 percent of those who moved from being uninsured to having employer-sponsored coverage were uninsured again within four months. These numbers should be treated with some caution, because the sample sizes are small in some of these categories, so there are quite large margins of error around the estimates.

We also learned from Mathematica's work that these types of transitions are frequently preceded by "trigger events," which include changes in parents' employment status, parents' hours worked, family income, headship of the family, family size or, in this case, participation in AFDC. I took just one set of these data to look at the transitions from employer-sponsored insurance, and found that 45 percent of transitions from employer-sponsored to uninsured were preceded by a trigger event in the previous month. By contrast, only about eight percent of children who remained in employer-sponsored coverage experienced one of those events in their family.

So, what are the long-term implications of these findings? The Mathematica researchers looked at that question in some detail. What they found was that half of the children who were uninsured at the end of the year were different than children who were uninsured at the beginning of the year.

# Children's Health Insurance Transitions

**Percent Reversed within 4 Months, July 1993-June 1994**

**To:**

| **From**: | Employer-Sponsored | Medicaid | Other Insurance | Uninsured |
|---|---|---|---|---|
| Employer-Sponsored | N/A | 55 | 48 | 40 |
| Medicaid | 16 | N/A | 18 | 35 |
| Other Insurance | 23 | 16 | N/A | 36 |
| Uninsured | 19 | 33 | 28 | N/A |

Source: Czajka and Olsen, Mathematica Policy Research

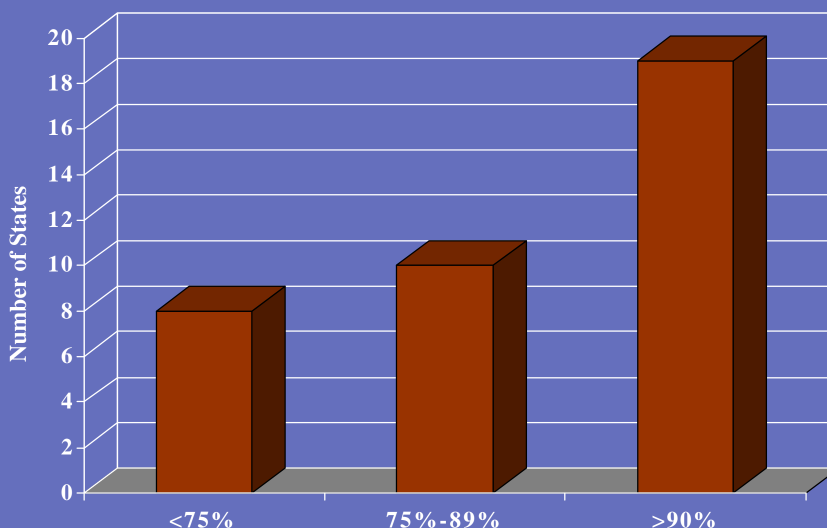
And this, I think, is the real headliner here: They concluded that if we were to insure all uninsured children today, within one year we would have half of that number of children uninsured again. That is, if we had ten million uninsured children and insured them in perpetuity, we would have another five million uninsured children within a year.

So are things getting any better? These are old data. Do we have any reason to believe that churning is being reduced? The data that we have on the public sector side don't give us an overwhelming sense of optimism. These data, again, should be treated carefully, but I think they raise important questions for policymakers.

The data are on SCHIP enrollment, and I have one slide that relates to 1999 and one slide that relates to 2000. What I did was to look at the number of children who were enrolled at a point in time—in the first case, December 1999—and looked at the percentage that point-in-time number represented of the number of children who were enrolled in SCHIP at any time in fiscal 1999 (that is October 1998 through September 1999). Thus, the December 1999 figure actually is beyond the end of the fiscal year.

## *State Data on Point-in-Time Vs. Ever-Enrolled*

**Point in Time (Dec 1999)**
**as % of Ever Enrolled (FY 1999)**




Sources: HCFA, Health Management Associates

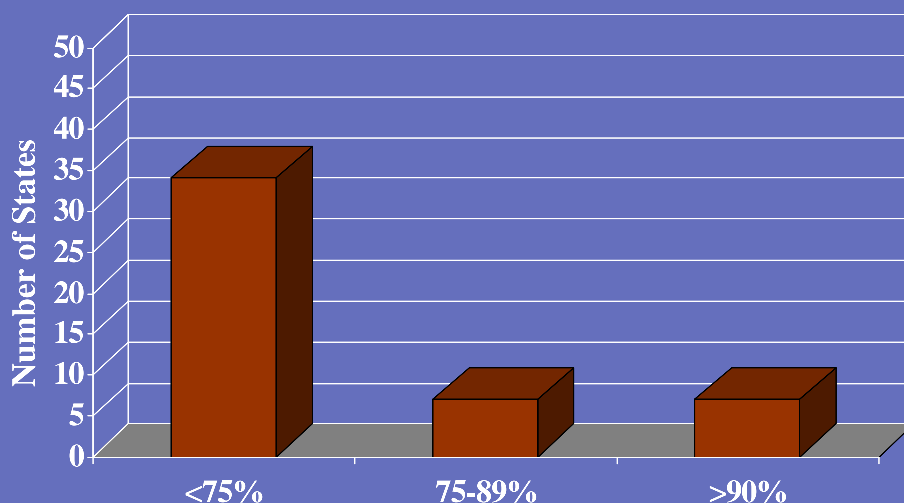
I looked at how the states have fared on that measure and, of the 36 states and D.C. that had enough experience with the SCHIP program at that point in time to use their data, we had eight states in which the number of children enrolled in December 1999 represented less than three-quarters of the children who were enrolled at some time during fiscal 1999. So a number of states experienced considerable turnover in their SCHIP programs.

I decided to look again in 2000 when more states had sufficient data. The next chart shows the results for 48 states and D.C., and you can see that in 34 states the point-in-time number was less than three-quarters of the number ever-enrolled during the year.

The data have to be qualified somewhat, however, because I compared the June 2000 point-in-time number with the fiscal 2000 ever-enrolled. Nonetheless, these data raise questions about what may be happening in some of the states, and it certainly reflects what we are finding in the Covering Kids program. Our grantees report SCHIP dropout rates of up to 50 percent within a year. The data certainly seem consistent with that finding.

## State Data on Point-in-Time Vs. Ever-Enrolled

**Point in Time (June 2000)**
**As % of Ever Enrolled (FY 2000)**




Sources: HCFA, Health Management Associates

Why does churning matter? Well, I think part of the problem is that policymakers do not understand the basic concept that the uninsured—and I know Rick always makes me say this phrase—"are a flow, not a stock." A good economist phrase!

Assuming that the uninsured are a stock raises false expectations about what the goals of coverage programs should be. I have heard state legislators say, the CPS told us that we had 100,000 uninsured children, we created this program, we've enrolled 100,000 children, and now our job is done. What else is there to do? We've met our target.

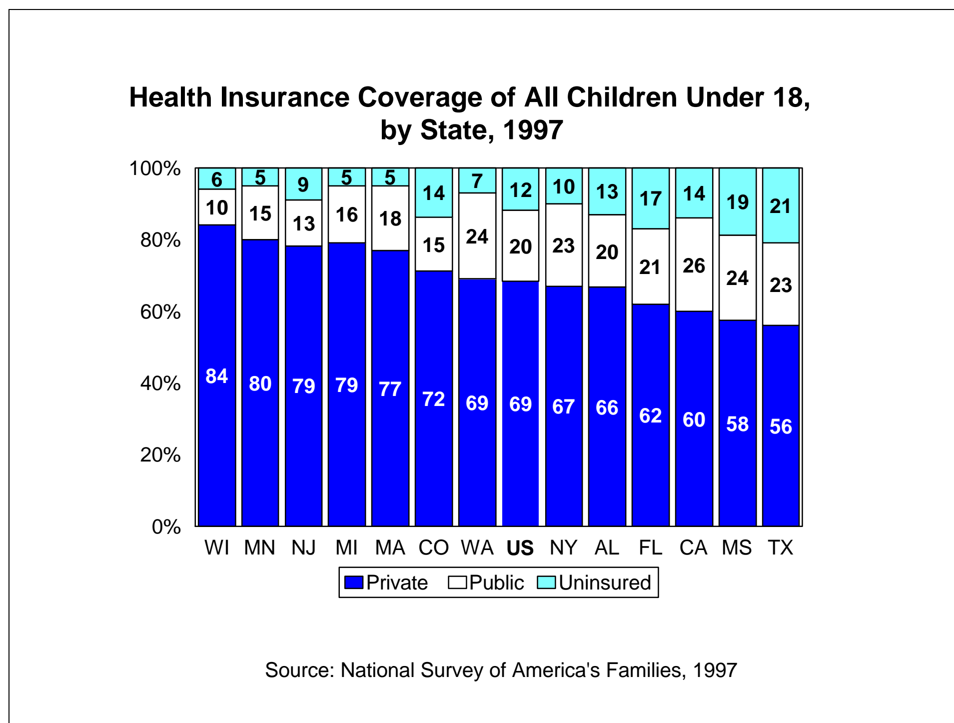
Well, if we think back to the notion that, if you insured all uninsured children, you'll have half that number again uninsured within a year, you begin to understand why legislators are scratching their heads over the fact that they are enrolling large numbers of kids, yet many remain uninsured.

Turnover and churning force us to think about the real policy goals of coverage initiatives. Are they to increase enrollment? Well, we spent a great deal of effort on increasing enrollment of children in public programs, only to see many of them drop out. We've got a leaky bucket.

Is it to ensure continuity of coverage regardless of the source of that coverage—which means we don't mind whether kids are in Medicaid, SCHIP, or employer-sponsored coverage as long as they have some type of coverage? Or is it to ensure continuity of care, which means keeping people in the same plan or with the same provider—a goal that may be much harder to accomplish when people move in and out of different types of coverage?

And I guess the question for this meeting is whether those goals are consistent with maximizing the use of employer-sponsored coverage when it's available, remembering that our target population is a group of people who change jobs frequently.

The other side of that policy coin is that, if we succeed in providing stable public coverage for this population, almost by definition we're going to displace some employer-sponsored coverage. If enrolled children are not moving backwards and forwards between employer-sponsored and public coverage, then we are gradually going to see an accrual of children in the public sector. Dynamic displacement of employer-sponsored coverage—as opposed to the more static notion of crowd-out being people dropping employer-sponsored coverage in order to move into public coverage—may in the long-term be the more important displacement issue for policymakers to consider.



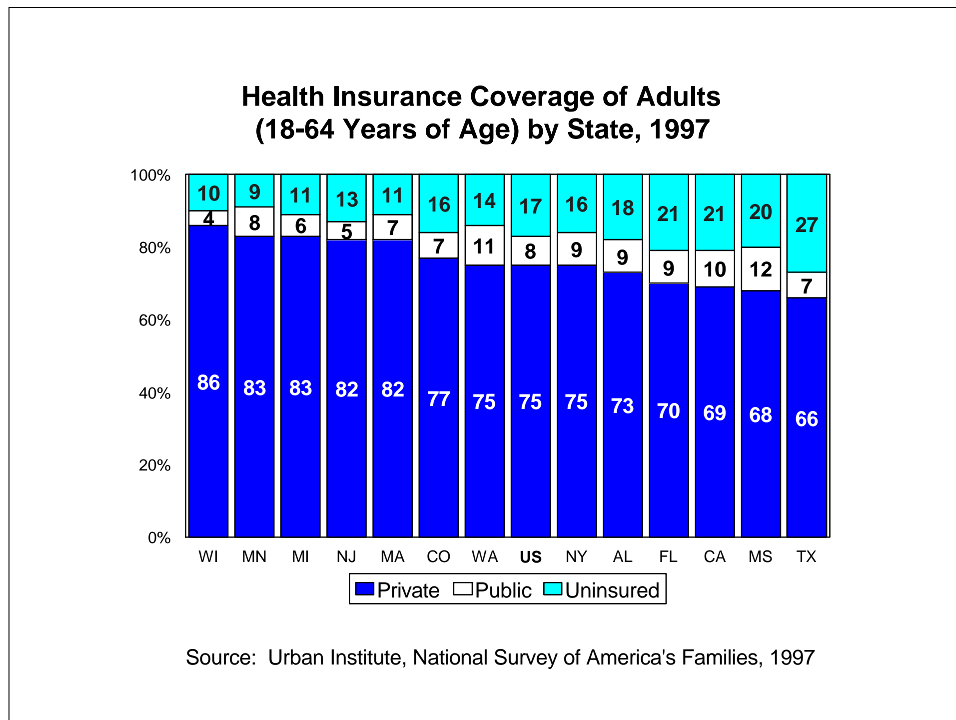

As we seek to develop alternative approaches, private or public, to expand coverage, we must recognize the enormous variation in the extent of the underlying coverage problem in the states and in their ability to address it. One of the issues that many policy makers, particularly in Washington, do not really understand is that the key driver of the difference in the uninsured

rates among the states is the extent of employer-sponsored insurance, not the relative generosity of their public programs as defined by the income eligibility standards for those programs.

These data are from the Urban Institute's 1997 National Survey of America's Families. (The 1999 data are available and show have similar findings.) You can see that there are large differences among the 13 NSAF states in the proportion of their population with employer-sponsored insurance.

That proportion ranges from 84 percent in Wisconsin to 56 percent in Texas. Moreover, some of the states with lower income eligibility standards for public programs are actually covering a much higher percentage of their population in those programs than are some of the states with generous income eligibility ceilings.

Those are the data for children, and we see a similar picture for adults. The range is 86 percent for Wisconsin to 66 percent for Texas. So what does that mean? Well, I think one of the realizations that policymakers have had—that we've all had—is that any initiatives to expand coverage, whether they're private through tax credits or public through expansions of SCHIP and Medicaid, depend critically on how employers are going to respond. Patricia Willis at the Department of Labor put on an interesting meeting recently in which we discussed how we know about potential responses by employers. And some of us left that meeting as uncertain as before!




But a key issue is: given this tremendous variation that we're seeing now, and given research which suggests that we don't really understand why these differences are so great,

should we not expect that the response of employers to new coverage initiatives is also going to vary tremendously across the country?

Indeed, there is a real possibility that some of the proposals that we're developing nationally to expand coverage may widen rather than reduce the differences among the states in the extent of employer-sponsored insurance. So with that note, I will turn it over to Rick and Ed.

MR. NEUSCHLER: Are there one or two burning questions for Linda? Marilyn?

MS. PARK: I don't think burning. Okay. You were saying that you could end up crowding out because children could end up staying in public coverage, rather than moving into employer coverage if it was possible to do so. But could you say the other way around too, that people who move in and out of coverage, aren't they moving out of coverage, if they had access to the kind of employer coverage that was flexible, you know—

MS. BILHEIMER: Absolutely. But I think a lot of our policies and a lot of policies among the states are focused on how we can keep children in a stable source of coverage. So some policies that may reduce the flow back and forth between private and public coverage, such as 12-month guaranteed eligibility, are going to displace some employer-sponsored insurance.

So the question is, what are your real policy goals here, because there isn't a free lunch. There really are tradeoffs here that you have to make, and you have to decide whether you want to get people back into employer-sponsored insurance as soon as possible or whether you want to provide them continuous stable coverage.

MR. NEUSCHLER: Do I see one other?

AUDIENCE PARTICIPANT: I just had a point of clarification. Public coverage means Medicaid?

MS. BILHEIMER: and SCHIP, yes.

MR. NEUSCHLER: Was there another question?

MS. LEDDY: I just want to make a comment. Rhode Island, as we heard from the Rhode Island panel this morning, has gotten down to 6.9 percent uninsured through expansions in coverage. And we can move forward with the premium assistance program, which is going to, hopefully, let us move forward with family coverage, avoid crowd-out and not have to do draconian measures like waiting periods.

But, given the churning that you describe in your data and the level of churning that you're describing in not only Medicaid and SCHIP but also in the employer-sponsored market, I think it just gives a level of importance to what we're talking about at this meeting, which is that states really need to find ways and flexibility within the federal Medicaid and SCHIP rules to move forward and implement effective premium assistance programs, because it's the only way that many of us in public programs can see to bridge that gap between people going in and out of

coverage and in and out of employer-sponsored coverage to public coverage because of job shifts or whatever.

And you can see that the level of interest is high. Yesterday there were about 18 states represented in the nuts-and-bolts session on how we implement premium assistance programs, even though a very small portion of Medicaid eligibles are actually enrolled at this point. But I just think that your data really gives us the underlying push to say, this is the way to go to further cover the uninsured once we do family coverage. It's just so critical that we continue to move forward with premium assistance programs or that kind of partnership between public coverage and employer-sponsored coverage.

So I just think that your data gives credence to what we're all talking about today.

MS. BILHEIMER: Well, thank you, and I hope, like I say, that next time I speak to you, Tricia, I hope I will have new data.

MR. CURTIS: An interesting point in the first set of data Linda presented was—of 42 million kids with employer sponsored coverage, there were seven million transitions in and seven million out. In other words, about one-sixth of the population. Medicaid, out of 13 million, five in and six out, which is close to half. So it was even more volatile.

But I know Linda worries a lot about—Gene Lewit worries a lot about—to tell you the truth, I worry a lot about assuming that either public or private would necessarily always be more stable for people. Even though a number of these people, especially those just above and below poverty, move in and out of jobs a lot and for many of them public coverage has the potential to be much more stable than employment-based coverage.

On the other hand, as you move above poverty and up to 200 percent of poverty, I suspect there are a lot of people for whom employment-based coverage may be more stable. And a trick here is going to be to determine in a systemic way, so you can easily administer it, when do you have which situation? Because this shouldn't just be about, as Linda was referring to, reducing the number of uninsured at a given point in time. It's also about creating stable coverage sources that allow accessing care in a way that's continuous so that people get the kind of care, including preventive care, they should be getting; right?

## About the Speaker

**Linda T. Bilheimer, PhD**, Senior Program Officer, The Robert Wood Johnson Foundation.

Dr. Bilheimer comes to the Foundation from the Congressional Budget Office (CBO), where she was the Deputy Assistant Director for Health and was responsible for the management for the health policy research group. Major areas of research included the Medicare and Medicaid programs, the State Children's Health Insurance Program, private health insurance markets, health insurance reform and patient protection initiatives.

Prior to joining CBO, Dr. Bilheimer was a senior researcher at Mathematica Policy Research, Inc. where she served as a project director, principal investigator, and task leader for research projects on Medicare, Medicaid, and WIC programs and various public health issues. Previously, she was the Director of the Division of Health Statistics and Epidemiology, Arkansas Department of Health, where she managed a statistics and policy analysis staff and guided policy research within the Health Department. Dr. Bilheimer was also an Assistant Professor of Behavioral Sciences and then an Associate Professor of Psychiatry at the University of Arkansas for Medical Sciences. She has had numerous articles, papers and reports published in her career. Dr. Bilheimer was a John F. Kennedy Memorial Scholar at Harvard University, where she received her Ph.D. in Economics.