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The Continuing Decline in Medicaid Coverage

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The number of Americans who received health insurance through the Medicaid program at any time during a given year increased from 28.9 million in federal fiscal year 1990 to 41.7 million in 1995.[1] This growth was fueled by federal and state policies designed to expand Medicaid eligibility, particularly for pregnant women and children, and by an economic downturn that increased the number of people in need. However, Medicaid reached a turning point in 1996, as participation dropped. In 1997, the last year for which Medicaid participation reports from all the states are available, Medicaid participation continued to fall to 40.6 million people, so that 1.1 million fewer people were covered. Recent census data indicate that Medicaid caseloads continued to fall in 1998.

An earlier article discussed the close connection between reductions in Aid to Families with Dependent Children (AFDC) caseloads and Medicaid participation through 1996 (Ellwood and Ku 1998). This brief addresses the continuing erosion of Medicaid coverage through 1997, the year after Congress passed the federal welfare reform law—the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

While the passage of the federal welfare reform law is an important part of the policy context in which the recent caseload declines occurred, the Medicaid caseload changes discussed here are not necessarily the result of this law. Welfare and Medicaid caseloads were already falling when PRWORA was enacted, and most states had already implemented major welfare policy changes under state welfare reform waivers. Indeed, PRWORA severed the direct link between welfare and Medicaid eligibility, seeking to prevent the loss of Medicaid coverage. While PRWORA was passed in August 1996, many states had not implemented all of its provisions as of 1997. Finally, these policy changes took place against a backdrop of economic growth and low unemployment, factors that could also reduce Medicaid enrollment.

For many years, increasing levels of uninsurance were viewed as a consequence of declining private health insurance coverage. Now, at a time when private coverage has stabilized somewhat, it is disappointing that Medicaid participation has eroded.

A Brief History of Recent Medicaid Eligibility Policies

From 1984 to 1990, many changes in federal and state Medicaid policies were made to broaden Medicaid coverage. Most noteworthy were the poverty-related expansions covering pregnant women, infants, and children—changes that were motivated by concerns about infant mortality and poor child health.[2] Medicaid coverage of the disabled grew when the Supplemental Security Income (SSI) program broadened eligibility for children, particularly those with learning disabilities, as a result of the Supreme Court's 1990 decision in *Sullivan v. Zebley* and changes in allowable child disabilities.

These policy changes, along with a weak economy in the early 1990s, fueled steady and often large increases in Medicaid participation between 1990 and 1995, with an average annual

growth rate of 7.6 percent per year. During this time, state and local agencies implemented the new policies, particularly the phased-in, poverty-related expansions for children. These enrollment increases helped to fuel double-digit growth in Medicaid spending in the early 1990s.

In light of states' fiscal difficulties, the federal government avoided further mandates to expand Medicaid coverage after 1990 and the locus of control shifted to the states. A handful of states, like Hawaii, Oregon, Rhode Island, and Tennessee, used Section 1115 waivers to expand Medicaid eligibility. A few others, like Vermont, expanded children's eligibility using Section 1902(r)(2) options.[3] Although there were some Medicaid eligibility expansions in the early 1990s, these were primarily state initiatives.

Also in the early 1990s, most states embraced welfare reform and adopted state waivers to decrease welfare dependency, initiating tougher AFDC requirements (such as stronger work requirements, time limits, and family caps) as well as policies like higher earnings disregards to let people keep more of their earnings. As a result, national AFDC caseloads began falling after 1994. The strong national interest in welfare reform led to PRWORA's 1996 enactment. This new law replaced AFDC with Temporary Assistance for Needy Families (TANF) and codified the policy of state flexibility in welfare management.

While Congress was aware that welfare reform would shrink welfare caseloads, it did not intend to reduce Medicaid at the same time, so it "delinked" welfare and Medicaid eligibility so that those affected by time limits or similar policies would not lose Medicaid.[4] Section 1931 gave states flexibility to expand eligibility for families beyond traditional welfare limits (Guyer and Mann 1998). In addition, PRWORA affected other aspects of Medicaid eligibility, such as changes in the SSI program and in the general eligibility of immigrants for public benefits (discussed later).

In August 1997, Congress passed the major expansion of the decade, the Children's Health Insurance Program (CHIP), which lets states expand health insurance for uninsured children. Again, state flexibility is a hallmark, and CHIP can be used for Medicaid expansions or for separate state programs. But CHIP funds were not available until federal fiscal year 1998, so CHIP expansions are not reflected in the data presented here.

Medicaid Caseload Changes, 1995–1997

The number of people who were ever enrolled in Medicaid during a given year fell from 41.7 million in federal fiscal year 1995 to 41.3 million in 1996 and to 40.6 million in 1997, a 2.7 percent decline overall from 1995 to 1997 (table 1). (An alternative way to express the Medicaid caseload is the average monthly enrollment, also called full-year equivalents. The average monthly Medicaid enrollment level was 32.8 million people in 1995 and fell to 32.0 million by 1997, a 2.2 percent decline.) Using either measure, the number of adults and children on Medicaid fell, the number of aged stayed roughly constant, and the number of disabled people rose slightly.

Adults and Children

Table 1 shows that between 1995 and 1997, enrollment of nonelderly, nondisabled adults and children fell 10.6 percent and 2.7 percent, respectively, but deeper reductions occurred for those getting welfare. The number of parents who received both Medicaid and cash assistance (AFDC or TANF) fell 24.2 percent during this period, while the number of children with both Medicaid and cash assistance dropped 20.4 percent. The Medicaid declines in 1997 exceed those in 1996 because there were larger reductions in welfare caseloads.

The changes in AFDC/TANF caseloads began under state welfare reform waivers in the early 1990s. State welfare policies changed gradually after PRWORA's passage in 1996 and further implementation in 1997 and 1998. Under both the waivers and PRWORA, federal policies specified that those who lost welfare due to welfare reform policies were generally still eligible for Medicaid. The extent to which state and local welfare offices implemented these protections is still unclear, but it appears that many people who were still Medicaid eligible lost their Medicaid coverage unnecessarily. For example, after legal challenges, Pennsylvania agreed to restore Medicaid eligibility to 32,000 ex-welfare recipients (Levin 1999).

The reduction in Medicaid cash assistance coverage was partly offset by the increase in noncash enrollment. For children, the 20.4 percent reduction in Medicaid cash enroll-

Table 1
National Medicaid Enrollment Levels in 1995, 1996, and 1997

	Enrollment Levels (thousands)			Percent Change		
	FY 1995	FY 1996	FY 1997	1995–96	1996–97	1995–97
Adults	9,627	9,275	8,604	–3.7	–7.2	–10.6
Cash (AFDC/TANF)	5,389	4,927	4,086	–8.6	–17.1	–24.2
Noncash	4,238	4,348	4,517	2.6	3.9	6.6
Children	21,603	21,239	21,019	–1.7	–1.0	–2.7
Cash (AFDC/TANF)	11,246	10,481	8,951	–6.8	–14.6	–20.4
Noncash	10,357	10,758	12,068	3.9	12.2	16.5
Aged	4,115	4,117	4,114	0.1	–0.1	0.0
Cash (SSI)	1,847	1,840	1,813	–0.4	–1.5	–1.9
Noncash	2,268	2,278	2,301	0.4	1.1	1.5
Disabled	6,333	6,664	6,833	5.2	2.5	7.9
Cash (SSI)	5,025	5,268	5,337	4.8	1.3	6.2
Noncash	1,308	1,396	1,495	6.7	7.1	14.3
Total Medicaid	**41,677**	**41,295**	**40,570**	**–0.9**	**–1.8**	**–2.7**

Source: HCFA 2082 data, as edited by the Urban Institute.
Note: Enrollment is defined as the unduplicated number of people signed up for Medicaid at any time in the federal fiscal year.

ment from 1995 to 1997 was largely offset by a 16.5 percent increase in other enrollment groups available for children. From the perspective of Medicaid eligibility, children's loss of welfare was eased because there were other ways that children could obtain (or retain) Medicaid coverage. In 1997, children under age 6 in all states were eligible if their families' net incomes were below 133 percent of the federal poverty level and those ages 6 to 14 were eligible with family incomes below 100 percent of the poverty level. Many states were even more generous.

In contrast, the 6.6 percent increase in other enrollment groups for adults from 1995 to 1997 was small compared with the cash enrollment decline of 24.2 percent, so there was a large overall reduction in adult Medicaid participation. The eligibility criteria for adults who are not on welfare are much more restrictive than for children. Adults can continue on Medicaid under medically needy programs, transitional Medicaid, or pregnancy-related eligibility criteria, but none of these have the breadth of children's poverty-related coverage. Thus, loss of welfare meant that more adults lost Medicaid coverage altogether.

Aged and Disabled

There was essentially no change in the number of aged enrollees from 1995 to 1997, but the number of disabled Medicaid enrollees increased 7.9 percent. The number of aged people who had both Medicaid and cash assistance (primarily SSI) fell slightly, which corresponds with Social Security Administration data on SSI recipients.[5] These slight reductions in the number of aged, cash assistance Medicaid enrollees were offset by increases among other aged enrollees, so there was virtually no change in the total number of aged Medicaid enrollees.

The number of blind and disabled people who received cash assistance (SSI) increased from 1995 to 1997, even though new SSI eligibility restrictions were enacted in 1996. The two main changes were the elimination of drug abuse and alcoholism as eligible disabilities and the elimination of "individual functional assessments" for disabled SSI children (including the Zebley children). The drug abuse/alcoholism provisions were implemented in 1997, but the effects were modest since many addicts could qualify under other conditions (e.g., cirrhosis, serious mental illness). The disabled child provisions were in an early stage of implementation by September 1997, so the effect on 1997 enrollment is small. More recent data from the Social Security Administration indicate that the number of SSI disabled beneficiaries dropped slightly in 1998.

State Trends

The national data obscure large and important differences in trends across the states. As seen in table 2, the change in the average monthly AFDC/TANF recipient levels varied greatly from 1995 to 1997, from a 50 percent loss in Wyoming and 42.5 percent loss in Wisconsin to an 8.4 percent increase in Hawaii.

Table 2 presents Medicaid participation in terms of the average monthly enrollment, since this is how AFDC/TANF recipients are counted; these average monthly levels are lower than those shown in table 1 because of the entrances and exits of participants during the year. The national caseload levels and percentage reductions in 1997 are similar for TANF and Medicaid cash assistance, and the percentage changes are generally similar for most states. However, readers should be cautious in interpreting discrepancies between the TANF and Medicaid cash assistance levels for any given state. There are differences in how states count Medicaid and welfare participants and discrepancies might be a result of accounting methods, not membership totals.[6]

One simple measure of a state's effectiveness in retaining Medicaid coverage for those leaving welfare is the overall change in its adult and child caseload, cash and noncash combined. The national average Medicaid enrollment of adults and children fell 5.3 percent from 1995 to 1997, meaning that the increase in noncash enrollment did not fully offset the loss of cash enrollees. Nine states had particularly large reductions (over 10 percent) in total adult and child enrollment levels: West Virginia, Nevada, Wisconsin, Ohio, Indiana, Utah, Wyoming, Kansas, and Florida.[7]

In general, states with deeper reductions in Medicaid cash assistance enrollment for adults and children had larger total caseload declines, but there were noteworthy exceptions. For example, while South Carolina had a sharp decline in the number of Medicaid cash assistance enrollees between 1995 and 1997 (nearly 45 percent), enrollment of other adults and children grew 55.4 percent and the state experienced an overall 7.8 percent increase in total adult and child enrollment. These changes were likely the result of the state's increased poverty-related child eligibility criteria and strong outreach program. Other states demonstrating overall adult and child caseload growth despite welfare reductions were Arkansas, Connecticut, Delaware, Minnesota, Nebraska, New Mexico, Oregon, South Dakota, Vermont, and Washington.[8]

Why did some states see their total adult and child participation rise, while others saw declines? A key factor may be differences in how states determine Medicaid and welfare eligibility. Some states may have been more attentive to redetermining the Medicaid eligibility of people leaving welfare, thereby ensuring coverage for qualified individuals. Ellwood and Lewis (1999) have shown how previous welfare enrollment leads to subsequent medical- or poverty-related Medicaid eligibility. Maloy and her associates (1999) indicated that welfare diversion policies may keep people from entering Medicaid in the first place. The U.S. General Accounting Office (1999) has reported other barriers to Medicaid enrollment and states' efforts to resolve these problems. More research should be conducted to understand the state and local administrative practices that help or hinder Medicaid coverage for welfare clients.

Table 2
Changes in Average Monthly AFDC/TANF and Medicaid Enrollment Levels for Nondisabled, Nonelderly Adults and Children, Ranked by Reduction in AFDC/TANF Recipients

State	AFDC/TANF Recipients		Medicaid Adult and Child Enrollees					
			Cash		Noncash		Total	
	1997 Level (thousands)	Percent Change 1995–97	1997 Level (thousands)	Percent Change 1995–97	1997 Level (thousands)	Percent Change 1995–97	1997 Level (thousands)	Percent Change 1995–97
Wyoming	7.3	–50.0	8.1	–52.8	16.9	46.3	24.9	–12.8
Wisconsin	119.9	–42.5	116.8	–41.9	154.6	16.9	271.4	–18.6
Oregon	62.5	–39.9	68.0	–29.2	233.0	70.8	300.9	29.5
Indiana	117.3	–37.9	125.3	–40.7	183.8	17.8	309.0	–15.8
Oklahoma	81.9	–33.8	110.4	–23.5	97.7	17.9	208.1	–8.4
Tennessee	184.5	–33.2	186.4	–43.4	807.1	10.1	993.5	–6.5
Idaho	16.1	–32.6	12.2	–49.2	49.8	15.4	62.0	–7.6
Kansas	53.7	–32.5	45.5	–42.9	81.8	27.1	127.3	–11.7
South Carolina	89.8	–30.3	72.1	–44.7	223.9	55.4	296.0	7.8
Virginia	129.9	–29.4	158.2	–20.2	212.3	6.5	370.5	–6.8
New Hampshire	19.7	–29.4	18.8	–29.3	40.7	21.7	59.5	–0.8
Mississippi	102.4	–28.9	114.0	–24.5	129.5	11.9	243.5	–8.7
Nevada	29.5	–27.9	26.2	–34.6	29.2	2.3	55.4	–19.3
Florida	451.3	–27.4	529.9	–24.3	466.0	10.7	995.9	–11.1
Alabama	85.8	–27.1	98.7	–21.0	184.9	11.1	283.6	–2.7
Maryland	163.1	–27.0	169.7	–23.4	121.6	26.4	291.4	–8.4
Colorado	79.6	–26.9	77.8	–28.2	92.0	16.6	169.8	–9.3
Georgia	282.1	–26.3	240.7	–33.9	443.7	30.2	684.3	–2.9
Utah	33.9	–25.8	29.7	–33.1	64.7	–3.8	94.4	–15.4
Louisiana	187.5	–25.4	184.8	–18.0	178.2	2.2	363.0	–9.2
Michigan	448.8	–24.9	412.8	–29.5	356.9	34.8	769.6	–9.4
Massachusetts	207.1	–24.3	247.0	–18.4	224.5	28.9	471.5	–1.1
Texas	573.9	–23.4	571.7	–22.4	902.7	6.5	1,474.4	–7.0
Pennsylvania	460.6	–22.8	434.6	–27.0	510.6	21.3	945.1	–7.0
Arizona	147.4	–22.5	165.5	–22.1	214.0	18.4	379.5	–3.5
Missouri	196.9	–22.4	179.6	–30.3	261.0	21.9	440.6	–6.6
North Carolina	243.2	–22.4	332.2	–8.3	262.9	6.1	595.1	–2.4
Iowa	78.3	–22.1	73.7	–23.7	81.7	14.7	155.4	–7.4
West Virginia	81.9	–21.8	87.8	–31.2	76.7	–4.6	164.4	–21.0
South Dakota	13.4	–21.6	13.3	–21.7	27.4	18.6	40.7	1.5
New Mexico	81.5	–21.4	81.0	–18.7	119.3	59.6	200.3	14.9
North Dakota	11.4	–21.4	10.2	–27.6	20.3	7.7	30.6	–7.4
New Jersey	250.8	–20.7	238.8	–26.2	218.4	30.2	457.2	–6.9
Ohio	493.6	–19.3	464.5	–29.7	328.5	5.8	793.1	–18.4
Maine	49.4	–17.5	53.1	–6.5	45.8	–4.5	98.9	–5.6
Kentucky	157.8	–16.7	148.3	–18.2	162.8	5.0	311.0	–7.5
Illinois	580.3	–16.6	575.8	–20.9	580.6	18.7	1,156.4	–4.9
New York	1,048.3	–16.5	1,114.5	–18.5	675.9	20.7	1,790.4	–7.1
Arkansas	53.2	–16.0	51.6	–19.0	96.7	20.2	148.3	2.9
Vermont	23.0	–15.4	21.9	–17.8	52.0	44.8	73.8	18.1
Montana	28.9	–14.5	23.9	–25.1	25.1	11.9	49.0	–9.8
Minnesota	156.9	–13.1	153.9	–16.2	199.0	35.7	352.9	6.8
Washington	254.0	–11.3	253.9	–12.1	318.1	43.8	572.0	12.1
Delaware	22.1	–11.2	21.5	–15.1	39.4	65.4	61.0	23.9
Rhode Island	54.5	–11.1	54.4	–16.1	25.0	19.6	79.4	–7.4
California	2,403.5	–0.3	2,198.4	–12.6	1,631.8	16.8	3,830.2	–2.1
Connecticut	154.3	–9.6	150.4	–13.1	91.2	35.5	241.6	0.5
District of Columbia	66.3	–9.1	74.9	–6.9	15.7	35.1	90.6	–1.6
Nebraska	38.9	–6.0	44.0	12.2	65.0	14.7	109.0	13.7
Alaska	35.4	–4.1	33.1	–14.9	17.3	13.0	50.4	–7.0
Hawaii	71.1	8.4	71.8	8.4	63.7	–14.0	135.5	–3.4
United States	**10,784.3**	**–20.0**	**10,751.3**	**–21.9**	**11,521.2**	**18.2**	**22,272.5**	**–5.3**

Source: HCFA 2082 data, as edited by the Urban Institute. AFDC/TANF data from ACF-3637, *Statistical Report on Recipients under Public Assistance.*
Note: All data are expressed as average monthly participation levels, to provide greater compatibility between AFDC/TANF and Medicaid data. The average monthly Medicaid levels are lower than the annual unduplicated enrollee levels shown in table 1, because many people enter and exit the program over the course of a year.

Insurance Coverage from 1995 to 1998

How did the reduction in Medicaid coverage affect the level of uninsurance in the United States? Medicaid administrative data do not report what happens to those no longer on the program, and we must analyze survey data. Analyses of survey data indicate that many of those losing Medicaid became uninsured (Families USA Foundation 1999). Garrett and Holahan (1999) report that, a year after leaving welfare, about one-quarter of the women and one-half of the children retained Medicaid and one-half of the women and one-third of the children became uninsured. In table 3, we present data from the Current Population Survey (CPS) on changes in the insurance coverage of low-income people from 1995 to 1998.

The share of low-income adults and children (with incomes below 200 percent of the federal poverty level) with Medicaid fell from 28.3 percent in 1995 to 25.3 percent in 1998, while the uninsured rose from 32.4 percent to 34.7 percent. There was a slight (0.6 percentage point) increase in the rate of private health insurance coverage. A major factor affecting the net growth in uninsurance rates was falling Medicaid coverage. Both adults and children lost Medicaid and saw increases in uninsurance. However, throughout this period, low-income adults were about half as likely as children to have Medicaid and about 50 percent more likely to be uninsured than low-income children.

Immigrants faced the greatest adversity. Low-income noncitizen immigrants' uninsurance levels were already 54.2 percent in 1995 and worsened. By 1998, immigrants lost Medicaid coverage and their uninsurance rates rose to 59.1 percent. Recent studies (Zimmermann and Fix 1998; Fix and Passel 1999) found large changes in immigrants' use of benefits beginning in 1996. U.S.-born children of immigrants also reduced participation. These immigration-related policies exacerbated well-known problems of high uninsurance rates among Latino children.

The rapid drop-off in immigrants' participation was at least partly related to publicity about the welfare reform changes and immigrants' fears about the "public charge" issue (Schlosberg and Wiley 1998). After some well-publicized enforcement activities by the Immigration and Naturalization Service (INS) and the California Medicaid agency, immigrants worried that getting Medicaid might hurt their chances to gain permanent residency and that they might be forced to repay Medicaid benefits. In mid-1999, INS clarified that getting Medicaid (with the exception of long-term care services) would not affect an immigrant's public charge status. This assurance ought to allay legal immigrants' worries and encourage them to reenter Medicaid. Even so, other new policies—such as deeming sponsors' income to immigrants when determining financial eligibility—will continue to bar many low-income immigrants from Medicaid coverage.

Both survey and administrative data indicate that the number of people with Medicaid coverage fell from 1995 to 1997, but the estimates differ slightly. The appendix discusses this in more detail; one important inference is that trends in the reduction in Medicaid coverage may be somewhat overstated in CPS data, compared with those from administrative counts.

Conclusions and Looking Ahead

Administrative data indicate that overall Medicaid participation fell about 3 percent from 1995 to 1997, with larger reductions among adults and children. This drop was primarily caused by sharp reductions in enrollment of adults and children receiving welfare. The Medicaid decline was not as large as the TANF decline because there was a partially offsetting increase in the number of those getting Medicaid without cash assistance.

Most states had fewer Medicaid beneficiaries, but some had caseload increases between 1995 and 1997. In general, states with larger welfare reductions had larger overall caseload declines. The decrease in Medicaid enrollment should not be interpreted as a result of the 1996 federal welfare reform law, since it is part of a process that began earlier with state welfare reform waivers and ran concurrently with a period of strong economic performance.

Table 3
Survey Trends in Insurance Coverage for Nonelderly People with Incomes below 200 Percent of the Federal Poverty Level, 1995–1998

	Percentage of Group with Coverage			
	1995	1996	1997	1998
Low-Income Adults and Children				
Medicaid	28.3	27.1	26.3	25.3
Private	36.0	36.3	36.3	36.6
Other	3.3	3.2	3.2	3.4
Uninsured	32.4	33.3	34.2	34.7
Low-Income Adults (21–64 Years Old)				
Medicaid	18.8	18.9	18.0	16.9
Private	38.4	38.5	38.1	38.4
Other	4.0	4.1	4.1	4.5
Uninsured	38.7	38.5	39.9	40.2
Low-Income Children (Under 21)				
Medicaid	40.1	37.4	36.7	35.7
Private	33.0	33.7	34.0	34.3
Other	2.3	2.1	2.1	2.1
Uninsured	24.6	26.8	27.2	27.9
Low-Income Noncitizen Immigrants				
Medicaid	19.3	16.4	15.0	13.7
Private	24.7	25.0	24.4	25.9
Other	1.8	1.4	1.4	1.3
Uninsured	54.2	57.3	59.3	59.1

Source: March 1996–99 Current Population Surveys, as tabulated by the Urban Institute.
Notes: Excludes members of the active military. Insurance is defined with a hierarchy, so that the few people with both Medicaid and private coverage are reported as Medicaid, and so on.

Survey data indicate that the number of people on Medicaid continued to fall through 1998 and that there was a corresponding increase in the number of uninsured people. The CPS data also demonstrate that uninsurance rates are particularly high among low-income adults and noncitizen immigrants, both groups specifically affected by welfare reform and related policies. For many years, increasing levels of uninsurance were viewed as a consequence of declining private health insurance coverage. Now, at a time when private coverage has stabilized somewhat, it is disappointing that Medicaid participation has eroded.

National Medicaid administrative data for 1998 are not available yet. Administrative data from TANF programs show that the number of welfare recipients continued to fall sharply. Data from a number of states show that Medicaid participation continued to drop through 1998 and 1999, but national data have not been released. It is frustrating that it takes so long to receive Medicaid administrative data; more timely data would assist state and federal policymakers and analysts in understanding this vital program.

However, it seems plausible that national Medicaid participation, particularly among children, will rise again in 1999 or 2000. One important reason is that CHIP enrollment is growing as states' initiatives begin to take hold. In many states, CHIP enrollees are in the Medicaid program and directly boost Medicaid caseload levels. Even where CHIP and Medicaid programs are separate, outreach efforts to identify CHIP children, along with simplified application procedures, appear to be bringing more people into Medicaid (Smith 1999). Additionally, many states are now strengthening their Medicaid eligibility operations, with federal encouragement and sometimes legal challenges, to ensure that those leaving welfare are able to keep their Medicaid coverage.[9] Finally, a few states—Rhode Island, Wisconsin, Missouri, Ohio, and California—along with the District of Columbia, have recently expanded Medicaid eligibility for families, including parents, beyond traditional welfare limits, using flexibility offered under Section 1931 provisions. Although the national Medicaid participation fell in 1997 and again in 1998, caseload levels may rise again in the near future.

Appendix

Differences between CPS and Administrative Data on Medicaid

There are a number of difficulties in measuring insurance coverage that lead to differences in survey and administrative data (Lewis, Ellwood, and Czajka 1998). Because CPS data are widely cited, it is worth summarizing key differences.

First, CPS data indicate that about 2.5 million fewer nonelderly people got Medicaid in 1997 than in 1995 (9.3 percent fewer), while administrative data indicate that 1.2 million (3.2 percent) lost Medicaid. (To make these data comparable, the administrative and CPS data include all nonelderly, noninstitutionalized people, including some disabled adults and children.) Second, CPS data indicate that more children lost coverage than adults from 1995 to 1997, while administrative data indicate the declines were larger for adults. Third, the total number of nonelderly people who had Medicaid at any time in a given year was about 25 to 30 percent lower in the CPS than in administrative counts. On balance, administrative data are probably more accurate than survey data, although both sources have flaws.

Another issue is that there appears to be a growing discrepancy between CPS and administrative data concerning the receipt of benefits like Medicaid, welfare, and food stamps in recent years (Besharov 1999). Using measures of enrollment during the year, the CPS Medicaid participation estimates were 75 percent of administrative counts in 1995, but fell to 70 percent in 1997.

Some believe that respondents to the CPS may be reporting their current insurance status, rather than answering the actual question about insurance at any time in the prior year. To examine this, we also compared CPS data with administrative average monthly enrollment levels. The administrative average monthly enrollment levels are closer to the CPS levels, but the number of people losing coverage is even farther from the CPS: CPS data show 2.5 million fewer people on Medicaid from 1995 to 1997, while annual unduplicated administrative counts show 1.2 million fewer and average monthly administrative counts show 0.9 million fewer people. On the other hand, both annual unduplicated and average monthly administrative counts show increasing gaps in CPS coverage.

Notes

1. Enrollment counts are based on states' annual reports to the Health Care Financing Administration (HCFA) using the HCFA Form 2082, as edited by the Urban Institute (see Liska et al. 1997).

2. By 1990, federal law required that states cover all pregnant women, infants, and children under age 6 with incomes up to 133 percent of the federal poverty level (FPL), with options for broader coverage of pregnant women and infants to 185 percent. States must cover children with incomes up to 100 percent of the FPL born after September 30, 1983; this provision phases in until all children through age 18 receive coverage in the year 2002.

3. Under Section 1902(r)(2), enacted in 1988, states may use less-restrictive methods of counting income or assets for pregnant women and children.

4. Under PRWORA, Medicaid eligibility related to welfare is linked to states' AFDC criteria in July 1996, not current TANF, although there are many caveats in the law. Even so, most states still automatically grant Medicaid to those getting TANF.

5. Aged and disabled enrollees who receive Medicaid cash assistance are primarily those getting federal SSI benefits. Many states provide Medicaid to additional aged or disabled people getting state SSI supplement. Other states do not use federal SSI

rules for Medicaid eligibility, but use their own state criteria under Section 209(b) (Bruen et al. 1999).

6. The U.S. General Accounting Office (1999) also presented average monthly enrollment in Medicaid from 1995 to 1997, although it used data reported by the states, rather than edited HCFA 2082 data as used by the Urban Institute. There are small discrepancies, but the trends are similar.

7. Some of the reductions in these states may be due to errors in the HCFA 2082 reports. Although we carefully review and edit these data, there are limits to the data's accuracy.

8. Oregon's data for adults and children reported on HCFA Form 2082 have been erratic since 1994. Periodic reports suggest that its enrollment of adults and children declined between 1995 and 1997, but these data are not necessarily comparable with the HCFA 2082.

9. The Administration for Children and Families and HCFA (1999) jointly issued guidance to state Medicaid and welfare agencies about the importance of retaining Medicaid eligibility.

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