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Public insurance expansions and the health of immigrant and native children☆,☆☆

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ABSTRACT

The costs of public insurance expansions are ordinarily justified by the claim that increased eligibility causes gains in insurance coverage, which translate into improved health care and health. This paper studies dramatic changes in public health insurance eligibility for immigrant and native children from 1998 to 2009 and finds that children's nativity status is crucial to understanding the impacts of recent eligibility expansions. I document a significantly higher degree of take-up (and less crowding out of private insurance) among first- and second-generation immigrant children than among children of U.S. natives. Eligibility expansions increased immigrant children's use of preventive and ambulatory care and decreased emergency care in hospitals, while estimated effects for children of natives are negligible. My results also suggest improvements in some health measures that would be expected to respond to preventive and ambulatory care.

1. Introduction

Children in immigrant families comprise one of the most rapidly growing segments of the U.S. population. These children, who are either foreign-born or have at least one immigrant parent, now account for 1 in 4 children in the U.S. (Fortuny et al., 2010) and are disproportionately represented among the poor and uninsured (Ku, 2007). Indeed, despite dramatic expansions in children's eligibility for public health insurance over the past fifteen years, and a nearly 50% reduction in the overall rate of uninsurance among low-income children, disparities in coverage by nativity status are striking. Over half of first-generation immigrant children and nearly one-quarter of second-generation immigrant children lack health insurance, while only one in seven children of U.S. natives is uninsured.[1]

Differences in health insurance coverage are due, in part, to severe restrictions that welfare reform legislation imposed on immigrants' eligibility for public programs.[2] Reflecting growing concern about the fiscal burden immigrants placed on the U.S. social safety net, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) banned recent legal immigrants from federal Medicaid coverage until they had been in the U.S. for at least 5 years. In the years that followed, along with the introduction and expansion of the State Children's Health Insurance Program (SCHIP), many states used their own funds to restore eligibility for recent immigrant children. But states did so at different times and to different extents, and substantial cross-state differences in immigrant children's eligibility for public insurance persisted. In 2009 the CHIP Reauthorization Act (CHIPRA) reversed this decision, again allowing states to use federal funds to cover recent legal immigrants. The years between PRWORA and CHIPRA thus represent a markedly different policy environment, characterized by enormous cross-state variation in children's eligibility for public insurance.

Existing research has reached mixed conclusions on the effects of these eligibility changes on immigrant children's health insurance coverage, and provides little to no evidence regarding impacts on their health care utilization and health.[3] Evidence from the more extensive literature studying impacts of Medicaid and SCHIP expansions on the *overall* population of children cannot be assumed to generalize to

☆ The primary data in this study include restricted-access state identifiers from the National Health Interview Survey (NHIS), which must be used on-site at the Centers for Disease Control National Center for Health Statistics (CDC-NCHS) Research Data Center (RDC). Interested users should contact Peter Meyer at rdca@cdc.gov. The findings and conclusions in this paper are those of the author and do not necessarily represent the views of the RDC, the NCHS, or the CDC.

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[1] Author's calculations from the National Health Interview Survey (NHIS) sample used in this paper, for children in families with incomes less than 200% of the federal poverty line.

[2] While 1st-generation immigrants were directly impacted by PRWORA, reduced coverage among 2nd-generation immigrants may be due to "chilling effects" of the legislation (Watson, 2014).

[3] See Borjas (2003); Kaestner and Kaushal (2003); Lurie (2008); Buchmueller et al. (2008) for studies of post-welfare reform changes in eligibility and insurance coverage.

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children in immigrant families (Currie, 2000; Buchmueller et al., 2008).[4] On one hand, because these children have lower baseline rates of insurance coverage, and more limited opportunities for private insurance, Medicaid/SCHIP eligibility may cause greater increases in coverage (and less crowd-out) than for children of natives, and thus, larger improvements in health care access and health outcomes. On the other hand, if eligibility expansions are met by lower take-up among children in immigrant families, because of higher transaction costs to enrollment (Currie, 2000; Sommers, 2010), language or other barriers (Aizer, 2007), or immigrant parents' concerns about immigration enforcement (e.g., Watson, 2014), then any positive impacts on health care utilization and health for this population may be small.

This paper directly examines the impacts of recent changes in public insurance eligibility on health insurance coverage, health care utilization, and health outcomes for children in immigrant families, and children of U.S. natives. I study a nationally representative sample of more than 140,000 children from the National Health Interview Survey (NHIS) for the years between welfare reform and CHIPRA (1998–2009), and incorporate all available information on children's eligibility for Medicaid and SCHIP, including nativity status and years since immigration. I rely on a simulated instrumental variables (IV) approach that uses cross-state variation in the timing and extent of changes in eligibility rules to identify the effects of legislated changes in public insurance eligibility.[5]

The study contributes to the growing body of evidence on the costs and benefits of public insurance expansions in two ways. First, I provide new evidence that SCHIP-era expansions were associated with a significantly *higher* degree of take-up, and less crowding out of private insurance, among children in immigrant families than among children of natives. My results indicate that eligibility increases Medicaid/SCHIP enrollment among children in immigrant families by 23 percentage points (relative to a mean of 42%), with three-quarters of this change accounted for by a reduction in uninsurance. For children of natives, the estimated effects of eligibility on take-up and overall coverage are less than half as large.

This finding is in contrast to evidence from prior research on earlier changes in public insurance eligibility. For example, a well-known study by Borjas (2003) found that PRWORA-related eligibility reductions for immigrants caused a decrease in public insurance coverage but a completely offsetting increase in private insurance, implying 100% crowd-out among the immigrant population (not restricted to children). For *children* in immigrant families, however, Kaushal and Kaestner (2005) and Lurie (2008) both show that many children lost coverage due to these eligibility restrictions, suggesting less substitution between public and private coverage. Studying the 1989–1992 Medicaid expansions, Currie (2000) finds eligibility increased enrollment among children of natives but had no significant effect on enrollment among children of immigrants. In contrast, Buchmueller et al. (2008) demonstrate that initial SCHIP expansions increased insurance coverage for children of immigrants, with take-up rates among children of immigrants equal to those for children of U.S. natives. My research differs in that I explicitly incorporate state-level differences in eligibility by nativity status, and I study a longer period (1998–2009) that includes both general SCHIP expansions and state-level decisions to restore eligibility for recent immigrants.

Second, I demonstrate that for children in immigrant families, post-welfare reform expansions in eligibility for public health insurance increased utilization of health care and beneficially impacted health. While there is a well-established literature showing that Medicaid expansions increased access and utilization among the general population, the prior evidence for SCHIP-era expansions is more mixed and has not typically distinguished between those of different nativity statuses.[6] The few papers that have analyzed health care utilization among children of immigrants include Kaushal and Kaestner (2007), which finds little effect of PRWORA-induced eligibility reductions on health care access, and Currie (2000), which studies earlier Medicaid expansions and finds that eligibility decreases the likelihood that children of immigrants go without a doctor's visit. In terms of health outcomes, results for the overall population of children generally suggest limited effects of public insurance on health.[7] To my knowledge, Royer (2005) is unique in examining health effects for immigrants; she finds that PRWORA-induced reductions in eligibility for pregnant immigrant mothers caused decreased prenatal care but did not impact birth outcomes.

My estimates indicate that eligibility for public insurance reduces the likelihood that a child in an immigrant family goes more than 12 months without a doctor's visit by 7 to 12 percentage points,[8] raises the probability he has a usual place for care by 5–8 percentage points, and decreases the probability of an emergency room (ER) visit in the past year by 4–6 percentage points. Taken together, these findings suggest public insurance eligibility causes an increase in utilization of more efficient (preventive and ambulatory) health care, and a decrease in costly ER care, for children in immigrant families.

The results also indicate that eligibility may cause modest improvements in some child health outcomes that could be expected to respond to ambulatory or preventive care, including the likelihood of an asthma attack in the past 12 months and the probability of being reported (by one's parent) to be in excellent health. The latter result should be interpreted cautiously given evidence in Finkelstein et al. (2012), of improvements in self-reported health status among adults randomly assigned to Medicaid, prior to any increase in their health care utilization. Nonetheless, the estimated increases in access and utilization for these children suggest mechanisms whereby public insurance could have improved their objective health.

Despite some convergence over the post-welfare reform era, immigrant-native disparities in health insurance coverage, health care, and health remain striking. Even at the end of my study period in 2009, children in low-income, immigrant families had lower reported health, were more likely to lack a usual place of care, and were more likely to have gone 12 months without a doctor's visit, than children of natives. The findings in this paper indicate that further expanding eligibility for Medicaid/SCHIP to this population is likely to reduce such disparities. By providing evidence on the benefits of expanding eligibility to children in immigrant families, my results can help inform

[4] Some prominent studies on the effects of Medicaid/SCHIP eligibility on insurance coverage for the overall population include: Currie and Gruber (1996a, b); Dubay and Kenney (1996); LoSasso and Buchmueller (2004); Ham and Shore-Sheppard (2005); Hudson et al. (2005); Shore-Sheppard (2008); and Gruber and Simon (2008). Additional studies on health care utilization and health for the general population are mentioned below.

[5] This approach estimates the intention-to-treat (ITT) effect of eligibility expansions, but I also evaluate the plausibility of my results for health care utilization and health outcomes by calculating average effects of the treatment (insurance *coverage*) on the treated (those who enroll).

[6] The broader literature on insurance and utilization dates back to the RAND Health Insurance Experiment (Newhouse, 1993), which found that cost-sharing reduced consumption of health services. Finkelstein et al. (2012) similarly find increases in health care utilization among low-income adults randomly assigned to Medicaid. For evidence on positive impacts of earlier Medicaid expansions on children's access and utilization, see Currie and Gruber (1996b), Dafny and Gruber (2005), or a review by Buchmueller et al. (2005). For SCHIP-era expansions, Lurie (2009) and Joyce and Racine (2005) document increases in physician visits and recommended vaccinations, respectively. However, White (2012) finds no net increase in utilization and access to physician services, and Garthwaite (2012) shows that SCHIP expansions caused pediatricians to reduce their labor supply.

[7] Currie and Gruber (1996b) show that expanding Medicaid eligibility to pregnant women in the late 1980s reduced infant mortality and low birth weight; Levine and Schanzenbach (2009) obtain similar results for SCHIP. Kaestner et al. (1999) find that Medicaid expansions improved maternal reports of child health among blacks and Hispanics, but not whites, and find no impact on morbidity. In short, "the extent to which medical care has a positive effect on health is not clear" (Gruber, 2000).

[8] This ITT estimate is similar in magnitude to that in Currie (2000) for earlier Medicaid expansions; however, I also find a larger increase in insurance coverage among the newly eligible, putting my estimate of the average effect of treatment on the treated in a plausible range.