Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature

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Introduction

One of the policy questions expected to receive considerable attention during the State Children's Health Insurance Program (SCHIP) reauthorization process is whether -- and if so, under what circumstances -- to permit states to use SCHIP funds to cover parents. In 2006, the average Medicaid income eligibility level for coverage of working parents stood at 65% of the federal poverty level, and 15 states and the District of Columbia set income eligibility levels for this group at 100 percent of the federal poverty level or higher.[1] In 2005, 8 states used some portion of their SCHIP allotment funding, in combination with federal waiver authority under §1115 of the Social Security Act, to extend coverage to parents of SCHIP or Medicaid-enrolled children who are not themselves eligible for Medicaid or SCHIP. In addition, five states extended assistance to pregnant women otherwise ineligible for SCHIP or Medicaid by covering their "unborn children."[2]

This analysis examines research published since 2000 that explores the relationship between public health insurance coverage of parents and the rate and effectiveness of coverage among children, as measured by insurance levels, coverage continuity, and appropriate use of pediatric health care. The analysis begins with a brief overview of current Medicaid and SCHIP coverage options for parents and children. It then summarizes key findings from the literature related to the impact of covering parents on children's insurance enrollment. The analysis concludes with a discussion of the implications of existing studies for the question of whether to expand state flexibility to use federal SCHIP allotments to cover parents.

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[1] Kaiser Commission on Medicaid and the Uninsured, 2007. *Health Coverage for Low Income Parents* http://www.kff.org/uninsured/upload/7616.pdf (Accessed April 28, 2007)
[2] Neva Kaye, Cynthia Pernice, and Anne Cullen, 2006. *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (National Academy for State health Policy, 2006). http://www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf (Accessed April 28, 2007)

Overview

Coverage of Low Income Parents

Like other low income persons, low income parents (family incomes at or below 200 percent of the federal poverty level) experience a high rate of uninsurance. The 10.9 million parents who were uninsured in 2005 comprised nearly a quarter of the more than 46 million uninsured persons that year.[3] Among 20.4 million low income parents, 37 percent lacked coverage, 36 percent had employer sponsored coverage, and 27 percent had coverage through Medicaid or another source of public financing.[4]

There is broad agreement that diminished health insurance coverage among non-elderly adults is a cause for concern, in view of the individual and community-wide effects of high uninsurance rates.[5] Both the President and Members of Congress have presented options for addressing the problem. In his FY 2008 Budget, the President proposed to revamp federal tax policy to place new limits on federal tax subsidies for employer-sponsored coverage while simultaneously creating a new tax subsidy arrangement de-linked from employer coverage and accessible to all individuals, including low income uninsured persons. Other policy makers have proposed to extend coverage to low income, non-elderly adults by expanding direct coverage under existing public insurance programs through the creation of health insurance subsidy options within existing public financing systems.

Numerous states have expanded public financing for low income adults, including parents, either through reforms in direct public coverage (e.g., Medicaid or SCHIP waiver expansions) or by creating other sources of funding for health insurance subsidies. Whatever form they take (i.e., individual payments or direct purchase through a publicly funded system), these subsidized arrangements typically involve enrollment in private coverage. Thus, regardless of whether effectuated through individual financing or direct, public insurance expansions under Medicaid or SCHIP, states actualize coverage by using market-based coverage strategies. As a practical matter therefore, the line between "direct" coverage and "coverage subsidies" has become increasingly blurred. What remains is a clear desire across the political spectrum to improve coverage of adults.

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[3] Kaiser Commission on Medicaid and the Uninsured, 2007. *Health Coverage for Low Income Parents* http://www.kff.org/uninsured/upload/7616.pdf (Accessed April 28, 2007)

[4] Id.

[5] Institute of Medicine, 2003. *A Shared Destiny: Community Effects of Uninsurance* (National Academy Press, Washington D.C.); Institute of Medicine, 2002. *Care without Coverage: too Little, Too Late* (National Academy Press, Washington D.C.); Jack Hadley, 2007. Insurance Coverage, Medical Care Use, and Short Term Health Changes Following An Unintentional Injury or the Onset of a Chronic Condition," *JAMA* 297:10 (March 14) 1073-1084; Kaiser Commission on Medicaid and the Uninsured, 2007. *Health Coverage for Low Income Americans: An Evidence-Based Approach to Public Policy* *http://www.kff.org/uninsured/7476a.cfm* (Accessed April 28, 2007)

For this reason, the fundamental policy question appears to be not *whether* to publicly subsidize coverage for low income parents but instead, how to finance and structure the subsidy (through tax expenditures or direct financing). Another question is how high up the family income range public subsidies – whatever form they take -- should reach. Those who advocate for the use of tax financing view this approach as one that brings equity to tax policy while promoting market efficiencies. Those who support public financing tend to focus on the natural and logical evolution of such an approach in light of current practice, as well as the greater ease by which direct spending policies can be used to create more broadly accessible and affordable health insurance markets. The Massachusetts health reform plan, which relies on direct public financing to make affordable care available through a mechanism known as the Connector, offers a good example of this hybrid strategy, which relies on direct public financing to create more widely available and affordable market options.

Low Income Parent Coverage in a SCHIP Reauthorization Context

Medicaid and SCHIP offer parallel pathways to expand public insurance coverage of low and moderate income children. In the context of SCHIP reauthorization, the question is whether to carry this parallelism where children are concerned into the parental coverage arena. The answer to this question lies at least part in a decision as to whether covering parents actually represents sound *child health policy.* Some have argued that coverage of parents is not only good for parents but furthermore, that extending coverage to parents promotes not only coverage of children but also the more effective use of coverage in terms of increased access to care and a greater use of appropriate care.[6]

It is because of this assertion regarding the *beneficial pediatric effects of family coverage* that the case for creating parallel parental coverage flexibility under both Medicaid and SCHIP has arisen.

The nation has a long history of approaching coverage in terms of families, not only children. It is the custom in the employer-sponsored market to offer family coverage. Furthermore, emphasizing family coverage under public insurance is of course not new to public insurance. From the time of its 1965 enactment, Medicaid has mandated coverage of family units consisting of impoverished "dependent children" and their "caretaker relatives" (as these terms historically were used in welfare policy).[7] Only during the past 30 years – since the first Medicaid child expansion proposals were introduced in 1977 by President Jimmy Carter[8] – has a child-specific expansion focus come to dominate national

[6] Richmond, L.M. 2007. Panelists Debate Appropriateness of covering Adults Under SCHIP. BNA Health Care Daily Report. 12(71) ISSN 1091-4021
[7] Sara Rosenbaum and David Rousseau, 2001. "Medicaid at Thirty-Five" *St. Louis University Law Jour.* 45:7. 7-42
[8] Id.

Medicaid policy reform discussions. Furthermore, two notable Medicaid expansions – the welfare reform amendments of 1987 and 1996 – contain provisions to either ensure or permit the coverage of parents.

Medicaid's original emphasis on coverage of families was not the result of an evidence-based policy decision; instead, it reflected the value placed on family coverage generally, as well as underlying federal cash welfare assistance policy, as modified through subsequent welfare reform initiatives.

The question now is whether there exists an independent evidentiary basis to further align SCHIP coverage options with Medicaid policy, in this case, in a parental coverage context. The result of this expanded parallelism would be that state coverage of parents, as is the case with children, would be incentivized by means of enhanced federal payments

Methods

Using standard literature search techniques aimed at both peer-reviewed studies and the more rapidly available "grey literature" that dominates much health services research linked to health policy, we identified 9 studies published since 2000 that expressly consider the child health effects of parental coverage through public insurance programs. Because the Medicaid parental coverage option was a feature of the welfare reform legislation of 1996,[9] it is not surprising that this research began to appear in 2000 and that the studies overwhelmingly focus on the effects of Medicaid parental coverage expansions. Several studies examine specific expansion efforts, while others use national or state-level survey data to consider the effects of parental coverage.

Findings

Although varying in the source of data used and the specific questions posed, the studies tend to be quite consistent, showing positive effects on children when parents have coverage.

Effects on Coverage

All studies measure the coverage effects on children of parental coverage. All studies show positive coverage effects on children – in some cases modest, and in some, substantial – from parental coverage. Gundelman and Pearl, Gundelman et. al., and Sommers et. al., also conclude that parental coverage improves the continuity of coverage in children and reduces the likelihood of breaks in coverage.

Parental coverage does not affect eligibility standards for children, in view of the fact that to begin with, children's eligibility standards typically are higher than

[9] Id.

those used for adults. (Aizer and Grogger) At the same time, the studies uniformly show that parental coverage increases enrollment rates among eligible children.

Two studies address health insurance crowd-out and find that extending coverage to parents results in little if any crowd-out effect on children, in light of the low levels of access to privately sponsored coverage among low income families to begin with. (Aizer and Grogger; Dubay and Kenney)

There are no studies that suggest that covering parents diminishes coverage for children. Because the proportion of eligible but unenrolled low income children is so high, the issue is the *significance* of the coverage gains for children, not whether states that cover parents do so by diminishing coverage for children.

Sommers et. al. find that the positive effects of parental coverage on children's coverage are substantially lessened in states that administer separate SCHIP programs while requiring parents to secure coverage through Medicaid. Thus, for example, a state may set Medicaid parental coverage at 200 percent of the federal poverty level and children's Medicaid coverage at 100 percent of the federal poverty level while reserving SCHIP funds for a separate program for children with incomes between 100 and 200 percent of the federal poverty level. The Sommers study might support a conclusion that parental coverage might help boost eligibility levels for the poorest children (i.e., those who also obtain coverage through Medicaid) while having only a modest effect on enrollment rates among near-poor children. The authors attribute this finding to the confusing effects of requiring that families navigate separate programs in order to achieve coverage for themselves and their children.

Effects on Access and Health Status as Measured by Use of Care, Use of Appropriate Care, Having a Regular Source of Care, and Other Measures

Six of the 9 studies show that parental coverage has a positive effect on access to health care in terms of use of any care, use of preventive services, having a regular source of care, and having unmet health care needs. One particularly interesting study by Gundelman et. al. finds that parental coverage also lessens feelings of discrimination, suggesting the broader psychological value of family coverage in addition to its value in achieving higher levels of more appropriate health care use.

Discussion

This review of studies examining the effects on children of parental coverage under public insurance program suggests that such coverage is associated with greater participation by children. The studies also support the conclusion that coverage tends to be more continuous and less interrupted and represents new, rather than substitution, coverage. Parental coverage also appears to be

associated with the *more effective use of coverage* among children, as measured by access to care, having a regular source of care, and using preventive services.

Making parental coverage possible also appears to be consistent with current employer coverage custom and practice, as well as with Medicaid's historical emphasis on family coverage. Over the past 30 years, particular attention has been paid to the coverage of children. At the same time, federal legislative policy dating to Medicaid's original enactment and continuing through the welfare reform laws enacted by Congress in the 1980s and 1990s have traditionally emphasized the importance of family coverage.

Offering coverage for parents – especially low income parents who are extensively uninsured and who may have significant unmet health needs – appears to operate as an incentive for families to both seek and use coverage. Low income parents who are uninsured have significantly reduced rates of health care use; coverage of parents appears to offer an important strategy for increasing access to, and use of, appropriate health care. Like other parents, low income parents who enroll in coverage also seek benefits for their children.

The question becomes the meaning of these studies for SCHIP policy reforms. States already have an option to extend Medicaid coverage to parents, at regular Medicaid federal matching rates. Recent federal Medicaid flexibility amendments enacted as part of the DRA may further encourage states to combine Medicaid and SCHIP coverage reform strategies, by using Medicaid to extend coverage to more parents, who in turn might then be enrolled in the same benchmark plans available to SCHIP-eligible children. (In the case of Medicaid-eligible children enrolled in such plans, benchmark coverage would be accompanied by EPSDT "wraparound" benefits). At least one study reviewed here also suggests that such two-pronged strategies should take care to make such expanded coverage arrangements as seamless as possible, so that parents do not view the task of enrolling both themselves and their children as effectively having doubled in the degree of difficulty involved. The more that the enrollment process diverges by payer source, the less may be the beneficial impact on children's enrollment of a family coverage strategy.

Given the state of current policy, therefore, the question is whether to expand SCHIP/Medicaid parallelism by adding parental coverage flexibility. Whether to expand this parallelism approach depends on the degree to which policy makers believe that *enhanced federal matching funds* should be preserved only for child health expansions and that expansion of coverage for parents should take place only at the regular federal matching rate.

Several SCHIP reauthorization measures introduced to date seek to incentivize states to use their allotments to reach uninsured children with moderate family incomes, as well as to streamline the eligibility determination and enrollment

process for all eligible children. One option might be to allow states that meet child coverage milestones to apply their remaining SCHIP allotment funds toward parental coverage. In this way, children would remain the principal beneficiaries of reform, while states that wish to do so could apply the balance of their allotments toward expanded coverage of parents at a preferred federal rate.

The benefit of this approach would be that it would result in parental coverage while also acting as a further enrollment incentive for children. Its limitation would be that once invested in parental coverage, federal SCHIP would not be available for re-allocation to states that had not yet met national child health coverage targets or whose federal allotments fall short of reaching actual need. Similarly, allowing the use of SCHIP funds to reach parents might lessen the level of federal funding available to invest in strengthening and improving pediatric coverage levels as well as the quality of pediatric health care.

Since the issue is not whether parental coverage is good for children but how much the federal government should be willing to pay to achieve family coverage, a logical response might be to permit the parallel use of SCHIP allotments when national child health coverage benchmarks are met. At the same time, the FY 2008 Conference Agreement reached on May 16 appears to set a proposed funding commitment tied to the number of children who are currently eligible but not enrolled in either Medicaid or SCHIP. Thus, bringing parental coverage parallelism to SCHIP policy might be expected to result in little if any parental coverage if the SCHIP reauthorization also contains expanded child coverage benchmarks. There simply would not be sufficient funds to cover all currently eligible children, meet expanded child health coverage benchmarks, and cover parents.

One additional option that might be considered is to permit the use of SCHIP allotments for parental coverage by states that achieve national children's coverage benchmarks through Medicaid expansions at the regular federal matching rate. Medicaid and SCHIP offer states parallel means of covering low and moderate income children and parents. Since the evidence shows that parental coverage is more costly than coverage of children, SCHIP's enhanced federal contribution formula ultimately might prove to be a more valuable financial incentive where adult coverage is concerned. This approach would give states an additional pathway toward improved family coverage while maintaining national children's coverage goals. The approach makes particular sense in states such as States such as Minnesota, Rhode Island, and New Mexico, whose regular Medicaid coverage policies for children had already reached enhanced levels (300 percent, 250 percent, and 185 percent of the federal poverty level respectively). Where a state already has made a child health investment at the regular Medicaid matching rate, it may make particular sense to permit the state to invest its allotment in parental coverage in order to avoid penalizing the state for having invested in children at the regular Medicaid financial contribution rate.

Studies Examining the Effects of Parental Coverage on Children's Health Insurance Coverage(C), Access (A), and Health Status Through Appropriate Health Care Use (H)

Study	Year	Issues	Summary
1. Ku, L., and M. Broaddus. 2000. *The Importance of Family-Based Insurance Expansions: New Research Findings About State Health Reforms.* (Center on Budget and Policy Priorities. Washington, DC.):	2000	C, A, H	Assessment of expansion implementation in 3 states in 1994, which produced the following results: • A 16 percentage point increase in Medicaid participation rates among low income children under age six compared to a 3 percentage point increase among young children in states that did not enact similar expansions. • Improved use of health care among both parents and children in expansion states, showing greater use of preventive services, more continuity of care, and fewer unmet health needs.
2. Lambrew, J.M. 2001. *Health Insurance: A Family Affair*. (The Commonwealth Fund, New York).	2001	C	Examination of the relationship between health insurance coverage of children and parents, showing the following: • 90% of low-income children with insured parents are covered through some form of health insurance, compared to 48% of children whose parents are uninsured. • Despite Medicaid/SCHIP eligibility, 95% of uninsured children with family incomes below 200% FPL remain unenrolled. Nearly 75% of uninsured children have at least one uninsured parent. • States that expand Medicaid to parents show uninsured rates among low income children that are over 40% lower.

Study	Year	Issues	Summary
3. Aizer, A., and J. Grogger. 2003. *Parental Medicaid Expansions and Health Insurance Coverage*. (NBER Working Paper 9907).	2003	C	Using data from the March annual demographic supplement of the Current Population Survey to examine Medicaid eligibility expansions for parents from 1996-2001, the authors analyze the effects of expansion on insurance status and find the following: • Parental eligibility expansions did not expand eligibility for children, because the expansions reached a group of parents with family income levels below those already established for children. expansions. • However, parental eligibility expansions increased the *likelihood of Medicaid coverage* for both minority parents and children (Hispanic: 4.8% for mothers and 6.7% for children; Black: 7% for mothers and 8% for children • Parental eligibility expansions increased the *likelihood of any kind of coverage for minority parents and children* (Hispanic: 4.2% for mothers and 3% for children; Black: 4.4% for mothers and 6.3% for children) • Among White non-Hispanic parents and children, parental eligibility expansions slightly decreased the likelihood of coverage among parents while slightly increasing coverage of children.
Davidoff, A., L. Dubey, G. Kenney, A. Yemane. 2003. The Effect of Parents Insurance Coverage on Access to Care for Low-Income	2003	C, A, H	Using data from the 1999 National Survey of America's Families, the authors examined the correlation between uninsured parents and children's coverage and access to health care and found the following: • In 1999, almost 90% of uninsured, low-income (family income below 200% FPL), children had an uninsured parent. • Low income children with uninsured parents are 6.7% less likely to

Study	Year	Issues	Summary
Children. Inquiry 40, (254-268)			have well child visits and 6.5% less likely to have any physician visit. Low income uninsured children are 9.6% less likely to have a usual source of care (compared to children covered by Medicaid). Uninsured children are 22.3% less likely to have any physician visits and 28.3% less likely to have well child care when compared to insured children. • Low income insured children, with an uninsured parent are 4.1 % less likely to have any physician visit and 4.2% less likely to have a well child visit. • There is only a marginal effect of parental insurance on the rates of care for children. • If a parent is uninsured, then there is an effect on the child's use of health care and a positive spillover effect on children in general. • Expanding care to parents has a small but meaningful gain in access for children who are already insured.
4. Dubay, L., G. M. Kenney. 2003. "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid". *Health Services Research.* 38(5).	2003	C	Using data from the 1997 and 1999 National Survey of America's Families, the authors examined whether public health insurance coverage expansions for parents increase child Medicaid participation rates and found as follows: • Extending coverage to parents increases participation in Medicaid among children and leads to lower overall uninsured rates among children. • Substitution effects (i.e., exchange of private for public coverage) are present but low because of the limited availability of private coverage for low income adults.

Study	Year	Issues	Summary
			• Expanding coverage for parents increases children's participation and utilization rates, even among children who are already insured. • States that do not provide family coverage have a lower percentage of poverty-related children participating in the Medicaid program (57.1%) when compared to states that do provide publicly financed family coverage plans (78.5%) as well as those that provide family coverage through Medicaid expansions (80.8%). • In a specific example, after its Medicaid expansion, Massachusetts: saw a 21.3% increase in children's coverage compared to a 3.6% increase in other states. Overall uninsured rates among children declined at an 11% greater rate than in other states.
5. Guendelman, S., and M. Pearl. 2004. "Children's Ability to Access and Use Health Care" *Health Affairs*. 23(2), 235-244.	2004	C, A, H	The authors examine data from the National Health Interview Survey and found the following: • There exists a strong relationship between parents' and children's insurance status and type of coverage. Specifically, 84% of uninsured children have parents without insurance, 13% had parents with private insurance and 3% had a parent with public coverage. Conversely, 53% of publicly insured children have parents with public insurance, 16% have at least one privately insured parent and only 32% had parents who themselves had no health insurance. Similarly, 95% of privately insured children have at least one parent with private insurance, 1% have a publicly insured parent and 4% have uninsured parents. • Among families with child-only health insurance, the probability of breaks in coverage is 4% higher, while the probability of having a regular source of health care is 8% lower. • Extending coverage to parents is associated with continuous

Study	Year	Issues	Summary
			coverage and a greater likelihood of regular use of health care among children. • Although the benefits to children that flow from parental coverage expansion are non-significant, parental coverage does appear to have some effect on reducing breaks in coverage and promoting continuity of care.
6. Gifford, E.J., R. Weech-Maldano, P. Farley-Short. 2005. Low-Income Children's Preventive Services Use: Implications of Parents' Medicaid Status. Health Care Financing Review. 26(4), 81-94	2005	C, A, H	Using data from the 1996 Medical Expenditure Panel Survey (MEPS), the authors examine the effect of parents' Medicaid status on health care utilization among young children and find as follows: • Children's use of health services is related to their parents' use of health services, an important correlation in a health insurance context, since uninsured adults use 60% less ambulatory health care than insured adults. • Extending Medicaid or SCHIP coverage to parents has a spillover benefit for children. While providing Medicaid to uninsured children results in a 14% increase in well-child visits, extending coverage to both children and parents increases well child visits by 24%. • Having an uninsured parent reduces the probability of a well child visit by 3.5% among publicly insured children and by 11.8 % among privately insured children.
7. Guendelman, L., M. Wier, V. Angulo, D. Omen. 2006. "The Effects of Child-Only Insurance Coverage	2006	C, A, H	Using secondary data from the 2001 California Health Interview Survey (CHIS), the authors compared child-only coverage to family coverage with respect to health care access and utilization among low income children and find as follows: • As in national estimates, there is an association between the

Study	Year	Issues	Summary
and Family Coverage on Health Care Access and Use: Recent Findings Among Low-Income Children," *California. Health Services Research*. 41 (1), 125-147.			insurance status of children and parents. 72% of uninsured children had uninsured parents, 20% had privately insured parents and 8 % had publicly insured parents. Conversely, 66% of publicly insured publicly insured children had publicly insured parents, 14% of parents were privately insured and 20% had uninsured parents. • The absence of family coverage had a significant effect on access and utilization. Parents who lacked family coverage showed 6 times the odds of lacking consistent care, an increase in the rate at which they felt affected by discrimination, and had a lower probability of care in a timely fashion. Child-only coverage also increased the odds of breaks in insurance coverage, the likelihood of no usual source of care, the likelihood of seeking public care, and feelings of discrimination. • Providing insurance to both children and parents would be associated with a decrease in health disparities and a reduced incidence of breaks in health insurance coverage. Coverage of parents would also increase the likelihood of a regular source of care and would reduce feelings of discrimination.
8. Ku, L., M. Broaddus. 2006. Coverage of Parents Helps Children, Too. Policy Priorities. Center on Budget and Policy Priorities. Washington, D.C.	2006	C, A, H	The authors summarize earlier research into parental coverage and conclude as follows: • Covering both parents and children creates an incentive for parents to obtain and keep coverage for their children and families. Covering parents also increases their knowledge of the system and thus informs them of their options for their children. • Covering parents affects children's access and utilization, improves child health, and improves the health of parents. Research suggests that increasing coverage to low-income parents will have a direct

Study	Year	Issues	Summary
			effect on coverage of children
9. Sommers, B.D. 2006. "Insuring Children or Insuring Families: Do Parental and Sibling Coverage Lead to Improved Retention of Children in Medicaid and CHIP" *Journal of Health Economics.* 25, 1154-1169.	2006	C	Using the Current Population Survey, March Supplement (1999-2004), the author studied the drop out rates among children in Medicaid and SCHIP, comparing children with and without parental coverage. • Approx. 30% of children in Medicaid/SCHIP will not be enrolled in 12 months, and drop-out accounts for almost 50% of this figure. • Previous research suggests that covering parents with Medicaid increases children's Medicaid enrollment by 3-14%. Parental (mostly maternal) coverage is a predictor of (and protector against) child drop-out. • At the same time, States that administer SCHIP as a separate program from Medicaid show a 45% increased risk of drop-out, a result potentially associated with the greater complexities families encounter in navigating separate programs.