

## **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.<sup>1</sup> 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."<sup>2</sup>

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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<sup>1</sup> 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)

<sup>2</sup> 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](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.<sup>3</sup> 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.<sup>4</sup>

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.<sup>5</sup> 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

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<sup>3</sup> 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)

<sup>4</sup> Id.

<sup>5</sup> 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)

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.

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.<sup>6</sup>

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

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<sup>6</sup> Richmond, L.M. 2007. Panelists Debate Appropriateness of covering Adults Under SCHIP. BNA Health Care Daily Report. 12(71) ISSN 1091-4021

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).<sup>7</sup> Only during the past 30 years – since the first Medicaid child expansion proposals were introduced in 1977 by President Jimmy Carter<sup>8</sup> – has a child-specific expansion focus come to dominate national 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,<sup>9</sup> 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**

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<sup>7</sup> Sara Rosenbaum and David Rousseau, 2001. “Medicaid at Thirty-Five” *St. Louis University Law Jour.* 45:7. 7-42

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

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 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.