
Access to Employer-Sponsored Health Insurance among Low-Income Families

Who Has Access and Who Doesn't?

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Who Has Access and Who Doesn't?

Lack of health insurance to facilitate access to health care can affect the health and productivity of workers as well as the health of workers' families. This is especially true for low-income families (families with incomes below 200 percent of the federal poverty level [FPL]), which are more likely to have members that are in poor health (Bloom, Dey, and Freeman 2006; Pleis and Lethbridge-Çejku 2006).

In 2005, just 39.8 percent of workers with family income below 100 percent of FPL were eligible for employer-sponsored health insurance (ESI), and 60.3 percent of workers with family income between 100 and 200 percent of FPL were eligible. In contrast, 89.6 percent of workers in families above 400 percent of FPL were eligible for ESI (Clemans-Cope, Garrett, and Hoffman 2006). Royalty (2000) finds that when employers are required to raise wages for low-wage workers through an increase in the minimum wage, they compensate by reducing worker benefits such as health insurance. According to Royalty, an increase in the minimum wage of \$0.50 from its 1999 level would decrease workers' eligibility for health insurance by 3.9 percentage points.

Even when workers are eligible, low-income workers may find the required premium contributions unaffordable, leading to lower rates of take-up conditional on offer. For example, among workers with family income below 100 percent of FPL who are offered ESI, only 63.5 percent take it up, relative to 83.7 percent of workers above 400 percent of FPL (Clemans-Cope and Garrett 2006). There is a direct, negative relationship between the percentage of the premium that workers are required to contribute and the rate of take-up (Kaiser Family Foundation 2007).

There is substantial evidence that people who are insured have access to better health care, both in the case of acute illnesses such as heart attacks and for management of chronic conditions such as hypertension. These access differences can result in measurable differences in health outcomes (Hadley 2003).

Declines in worker productivity from neglecting to maintain health can result from absenteeism or disability. In addition, past research has estimated the costs of “presenteeism” (lower productivity due to illness) to be higher than the medical costs of treating the condition in the case of many illness examined (Burton et al. 1999; Goetzel et al. 2004). Mental illness, in particular, can have negative effects on productivity in the workplace (Goetzel et al. 2004).

In addition to the costs to the employer in terms of missed workdays and lower productivity, lack of insurance coverage for parents may have other adverse impacts on the children. For example, Davidoff and colleagues (2003) show if a low-income *insured* child has an uninsured parent, he or she is 4.1 percentage points less likely to have had any visit with a medical provider in the past 12 months, and 4.2 percentage point less likely to have had a well-child visit, relative to a similar insured child with an insured parent. Guendelman and colleagues (2006) show that children are more likely to have a usual source of care if their parents are also insured.

Lastly, parental illness—particularly mental illness—is correlated with poor child health outcomes. When untreated, mental illness among parents, such as depression, can reduce the likelihood that children get appropriate medical care. For example, Minkovitz and colleagues (2005) and Fairbrother and colleagues (2005) show that children with depressed mothers were less likely to use preventive care, and Perry (forthcoming) shows that treating maternal depression improves pediatric asthma management.

This paper uses the 2003 and 2004 Medical Expenditure Panel Survey (MEPS) to examine access to employer-sponsored health insurance. Our analysis focuses on “low-income working families,” which we define as families with income below 200 percent of FPL with at least one adult working in an establishment (i.e., not self-employed) for at least some part of the year. We present bivariate and multivariate analyses to examine patterns of access to this benefit within low-income working families. A description of the data and methods used in this analysis is contained in the appendix.

Our key findings are as follows:

- **In 2003 and 2004, about one in two children in low-income families did not have access to ESI, despite having one or more employed adults in the family.**
- **Among low-income working families, families with lower levels of income, families with lower parental education, families where parents work in smaller establishments, and families in which no parent has union representation are all less likely to have access to ESI.**
- **Public insurance fills a substantial part of the gap in health insurance coverage left by lack of ESI access for children in low-income working families, but parents without an offer of ESI remain uninsured at high rates. In fact, among families without an ESI offer, children are twice as likely—and parents nearly three times as likely—to be uninsured than families with an offer.**

In sum, we show that the children in low-income families are at a disadvantage not only because their parents have low levels of income, but also because of a lack of access to ESI. Public programs fill in some gaps among children who lack access to ESI, but parents without ESI offers remain uninsured at high rates.

Findings

How does access to ESI vary with income for children in low-income working families? (Table 1)

While 91 percent of higher-income children live in families where at least one employed parent is offered health insurance through an employer, this is true of just 53 percent of low-income children. Across the income spectrum, children are more likely to live in a family with access to ESI if they have at least one parent working full time (84 percent); nearly 96 percent of children with two full-time working parents have access to ESI. The gap between working in a firm that sponsors ESI for at least some employees and being eligible to participate in ESI (i.e., “has an offer”) also varies with family income. Among higher-income families, 94 percent report that their firm sponsored health insurance for at least some of their employees, and 91 percent report that they had an ESI offer. For low-income families, while 61 percent report that their firms

Table 1. Access to Employer-Sponsored Insurance by Family Income, by Parental Work Status, 2003–04 (percent)

Parental work status	Parent’s employer offers health insurance to parent	Parent’s employer offers health insurance to at least some employees
Children in families with an establishment worker	78.1	82.6
Two full-time/full-year employees	95.8	97.0
Only one full-time/full-year employee	83.8	86.8
Only part-time or part-year employees	33.7	48.3
Low-income children (under 200% FPL) in families with an establishment worker	53.3	61.1
Two full-time/full-year employees	79.2	83.9
Only one full-time/full-year employee	66.0	70.8
Only part-time or part-year employees	22.8	37.0
Higher-income children (200% FPL or more) in families with an establishment worker	91.1	94.0
Two full-time/full-year employees	97.8	98.6
Only one full-time/full-year employee	93.3	95.3
Only part-time or part-year employees	53.8	69.3

Source: Medical Expenditure Panel Survey, 2003–04.

Notes: The sample is children (under age 19), excluding those with only self-employed parents or unemployed parents, 2.7 and 10.2 percent of the overall sample, respectively. Establishment workers are those who work for a firm. Employed parents are people who report being currently employed at an establishment. Part-time refers to people who reported working less than 35 hours a week for their current main job. Part-year refers to people who changed employment status during the course of the year and did not work continuously throughout the year. The total unweighted sample was 15,225 children. The federal poverty level is defined using the Health and Human Services guidelines for 2003–04 depending on the year in which the MEPS recorded data from the respondent.

sponsored health insurance to at least some employees, just 53 percent report having an offer. The gap between sponsorship and eligibility exists even for low-income families with two full-time workers, where 84 percent report that the firm offers insurance to some workers, but only 79 percent report having an offer.

How does children's access to ESI vary among low-income working families? (Tables 2 and 3)

Hispanic ethnicity is correlated with lower access to ESI. Among low-income working families, 53 percent have access to ESI. In contrast, only 41 percent of Hispanic children have a parent with access to these benefits.

Within low-income working families, children in families with the lowest income have the least access to ESI. Children in the lowest income group (less than 50 percent of FPL) had access to ESI at a rate of just 22 percent; families with income between 150 and 200 percent of FPL had an access rate more than three times as high.

Families with less-educated workers, workers in smaller establishments, or workers without union representation are less likely to have access to ESI. For example, coefficients from regression analyses suggest that, controlling for other factors, children whose parents' largest employer has fewer than 10 employees and only one location are 32.7 percentage points less likely to have an ESI offer in the family ($p < 0.01$). Those whose parents are without union representation are 20.5 percentage points less likely to have an ESI offer in the family ($p < .01$).

To what extent do public programs close gaps in employer-sponsored insurance coverage? (Table 4)

Among children in low-income working families, public programs (i.e., Medicaid and SCHIP) narrow but do not eliminate the coverage gap for children who do not have access to ESI through their parents. Almost three-quarters (71 percent) of children in low-income working families without access to ESI are publicly insured, compared with 36 percent when families do have an ESI offer. Still, public insurance does not close the gap entirely. Children whose families do not have an ESI offer are twice as likely to be uninsured as those whose families do have an ESI offer (18 versus 9 percent).

Public programs disproportionately provide insurance to low-income children with health problems. Among all low-income working families, 65 percent of children with special health care needs who are in fair or poor health are covered by public insurance, compared with 52 percent of those who do not have a special health care need and are not in fair or poor health. Fully 83 percent of children with special health care needs who are in fair or poor health are covered by public insurance among families without

Table 2. Percentage of Low-Income Children with at Least One Parent with Access to Employer-Sponsored Insurance, by Demographic Characteristics, 2003–04

	Access to ESI
All low-income children in families with an establishment worker	53.1
Child race/ethnicity	
White non-Hispanic ^{ref}	58.3
Black non-Hispanic	60.9
Hispanic	41.4*
Other	54.7
Child's age	
0–5 ^{ref}	50.5
6–12	55.0
13–18	53.8
Child w/special health care needs (SCHN) ^a	
CSHCN in fair/poor health	48.2
CSHCN not in fair/poor health	58.0
Child w/o SHCN in fair/poor health	45.2*
Child w/o SHCN not in fair/poor health ^{ref}	53.4
Health status of least healthy parent	
Good/very good/excellent ^{ref}	56.6
Fair/poor	48.5*
Income relative to poverty level	
151–200%	73.7*
101–150%	57.9*
51–100%	36.7*
0–50% ^{ref}	22.3
Parent's highest degree	
Higher than high school degree	68.5*
High school degree or GED	57.0*
No degree ^{ref}	34.6
Establishment size among parent's employer	
101+ employees or > 1 location ^{ref}	72.3
26–100 employees	58.8*
10–25 employees and 1 location	45.1*
1–9 employees and 1 location	21.2*
Parental union status	
At least one parent belongs to a union	92.4*
No parent belongs to a union ^{ref}	49.1

Source: Medical Expenditure Panel Survey, 2003–04.

Notes: The sample includes children under age 19 living in families with at least one parent employed by an establishment and family income below 200% of the federal poverty level. The total unweighted sample was 7,943 children. Employed parents are people who report being currently employed at an establishment.

^a Eighteen-year-old children were excluded from CSHCN tabulations because only children under age 18 are asked about having a SHCN.

* Statistically significant difference from reference group at the .05 level.

^{ref} Reference group

Table 3. Determinants of Parental Access to Employer-Sponsored Insurance in Low-Income Working Families, 2003–04

	Access to ESI
Child's race/ethnicity	
Black non-Hispanic	0.04
Hispanic	-0.095**
Other	-0.04
Child's age	
6–12	-0.002
13–18	0.001
Child w/special health care needs (SHCN) ^a	
CSHCN in fair/poor health	-0.019
CSHCN not in fair/poor health	0.026
Child w/o SHCN in fair/poor health	-0.002
Health status of least healthy parent	
Fair/poor	-0.013
Income relative to poverty level	
51–100%	0.041
101–150%	0.173**
151–200%	0.254**
Parent's highest degree	
High school degree or GED	0.11**
Higher than high school degree	0.14**
Largest establishment size among parents' employers	
26–100 employees and 1 location	-0.098**
10–25 employees and 1 location	-0.188**
1–9 employees and 1 location	-0.327**
Parental union status	
At least one parent belongs to a union	0.205**
Observations	6,176
R-squared	0.32

Source: Medical Expenditure Panel Survey, 2003–04.

Notes: Coefficients are from OLS regressions for the dependent variable listed at the top of each column. Additional controls in the regressions were number of full-time workers, number of parents, children, and unrelated adults in household, industry (assigned according to parent with largest establishment size), census region, metropolitan statistical area, survey year, and data not taken from the first round of the survey. Standard errors were adjusted for MEPS survey design.

Reference categories in order from top to bottom of the table: White non-Hispanic; 0–5; Child w/o SHCN not in fair/poor health; Good/very good/excellent; 0–50%; No degree; 101+ employees or > 1 location; and no parent belongs to a union.

^a Eighteen-year-old children were excluded from CSHCN tabulations because only children under age 18 are asked about having a SHCN.

* Significant at the .05 level.

** Significant at the .01 level.

an ESI offer, compared with 70 percent of children who do not have a special health care need and are not in fair or poor health.

Among low-income working parents, large gaps in insurance coverage remain despite some access to public coverage. Overall, over a third (37 percent) of children in

Table 4. Insurance Coverage among Low-Income Children with an Employed Parent, by Child Health Status, 2003–04 (percent)

	Child is uninsured	Child has coverage through ESI	Child has public coverage	At least one uninsured parent	At least one parent with ESI coverage	At least one parent with public coverage
All low-income children with employed parent	13.2	30.9	52.3	37.2	46.8	27.3
<i>Child health status and special health care need status^d</i>						
CSHCN in fair/poor health	5.5*	28.8	64.7*	29.7*	42.4	38.1*
CSHCN not in fair/poor health	6.6*	38.5*	52.6	28.1*	51.6	29.7
Child w/o SHCN in fair/poor health	15.3	22.8*	59.9*	39.8	39.5*	32.7*
Child w/o SHCN not in fair/poor health ^{ef}	14.4	30.6	52.2	38.6	47.0	25.9
<i>Health status of least healthy parent</i>						
Fair/poor	13.2	28.7	54.8	38.2	42.6*	32.5*
Good/very good/excellent ^{ef}	13.3	32.5	50.5	36.5	50.0	23.4
Low-income children with employed parent without ESI offer	18.1	N/A	71.1	56.2	N/A	43.4
<i>Child health status and special health care need status^d</i>						
CSHCN in fair/poor health	6.9*	N/A	83.8*#	43.6*#	N/A	55.5*#
CSHCN not in fair/poor health	7.5*	N/A	78.0*#	43.7*#	N/A	51.6*#
Child w/o SHCN in fair/poor health	20.1#	N/A	75.3*#	53.6*#	N/A	49.2*#
Child w/o SHCN not in fair/poor health ^{ef}	19.7#	N/A	70.3*#	58.5*#	N/A	41.1*#
<i>Health status of least healthy parent</i>						
Fair/poor	17.1#	N/A	72.8*#	55.3*#	N/A	48.1*#
Good/very good/excellent ^{ef}	19.0#	N/A	69.0*#	57.0*#	N/A	39.2*#
Low-income children with employed parent who has ESI offer	8.8	52.0	36.1	20.3	81.9	13.0
<i>Child health status and special health care need status^d</i>						
CSHCN in fair/poor health	4.1*	50.8	44.1	15.0	79.6	19.2
CSHCN not in fair/poor health	5.6*	58.6	34.5	16.6	81.4	13.9
Child w/o SHCN in fair/poor health	9.5	46.7	41.1	23.1	79.6	12.6
Child w/o SHCN not in fair/poor health ^{ef}	9.7	51.5	36.5	21.1	82.0	12.7
<i>Health status of least healthy parent</i>						
Fair/poor	8.9	52.5	35.7	19.9	80.2	15.8
Good/very good/excellent ^{ef}	8.6	51.6	36.3	20.5	82.9	11.2

Source: Medical Expenditure Panel Survey, 2003–04.

ESI=employer-sponsored insurance; N/A=not applicable

Notes: The sample includes children under age 19 living in families with at least one parent employed by an establishment and family income below 200 percent of the federal poverty level. The total unweighted sample was 7,977 children. Employed parents are people who report being currently employed at an establishment.

^aEighteen-year-old children were excluded from CSHCN tabulations because only children under age 18 are asked about having a SHCN.

*Statistically significant difference from reference group at the 95% confidence level.

Statistically significant difference between families with and without ESI offer at the 95% confidence level.

low-income working families have at least one uninsured parent, even in families with a parent who has health problems. Public coverage is more prevalent among the low-income families in which a parent is in fair or poor health; 33 percent of children in these families have at least one parent with public coverage, compared with 23 percent of children whose parents are not in fair or poor health. Low-income children are much more likely to have a parent with public coverage in families without access to ESI—43 percent compared with 13 percent for those with access to ESI. However, public coverage only closes some of the gap, since over half (56 percent) of the low-income children in families without access to an ESI offer have uninsured parents, compared with 20 percent in families with ESI access.

Discussion

Low-income workers are not the only ones who benefit from access to employer-sponsored insurance; lack of access to health insurance may lead to lower levels of health and well-being for both children and parents. We have shown that the burden of poor health is exacerbated by lack of access to ESI for low-income children. Public insurance fills some of the gap left by lack of an ESI offer, but children whose parents are not offered health insurance through their employer remain more likely to be uninsured than children whose parents do have this benefit.

Our findings suggest that if more low-income families had at least one full-time/full-year worker in the household, both workers and their children would be more likely to have access to ESI. Even greater gains would occur if more low-income families had two full-time/full-year workers, but the potential for this to occur is limited given that almost half of all low-income children live in single-parent families (Acs and Nichols 2007). Further, over time, jobs that offer this benefit to workers without high levels of education—especially jobs with union representation and jobs with larger employers—have become less available (Farber 1990; Glied, Lambrew, and Little 2003). For families with only one parent in the household, the availability of adequate, affordable childcare can affect whether it is possible for that parent to work full time even if positions are available (Winston 2007). Similarly, if that parent has his or her own health problems to attend to, full-time work may not be a viable option.

The consequences of lack of access to ESI are unclear. Some low-income families with ESI offers do not enroll in ESI coverage. The high financial burden of premiums and cost-sharing may put the coverage beyond financial reach for many low-income families. Yet, relative to those without ESI offers, low-income families with ESI offers are more likely to have insurance coverage for both the children and parents.

Public insurance programs narrow, but do not eliminate, gaps in coverage between low-income families with ESI offers and those that lack ESI offers, with particularly large gaps remaining for low-income parents. Fully 56 percent of low-income children whose parents do not have an ESI offer have an uninsured parent, compared with 20 percent

of those whose parents have an ESI offer. Increasing take-up of existing ESI offers among low-income families would reduce uninsurance among low-income children and parents to an extent, but because most low-income uninsured families do not have access to ESI, other policy solutions are needed.

Some low-income uninsured parents are eligible for Medicaid or SCHIP but not enrolled, but most low-income uninsured parents cannot qualify for Medicaid or SCHIP under current rules (Kenney 2007). In contrast, most low-income uninsured children are eligible for Medicaid or SCHIP but are not enrolled (Dubay, Holahan, and Cook 2007). One strategy for reaching and enrolling more of these children could involve targeting more outreach efforts to small employers with nonunion workforces who are less likely to offer health insurance to their employees. Such a strategy could prove costly however, if it reduces participation in ESI among those employers that are offering coverage, thereby shifting costs to the government.

Given that some low-income children and parents have public coverage despite an offer of ESI in the family, the question arises whether the provision of wraparound benefits, such as dental care, which is currently possible only under Medicaid but not under SCHIP or premium assistance programs, could be used more effectively to maintain ESI for these families (Blumberg 2007). While making greater use of these options could achieve that objective, it could also shift financing for health insurance coverage away from private sources toward public sources.

Availability of paid sick leave would increase the attractiveness of ESI because workers would not suffer an income loss if they use their health insurance benefits during working hours. Unfortunately, other research shows that sick leave—a fringe benefit that is also critical for the well-being of workers and their children—is also offered at low rates for low-income workers (Clemans-Cope et al. forthcoming).

Requiring employers to offer insurance would increase access for low-income workers and their families, but the consequences of such regulations on wages and employment could counterbalance these benefits. In particular, if employers were to respond by reducing wages or by cutting back on staff, it could worsen the economic circumstances of some of the very families it is designed to benefit.

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Appendix

This analysis uses data from the 2003 and 2004 Medical Expenditure Panel Survey (MEPS) to assess the extent to which low-income children live in working families with access to ESI. Our primary analytic sample consists of low-income children age 18 and under who have at least one parent who was employed at an establishment, either part time or full time for at least part of the year. Because they do not have a parent who works for an employer, we excluded children whose parents were unemployed for the full year (10.2 percent of all children) and children whose parents were self-employed for the full year (2.7 percent of all children).

Our analysis sample consists of 20,296 children. We reweighted the original MEPS sample of 21,841 children to compensate for missing information on some key variables, including parental education, employer insurance offer, employer insurance eligibility, health status, mental health status, special health care needs status, parent health status, and parental work hours. Children missing key information were dropped, and the children retained in our analysis sample were assigned new weights that compensated for observed differences between our analysis sample and the original sample. This weighting adjustment reduces any biases that might result from nonrandom selection into the analysis group, and brings weighted population totals for children close to the MEPS national estimates. The new weights were based on the insurance status, parental work status, number of parents in the household, number of children in the household, race of the child, and age of the child. Our final sample consisted of 11,713 children in low-income families, 8,175 of whom had parents who worked at an establishment during the year, and 8,583 children in higher-income families, 7,559 of whom had a parent who worked at an establishment during the past year.

To define parental employment characteristics, we use variables that identify employment status and hours worked per week in each of three rounds during the year. We defined “full time” as working more than 34 hours a week. If a parent had missing employment status or hours data, we imputed based on data in other rounds during the year. For these and all other job-related variables, we used the parent’s current main job as the reference, which is defined by the respondent as the main source of employment. Income and other family-level characteristics are defined based on the

child's health insurance unit (HIU). HIUs contain the members of a nuclear family who could be considered eligible for a family health insurance policy and constitute the unit used to determine eligibility for public and private sources of coverage.

We focus on whether either parent is offered health insurance coverage by his or her employer. While other fringe benefits—such as access to retirement plans—are important facets of overall job quality for low-income workers, we focus on health insurance offer because this benefit has a direct effect on the well-being of children. It is important to note that the MEPS does not contain information on whether the ESI offer is extended to dependents. In addition, information is lacking on the nature of the ESI coverage available in terms of its benefits and required premiums and cost sharing.

We use descriptive and multivariate analyses to examine how access to this benefit varies among low-income families. We consider the characteristics of the child (age, race/ethnicity, and health/special health care needs status); parents' work status (presence of two full-time/full-year establishment workers, one full-time/full-year establishment worker, or only part-time or part-year establishment workers); parents' employer type (establishment/firm size and industry category of highest wage earner); parents' other characteristics (educational attainment, union status, health status); family structure (number of parents in the family, number of children in the family, and presence of other adults); and income as a percentage of the federal poverty level (less than or equal to 50 percent of FPL, 51 to 100 percent of FPL, 101 to 150 percent of FPL, and 151 to 199 percent of FPL).

Since health variables are asked three times a year, we recorded a child or parent as having fair/poor health if they were reported to have either fair or poor health (other choices are good, very good, and excellent) in at least one round. In addition, if a parent reported needing any help with activities or instrumental activities of daily living, or having any activity, functional, or sensory limitations, they were recorded as being in fair/poor health for our analysis. For parental education, we used information from the parent with the most education, and for establishment size, we used the parent with the largest establishment size.

The estimates presented in the text are derived from multivariate models based on ordinary least squares regressions that take into account the complex nature of the sample design of the MEPS when calculating standard errors. Probit models were also estimated, which produced findings qualitatively similar to those presented here.

