

Setting Income Thresholds in Medicaid/SCHIP: Which Children Should Be Eligible?

Timely Analysis of Immediate Health Policy Issues

January 2009

Genevieve Kenney and Jennifer Pelletier

Summary

As the reauthorization of the State Children's Health Insurance Program (SCHIP) is being considered, important policy questions will include where eligibility thresholds should be set for public coverage and how much latitude states should have in setting their thresholds. The original SCHIP bill targeted children with incomes below 200 percent of the federal poverty level (FPL). For families at that income level in 1996, just before SCHIP was enacted, employer-sponsored insurance (ESI) premiums for family health insurance coverage made up 16 percent of income on average for a family of four. Since then, health insurance costs have risen so much that for families at 300 percent of the FPL, ESI premiums for family coverage now make up 19 percent of income on average for a family of four. Put differently, ESI coverage is less affordable for families at 300 percent of the FPL today than it was for families at 200 percent of the FPL when SCHIP was passed. In addition, the large differences in cost of living that prevail both across and within states mean that imposing a single eligibility threshold nationally would place families in higher-cost areas at a disadvantage.

Introduction

SCHIP was designed to address gaps in health insurance coverage for children whose family incomes were too high to allow them to qualify for Medicaid but too low to afford private coverage. One of the issues that received considerable attention during the 2007 SCHIP reauthorization debate was the income level at which subsidized public coverage should be available to children through Medicaid and SCHIP.^{1,2} On the one hand, some argued that SCHIP had drifted from its statutory intent by allowing children with incomes above 200 percent of the FPL to be covered in so many states, exposing the programs to an increased

risk that public coverage will substitute for—or crowd out—private coverage.^{3,4} On the other hand, it was argued that private premiums had grown faster than the federal poverty level since the inception of SCHIP, which in turn was placing private insurance out of reach for a growing number of moderate-income families with incomes above 200 percent of the FPL, and that cost-of-living differences across states affect how affordable health insurance premiums are for families.⁵ Where eligibility thresholds are set and the extent to which states have latitude over their thresholds are important because they likely affect how effective SCHIP and Medicaid will be at filling gaps in coverage for children.

Background

The United States has experienced sharp growth in health care spending in recent decades. Between 1985 and 2005, health care spending nearly tripled in real terms, reaching \$1.9 trillion in 2005.⁶ Rising health care costs over this time period have numerous root causes, including advances in medical technology and increases in personal income, health sector prices, and administrative costs.⁷ Increases in health care costs exert upward pressure on premiums and cost-sharing.⁸ Between 2001 and 2005 alone, total annual premiums for family coverage increased nearly 30 percent per enrolled employee in private sector firms, or about \$2,500.⁹ Cost-sharing in the form of deductibles and copayments has also been on the rise.¹⁰ Moreover, while no comprehensive data are available to compare cost-of-living differences for families targeted by Medicaid and SCHIP in different areas of the country, the information that is available shows that the cost of living varies substantially across areas, both within and across states.¹¹

Historically, states have had flexibility to set their income eligibility limit in Medicaid/SCHIP.¹² Nationally, seven states have implemented an income limit of less than 200 percent of the FPL, 20 states have implemented an income limit at 200 percent of the FPL, and 24 states cover kids above 200 percent of the FPL. Of the states with higher income limits, 13 cover kids up to 250



Robert Wood Johnson Foundation



Urban Institute

percent of the FPL, 10 cover kids up to 300 percent of the FPL, and only one state—New Jersey—covers kids above 300 percent of the FPL with federal funds.¹³ Most states that cover children with incomes above 200 percent of the FPL under Medicaid and SCHIP charge premiums for coverage, but public premiums vary substantially across states and across income levels.¹⁴

Despite the fact that nearly half of all states cover children with incomes above 200 percent of the FPL, the vast majority of children enrolled in these programs appear to be from low-income families. Nationally, 91 percent of children enrolled in SCHIP live in families earning 200 percent of the FPL or less.^{15,16} In addition, legislation passed in 2007 to reauthorize SCHIP (H.R. 3963) would have covered an additional 3.9 million uninsured children, an estimated 80 percent of whom would have had incomes below 200 percent of the FPL; an earlier version of the bill passed by the House was even more targeted, with the share of newly-insured children who would be low-income estimated to be about 85 percent.¹⁷

This brief examines the extent to which increases in the costs of employer-sponsored insurance have outstripped income growth since the time that SCHIP was enacted. The implications of cost-of-living differences are also addressed.

Data and Methods

To assess how the affordability of private health insurance coverage has been changing over the past decade, we use information on the cost of employer-sponsored insurance premiums from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). The MEPS-IC includes survey information for an average of 38,500 private sector establishments per year, going back to 1996. Response rates range from 67 percent to 81 percent, with the early years of the survey experiencing lower response rates.¹⁸ The standard errors on the premium data are small, making the annual estimates of average employer-sponsored insurance premiums very precise. For example, the standard error

associated with the average total family premium in 2006 was less than 0.3 percent as large as the average premium for that year. The survey contains data on the insurance plan offered, including total premiums, employer contributions, cost sharing arrangements and information on the establishment. Data on the average premium cost for single coverage (employee only) and family coverage are available back to 1996.

The FPL for a family of four was obtained for each year from the Department of Health and Human Services (DHHS) Poverty Guidelines for the 48 contiguous states.¹⁹ The poverty guidelines are updated each year by DHHS using the consumer price index. With the exception of Hawaii and Alaska, the same federal poverty thresholds are defined for each state.

We create ratios of average employer-sponsored insurance family premium levels to income for families of four with two different income levels: at 200 percent of the FPL and at 300 percent of the FPL.²⁰ We focus on changes in the average premium relative to family income for ease of presentation. We also examined alternative affordability measures including (1) the average employee premium contribution for family coverage combined with average total out-of-pocket spending on deductibles, coinsurance, and copayments²¹ relative to income (to capture the direct burden on employees); (2) the average premium for family coverage relative to an adjusted income measure that includes the average premium measure (to approximate total compensation), and (3) the average nongroup premium for family coverage relative to income. We found that changes in all three alternative measures tracked closely with changes in the average premium for family coverage relative to income.

We use changes in the average employer premium for family coverage as a proxy for how the costs of private insurance coverage have been changing over time. Fully capturing how the affordability of private coverage has been changing over time would ideally rely on information

on how private nongroup premiums have been changing. However, only limited information is available to estimate changes in nongroup premiums. The MEPS Household Component (MEPS-HC) contains data on nongroup premiums, which are based on small samples of respondents with nongroup family coverage, and even smaller samples that represent a family size of four.²² Studies using the MEPS-HC data found that nongroup premiums for family coverage increased about 25 percent between 2002 and 2005 and by about 67 percent between 1996 and 2005.²³ Using the average premium growth between 2002 and 2005, we estimated the average premium cost for nongroup family coverage in 2006. While the MEPS data suggest that the nongroup premiums have not risen as fast as ESI premiums, we still found substantial growth in nongroup family premiums.²⁴

To assess the implications of the area-variation in the cost of living, we use the Council for Community and Economic Research ACCRA Cost of Living Index data for the third quarter of 2008.²⁵ This index takes into account relative prices for a market basket of consumer goods (including grocery items, housing, utilities, transportation, health care, and miscellaneous goods and services) for a “mid-management standard of living,” which is defined according to spending in the highest quintile in more than 300 urban areas across the country.²⁶

Findings

On average, employer-sponsored insurance premiums for family health insurance coverage rose by 8.7 percent per year between 1996 and 2006, increasing from \$4,954 in 1996 to more than double that at \$11,381 in 2006.²⁷ At the same time, the federal poverty level rose by an average of just 2.4 percent per year. As a consequence, where family employer-sponsored insurance premiums constituted 16 and 11 percent of family income, respectively, for families at 200 and 300 percent of the FPL in 1996, by 2006, those ratios had risen to 28 and 19 percent (figure 1). Overall, the ratio of

total premiums to income rose by about 75 percent for both groups between 1996 and 2006.

Similar growth was found in the ratio of average employee ESI costs (employee contributions to premiums and total out-of-pocket costs) to income over the period, increasing from less than 8 percent of family income in 1996 to 12 percent in 2006 for families at 200 percent of the FPL and from 5 to 8 percent for families at 300 percent of the FPL.²⁸ Because premiums paid by employers are part of an employee's total benefit package, we also examined the share of income spent on premiums after including the value of the employer's premium contribution in the family's income. The trend using this definition of family income tracks very closely to the trend using the simpler definition, increasing from 14 percent in 1996 to 24 percent in 2006 for families at 200 percent of the FPL and from 10 to 17 percent for families at 300 percent of the FPL (data not shown). Regardless of the definition used, the ratio of ESI costs to income was higher for families with incomes at 300 percent of the FPL in 2006 than it was for families with incomes at 200 percent of the FPL in 1996, the year before SCHIP was enacted.

Growth in nongroup premiums, though not as high as that in ESI premiums, was also large. In 1996, the average nongroup premium for family coverage in the nongroup market was \$3,329, representing 11 percent of income for families earning 200 percent of the FPL and 7 percent of income for families at 300 percent of the FPL. In 2006, the average nongroup premium for family coverage rose to an estimated \$6,038, making up 15 percent of income for families at 200 percent of the FPL and 10 percent of income for families at 300 percent of the FPL.²⁹

Another factor determining whether available coverage is affordable for families is the cost of living, which translates into very different effective incomes for families with the same nominal income living in different areas. For example, in 2008, families living in San Francisco and Philadelphia,

two urban areas with higher than average cost of living than the other areas included in the ACCRA index, would have to earn 2.1 and 1.5 times as much, respectively, to have the same purchasing power as families living in Douglas, Georgia, the lowest cost urban area in the study (figure 2). Consequently, a family living in San Francisco or Philadelphia earning 200 percent of the FPL is much less well-off than a family earning the same income but living in Douglas, Georgia and has fewer resources available to devote to health care. Even within a given state, families face very different costs of living; families living in Philadelphia have to earn 1.4 times as much as those living in Pittsburgh while families living in San Francisco have to earn 1.6 times as much as families living in Bakersfield to have equivalent purchasing power.

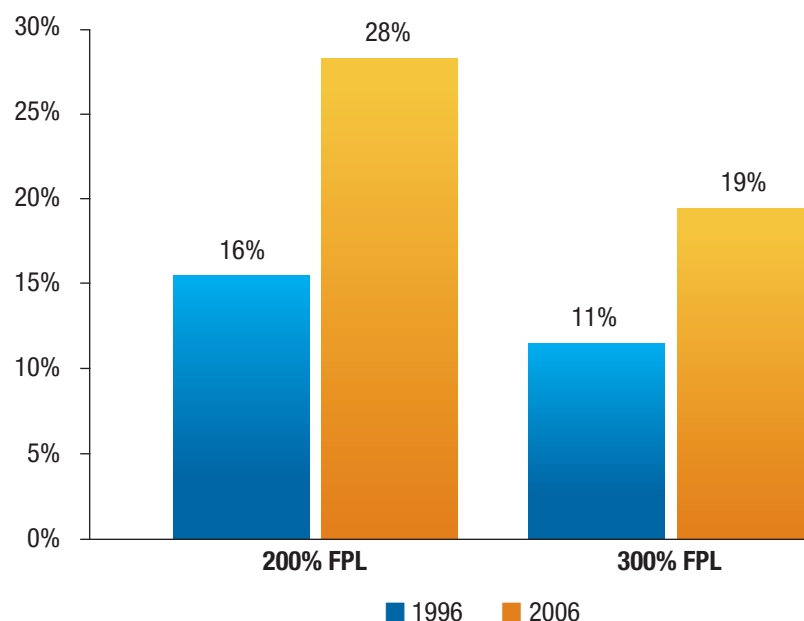
Discussion

Given that health care cost growth has historically exceeded general inflation rates, capping eligibility levels for public

coverage at an income level indexed to inflation rather than indexed to changes in the costs of health care premiums will likely mean that more and more moderate-income children are likely to become uninsured as their parents find that they cannot afford the increasingly high costs of private coverage. The effect of the rising premium burdens may have contributed to recent increases in the uninsured rate among children with moderate incomes. Between 2005 and 2006, the number of uninsured children rose by more than 700,000, and fully two-thirds of the increase was composed of children from families earning more than 200 percent of the FPL.³⁰ Over ten states have responded to the declining affordability of private coverage by enacting income eligibility expansions in the past five years.³¹

In addition, imposing a single eligibility threshold nationally, without regard for the substantial variation in purchasing power both across and within states, places families living in higher-cost areas at a disadvantage. Moreover,

Figure 1. Average Total ESI Premium for Family Coverage as a Share of Income at Selected Income Levels



Note: Share of income evaluated for families earning exactly 200% and exactly 300% of the FPL.

Source: 1996 and 2006 Medical Expenditure Panel Survey Insurance Component. Premiums reported are for a family of four. Federal poverty level for a family of four from the Department of Health and Human Services available at <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>

expanding eligibility to higher income levels has been shown to have positive spillover effects on the enrollment of lower-income children who were previously eligible.³² At the same time however, allowing states to expand public eligibility to higher income levels increases the risks that public coverage will substitute for ESI coverage and raises questions about the target efficiency of public subsidies.³³

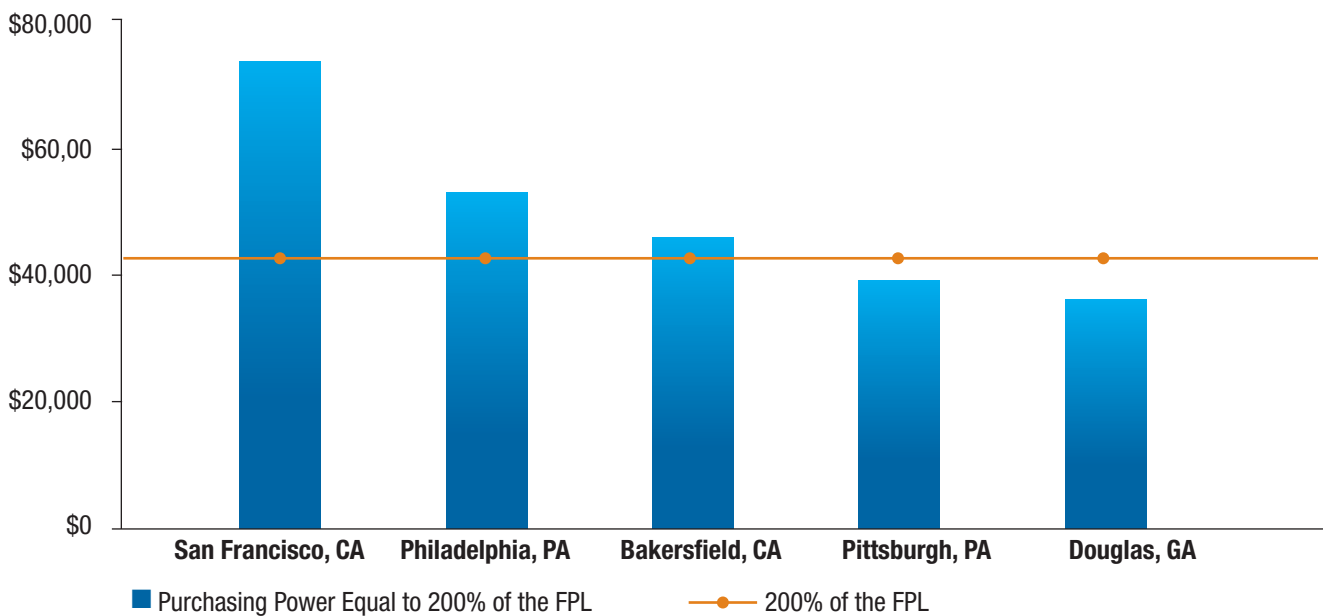
As states expand coverage to higher incomes, it is also important to consider whether their premium schedules adequately reflect the greater ability of higher-income families to afford coverage. It is important to note that past research has shown that premiums charged in public programs have a negative effect on enrollment, despite being much lower than premiums in the private insurance market, suggesting that even low amounts of cost sharing

can deter families from enrolling their children in coverage.³⁴ At the same time, however, there may be room for some states to raise premium levels, especially for moderate income children, without incurring significant enrollment declines. There is substantial variation in the premiums that states charge in their Medicaid/SCHIP programs to cover families above 200 percent of the FPL—of the eleven states that cover children in SCHIP at 300 percent of the FPL, monthly premiums range from zero in the District of Columbia to over \$100 in New Jersey and Missouri for one child.³⁵ While defining what is Affordable for families of different income levels is analytically difficult because the concept is inherently subjective, it is critical to efforts to achieve and finance universal coverage.³⁶

Whereas 200 percent of the FPL might have been a reasonable eligibility

threshold for coverage in many states when SCHIP was first created, that may not be the case today, particularly in high cost-of-living areas, given the large increases in health care premiums relative to income that have occurred over the past decade. In fact, this analysis suggests that ESI premiums now constitute an even higher share of family income for families at 300 percent of the FPL than they did for families at 200 percent of the FPL in 1996—that is, where health insurance premiums are concerned, 300 percent of the FPL has become what 200 percent of the FPL was over 10 years ago when SCHIP was enacted.³⁷ In addition, this analysis suggests that unless effective cost containment strategies are implemented that reduce the rate of increase of private premiums, pressures on public programs are going to continue to increase.

Figure 2. Income Needed for a Family of Four to Have Purchasing Power Equal to 200 Percent of the FPL in Selected Cities



Source: ACCRA Cost of Living Index, based on the data provided by Kaiser State Health Facts 2008. Income data were adapted to reflect purchasing power at 200% of the FPL by multiplying given income data (for purchasing power at 300% of the FPL) by 2/3. Federal poverty level from the Department of Health and Human Services available at <http://aspe.hhs.gov/poverty/figures-fed-reg.html>

Notes

- ¹ See Kenney, G. "The Failure of SCHIP Reauthorization: What Next?" Washington, DC: The Urban Institute. 2008. <http://www.urban.org/publications/411628.html>.
- ² SCHIP was established over a decade ago as part of the Balanced Budget Act of 1997. Though an optional program, all states expanded coverage under SCHIP, with an estimated 6.7 million children and 700,000 adults having coverage under SCHIP at some point during 2006. State programs vary in terms of their structure and characteristics (e.g., cost sharing arrangements and income eligibility levels), reflecting the flexibility over program design that was built into the SCHIP statute (Kenney 2008).
- ³ Hederman, R. "Expanding SCHIP into AMT Territory: SCHIP Plan Would Extend Welfare to Wealthy Families." Web Memo No. 1546. Washington, DC: The Heritage Foundation. July 10, 2007; Owcharenko, N. "The SCHIP Negotiations: A Backdoor Approach to Expanding Medicaid to the Middle Class?" Web Memo No. 1716. Washington, DC: The Heritage Foundation. December 3, 2007; Winfree, P. and G. D'Angelo. "SCHIP and 'Crowd-Out': The High Cost of Expanding Eligibility." Web Memo No. 1627. Washington, DC: The Heritage Foundation. September 20, 2007.
- ⁴ When SCHIP was enacted in 1997, the statute designated children in low-income families (defined as less than 200 percent of the FPL) as the target population for SCHIP, but states had the flexibility to use disregards in setting their thresholds, and an explicit exception was made for states that already were covering children through prior Medicaid expansions above 150 percent of the FPL, who were allowed to cover children in SCHIP up to 50 percentage points greater than their Medicaid eligibility level (The Balanced Budget Act of 1997, PL-105-33).
- ⁵ Mann, C. and M. Odeh. "The Growing Health Insurance Affordability Gap For Children and Families." Georgetown Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. 2007a; Kaiser Family Foundation. "Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level." Snapshots: Health Care Costs. Menlo Park, CA and Washington, DC: The Kaiser Family Foundation. February 2007. <http://www.kff.org/insurance/snapshot/chcm021507oth.cfm>
- ⁶ Congressional Budget Office. "Technological Change and the Growth of Health Care Spending." A CBO Paper. Washington, DC: Congressional Budget Office. January 2008.
- ⁷ Congressional Budget Office 2008.
- ⁸ Seliger Keenan, P. "What's Driving Health Care Costs?" The Commonwealth Fund/John F. Kennedy School of Government 2004 Bipartisan Congressional Health Policy Conference Issue Brief. Washington, DC: The Commonwealth Fund. November 2004.
- ⁹ State Health Access Data Assistance Center (SHADAC). "Squeezed: How Costs for Insuring Families are Outpacing Income." University of Minnesota: State Health Access Data Assistance Center. April 2008.
- ¹⁰ Seliger Keenan 2004; Kaiser Family Foundation and Health Research and Educational Trust. "Employer Health Benefits 2008 Annual Survey." Washington, DC: The Kaiser Family Foundation and Health Research and Educational Trust. September 2008. <http://ehbs.kff.org/>
- ¹¹ Kaiser State Health Facts. "Cost of Living Variation." Menlo Park, CA and Washington, DC: The Kaiser Family Foundation. 2008. <http://www.statehealthfacts.kff.org/comparetable.jsp?ind=600&cat=1>; Jolliffe, D. "The Cost of Living and the Geographic Distribution of Poverty." Economic Research Service. Washington, DC: US Department of Agriculture. September 2006. <http://www.ers.usda.gov/publications/err26/>
- ¹² Before 2007, states had broad latitude to set their own eligibility levels and to use income disregards to subtract costs of child care or work expenses from a family's gross income, thereby establishing eligibility based on the family's net income; states also applied "blanket" income disregards to reach children at higher income levels, as had long been permitted for Medicaid under Section 1902(r)(2) of the Social Security Act. On August 17, 2007, the Centers for Medicare and Medicaid Services issued a letter to state health officials (SHO-#07-001) restricting states' ability to cover children in families with gross income above 250 percent of the FPL. Specifically, in order to expand income eligibility above 250 percent of the FPL, the letter required states to achieve a coverage rate of 95 percent for low-income children and to ensure that the rate of employer-sponsored coverage for children had not dropped more than two percentage points in the past five years. States were also required to impose a 12-month waiting period for children coming off of other insurance before they could enroll in SCHIP and to charge the maximum amount of cost sharing allowable by law (5 percent of family income) for children in families earning more than 250 percent of the FPL (Mann, C. and M. Odeh. "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children." Georgetown Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. 2007b). Both SCHIP reauthorization bills that passed Congress but were vetoed by the president in 2007 (H.R. 976 and H.R. 3963) would have overturned the August 17th Directive. The Directive was set to take effect on August 17, 2008 for states already covering children above 250 percent of the FPL; however, CMS has applied the new rules only to states seeking to expand coverage (including New York, Ohio, Oklahoma, Louisiana, Indiana, and Wisconsin) and not to those who had already implemented coverage expansions (Associated Press, "States Won't Be Sanctioned over Kids' Health Insurance." 2008. http://www.usatoday.com/news/health/2008-08-14-children-insurance_N.htm?csp=34).
- ¹³ These income eligibility levels reflect those in effect as of October 2008. Several states have authorized income eligibility increases that have not yet been implemented either because of legislative delays or CMS denials of the increases (see footnote 12). In addition, four states have moved to use state-only funds to increase their income eligibility levels above the limit set in their SCHIP program. Illinois and Wisconsin use state funds to cover kids up to 300 percent of the FPL (Illinois' SCHIP eligibility level is 200 percent of the FPL; Wisconsin's is 250 percent of the FPL); Massachusetts and New York cover kids up to 400 percent of the FPL (Massachusetts' SCHIP eligibility level is 300 percent of the FPL; New York's is 250 percent of the FPL) (Georgetown Center for Children and Families. "Eligibility Levels in Medicaid & SCHIP for Children, by State as of October 1, 2008." Georgetown University Health Policy Institute. October 20, 2008).
- ¹⁴ Selden, T., G. Kenney, M. Pantell, and J. Ruhter. "Cost Sharing Arrangements in Medicaid and SCHIP: Implications for Out-of-Pocket Spending Burdens." Under Review.
- ¹⁵ Congressional Research Service. "REVISED: Estimates of SCHIP Child Enrollees up to 200% of Poverty, above 200% of Poverty, and of SCHIP Adult Enrollees, 2007." May 30, 2008. This study evaluated low-income families by their net income since that is how SCHIP eligibility is determined in most states. Some children with net income of less than 200 percent of the FPL have gross income above 200 percent of the FPL after adding back in child care and work-related expenses and other disregards.
- ¹⁶ When both Medicaid and SCHIP children are considered together, the proportion of enrollees who are low-income rises to 98 percent (Author's tabulation based on SCHIP enrollment as reported in Congressional Research Service 2008 and Medicaid enrollment from Georgetown Center for Children and Families, "Number of Children Ever Enrolled in Medicaid/SCHIP by Program Type and State, FY 2007." Washington, DC: Georgetown University Health Policy Institute. 2008).
- ¹⁷ Kenney, G., A. Cook, and J. Pelletier. "SCHIP Reauthorization: How Will Low-Income Kids Benefit under House and Senate Bills?" Washington, DC: Urban Institute. 2007. <http://www.urban.org/publications/411545.html>
- ¹⁸ Establishments are pre-screened over the phone, and those that offer health insurance to their employees are mailed a complete questionnaire. Those who do not offer health insurance to their employees are only asked a few questions over the phone. Establishments that do not return the questionnaire are sent a second mailing, and those that do not return the second mailing are called to complete the information over the phone.
- ¹⁹ Available at <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>
- ²⁰ Two-hundred percent of the FPL for a family of four translates into \$31,200 in 1996 and \$40,000 in 2006. Three-hundred percent of the FPL translates into \$46,800 in 1996 and \$60,000 in 2006.
- ²¹ Data on out-of-pocket costs are based on Urban Institute tabulations of the Household Component of the 1996 and 2006 Medical Expenditure Panel Survey and include average out-of-pocket costs for families with ESI coverage for the entire survey year.

- ²² Examining nongroup premium growth is also important when considering coverage options for this income group because few low- and moderate-income children have access to ESI coverage. (Kenney, Cook, and Pelletier. "Prospects for Reducing Uninsured Rates Among Children: How Much Can Premium Assistance Programs Help?" Urban Institute. Forthcoming).
- ²³ Bernard, D. "Premiums in the Individual Health Insurance Market for Policyholders under Age 65, 1996 and 2002." Statistical Brief #72. Rockville, MD: Agency for Healthcare Research and Quality. March 2005; Bernard, D. and J. Bantnin. "Premiums in the Individual Health Insurance Market for Policyholders under Age 65: 2002 and 2005." Statistical Brief #202. Rockville, MD: Agency for Healthcare Research and Quality. April 2008.
- ²⁴ Because of the small sample sizes, the nongroup premium estimates in the MEPS have large standard errors associated with them and are therefore much less precise than the ESI premium data. For example, the standard error associated with the mean nongroup family premium for 2005 was close to 10 percent of the mean, compared to a ratio of less than 0.3 percent for the mean ESI family premium in 2006 (MEPS-IC Table I.D.1(2006); Bernard and Bantnin 2008). We also looked at out-of-pocket spending when evaluating the cost of nongroup coverage but chose not to include it because the sample sizes for families of four are very small.
- ²⁵ Kaiser State Health Facts (2008) provides ACCRA data on what a family of four would need to earn in select U.S. cities to have purchasing power equal to 300 percent of the FPL. Because the focus of this brief is on children currently targeted by SCHIP, the income figures were multiplied by 2/3 in order to represent purchasing power equal to 200 percent of the FPL. Mann and Odeh (2007a) used ACCRA data and a similar method to show purchasing power for a family of three at 200 percent of the FPL.
- ²⁶ The index is based on the spending distribution across the six major categories of purchases listed on page 2 for consumers in the top income quintile in the Consumer Expenditure Survey. The distribution is relatively similar to the distribution for the lowest income quintile, which would represent lower-income families. The largest share of expenditures for both quintiles is due to housing costs, which represent 37 and 35 percent of total expenditures in the six categories of goods and services for the top and bottom quintiles, respectively. Because housing costs are highly variable across the country and constitute such a large share of expenditures in the index, the cost of living can vary greatly between cities. Transportation costs make up the second-largest share of expenditures (31 percent for the top quintile and 23 percent for the bottom quintile); groceries and utilities each constitute 10 percent of expenditures for the top quintile and 15 percent for the bottom quintile. Health care costs account for 8 percent of spending in the top quintile and 10 percent of spending in the bottom quintile (Urban Institute tabulations of the 2007 Consumer Expenditure Survey).
- ²⁷ The standard errors associated with these estimates were \$32.33 in 2006 and \$36.06 in 1996 (MEPS-IC Table I.D.1 from 1996 and 2006).
- ²⁸ For firms with large shares of low-wage workers (50 percent or more), the ratio of average employee premium to income is slightly higher than for all firms: For families at 200 percent of the FPL, the ratio is 6 percent in 1996 and 8 percent in 2006, and for families at 300 percent of the FPL, the ratio is 4 percent in 1996 and 5 percent in 2006 (data not shown). Employee contributions remained fairly constant over the period, constituting about a quarter of the total premium (data not shown).
- ²⁹ The premium for 2006 was estimated using the average growth rate in the nongroup premium between 2002 and 2005. The standard errors associated with these estimates are large, \$241 in 1996, or 7.2 percent of the mean, and \$513 in 2005, or 9.2 percent of the mean.
- ³⁰ Holahan, J. and A. Cook. "What Happened to the Insurance Coverage of Children and Adults in 2006?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. September 2007.
- ³¹ Smith, V. and D. Rousseau. "SCHIP Program Enrollment: June 2003 Update." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. December 2003. <http://www.kff.org/medicaid/upload/SCHIP-Program-Enrollment-June-2003-Update.pdf>; Cohen Ross, D. A. Horn, and C. Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. January 2008. <http://www.kff.org/medicaid/upload/7740.pdf>
- ³² Arjun, L. and J. Guyer. "Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children." Georgetown Center for Children and Families. Washington, DC: Georgetown Health Policy Institute. 2008; Kenney, G., L. Blumberg, and J. Pelletier. "State Buy-In Programs: Prospects and Challenges." Washington, DC: Urban Institute. 2008.
- ³³ Winfree and D'Angelo 2007.
- ³⁴ Hadley, J., J. Reschovsky, P. Cunningham, G. Kenney, and L. Dubay. 2007. "Insurance Premiums and Insurance Coverage of Near-Poor Children." *Inquiry* 43, no. 4: 362-377; Kenney, G., J. Hadley, and F. Blavin. 2007. "The Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003." *Inquiry* 43, no. 4: 345-361; Kenney, G., R.A. Allison, J. Costich, J. Marton, and J. McFeeters. 2007. "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States." *Inquiry* 43, no. 4: 378-392.
- ³⁵ The cost of enrolling two children in both Missouri and New Jersey is the same as enrolling one child (Selden et al. Under Review).
- ³⁶ Blumberg, L., J. Holahan, J. Hadley, and K. Nordahl. "Setting a Standard of Affordability for Health Insurance Coverage." *Health Affairs* 26(4): w463-w473. 2007.
- ³⁷ These numbers understate the extent to which coverage has become unaffordable at 300 percent of FPL, compared to coverage at 200 percent of FPL when SCHIP was signed into law. The 1996 estimates in the text represent the cost of coverage one year before the 1997 enactment of SCHIP. The 2006 estimates, by contrast, are at least three years before the potential reauthorization of SCHIP; if SCHIP is reauthorized at its earlier possible point (2009), the year most directly analogous to 1996 would be 2008. Between 2006 and 2008, premium growth continued to outstrip increases in the FPL. According to surveys by the Kaiser Family Foundation (KFF) and the Health Research & Educational Trust (HRET), average premiums for family coverage rose by 10.5 percent from 2006 to 2008 (KFF/HRET 2008. Available at <http://ehbs.kff.org/>). During that same period, the FPL rose by 6 percent. Using the recent premium increase reported by KFF/HRET to project ESI premiums for 2008, ESI family coverage in 2008 consumed an average of 30 percent of family income at 200 percent of FPL and 20 percent of family income at 300 percent of FPL. If average nongroup premiums are estimated for 2008 based on the growth rate between 2002 and 2005, nongroup premiums would have constituted 17 percent of income for families at 200 percent of the FPL and 11 percent of income for families at 300 percent of the FPL.

The views expressed are those of the authors and should not be attributed to any campaign or to the Robert Wood Johnson Foundation, or the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgements

Genevieve Kenney is a principal research associate and Jennifer Pelletier is a research associate in the Health Policy Center of the Urban Institute.

This research was funded by the Robert Wood Johnson Foundation. The authors appreciate the excellent research assistance of Joel Ruhter and the helpful comments and suggestions of Stan Dorn, John Holahan, Bruce Lesley, Cindy Mann, Brian Quinn and Stephen Zuckerman.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 35 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.