



## SCHIP

State Children's  
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Program Evaluation

*Fragmented child-parent coverage is particularly prevalent among low-income children with public coverage, among whom more than one-third have an uninsured primary parent and only slightly more than one-half have the same type of coverage as the primary parent.*

## Patterns of Child-Parent Insurance Coverage: Implications for Coverage Expansions

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Navigating health insurance and health care delivery systems to obtain adequate access to health care can be challenging, and parents must act as advocates for their children in this process. Parents who are covered by the same insurance as their children are likely to be the most effective advocates because they are familiar with the specific systems. The burden on parents may be magnified if the child and the parents have different insurance plans or different types of coverage. Parents who do not have their own insurance are likely to be the least effective in working with the insurance system that covers their child.

Changes in public program eligibility over the past 15 years have enhanced access to public insurance coverage, but they have created a situation in many low-income families where only some members are eligible for specific programs (Hanson 2001). The mandated poverty-related expansions to Medicaid eligibility, along with the State Children's Health Insurance Programs (SCHIP), and even many state-specific expansions that include adults, have created new categories of public program eligibility that include some but not all family members.<sup>1</sup> These changes have increased the likelihood that low-income parents and children will have different coverage.<sup>2</sup>

Employer practices and family demographics may also result in fragmentation of coverage for families with private coverage. Employer practices of subsidizing insurance coverage for the employee but passing through the costs of dependent

coverage may make it prohibitive for workers to buy family coverage. As a result of divorce and remarriage in the United States, some children may be covered by a different plan from the parent with whom they live, or they may have coverage while a parent is uninsured.

Understanding the nature and extent of fragmentation of insurance coverage in families is important in evaluating the effects of various public coverage expansions and their interactions with the private insurance market. This brief uses the 1999 National Survey of America's Families (NSAF) to examine patterns of insurance coverage for children and their primary parent (the parent identified as most knowledgeable about the child's health care). Overall, 11 percent, or 7.5 million children, have a primary parent with discordant coverage—either the parent and the child are covered by different types of insurance, the child is insured but the parent is uninsured, or the reverse. The rate of discordant coverage among low-income children is 21.5 percent, affecting 5.6 million children. This rate is almost five times as high as the rate of discordant child-parent coverage for higher-income children (4.5 percent). Much of the difference between low- and higher-income children derives from the high rate of low-income children who have insurance when their parent is uninsured (14.9 percent).

Fragmented child-parent coverage is particularly prevalent among low-income children with public coverage, among whom more than one-third have an

uninsured primary parent and only slightly more than one-half have the same type of coverage as the primary parent. Patterns of parent insurance coverage for low-income publicly insured children vary dramatically across states. For example, in Alabama, only 31 percent of parents of publicly insured children also have publicly sponsored insurance, and 56 percent are uninsured. At the other end of the spectrum, in Massachusetts, 84 percent of publicly insured children have parents with public insurance coverage, and only 11 percent are uninsured. These findings suggest that there is considerable scope not only for improving consistency of coverage within families, particularly for publicly insured children, but also for improving the coverage of low-income children and their parents.

### The NSAF—Data and Methods

The source of data for this study is the 1999 NSAF, a household survey that provides information on more than 100,000 children and nonelderly adults representing the noninstitutionalized civilian population under 65 nationally and in 13 states. It oversamples the low-income population. Detailed information was collected from the adult who knew the most about the education and health care (the primary caregiver) of up to two children in each household (one age 5 or under and one age 6 to 17). The children selected were those for whom the primary caregiver was the parent (biological, adoptive, or stepparent);<sup>3</sup> this person is designated the primary parent.

Current insurance coverage is measured for each member of the family.<sup>4</sup> The current coverage information was used to create a hierarchy of coverage, with private employer-sponsored insurance (ESI) at the top of the hierarchy and being uninsured at the bottom. The coverage types are grouped into private or employer-sponsored (ESI, private nongroup, CHAMPUS) and public (Medicaid, SCHIP, Medicare, other state). For each child, we linked insurance information for the primary parent. We compared the reported insurance coverage for the child with the coverage for the primary parent alone or with the primary parent and spouse.<sup>5</sup>

Comparisons were made to determine whether the child and parent had the same type of coverage (both public or both private), were both uninsured, had mixed coverage (either child or parent uninsured), or had mixed type status (both insured but different types of coverage). The distribution of child-parent coverage was calculated nationally, by income and by child insurance type. The distribution of child-parent coverage for low-income children was also compared with public insurance by state for each of the 13 *Assessing the New Federalism* (ANF) states. Tests of homogeneity were performed to determine whether the distributions of child-parent coverage were significantly different between low- and high-income children, across types of child insurance, and for each state compared with the balance of the nation.

### Patterns of Child and Parent Coverage

The majority of children have the same coverage status as the primary caregiver parent, but many children and parents have discordant insurance plans or types of coverage, and patterns vary dramatically by income and by whether the child has public or private coverage.

#### All Children

As shown in table 1, 11 percent of children (7.5 million) have parents with discordant coverage—the parent has a different type of insurance from the child, the child has insurance but the parent does not, or vice versa. The most common of these scenarios is that a child is covered and the parent is uninsured, which occurs for 7.3 percent of children overall. In addition, 1.7 percent of children are uninsured while the primary parent is covered by insurance. Children whose primary parents are covered by a different type of insurance make up 2.0 percent of all children. Finally, 10.4 percent of child-parent pairs are uninsured.

#### Low-Income Children

The prevalence of discordant coverage is much greater for children in families with incomes below 200 percent of the federal poverty level (FPL) compared with higher-income children. Overall, 21.5 percent of

TABLE 1. Comparison of Child and Primary Parent Insurance Coverage

	All Children (SE)	Low-Income Children (SE)	Higher-Income Children (SE)
<b>Child, primary parent have mixed coverage type or coverage status (percentage)</b>	<b>11.0%</b> (0.3)	<b>21.5%</b> (0.7)	<b>4.5%</b> (0.3)
Child, primary parent are both covered, have different types of insurance	2.0% (0.1)	3.9% (0.3)	0.9% (0.1)
Child is covered, primary parent is uninsured	7.3% (0.3)	14.9% (0.6)	2.6% (0.2)
Child is uninsured, primary parent is covered	1.7% (0.1)	2.8% (0.3)	1.0% (0.1)
<b>Child, primary parent have same type of insurance (percentage)</b>	<b>78.6%</b> (0.5)	<b>58.8%</b> (1.0)	<b>90.8%</b> (0.3)
<b>Child and primary parent are uninsured (percentage)</b>	<b>10.4%</b> (0.5)	<b>19.7%</b> (1.0)	<b>4.7%</b> (0.3)
<b>Number of children (millions)</b>	68.2	26.1	42.1
<b>Percentage of all children living with parent</b>	100.0%	38.3% (0.5)	61.7% (0.5)

Source: Urban Institute tabulations from the 1999 National Survey of America's Families.

Notes: SE = standard error. Low-income children have family income under 200 percent of the federal poverty level. Distributions of child and parent coverage are significantly different for higher-income relative to low-income children,  $p < 0.001$ . Children who did not live with a parent were excluded from the analysis. The excluded children are disproportionately low-income; thus the analysis sample understates the proportion of low-income children in the general population.

low-income children (5.6 million) have a primary parent with discordant coverage. Moreover, 14.9 percent of low-income children have insurance coverage and an uninsured primary parent. The primary parent has a different type of insurance coverage for 3.9 percent of low-income children. Relatively few low-income children (2.8 percent) are uninsured themselves but have a primary parent with insurance coverage.<sup>6</sup> Almost one-fifth (19.7 percent) of low-income children are uninsured along with their parents, a rate that is more than four times that of higher-income children. Fewer than 60 percent of low-income children have a primary parent who is covered by the same type of insurance plan or program.

### Publicly Insured Children

Table 2 shows the distribution of child-parent coverage for low-income children, stratified by whether the child has public or private insurance coverage, or is uninsured. Among low-income children with public coverage, more than a third (36.5 percent) have a primary parent who is uninsured. This pattern is consistent with the fact that many of these children are covered by Medicaid or SCHIP programs in which eligibility had not yet been extended to their parents.<sup>7</sup>

Some families opt for employer-sponsored insurance or buy nongroup cov-

erage for the parents and enroll their children in public programs. This situation is most likely to be reported when ESI with dependent coverage is not offered or is unaffordable to parents and when only children are eligible for the public coverage.<sup>8</sup> This type of mixed coverage was reported for 8.1 percent of all children with public coverage, with the vast majority of these primary parents (7.8 percent) having ESI (data not shown). This group is of policy interest because, under certain circumstances, public funds can be used to help workers buy family ESI coverage instead of covering children separately under a public program.

Comparison of coverage patterns for low-income publicly insured children in two-parent versus single-parent families (data not shown) reveals that the primary parent in a two-parent family is more than twice as likely to be uninsured (50 percent) as in a single-parent family (24.7 percent). Conversely, single low-income parents with a publicly insured child are much more likely than married parents to have the same coverage as their child (65.2 percent for single versus 38.9 percent for two-parent families). These different patterns likely reflect differences in Medicaid eligibility rules for single-parent and two-parent families associated with work history (e.g., the 100-hour rule) and the fact that two-parent families are likely to have

TABLE 2. Comparison of Child and Parent Insurance Coverage for Low-Income Children

	Children	SE
<b>Low-Income Children with Public Insurance</b>		
Primary parent has public coverage (percentage)	55.4%	1.5
Primary parent is uninsured (percentage)	36.5%	1.8
Primary parent has private insurance (percentage)	8.1%	1.0
Number of children (millions)	8.9	0.3
Percentage of all children with public coverage	86.5%	17.9
<b>Low-Income Children with Private Insurance</b>		
Primary parent has private insurance (percentage)	92.0%	6.0
Primary parent is uninsured (percentage)	5.5%	6.0
Primary parent has public insurance (percentage)	2.5%	0.3
Number of children (millions)	11.3	0.8
Percentage of all children with private coverage	22.8%	4.1
<b>Low-Income Uninsured Children</b>		
Primary parent is uninsured (percentage)	87.7%	5.6
Primary parent has private insurance (percentage)	8.3%	8.7
Primary parent has public insurance (percentage)	4.0%	3.3
Number of children (millions)	5.8	4.0
Percentage of all uninsured children	71.1%	3.9

Source: Urban Institute tabulations from the 1999 National Survey of America's Families.

Notes: SE = standard error. The distribution of child and parent coverage is significantly different for low-income children with private coverage and the uninsured relative to those with public coverage.

higher incomes than single-parent families, reducing their chances of meeting Medicaid eligibility thresholds.

### **Low-Income Publicly Insured Children—Variation across States**

As shown in figure 1, states vary dramatically in their patterns of parent insurance coverage for low-income publicly insured children. Cross-state differences in coverage among the parents of publicly insured children appear to be closely related to the gaps in eligibility thresholds for children and their parents. States such as Texas, Alabama, Colorado, and Mississippi, which have low-income eligibility thresholds for family coverage through Medicaid, have the largest proportions of children with uninsured parents.<sup>9</sup> For example, 57.0 percent of publicly insured children in Texas have an uninsured primary parent, while only 39.5 percent of children have a parent with public coverage. At the other end of the spectrum, states such as Massachusetts and Minnesota, which implemented moderate-to large-scale expansions of eligibility for adults, have relatively few publicly insured children with uninsured parents. Only 10.8 percent of publicly insured chil-

dren in Massachusetts have an uninsured primary parent, while 84.3 percent have a parent with public coverage.<sup>10</sup> The proportion of publicly insured children with parents who are privately insured also varies by state, although the degree of variation is much more limited.

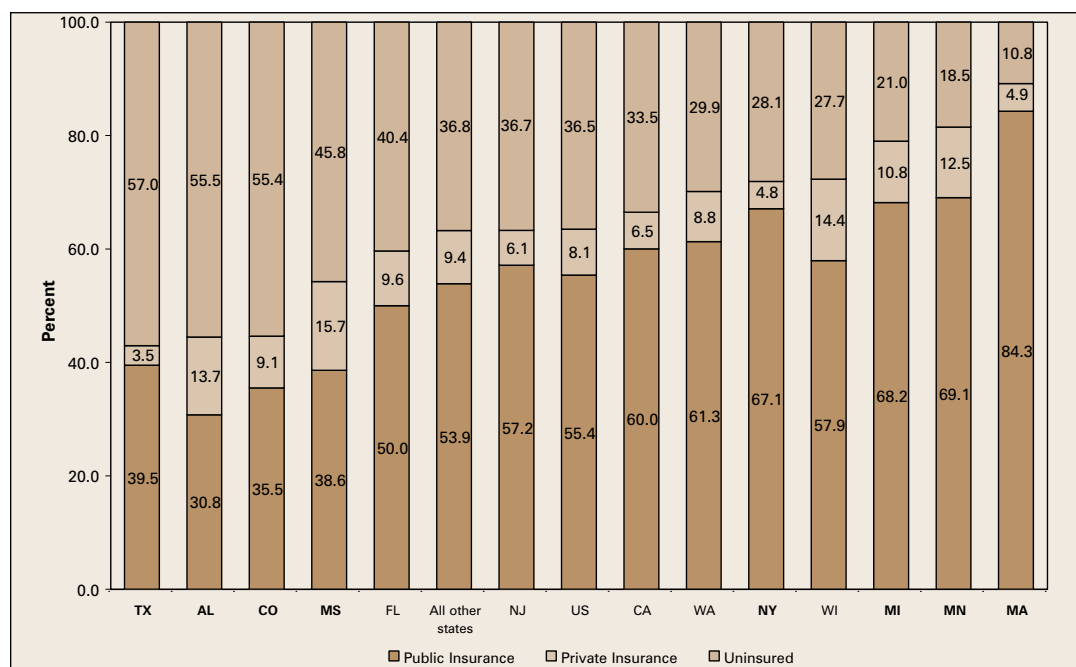
### **Privately Insured Children**

In contrast to publicly insured children, those with private coverage are likely to have the same coverage as the primary parent. This is true for 92.0 percent of low-income children (table 2). An additional 5.5 percent have private coverage, but the parent is uninsured; 2.5 percent of low-income children with private coverage have a primary parent with public coverage. Higher-income children with private insurance (data not shown) are even less likely to have a primary parent who is uninsured or has public coverage and are more likely to have a primary parent with the same type of coverage (98.3 percent).

### **Uninsured Children**

Most of the low-income children who are uninsured have uninsured parents (87.7 percent) (table 2). A small proportion (8.3 percent) of uninsured children have par-

FIGURE 1. *Distribution of Primary Parent Insurance Coverage for Low-Income Children with Public Insurance, by State, Balance of Nation*



Source: Urban Institute tabulations from the 1999 National Survey of America's Families.

Note: State names in bold indicate that the distribution of child-parent coverage is significantly different relative to the balance of the nation.

ents with private coverage, while 4.0 percent of these children have a parent with some form of public coverage. Uninsured children who have a privately insured parent are of policy interest because of the potential role of public support for employment-related family coverage.

### Policy Implications: Opportunities to Expand and Simplify Coverage

Differences in type of coverage between children and their parents introduce complexity in the lives of families already stressed by factors in the home environment, the workplace, and school. This study reveals that a large proportion of low-income children are insured while their primary parent is uninsured, and fewer than 60 percent have a primary parent who is covered by the same type of insurance plan or program.

Of particular concern is that 36.5 percent of low-income children with public coverage have a primary parent who is uninsured. To the extent that being covered under the same insurance plan or program enhances the ability of parents to gain access to health care on behalf of their child, low-income publicly insured children may be at a real disadvantage relative

to higher-income or privately insured children (Hanson 1998). Providing both child and parent with Medicaid or SCHIP coverage may enhance the efficiency with which these programs provide care to children. Furthermore, perceived difficulty in enrolling in the program and getting care for a child may further discourage parents who are not themselves eligible from enrolling their Medicaid-eligible child (Dubay and Kenney, forthcoming). Analysis of child-parent coverage patterns across states reveals that low-income publicly insured children in states such as Texas, Alabama, Colorado, and Mississippi may be particularly disadvantaged in these respects.

In the current policy environment, states have unprecedented flexibility to use federal subsidies to expand public insurance coverage to low-income parents (Holahan and Krebs-Carter 2000). Some states have established more generous income disregards and eliminated work history rules for two-parent families under Section 1931. A strength of this approach is that not only are more parents made eligible for coverage, but the coverage is identical for the child and the parents. Other states have used or have proposed



Medicaid Section 1115 or SCHIP waivers to expand coverage to parents and other adults at even higher levels of income. However, among the states analyzed for this study, those with the greatest rates of discordant child-parent coverage have not begun to actively pursue broad public coverage expansions for parents.<sup>11</sup>

Even among states that have proposed or implemented expansions in eligibility for adults, there is room for enhanced coordination within families. Some state programs provide the same coverage to both children and adults within a family up to a certain income level. However, many states have expanded coverage for children at higher income levels, leaving a residual gap between child and adult eligibility. Other states provide children and adults with coverage through different programs. Although providing coverage to the adults is a major improvement over leaving them uninsured, it does not reduce the complexity of maneuvering through multiple insurance plans within a family.

Families in which the parents have ESI and the children have public coverage represent an opportunity to unify coverage for the family through an ESI subsidy under Medicaid or SCHIP. The ESI buy-in approach could also be useful in extending ESI coverage to uninsured low-income children whose parents have ESI or have offers of ESI. For children on Medicaid, states may subsidize purchase of family ESI coverage if it is more cost-effective than providing full Medicaid coverage to the children in a family. This option is available, but it is used infrequently by the states because of the restrictive nature of the cost-effectiveness requirement and the complexities of providing wraparound coverage. Similar extensions are available through the SCHIP program, but the requirements for cost-effectiveness are more stringent (Tollen 1999).

As states continue to extend coverage to adults at higher income levels, states may want to design programs that unify coverage within families. For families where the child is covered by a public program but one or both of the parents are uninsured, limiting coverage to children represents a failed opportunity to cover an important segment of the population.

Expansions to parents that use different mechanisms or are keyed to different income levels likely cause confusion among eligible persons, though, and create added burdens within families.

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## Notes

1. The Omnibus Budget Reconciliation Act (OBRA) expansions to the Medicaid program require states to cover pregnant women and children up to age 6 at 133 percent of the federal poverty level (FPL), and children born after October 1, 1983, at 100 percent of FPL. Later legislation allowed states to cover children and pregnant women at even higher income levels under Section 1902(r)(2) of the Social Security Act. The SCHIP program allows states to cover children at even higher income levels with a higher federal match, and allows states to provide insurance through separate non-Medicaid programs.
2. Before the enactment of OBRA in 1986, public insurance coverage was available through the Medicaid program primarily to very low-income children and their single parents. States permitted coverage of two-parent families through the Aid to Families with Dependent Children-Unemployed Parents (AFDC-UP) program if the primary earner was unemployed or one parent was disabled. The small Ribicoff Program provided Medicaid coverage to children in families that met the income but not the family structure and employment requirements of the AFDC and AFDC-UP programs.
3. The analysis sample excludes 1,726 children (4.8 percent) because the person most knowledgeable about their health care is not the child's parent.
4. Data are collected on coverage through private employer-sponsored and nongroup plans, and through public programs including Medicaid,

SCHIP, other state programs, Medicare, and programs such as CHAMPUS. For private plans, information is collected on the policyholder for the plan.

5. Insurance coverage for the child there is compared with coverage for parents because the parents are responsible for making decisions about a child's coverage and use of health care.

Comparisons of coverage across siblings within a family would add information on the complexity faced by parents. Because of limitations on data collection, this brief focuses only on the sampled child(ren) in the family. A hierarchy of insurance coverage is used to simplify the comparisons, but the result of using the hierarchy is a slight understatement of the degree of concordance between children and parents. For example, if a child has both private coverage and Medicaid, that child would be assigned to the private group, because the private coverage is the primary coverage. If the primary parent has Medicaid, the child and the primary parent would not be identified as having the same coverage. This specific situation arose in fewer than 100 cases.

6. The focus on comparing insurance coverage for the child and primary parent tends to understate the complexity of coverage in two-parent families. For example, 15.0 percent of low-income children in two-parent families are insured, while the primary parent is uninsured. But 19.5 percent of children in two-parent families have at least one parent who is uninsured. On the other hand, about half of low-income children (51.3 percent) are covered by the same insurance as both of their parents, which is somewhat fewer than the 56.1 percent of low-income children in two-parent families who are covered by the same insurance as the primary parent. Furthermore, 59.6 percent of children in two-parent families have at least one parent covered by the same insurance plan. Any overlap in coverage for the child and the secondary parent may provide some benefit to the child with respect to health care access, relative to the situation where neither parent is covered by the same plan.

7. Publicly insured children with ineligible immigrant parents likely contribute to this scenario.

8. In fact, it is possible that the parent is enrolled in both Medicaid and private coverage, but the hierarchy of insurance coverage used in this study masks this situation in a small number of cases.

9. Among the ANF states, the effective income threshold (after disregards) for Section 1931 family coverage for an applicant family of three in 1999 ranged from 22 percent of FPL in Alabama to 133 percent of FPL in Massachusetts. The source is the authors' calculation based on data from "States' Implementation of Selected Medicaid Provisions of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996," by the State Policy Documentation Project ([www.spdp.org](http://www.spdp.org)).

10. Washington state also offers the Basic Health Plan at minimal cost for families with incomes

below 200 percent of FPL. However, the premium requirements may discourage participation by parents of Medicaid-eligible children, resulting in higher levels of fragmented parent-child coverage.

11. New Jersey, which had a moderately high rate of discordant parent-child coverage (42.8 percent), had an effective income threshold for Section 1931 of 46 percent of FPL in 1999. Since that time New Jersey has extended eligibility so that parents with family incomes up to 200 percent of FPL are eligible for Medicaid. California also expanded eligibility for coverage to 100 percent of FPL during this period, but it started from a higher base. Additional expansions have been proposed but are not yet approved.

## About the Authors



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This series presents findings from the 1997 and 1999 rounds of the National Survey of America's Families (NSAF). Information on more than 100,000 people was gathered in each round from more than 42,000 households with and without telephones that are representative of the nation as a whole and of 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on the NSAF can be obtained at <http://newfederalism.urban.org>.

The NSAF is part of ***Assessing the New Federalism***, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

This brief is part of a comprehensive evaluation of the State Children's Health Insurance Program primarily funded by the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation as part of the Urban Institute's ***Assessing the New Federalism*** project. Additional financial support came from The Annie E. Casey Foundation, the W.K. Kellogg Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, The McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, The Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.

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