

Coverage Patterns among SCHIP-Eligible Children and Their Parents

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The State Children's Health Insurance Program, or SCHIP, is slated for reauthorization in 2007. At stake is the level of federal funding that will be available to support the program and whether the federal funding level and allocation across states will allow states to maintain their current programs, let alone expand to cover more uninsured children who are eligible for coverage but not yet enrolled. If SCHIP is funded at the baseline level used in Congressional Budget Office (CBO) projections, there will be a shortfall in SCHIP funding between \$12.7 and \$14.6 billion over the next five years (Broaddus and Park 2006; Peterson 2006). In addition, the Centers for Medicare and Medicaid Services project that if the program is funded at the baseline level in CBO projections, enrollment in the program will decline by over a million children.

SCHIP was enacted in 1997 to expand health insurance coverage to low-income uninsured children. Under SCHIP, states could use enhanced federal matching dollars to expand public coverage for children beyond Medicaid eligibility levels. Because of concerns that SCHIP would substitute for—or crowd out—private coverage, the SCHIP statute precluded states from covering children enrolled in employer coverage and required that states implement mechanisms to prevent SCHIP from substituting for employer coverage.¹ SCHIP led to coverage expansions in all states and sparked new investments in outreach and enrollment simplification aimed at increasing participation rates for children in both Medicaid and SCHIP. Since SCHIP was enacted, uninsurance rates have fallen among children, particularly low-income children, but progress appears to have stalled in recent years (Kenney and Yee forthcoming).

This brief addresses three important issues that merit attention as SCHIP faces reauthorization. The first issue is how many children remain uninsured despite being eligible for coverage under SCHIP. It appears that public programs are not reaching all the uninsured children eligible for coverage (Dubay, Holahan, and Cook 2006; Summer and Mann 2006) and that participation rates vary across different subgroups of children (Dubay, Kenney, and Haley 2002). According to one estimate from 2002, close to 3 million children were uninsured despite being eligible for SCHIP coverage (Selden, Hudson, and Banthin 2004). Understanding how many uninsured children remain eligible for SCHIP is important as it affects the amount of federal funding required to fully fund SCHIP programs to maintain current enrollment and to cover all the remaining uninsured children who qualify for the program.

The second issue is how many SCHIP enrollees have access to employer-sponsored coverage through their parents.² Understanding the extent to which SCHIP enrollees have access

¹ Almost all states with separate non-Medicaid SCHIP programs impose waiting periods before children who have had employer-sponsored coverage can enroll in SCHIP, making exceptions in cases where the coverage was lost owing to circumstances outside the family's control (Cohen Ross, Cox, and Marks 2007; Lutzky and Hill 2001).

² Recently, lawmakers in a number of states have introduced legislation aimed at reducing the number of children covered by public health insurance programs whose parents work for large, prominent employers. However, a federal judge struck down a law passed in Maryland in July 2006 targeted at employers with more than 10,000 workers.

to employer-sponsored coverage is important because it will shape what happens to the children who would lose SCHIP coverage in the event of funding shortfalls. In addition, we use information on access to employer-sponsored coverage among SCHIP enrollees to assess whether SCHIP may be substituting for employer coverage nationally, building on several state-specific studies (Allison et al. 2003; Sommers, Zuckerman, and Dubay 2005).³ These studies have found that most SCHIP enrollees do not have access to employer-sponsored insurance, but this statistic appears to vary from state to state.

The third issue is how many SCHIP enrollees have uninsured parents. There is growing evidence that the uninsurance problems experienced by parents can have adverse spillover effects on their children (Ku and Broaddus 2006). Understanding how often SCHIP enrollees have uninsured parents is important, since lack of coverage may affect not only the health and well-being of parents, but that of their children as well.

This brief uses the 2005 Current Population Survey (CPS) to examine national patterns of coverage for children who meet the income requirements for SCHIP coverage (a complete description of the data and methods used in this analysis is contained in the appendix). The analysis simulates eligibility for both SCHIP and Medicaid, taking into account the eligibility rules in each state and using the information available on the CPS related to the child's age, household structure, and family income. We examine the insurance coverage distribution of children who meet the income eligibility requirements for SCHIP, assessing how many remain uninsured and variation in participation rates. We also assess whether the parents of SCHIP enrollees have employer-coverage or whether they lack health insurance coverage. This analysis focuses on SCHIP, although selected estimates are also presented for Medicaid because it is such an important source of insurance coverage, particularly for low-income children.

This brief has three important implications for SCHIP as it faces reauthorization. First, federal funding will have to be increased substantially if the allotments are to include coverage for the close to 2 million uninsured children who are eligible for SCHIP but not yet enrolled. Second, many children stand to lose coverage altogether if federal funds are inadequate to meet existing program need. Finally, addressing the insurance coverage needs of low-income parents through SCHIP would likely improve the lives of both low-income children and their parents but would require a substantial expansion in the federal funding commitment to the program. The following sections present the key findings and discuss the policy implications.

³ A number of other studies have attempted to examine the extent to which SCHIP is substituting for employer coverage, producing very different estimates. State-specific studies have found that very few children who enroll in SCHIP had employer-sponsored coverage before they enrolled in the program (Hughes, Angeles, and Stilling 2002; Shenkman, Steingraber, and Bono 2002; Sommers et al. forthcoming). For example, estimates available from a congressionally mandated study indicate that only 28 percent of children newly enrolling in SCHIP in 10 states had had employer-sponsored coverage in the preceding six months and that only half of them, or 14 percent overall, could have retained that coverage. The econometric studies that have attempted to address this issue nationally have found substitution estimates that range from 10 to 70 percent (Cunningham, Hadley, and Reschovsky 2002; Davidoff, Kenney, and Dubay 2005; Davidson, Blewett, and Call 2004; Hudson, Selden, and Banthin 2005; Lo Sasso and Buchmueller 2004). It is unclear why the crowd-out estimates from the econometric studies vary so much, although these studies have used different data sets and different approaches to control for other possibly confounding changes occurring over the same period as the SCHIP expansions.

Findings

Insurance Coverage among SCHIP-Eligible Children. Figure 1 shows the insurance distribution of children who meet the income eligibility requirements for SCHIP.⁴ Among the 13.3 million children who appear eligible for SCHIP, 29 percent, or about 3.9 million children, have SCHIP coverage; 50 percent, or 6.6 million, have employer-sponsored coverage; and 15 percent, or nearly 2.0 million, are uninsured. The remaining SCHIP-eligible children have some other type of public coverage or private nongroup coverage (6 percent).

As indicated above, about 3.9 million SCHIP-eligible children appear to rely on SCHIP for coverage, based on our analysis. The 3.9 million figure is very close to the number of children reported to have been enrolled in SCHIP at this time, based on administrative data (Smith and Rousseau 2005). The estimated number of children relying on Medicaid is close to four times higher than the number estimated to rely on SCHIP for coverage (data not shown).⁵ Among income-eligible children, it appears that those in lower-income families and those in fair or poor health are more likely to have SCHIP coverage than other children (table 1). For example, SCHIP is a key coverage source for eligible children in fair or poor health; almost half (49.3 percent) of these children have public coverage, compared with just over a quarter (27.5 percent) of those reported to be in excellent or very good health. These patterns are similar to ones found among Medicaid-eligible children (data not shown).

It appears that employer-sponsored insurance (ESI) covers half the children in the SCHIP-income eligible group. In contrast, ESI covers less than 20 percent of the children in the Medicaid-eligible income group (data not shown). Employer-sponsored coverage is most prevalent among potentially SCHIP-eligible children in families with higher incomes, children who are citizens, and those whose parents work for large firms (table 1). For example, 60 percent of income-eligible children who have at least one parent working for a large firm (with more than 500 workers) have ESI, compared with 29 percent of children whose parents work in small firms (with fewer than 10 employees).

The nearly 2.0 million uninsured children who appear eligible for SCHIP constitute over a fifth of the estimated total number of children who are uninsured.⁶ However, 18.7 percent of uninsured children who meet the income requirements for SCHIP are noncitizens, some of whom might not qualify for SCHIP coverage because of their immigration status (data not shown). Recent estimates suggest that over 30 percent of all uninsured noncitizen children are documented legal aliens, which would allow them to qualify for coverage under SCHIP provided they met the other eligibility requirements.⁷ If that statistic applies here, nearly 70 percent of all

⁴ SCHIP-eligible children are defined as those who meet the income and related financial requirements for coverage.

⁵ Administrative data also indicate that Medicaid covers many more children than SCHIP (Kaiser Commission on Medicaid and the Uninsured 2006a). A number of children who are classified as having public coverage on the CPS do not appear to meet the eligibility requirements for either program. These children are not included in this analysis since it was not possible to classify them as eligible for Medicaid or SCHIP.

⁶ Urban Institute tabulations of the 2006 Annual Social and Economic Supplement to the Current Population Survey. Unlike Dubay and colleagues (2006), which adjusts the uninsured estimate to take into account potential underreporting of public coverage among uninsured children, we do not adjust the coverage estimates for SCHIP-eligible children.

⁷ Urban Institute tabulations of data from the 2005 CPS with imputations for legal status. The methodology used to determine legal status was developed by Passel and Clark (1998) and updated in subsequent years.

uninsured noncitizen children could not qualify for SCHIP. This would imply that 1.8 million children are uninsured despite being eligible for SCHIP, constituting around a fifth of all uninsured children.

Therefore, even after adjusting for the fact that some noncitizen children who meet the income criteria for SCHIP may not qualify due to restrictions that limit eligibility to certain immigrant groups, it appears that close to 2 million children—or about one in every five uninsured children—are eligible for SCHIP but remain uninsured. This compares with an estimated close to 4 million children who appear eligible for Medicaid coverage but remain uninsured (data not shown).

Uninsured rates among SCHIP-eligible children appear to vary with the characteristics of the children and their families. For example, SCHIP-eligible children age 6 to 18 are about 5 percentage points more likely than children under age 6 to be uninsured. In addition, about one in four SCHIP-eligible children are uninsured in families with only self-employed workers or with workers who work for firms with fewer than 10 employees, compared with about one in ten in families with a worker in a large firm.

SCHIP Participation Rates. SCHIP appears to be reaching around two-thirds to 69 percent of its target population (table 2), which is somewhat less than the participation rate found for Medicaid (data not shown).⁸ Consistent with past research, SCHIP/Medicaid participation rates are defined as the number of SCHIP/Medicaid-eligible children with SCHIP/Medicaid coverage divided by the sum of the number of eligible children with SCHIP/Medicaid coverage and the number of eligible children who remain uninsured (Selden et al. 2004; Dubay, Haley, and Kenney 2002). Because we do not take into account the possible underreporting of public coverage in determining participation for these programs, participation rates may be higher than estimated here. SCHIP participation rates appear higher for children in fair or poor health and for those who are under age 6, which is consistent with findings from prior studies (Dubay, Kenney, et al. 2002). For example, 80 percent of eligible children reportedly in fair or poor health participate in SCHIP, compared with 65 percent of children in excellent, very good, or good health. Almost three-quarters (73 percent) of eligible children under the age of 6 participate in SCHIP, compared with 64 percent for children between the ages of 6 and 18. Participation is highest among blacks compared with whites, Hispanics, and other racial and ethnic groups. Hispanic children appear to have significantly lower rates of participation (60 percent) than whites, blacks, and other races and ethnicities. However, among citizen children, participation rates for Hispanics and whites are the same (67 percent), both of which appear lower than participation rates for black citizen children. After adjusting for immigration status among noncitizens, participation rates among eligible noncitizen children do not appear significantly different from the rates found for citizen children.⁹

⁸ The lower bound assumes that all uninsured noncitizen children who meet the other eligibility requirements for SCHIP could qualify for SCHIP coverage, while the upper bound assumes that only some noncitizen children in that category could qualify for SCHIP coverage.

⁹ Urban Institute tabulations of data from the 2005 CPS with adjustments for immigration status based on 2004 CPS data and methodology developed by Passel and Clark (1998) at the Urban Institute and updated in subsequent years. We assumed that noncitizen children currently enrolled in SCHIP meet all the eligibility requirements for coverage.

Among eligible children in working families, participation rates appear highest for those in families with one or more workers employed in a very large firm (500 or more employees) and in firms with 100 to 499 employees, at 72 and 69 percent, respectively.¹⁰ Participation rates appear significantly lower for children in families with small-firm workers or self-employed workers at 59 and 50 percent, respectively.

Coverage Status of SCHIP Enrollees' Parents. We look at the coverage status of the parents of SCHIP enrollees to gain insights into their access to employer-sponsored coverage.¹¹ One-third (1.3 million) of children enrolled in SCHIP live in families where one or both parents have job-based coverage, and one-quarter (1.0 million) live in families where all parents have employer-sponsored coverage (figure 2). This implies that two-thirds of SCHIP enrollees live in families where there is no ESI coverage for either parent and that three-quarters live in families in which at least one parent is not covered by ESI. Thus, most SCHIP enrollees could not be enrolled in an employer plan because their parents do not have employer coverage. Not surprisingly, given their lower incomes, ESI coverage is even more rare among Medicaid-covered children, where only about 10 percent (1.4 million) and 7 percent (1.0 million) of children enrolled in Medicaid have one or both parents enrolled in job-based coverage, or all parents in job-based coverage, respectively (data not shown).

In addition, many SCHIP enrollees have uninsured parents, which may have adverse affects on health for the families. It appears that 38 percent of SCHIP enrollees (1.5 million) have at least one parent who lacks insurance coverage and that very few (4 percent) have parents (136,000) who are eligible for public coverage (figure 3). Most SCHIP enrollees with uninsured parent(s) are from working families, and one-quarter are from families with two full-time workers (data not shown). Thus, almost four in every ten SCHIP enrollees is living with at least one uninsured parent. Moreover, close to 4 million children enrolled in Medicaid have one or more uninsured parents (data not shown).

Discussion

Following the implementation of eligibility expansions under SCHIP and the significant investments in outreach and enrollment simplification under both Medicaid and SCHIP, uninsurance rates have fallen for low-income children (Dubay and Kenney 2004; Dubay, Hill, and Kenney 2002; Kenney, Haley, and Tebay 2003; Schiller, Martinez, and Barnes 2006; Vistnes and Rhoades 2006). Coverage gains have slowed, however, and the most recent CPS even indicated that uninsurance may be on the rise for children (Holahan and Cook 2006). This analysis indicates that increasing participation in SCHIP to 100 percent among eligible children who remain uninsured could bring down the number of uninsured children by close to 2 million. This would raise the number of children covered under SCHIP by about 45 percent, which means that SCHIP allocations would need to increase substantially in order to cover all children who are eligible but uninsured. And even more federal resources would be required if the number of

¹⁰ Overall, 38.9 percent of SCHIP *enrollees* live in families in which at least one parent works for a firm with over 500 employees, while 43.9 percent of all SCHIP-*eligible* children live in families where at least one parent works for a firm with over 500 employees.

¹¹ Approximately 6 percent of children do not reside with their parents (i.e., foster children, children living with other family members, or children living on their own). We consider these children to be in their own health insurance unit because many are eligible for Medicaid/SCHIP due to the fact that they lack parental support.

SCHIP-eligible children were to increase, owing to a downturn in the economy or a further erosion of employer coverage.

All together, it appears that Medicaid and SCHIP could cover over two-thirds of all children who are uninsured (Dubay et al. 2006). Since about twice as many uninsured children appear to be eligible for Medicaid as are eligible for SCHIP, achieving further increases in participation hinges on undertaking additional effective enrollment, retention, and outreach efforts not just in SCHIP, but in Medicaid as well. Such efforts are likely to pay off since the majority of low-income parents say they would enroll their uninsured child in Medicaid or SCHIP if they knew that their child was eligible for coverage (Kenney et al. 2003, 2004). However, many parents do not know that their child could qualify for Medicaid or SCHIP coverage, are not aware of the programs, or do not think that the application processes are easy (Kenney et al. 2004; Haley and Kenney 2007).

While many steps have been taken to simplify the application process, new federal requirements in Medicaid regarding proof of citizenship and identity, implemented as part of the 2004 Deficit Reduction Act, have added to the complexity of the application process, which could deter or delay enrollment (Ku and Broaddus 2006). Early reports from some states that have implemented these documentation requirements indicate that they have been associated with Medicaid enrollment declines (Cohen Ross et al. 2007).

In addition, the use of automatic or default enrollment strategies that build off other means-tested programs like the National School Lunch Program, which have proven successful in other areas, would be much more effective if several federal policy changes were made (Dorn and Kenney 2006). These include giving states the option to grant eligibility for Medicaid and SCHIP based on the final income determinations of other means-tested programs, disregarding differences between the income methodologies used by health and nonhealth programs (e.g., definition of household, income disregards, and so on), and providing enhanced federal matching funds to states for investments in information technology (IT). Investments in IT would allow states to link Medicaid and SCHIP eligibility/enrollment data to school lunch enrollment data and other databases (such as the National New Hires Data Base), which would facilitate automatic enrollment strategies. Currently, under most circumstances, states fund upgrades to their enrollment and retention databases with the standard federal matching rate for ordinary administrative costs.

This study finds that most SCHIP enrollees do not have access to employer-sponsored insurance through their parents. This implies that declines in SCHIP enrollment that result from funding shortfalls will translate into higher uninsurance among children, since so few SCHIP enrollees have access to affordable private coverage. Our analysis suggests that 33 percent of all SCHIP enrollees in the nation live in families where at least one parent has employer-sponsored coverage. This national estimate is consistent with analysis done for 10 states as a part of congressionally mandated SCHIP evaluation, which found that 39 percent of all SCHIP enrollees in these 10 states had at least one parent with ESI (Sommers et al. 2005).

In addition, our analysis indicates that just 25 percent of all SCHIP enrollees live in families where one parent (in single-parent families) or both parents (in two-parent families) have employer coverage and that the rest have at least one parent who does not have ESI. The 25

percent figure is likely an upper bound on how often SCHIP is substituting for employer coverage since it does not indicate the availability or affordability of dependent coverage for these families. Indeed, this estimate is higher than state-specific estimates that show very few children who enroll in SCHIP reportedly had ESI in the six months before enrolling (Sommers et al. forthcoming). While there was concern from the outset that SCHIP would substitute for employer-coverage, this 25 percent estimate is below the 40 percent crowd-out level the Congressional Budget Office assumed in its baseline projections for SCHIP in 1997.

While most SCHIP enrollees do not have the option of ESI coverage, for the 25 percent of the caseload with potential access to ESI, it may be less costly for states to buy the children into their parent's employer-sponsored insurance policy than to cover the children directly under SCHIP. To date, however, premium assistance programs have not achieved high enrollment levels, with a few notable exceptions (Hill and Lutzky 2003; Shirk and Ryan 2006). Further, as indicated in table 1, about half of all children who are eligible for SCHIP have employer-sponsored coverage, so large-scale premium assistance programs could place states at risk for financing care for the millions of SCHIP-eligible children who now have ESI. Those additional costs could exceed the savings from enrolling current SCHIP recipients into available coverage.

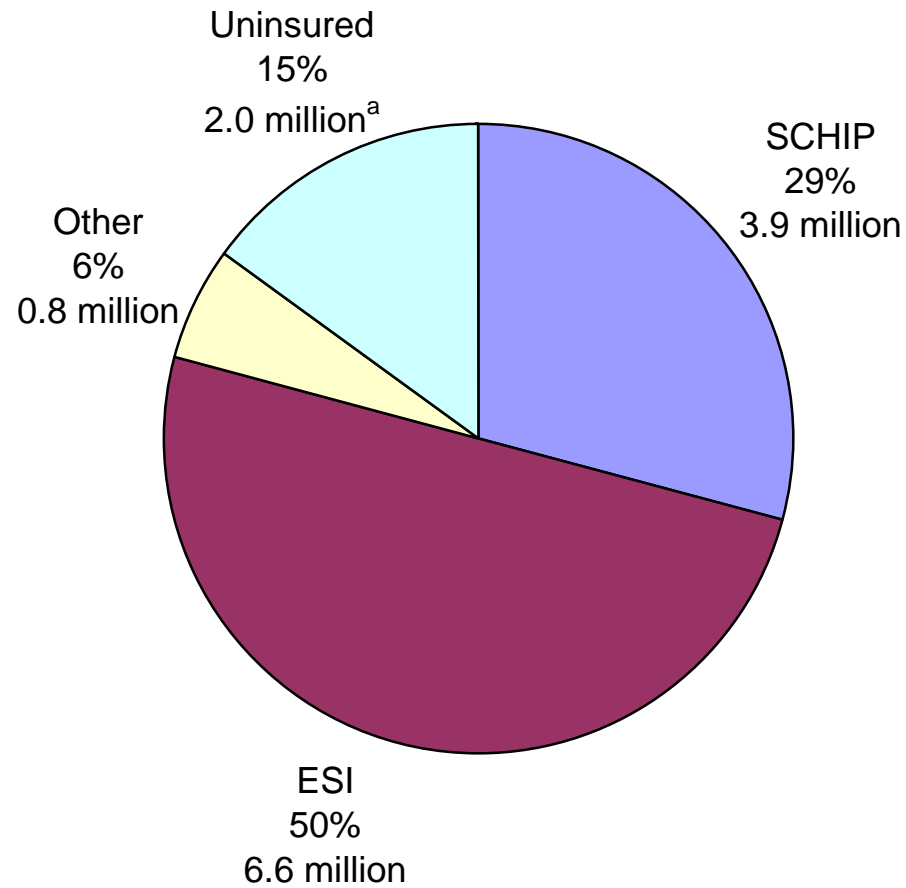
Premium assistance programs represent one approach that taps both private and public funds for coverage. Another approach involves the provision of wraparound services to children who meet the eligibility requirements for SCHIP but retain private coverage. Coverage of wraparound services is permitted in Medicaid but is prohibited under the existing SCHIP statute. While allowing wraparound services under SCHIP could ultimately raise program costs, it would alleviate the underinsurance problems (e.g., the absence of dental benefits) facing some low-income families with private coverage and reduce inequities in the provision of public subsidies for health insurance coverage (Blumberg 2003; Kenney, McFeeters, and Yee 2006).

According to this analysis, nearly four in ten SCHIP enrollees are living with a parent who is uninsured. An even larger number of SCHIP-eligible unenrolled children have uninsured parents, as most of the close to 2 million SCHIP-eligible children who are uninsured also have uninsured parents (data not shown). Currently, most states have much higher eligibility thresholds for children than for working parents—the median eligibility threshold for working parents is 65 percent of the federal poverty level (FPL) compared with 200 percent of FPL for children (Cohen Ross et al. 2007). All together, over 11 million parents appear to lack health insurance coverage, of whom just over a quarter (27.7 percent) appear eligible for coverage under Medicaid or SCHIP (data not shown).

Recent estimates indicate that nearly 37 percent of low-income parents lack health insurance coverage (Kaiser Commission 2006b). When parents lack health insurance coverage, they are more likely to experience unmet health needs, which in turn can adversely affect their children (Ku and Broaddus 2006). For example, children whose parents experience mental health problems are more likely to report difficulties accessing medical care and are less likely to receive needed care (Fairbrother et al. 2005; Kenney et al. 2006; Olfson et al. 2003). It also appears that offering coverage to parents at higher rates raises participation and retention rates among children and increases the likelihood that a child's health care needs are met (Aizer and Grogger 2003; Davidoff, Kenney, and Yemane 2003; Dubay and Kenney 2003; B. Sommers 2006). But without greater federal subsidies for covering low-income parents, it is unlikely that

the insurance picture will improve for them since the already limited access to ESI among low-income families is expected to further erode in the coming years (Gilmer and Kronick 2005).

Figure 1. Insurance Coverage among Children Who Qualify for SCHIP Based on Income

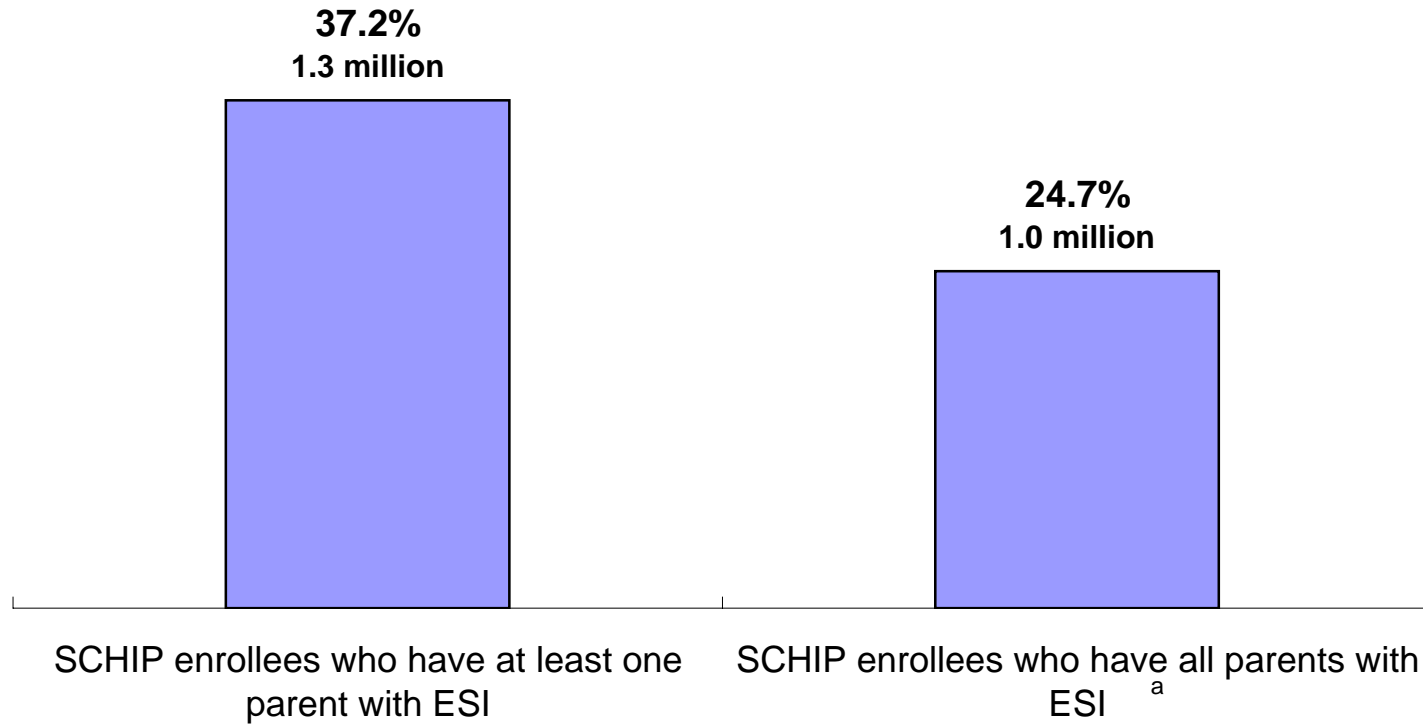


Source: Urban Institute tabulations of the 2005 Annual Social and Economic Supplement to the Current Population Survey.

ESI: Employer sponsored insurance

^a Of these 2 million uninsured children, 1.8 million also appear to meet the immigration requirements for eligibility.

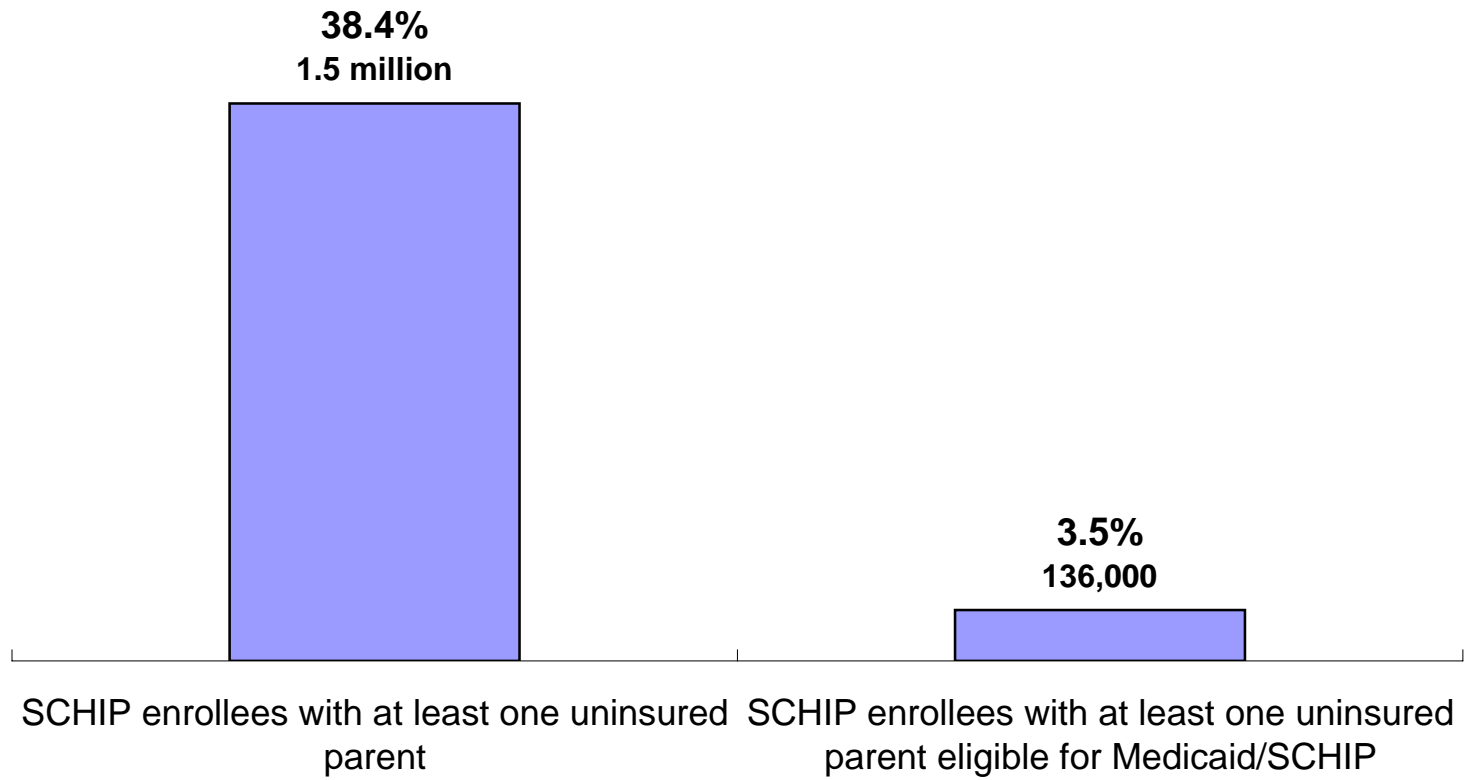
Figure 2. Employer-Sponsored Insurance (ESI) among Parents of SCHIP Enrollees



Source: Urban Institute tabulations of the 2005 Annual Social and Economic Supplement to the Current Population Survey.

^a Where both parents have ESI in two-parent families and where one parent has ESI in single-parent families.

Figure 3. Uninsurance among Parents of SCHIP Enrollees



Source: Urban Institute tabulations of the 2005 Annual Social and Economic Supplement to the Current Population Survey.

Table 1.
Insurance Status of Children Who Qualify for SCHIP based on Income, by Child and Family Characteristics (percent)

	SCHIP	Employer	Other	Uninsured
Age				
0-5 [^]	31.3	0.52	5.3	11.4
6-18	28.5 #	49.26	6.0	16.2 *
Race/Ethnicity				
White	25.0 *	55.4 *	7.3 *	12.2 *
Black	33.7	50.2 *	4.5	11.6 *
Hispanic [^]	33.1	41.1	3.6	22.2
Other	30.7	47.7 #	8.1 *	13.6 *
Health Status				
Excellent/very good	27.5 *	51.8 *	6.3 *	14.4
Good	33.5 *	43.8 #	4.2	18.4 #
Fair/poor [^]	49.3	35.2	3.0	12.4
Citizenship				
Citizen [^]	28.9	51.8	6.1	13.2
Noncitizen ^a	32.2	22.8 *	2.4 *	42.5 *
HIU Income				
Less than 150% FPL [^]	39.7	33.5	5.7	21.0
150-249% FPL	27.6 *	53.0 *	5.7	13.7 *
250%+	14.5 *	68.4 *	6.6	10.4 *
HIU Work Status				
2 full-time workers [^]	27.5	54.4	3.6	14.5
1 full-time worker	28.6	50.8 *	5.9 *	14.7
Only part-time workers	34.5 *	32.9 *	12.3 *	20.3 *
No workers	46.9 *	19.4 *	10.9 *	22.8 *
HIU Firm Size				
500+ [^]	25.9	60.0	3.9	10.2
100-499	28.8	55.3 *	3.1	12.8 #
10-99	31.2 *	45.7 *	4.9	18.2 *
Less than 10	35.6 *	28.7 *	11.2 *	24.5 *
Self-employed	26.9	26.8 *	19.3 *	27.1 *
Nonworking	46.9 *	19.4 *	10.9 *	22.8 *
Total	29.2	49.9	5.8	15.1

Source: Source: Urban Institute tabulations of the 2005 Annual Social and Economic Supplement to the Current Population Survey.

Note: Coverage distribution based on the following hierarchy: Medicaid/SCHIP, employer, other public, individual, and uninsured.

[^] Reference group for test of statistical significance.

* Estimate is significantly different from reference group at the 5% level.

Estimate is significantly different from reference group at the 10% level.

^a The noncitizen group includes some children who may not qualify for SCHIP due to their immigration status.

Table 2.
SCHIP Participation Rates, by Child and Family Characteristics
(percent)

Age	
0-5 [^]	73.4
6-18	63.8 *
Race/Ethnicity (Citizen and Noncitizen)	
White	67.2 *
Black	74.5 *
Hispanic [^]	59.9
Other	69.3 #
Race/Ethnicity (Citizen Only)	
White	67.2
Black	75.8 *
Hispanic [^]	67.1
Other	68.5
Health Status	
Excellent/very good	65.6 *
Good	64.5 *
Fair/poor [^]	79.8
Citizenship	
Citizen [^]	68.7
Qualified noncitizen ^a	70.8
HIU Income	
Less than 150% FPL [^]	65.4
150-249% FPL	66.8
250%+	58.2
HIU Work Status	
2 full-time workers [^]	65.5
1 full-time worker	66.1
Only part-time workers	62.9
No workers	67.3
HIU Firm Size	
500+ [^]	71.8
100-499	69.2
10-99	63.2 *
Less than 10	59.3 *
Self-employed	49.8 *
Nonworking	67.3
Total	65.8

Source: Source: Urban Institute tabulations of the 2005 Annual Social and Economic Supplement to the Current Population Survey.

Note: Participation is defined as the number of SCHIP enrollees divided by the sum of SCHIP enrollees and uninsured who are SCHIP-eligible.

[^] Reference group for test of statistical significance.

* Estimate is significantly different from reference group at the 5% level.

Estimate is significantly different from reference group at the 10% level.

^a Based on estimates of citizenship status from the 2004 CPS that have been adjusted for immigration status using methodology developed by Passel and Clark (1998) and updated in subsequent years.

Appendix: Data and Methods

The data for the analysis are derived from the Annual Social and Economic Supplement (ASEC) to the 2005 CPS. The CPS is designed to produce employment and unemployment statistics on the civilian noninstitutionalized population. Health insurance and income data are collected on the ASEC about the calendar year before the fielding of the survey. The 2005 ASEC includes a sample of around 100,000 households, with information on over 200,000 persons. The CPS is based on an area frame and is conducted with both telephone and in-person interviews, yielding a response rate of over 80 percent. The CPS contains detailed information on household composition and on the demographic and socioeconomic characteristics of household members. The CPS also collects comprehensive and detailed income information, including earned and unearned income, from multiple sources for each person in the household.

Health Insurance Units. To model eligibility for Medicaid and SCHIP, we group household members into health insurance units (HIUs) using the information provided on the CPS about how members of the household are related to one another. HIUs contain the members of a nuclear family who could be considered eligible for a family health insurance policy. While HIUs are very similar to Census subfamilies, they exclude some individuals who could not be covered under the same health insurance policy as their subfamily. For example, part-time students or non-students over age 18 who are living with their parents would not be included in an HIU with their parents because they would no longer be considered their dependents.

Eligibility Simulation. Our analytic sample consists of children age 18 and under who are simulated to be eligible for SCHIP. HIU income is used to determine income eligibility for SCHIP because the income of HIU members closely approximates the income that is counted by states when determining eligibility for public coverage. The analysis presented here relies on a simulation that takes into account family composition, adult work status, child's age, earned and unearned income, assets, child care expenses, work expenses, and state of residence and compares this information to detailed state-specific rules for SCHIP eligibility. In addition, the model takes into account the citizenship status of children based on whether the state provides SCHIP coverage to those who have been in the country since 1996, for less than five years, or for more than five years. Because the CPS does not collect data that allows researchers to directly differentiate noncitizens based on their legal status, we are likely overstating the number of noncitizen children who are eligible for SCHIP. To address this issue, we use external estimates to adjust downward the number of uninsured children eligible for SCHIP to take into account that some noncitizen children cannot qualify for SCHIP despite meeting the income and resource requirements for the program.¹² With the exception of selected participation rates, which are adjusted for documentation status, none of the other estimates provided by subgroup (e.g., age, firm size, etc.) make an adjustment for legal status.

Children with employer-sponsored insurance coverage who meet all other eligibility requirements are considered eligible for SCHIP, even though the legislation specifically excludes them under the crowd-out provisions.¹³ This is done because these children may become eligible

¹² This estimate was developed using 2004 CPS data, based on a method developed by Passel and Clark (1998) at the Urban Institute that imputes the immigration status of noncitizens.

¹³ In contrast, children are generally eligible for Medicaid regardless of their insurance status.

for a separate SCHIP program if they lose their insurance coverage or if they meet the waiting period requirements or qualify for a Medicaid expansion program.

Insurance Questions. Information on the insurance coverage of each child in the sample is ascertained on the CPS using the following question format: “At any time in (the previous year) was anyone in the household covered by (a particular type of insurance)?” The survey names each of several possible types of private and public insurance. For each positive response on the various types of insurance, the survey then asks which household member(s) was covered by that particular kind of insurance.¹⁴ There are concerns as to whether this form of questioning captures insurance coverage for the entire previous year. Doubt arises about the accuracy of the CPS estimates of full-year uninsured because those estimates are more consistent with other surveys’ estimates of uninsurance *at a point in time* than with the estimates of uninsurance *over a whole year*.¹⁵ The Census Bureau commented on this in its most recent release, stating that CPS estimates of uninsured closely align with other national surveys’ point-in-time estimates (DeNavas-Walt, Proctor, and Lee 2006), which is how the estimates are interpreted in this brief. There is also concern that the CPS might be understating the number of people enrolled in Medicaid and overstating the number of uninsured. Research suggests that while most Medicaid enrollees report Medicaid on surveys, those who do not are more likely to report that they have private coverage than that they have no coverage (Call et al. 2001). An additional concern about CPS estimates of coverage is that item nonresponse is over 10 percent for the health insurance questions (Davern et al. 2001).

Insurance Status of Children. Because the CPS allows respondents to report more than one type of coverage, we use a hierarchy to categorize the insurance status of children in the sample: Medicaid/SCHIP coverage is at the top of the hierarchy, followed by ESI, other public coverage, and individual coverage. Although the CPS added a question in 2001 asking respondents specifically about whether any family member had been enrolled in a separate SCHIP program, we cannot distinguish between coverage financed by the Medicaid program and coverage financed under the SCHIP program with this question for various reasons.¹⁶ Instead, we define SCHIP enrollees as children who meet the SCHIP eligibility requirements and are reported to have either Medicaid or SCHIP coverage. We characterize how well SCHIP is reaching its target population by calculating the participation rate, which is defined as the number of SCHIP-eligible children with SCHIP coverage divided by the sum of the number of SCHIP-eligible children with SCHIP coverage and the number of SCHIP-eligible children who are uninsured. This calculation follows past research (Dubay et al. 2006; Selden et al. 2004).

Insurance Status of Parents. Information on the parents’ insurance coverage status is used to classify children according to whether at least one parent is uninsured; whether at least

¹⁴ The CPS question verifying that each individual for whom no coverage is reported is in fact uninsured (Short 2001) was included in all the survey years used in this analysis.

¹⁵ This inconsistency has led researchers to debate whether CPS respondents are either (a) responding to the CPS by actually providing their current coverage at the time of the survey, or instead (b) responding correctly about the past year, but with some recall error because of the long reference period (Short 2001; Swartz 1986; U.S. Congressional Budget Office 2003).

¹⁶ In some states, the coverage financed by each program is indistinguishable to families since the program names are the same. Moreover, respondents were not asked this question if they had responded affirmatively to the Medicaid question. As a result, we do not make a distinction between the two types of coverage and consider them together as Medicaid/SCHIP coverage.

one parent has ESI; and whether one parent (in two-parent households) or one or two parents (in one- or two-parent households, respectively) have employer-sponsored coverage. A key question is what these estimates indicate about whether these children would have had ESI in the absence of the SCHIP program. If there is no existing ESI coverage in the HIU, it is likely that ESI coverage would not be an option for the child in the absence of Medicaid/SCHIP coverage, since covering the child on the ESI plan would also involve covering the employee, who is not currently on the plan. Likewise, if only one of the two parents has ESI, it is doubtful whether the family would have elected to cover the child on the ESI plan in the absence of the public program. However, while the fact that ESI coverage was declined on behalf of the spouse may be a sign that dependent coverage was not available or that it was so costly that the family would not have been able to afford ESI coverage, it is also possible that without the ability to cover the child under SCHIP, the family might have been more likely to take up dependent coverage that would have included both the spouse and child/children.

Unfortunately, the 2005 ASEC lacks information on whether the parent's coverage could include the spouse or child (i.e., whether dependent coverage is offered) and reliable information on how much the employer contributes toward the premium payment. The first issue may not be very important since previous research indicates that only about 6 percent of employers offer insurance without dependent coverage to their employees (Fronstein, Helman, and Greenwald 2003), though it may be more prevalent among lower-income families. The second issue is more problematic since employees have to contribute much more toward dependent coverage (both in absolute and relative terms) than for single coverage (Claxton et al. 2006). Thus, this analysis only indicates whether it might have been possible for the child to be covered under a parent's ESI policy, not whether the family could have afforded to pay the premiums associated with covering the child. Nor does the analysis indicate anything about the benefits that would be available or the out-of-pocket cost sharing that would be required.

Limitations. The major limitation of this analysis derives from measurement error in the both the insurance coverage variable and in the eligibility simulation. As described above, insurance coverage status may be misreported on the CPS; thus, our insurance distribution may overstate the number of children who are uninsured. In addition, our simulation of SCHIP eligibility uses income information provided for the past calendar year, which is measured with error, both because of misreporting and item nonresponse. Moreover, our simulation does not take into account fluctuations in income over the course of a year nor does it contain sufficient information on immigration status to determine whether all children meet the eligibility criteria for coverage. Finally, these estimates reflect the status at a particular point in time and may vary substantially with changes in the economy that affect both the income distribution and the cost of ESI.

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