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Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children

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Results in Brief

In 1999, there were 10.6 million parents – 16 percent of all parents -- who lacked health insurance coverage. If states were to cover parents under Medicaid and SCHIP to the same extent as they currently cover children, 7.4 million uninsured parents – 70 percent of all uninsured parents -- would gain eligibility for coverage.

By expanding Medicaid and SCHIP to parents, states could significantly increase the access of low-income parents to health care services. In 1999, uninsured parents were more likely than their counterparts with Medicaid coverage to lack a usual source of care; to have unmet health care needs; to have gone without a physician or dental visit in the past year; and to have gone without a breast exam in the past year.

By covering parents, states also can increase the extent to which uninsured *children* are enrolled in Medicaid and SCHIP. In states that have expanded coverage for parents under Medicaid, 81 percent of eligible children participate in Medicaid compared to only 57 percent of children in states without family-based coverage programs.

Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children

Even though much of the policy discussion about uninsured populations focuses on low-income children, low-income parents are substantially more likely than their children to be uninsured (Lambrew 2001, Zuckerman et al. 2000). Almost ten million parents were uninsured in 1997, three quarters of whom had incomes below 200 percent of the federal poverty level (Dubay et al. 2000) and more than a third of all children with public health insurance coverage have an uninsured parent (Davidoff et al. 2001). This is an important policy concern, not only because parents who lack insurance coverage are likely to experience more barriers to care than parents who have coverage, but also because uninsured parents may be less effective at managing the health care needs of their children, even those with insurance (Hanson 1998, Gifford 2001, Krebs-Carter and Holahan 2000). There is also emerging evidence that family coverage may stimulate greater participation among children (Selden et al 1999; Ku and Broaddus 2000).

Lower-income children are much more likely than their parents to qualify for some type of public coverage, for the obvious reason that, until very recently, expansions of public health insurance programs have been targeted primarily at low-income children. Beginning in the mid 1980s, a series of legislation first mandated expansions in Medicaid eligibility for children and then allowed states to expand Medicaid eligibility beyond the mandated levels under Title XIX of the Social Security Act. These expansions were followed in 1997 with the State Children's Health Insurance Program (SCHIP) created under Title XXI. States that expand coverage to children receive federal matching dollars at higher rates under Title XXI than under Title XIX even if their SCHIP programs are

implemented through their Medicaid programs. By September 2000, 33 states had Medicaid or SCHIP eligibility levels at or above 200 percent of poverty for children ages 18 and under (HCFA 2000). Although Medicaid coverage for adults has expanded to include many low-income pregnant women, coverage for parents in most states has historically been limited to those who qualify for cash assistance programs, which typically restrict income eligibility to levels well below the federal poverty line.

Beginning with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, (PRWORA), recent changes in federal policy have provided greater access to federal matching dollars to states that want to expand coverage to parents. PRWORA gave states the option of using less restrictive Medicaid eligibility standards for low-income families. In addition, policy guidance issued by the Department of Health and Human Services in July of 2000 provides a new option to use unspent SCHIP funds to expand coverage to parents through SCHIP waivers. In light of growing interest in expanding coverage to parents, this paper examines the extent to which expanding coverage to parents through Medicaid and SCHIP programs could help low-income families by (a) reducing uninsurance among parents; (b) improving access and use by enrolling more parents in these programs; and (c) reducing uninsurance rates among children.

Three sets of findings stand out. First, fully 7.4 of the almost 10.6 million uninsured parents could be eligible for insurance coverage if Medicaid and SCHIP programs were expanded to cover parents at the same income level at which their children are currently eligible. About three million of these could be easily enrolled because their children are already participating in Medicaid or SCHIP. Reaching the

uninsured parents of uninsured or privately-insured children may prove more challenging since they may be unfamiliar with Medicaid and SCHIP programs.

Second, coverage expansions targeted to parents offer the potential to increase access to care substantially, because uninsured parents of Medicaid and SCHIP eligible children experience greater access problems than their insured counterparts. They are over twice as likely to lack a usual source of care and only about two-thirds as likely to have received physician visits, dental care, or breast exams in the prior year.

Third, coverage expansions targeted to parents increase Medicaid participation among children by potentially as much as 20 percentage points. Results from two separate analyses indicate that extending eligibility for insurance coverage to parents increases participation in Medicaid among children and leads to lower rates of uninsurance, although some of the increased participation may be due to families substituting public coverage for the private coverage they used to have. By extending eligibility to more parents, states may increase coverage for both parents and children. One potential caveat to our analysis is that our findings come from a limited number of states that have been ahead of the curve in family coverage expansions and outreach efforts. It will be important to watch whether their experiences repeat themselves as other states expand coverage to low-income parents.

Section I of the paper provides background information on policies governing public coverage of low-income families. Section II describes the data used in our analysis. Section III presents our methods and findings. Section IV ends the paper by discussing the policy implications of our findings.

I. Background on Medicaid and SCHIP Coverage Policies

Until the mid 1980s, Medicaid coverage for children was limited primarily to children living in families that qualified for Aid to Families with Dependent Children (AFDC). Beginning with the Medicare Catastrophic Coverage Act (MCCA) of 1988, a series of eligibility expansions were mandated for children, called the poverty-related expansions. Ultimately, states were required to cover children under age six in families with incomes up to 133 percent of poverty and children born after September 30, 1983 in families with incomes up to 100 percent of poverty. In addition to these mandates, a number of states took advantage of options through Section 1902(r)(2) provisions and Section 1115 waivers in the early to mid 1990s to further expand coverage to children. Following the creation of SCHIP in 1997, additional eligibility expansions occurred for children in all states. As a consequence, all but 16 percent of low-income uninsured children are now eligible for coverage under either Title XIX or Title XXI (Dubay, Haley, and Kenney 2001).

Coverage expansions for parents have not kept pace with the expansions for children. Coverage of non-elderly adults under Medicaid has historically been limited to parents receiving cash assistance under Aid to Families with Dependent Children (AFDC), disabled adults receiving Supplemental Security Income (SSI), and, since the mid-1980s, pregnant women. Many poor and near-poor parents were ineligible for Medicaid because AFDC eligibility was restricted to very low-income, single-parent families and two-parent families where either one parent was incapacitated or the principal wage earner was unemployed.[1]

[1] In order to be considered unemployed, the principal wage earner must have worked fewer than 100 hours a month and have had a history of work-force participation, further restricting coverage.

Three recent federal changes dramatically expanded the options available to states for covering low-income parents under Medicaid and/or SCHIP.[2] First, PRWORA in 1996 created a new category of Medicaid eligibility in Section 1931 of the Social Security Act. Section 1931 does several things. It requires states to grant such eligibility to those adults and children who would have been entitled to AFDC under the income and resource standards in effect on July 16, 1996.[3] It also gives states the option to use less restrictive methodologies for counting income and resources when determining eligibility—thus allowing states to make higher income families that meet the categorical requirements under the old AFDC program eligible for Medicaid.[4] Second, the Department of Health and Human Services issued a regulation in August 1998 that permits states to use less restrictive rules in defining unemployment for two-parent families essentially allowing states to cover all two-parent families that meet the Section 1931 income and resource requirements.[5] Importantly, Section 1931 eligibility provisions apply to families, making it impossible for parents to be made eligible without their children.

The third major federal change came in July 2000, when HCFA issued guidance to states regarding the use of SCHIP waivers to cover low-income parents under SCHIP. In order to obtain a waiver to cover parents under SCHIP, states must be covering children up to 200 percent of poverty, be enrolling children statewide without any waiting

[2] For a more complete discussion of this issue, see Guyer and Mann (1998).
[3] States also have the option to use a lower resource standard for determining eligibility under Section 1931, but these standards cannot go below those in effect on May 1, 1998. States can also adjust their income and resource standards upward in accordance with the consumer price index.
[4] In essence, the latter provision allows states to disregard income and resources, effectively making certain families eligible for Medicaid at higher incomes than under old AFDC rules. This provision is similar to 1902(r)(2) provisions that allowed states to cover children and pregnant women with incomes above the mandated and optional levels.

list, demonstrate that the application and re-determination processes for Medicaid and SCHIP promote enrollment and retention of children in the programs, and make lower income parents eligible for coverage prior to making higher income parents eligible. Under these waivers, states that implemented expansions for parents prior to March 31, 2000 will continue to receive the Medicaid matching rate for parents with incomes below 100 percent of the FPL and will get the higher SCHIP match for parents with higher incomes. States that implement expansions to parents after March 31, 2000 will receive the enhanced SCHIP match for all parents with incomes above the threshold they had in place prior to the expansion (Letter to State Health Officials, July 2000). Under both of these circumstances, the enhanced SCHIP match will only be available if unspent SCHIP funds exist for a given state.

Exhibit 1 summarizes the country's progress in state initiatives to expand coverage of low-income parents beyond the welfare thresholds as of 1997 and 1999, the two years examined in our study. In 1997, five states (Delaware, Hawaii, Massachusetts, Tennessee, and Vermont) had expanded coverage to parents solely through their Medicaid program; two (Minnesota and Washington) had expanded coverage to low-income parents solely through a state-funded program; one (Oregon) had expanded coverage to low-income parents though both routes. By 1999, four additional states (District of Columbia, Missouri, Rhode Island, and Wisconsin) had expanded coverage to low-income parents through their Medicaid program.

[5] Specifically, states can now eliminate the 100-hour rule, effectively making all two-parent families that meet the income and resource standards under the Section 1931 provisions eligible for Medicaid.

II. Data

This analysis draws on the 1997 and 1999 waves of the National Survey of America's Families (NSAF). NSAF is a household survey that provides information on more than 100,000 children and adults representing the non-institutionalized civilian population under age sixty-five. The NSAF over-samples the low-income population (defined as having incomes below 200 percent of the federal poverty level, $33,400 for a family of four in 1999) and provides nationally representative estimates as well as state-representative estimates for 13 states. [6] These 13 states were selected for intensive study because they represented a mixture of approaches to health and social policy and because they were diverse geographically and economically.

Four of the 13 NSAF focal states (Massachusetts, Minnesota, Washington, and Wisconsin) appear in Figure 1 above as having expanded coverage to parents beyond welfare thresholds by the end of 1999. Since Massachusetts did not introduce its 1997 initiative until July, which was very late in the first NSAF survey period, we are able to do a special analysis comparing Massachusetts pre-expansion in 1997 with Massachusetts post-expansion in 1999. (We cannot do the same with Wisconsin, because its introduction of parent coverage was similarly late in the second NSAF survey period.)

NSAF interviews were conducted in households with and without telephones using computer-assisted telephone interviewing technology. The data are weighted to provide reliable national and state estimates. The standard errors are based on the balanced repeated replication method to account for the complex nature of the sample design (Brick et al. 2000). Detailed information was collected from the adult (called the

[6] These states include Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.

most knowledgeable adult or MKA) who knew most about the education and health care of up to two children (one age five and under and one age 6 to 17) in each selected household. For this analysis, parents are defined to include biological, adoptive, or step, as long as they are living in the household of the child.[7]

Current insurance coverage is measured through a series of questions on coverage at the time of the survey.[8] Coverage includes private employer-sponsored and non-group plans, as well as Medicaid, SCHIP, other state programs, Medicare, and other public programs such as CHAMPUS. State-specific program names were inserted in these questions to enhance respondents' recognition of programs and we added a new question to the 1999 instrument asking about separate SCHIP programs. Because more than one type of coverage was reported for a small number of children, a hierarchy was to classify people into mutually exclusive groups. Coverage through Medicaid, SCHIP, or another state program took precedence, followed by employer-sponsored and non-group plans, and then any other insurance coverage.

The analyses presented in this paper rely on a detailed Medicaid and SCHIP eligibility simulation model, designed to mimic the eligibility determination process faced by families applying for Medicaid or SCHIP.[9] First, eligibility units are created from the household survey data. Individuals included in the unit are only those who would be considered in the eligibility determination process.[10] Second, Medicaid and SCHIP eligibility rules in place in July of each year are applied to each unit. Relevant

[7] Parents with children who are 18 years and older are not included in this analysis. The part of this exclusion that is potentially relevant involves parents of eighteen year olds who do not have younger children.

[8] When no coverage was reported for a family member, the respondent was asked a follow-up question to confirm that the person, in fact, did not have any health care coverage at the time of the survey. For more details, see Rajan, Zuckerman and Brennan (2000).

[9] For a complete discussion of the simulation model see Dubay and Haley (2001).

rules include those regarding: eligibility thresholds, which vary by age of the child, family composition, and work status of the parents; how income is counted including whose income is counted and what types of unearned income are counted; work, earned income, child care, and child support disregards; asset limits and disregards; and deeming of step-parent and grand-parent income. Third, children are categorized into three eligibility groups hierarchically: (a) those who are eligible for Medicaid but would also have been eligible for TANF (TANF-related);[11,12] (b) those who are eligible for Medicaid based on the poverty related expansions, both those federally mandated and those allowed under Section 1902(r)(2) provisions, and Section 1115 waiver authority (poverty-related)[13]; and (c) those who are eligible for SCHIP whether through expanded Medicaid or through separate programs created under SCHIP.

The legal status of non-citizens is another factor that affects eligibility for Medicaid and SCHIP. In particular, states have the option to use matching funds to cover "qualified aliens" who entered before August 22, 1996 and are banned from using federal funds to cover "qualified aliens" entering after that date for the first five years they are in this country. "Qualified aliens" broadly include lawful permanent residents, refugees,

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[10] These units vary across states and within states across programs.

[11] This group also includes children eligible for Medicaid due to their receipt of SSI and to being in foster care.

[12] As mentioned earlier, PWRORA created a new category of Medicaid eligibility for families in Section 1931 of the Social Security Act. Importantly, we use the TANF rules in place in 1997 to identify the TANF-related group in 1999. We do this in order to identify children who would have be eligible for Medicaid due to their eligibility for AFDC/TANF separately from those due to the poverty related expansions in the absence of states' options to cover parents. If we were to use the Section 1931 rules for 1999 instead of the 1997 TANF rules, we would move some children from the poverty-related group into the TANF-related group. The children who would move are those that were affected by the family coverage expansions. In order to conduct our analysis we need to keep these children in their pre-expansion group.

[13] This group also includes children eligible for Medicaid under Ribicoff, medically needy, and transitional medical assistance provisions.

asylees, and certain other individuals.[14] Medicaid eligibility for undocumented aliens is restricted to emergency services. Only 14 states use state funds to cover qualified aliens entering after August 22, 1996 during the five-year ban and just 9 use state funds to provide health insurance to undocumented aliens (Zimmerman and Tumlin 1999).

The NSAF does not collect sufficient information to determine the legal status of non-citizen children and parents and thus cannot precisely determine eligibility for non-citizens. Urban Institute estimates based on the March 2000 Current Population Survey where legal status is imputed to non-citizens indicate that 50.2 percent of all uninsured non-citizen parents and 52.2 percent of low-income uninsured non-citizen parents are undocumented—and thus would fail to qualify for Medicaid or SCHIP even if they met all other requirements.[15]

To address this issue in our analysis of the potential to cover uninsured parents under Medicaid and SCHIP, we present unadjusted estimates which assume that all uninsured non-citizen parents with Medicaid or SCHIP eligible children could potentially be made eligible for these programs under family coverage expansions. We also present adjusted estimates that assume that 52.2% of the non-citizen uninsured parents whose children are eligible for Medicaid or SCHIP are undocumented and thus cannot qualify for Medicaid or SCHIP. Our discussion focuses on the estimates that have been adjusted to take into account the legal status of non-citizen parents because these results are most closely aligned with current law.

[14] For a full discussion of these provisions see Zimmerman and Tumlin (1999).
[15] The methodology used to impute legal status to foreign born, non-citizens using the CPS is described in Passel and Clark (1991). Estimates of the share of foreign-born, non-citizen parents who are undocumented in 1999 were produced for this analysis by Jeffrey Passel and Randy Capps.

Results regarding the ease of enrollment of potentially eligible parents based on their children's health insurance status and access and use among potentially eligible parents assume that all foreign-born non-citizen parents could be made eligible. Similarly, analyses of the effects of family coverage on children's participation assume that foreign-born, non-citizen who meet the other eligibility requirements are eligible. This is done because we cannot determine the legal status of each individual.

III. Methods and Findings

Our analysis addresses three questions:

- To what extent would expanding Medicaid and SCHIP programs to cover uninsured parents of eligible children reduce the uninsurance rate of those parents?
- To what extent would such expansions improve those parents' access to and use of health care services?
- To what extent would extending coverage to parents increase the Medicaid participation of eligible children?

Our methods and findings are discussed for each question in turn.

To What Extent Would Expanding Medicaid/SCHIP to Cover the Parents of Eligible Children Reduce the Uninsurance Rate of Those Parents?

We begin this analysis by determining the number of uninsured parents in 1999. We then estimate how many uninsured parents had children eligible for Title XIX and XXI based on the eligibility rules in place for children as of July 2000. We also estimate (a) how many of these parents are non-citizens, and therefore potentially ineligible for Medicaid and SCHIP expansions, and (b) how many parents had children who were enrolled in Medicaid or SCHIP at the time the NSAF survey was fielded in 1999 and, therefore, readily enrollable under an expansion.

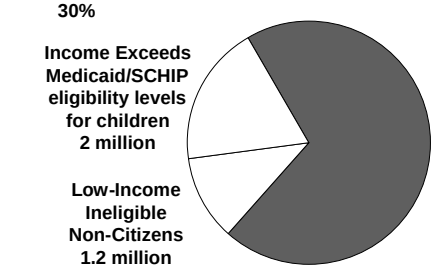
In 1999, 10.6 million parents — 16 percent of all parents — lacked health insurance coverage (Table 1). Low-income parents were over five times as likely as higher income parents to be uninsured - - 35.9 percent compared to 6.8 percent.

Our findings reveal tremendous potential to greatly reduce uninsurance among parents through expansions of existing Medicaid and SCHIP programs. In total, 8.6 million uninsured parents have incomes that fall below current Medicaid/SCHIP eligibility levels for children. However, a significant minority—2.3million—are non-citizens who may not be eligible for Medicaid or SCHIP under current law. We estimate that 1.2 million of the 8.6 million uninsured parents whose incomes fall below current eligibility thresholds for children would not qualify for Medicaid or SCHIP because federal laws restricting these programs to particular subsets of the non-citizen population.

Thus, taking into account the legal status of non-citizen uninsured parents, Medicaid and SCHIP expansions have the potential to reach 7.4 million uninsured parents (Figure 1). These 7.4 million potentially eligible parents account for 70 percent of all uninsured parents (see adjusted figures in Table 2). Medicaid expansions alone could cover half of all uninsured parents potentially providing coverage to roughly 5.6 million uninsured parents, while

Figure 1

Potential Eligibility of Uninsured Parents for Medicaid/SCHIP, 1999



Total Uninsured Parents = 10.6 million

SOURCE: Urban Institute analysis of 1999 NSAF, based on Medicaid and SCHIP rules in place for children in July 2000

KAISER COMMISSION ON Medicaid and the Uninsured

expansions up to the higher SCHIP eligibility levels could provide coverage to another 20 percent of uninsured parents.[16] (Data not shown)

How easy it would be to reach these potentially eligible uninsured parents is likely to depend on whether their children are already enrolled in Medicaid or SCHIP. Data from 1999 suggest that 2.3 million uninsured parents who are citizens have children who are already enrolled in Medicaid or SCHIP who could themselves easily be enrolled in these programs (Table 3). Another .9 million uninsured parents who are non-citizens also had children who were enrolled in Medicaid or SCHIP. Some share of these non-citizen parents are qualified aliens and could also easily be enrolled. Thus, altogether about three million uninsured parents could be readily enrolled in Medicaid or SCHIP since their children are already participating. Importantly, given the continued growth in SCHIP programs since the 1999 NSAF survey (Smith et al. 2001), even more uninsured parents are likely to have SCHIP-enrolled children at this point in time. Reaching and enrolling the remaining uninsured parents presents more challenges to Medicaid and SCHIP programs, since over half of the potentially eligible uninsured parents have uninsured children.

To What Extent Would Expanding Coverage to Parents Improve their Access to and Use of Care?

We use six key indicators to compare health care access and use levels of uninsured parents of Medicaid and SCHIP eligible children with the levels of their counterparts who are covered by Medicaid or private insurance: having a usual source of

[16] The majority of states could cover these parents through Medicaid using 1931 provisions; the remaining states would need to equalize their Title XIX standards for children to cover all these parents. By 2002, all states could cover parents up to 100% of the FPL under the Medicaid program. For a full discussion of this issue, see Dubay et al. 2000. To cover parents under Title XXI, a waiver is required from HCFA.

care; confidence in the ability to obtain care for the family; unmet need; physician and dental visits; and breast exams. We conduct both descriptive and multivariate analyses of our access and use measures. We estimate linear probability models to test for the effects of insurance coverage that control for age, race, work-status, education, health status, activity limitations, and citizenship of the parent and the income and welfare history of their family.

We find that uninsured parents who could be targeted by Medicaid or SCHIP expansions experience significant access problems—in 1999, 37 percent had no usual source of care or used the emergency room as a usual source of care and 28 percent experienced some type of unmet need for care (Table 4).[17] Moreover, in the 12 months prior to the survey, only 43 percent of these uninsured parents had seen a physician, only 37 percent had received dental care, and just 33 percent of the mothers had had a breast exam.

When it comes to gaining access to the health care system, uninsured parents appear to be substantially disadvantaged relative to Medicaid-covered parents (Figure 2).[18] These uninsured parents are about twice as likely as Medicaid-covered parents to have no usual source of care or to rely on the emergency room, and to lack confidence in

[17] This analysis examines access and use measures for uninsured parents who have children who are eligible for Medicaid or SCHIP. The point estimates for these measures were very similar when we examined the subset of uninsured parents whose children are already enrolled in Medicaid or SCHIP.

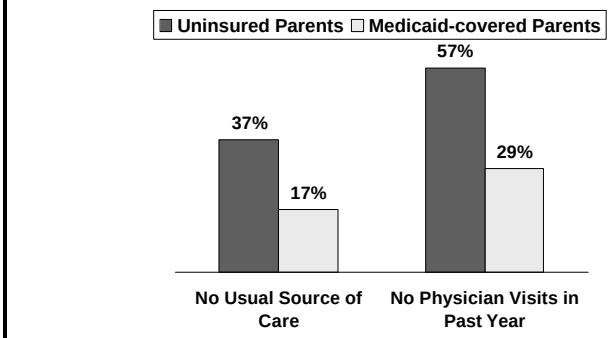
[18] The access and use differentials reported here are similar to those that prevail when we only examined the subset of uninsured parents whose children are already enrolled in Medicaid or SCHIP and when we contrasted the experiences of these uninsured parents with the privately insured parents whose children meet the income eligibility criteria for Medicaid/SCHIP coverage. While we have attempted to control for underlying differences between uninsured and insured parents, it is possible that there are additional factors that differentiate these two groups and which also affect health seeking behavior. The large magnitude of the access and use differentials found in the multivariate models make it unlikely that additional attempts to account for possible selection bias would close these gaps.

their family's ability to receive needed care. They are also just two-thirds as likely to have had physician visits, dental care, or breast examinations in the preceding year.

These access gaps persist even when we control for a number of factors that affect access and use. Other things equal, relative to Medicaid-covered parents, uninsured parents are 16 percentage points more likely to have no usual source of care or to rely on the emergency room for care; seven percentage points more likely to have unmet health care needs; and almost 20 percentage points less likely to have received a physician or dental visit in the past year. In addition, uninsured mothers are 11 percentage points less likely than Medicaid-covered mothers to have received a breast exam in the past year. Together these findings suggest that these uninsured parents would experience meaningful improvements in their health care access if they were to gain coverage under Medicaid or SCHIP.

Figure 2

Access to Care Among Parents with Medicaid/SCHIP Eligible Children, 1999



SOURCE: Urban Institute analysis of 1999 NSAF

KAISER COMMISSION ON Medicaid and the Uninsured

To What Extent Would Expanded Coverage of Parents Increase the Medicaid Participation of Eligible Children?

We use two different approaches in addressing this question. In the first, we contrast Medicaid participation rates in 1999 for children eligible for Medicaid under the poverty-related expansions in states that have expanded coverage to parents to

participation rates for children in states that do not cover parents of children. In the second, we take advantage of the fact that Massachusetts, one of 13 states oversampled in the NSAF, implemented its family coverage expansion after the first round and before the second round of the NSAF.[19]

Comparison of State Groups. In this analysis we focus on children eligible under the poverty-related expansions prior to welfare reform for two reasons. First, the parents of these children were not eligible for public coverage unless the state had a Section 1115 waiver under Medicaid or had a state-funded program.[20] Second, these are the parents targeted by the recent policies to expand family coverage. Parents of children eligible under the TANF-related rules, in contrast, have always been eligible for Medicaid. We make separate 1999 estimates for states that had expanded Medicaid to parents under either Section 1115 waivers or through Section 1931 provisions (Delaware, District of Columbia, Hawaii, Massachusetts, Missouri, Oregon, Rhode Island, Tennessee, and Vermont) and for states that created state-funded, non-Medicaid, programs to cover parents (Minnesota and Washington).

We exclude from the participation rate calculation children with private insurance coverage because we want to measure the extent to which the Medicaid program is reaching the eligible but uninsured population.[21] This approach allows us to account for the variation in private insurance coverage across states by examining the extent to which public programs close the gap in coverage left by private insurance (Spillman 2000). We

[19] In fact, Massachusetts implemented its family coverage expansion in July of 1997. Since implementation occurred so late in the field period, we treat this year as the pre-expansion period.
[20] Some states that have implemented family coverage also extend coverage to parents of SCHIP eligible children. We do not include these children. This is because their inclusion would likely bias downward observed effects of family coverage since SCHIP is relatively new.
[21] We also exclude children whose only insurance coverage is through the Medicare program. This group of children constitutes a very small share of low-income children.

present both descriptive and multivariate results. In the multivariate analyses, we estimate linear probability models of Medicaid participation that control for age, race, and health status of the child; work status, education, and nativity of the parent; income and welfare history of the family; and number of children in the family.

It is important to note here that differences in Medicaid participation that are observed between states with and without family coverage in this type of cross-sectional analysis may be due to unmeasured differences between the two groups of states in factors such as program quality, awareness of the program, or ease of enrollment. We conduct a number of additional analyses to assess the extent to which these results appear to be attributable to unmeasured differences rather than to family coverage differences. Specifically, we examine whether similar differences exist across these states in Medicaid participation among those eligible for Medicaid under the TANF-related rules. We also examine whether the difference in participation rates between children eligible under the poverty-related expansions and under TANF-related rules vary by whether the state has expanded family coverage. Finally, we net out underlying differences in participation across the different types of states and then assess whether children eligible under the poverty related expansions participate in Medicaid at higher rates when family coverage is expanded.[22]

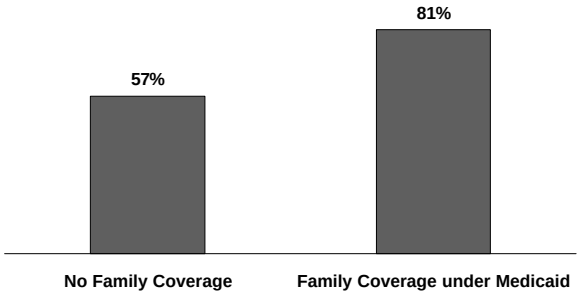
Table 5 presents Medicaid participation rates for children eligible for Medicaid under the poverty-related expansions for states with different family coverage policies.[23] In addition to being beneficial to parents, expanding coverage to parents leads to greater Medicaid participation among eligible children. In states without family coverage

[22] See Appendix I for the detailed specification of this model.
[23] Children with private coverage and Medicare only coverage are excluded from the participation rates.

expansions, 57.1 percent of poverty-related children participate in the Medicaid program, compared to 78.5 percent in states that have state-funded family coverage expansions and 80.8 percent in states that have Medicaid family coverage expansions (Figure 3). When we control for differences across states in the characteristics of the eligible population, we still find that Medicaid participation rates among poverty-related children in states with family coverage expansions are more than 20 percentage points higher than in states with no family coverage.

Figure 3

Medicaid Participation Rates for Children under the Poverty-Related Expansions, 1999



Note: Excludes children with private insurance coverage. States with family coverage include OR, VT, DE, HI, TN, MO, MA, DC and RI. Participation rates in family coverage under state-funded programs in MN and WA equals 79 percent (not shown).
SOURCE: Urban Institute analysis of 1999 NSAF

KAISER COMMISSION ON Medicaid and the Uninsured

Our additional analyses indicate that these differences are attributable to family coverage differences and not to other unmeasured differences across states. First, we do not find analogous participation differentials across states when we examine TANF-related eligibles (Table 6). TANF-related eligible children in states with no family coverage expansions are only about 4 percentage points less likely to participate in Medicaid compared with children in states with family coverage expansions. Moreover, the cross-state participation differentials among TANF-related eligibles are not statistically significant in either the univariate or multivariate analyses.

Second, we find that TANF-related and poverty-related eligibles have comparable participation rates in states with family coverage policies whereas there are large,

statistically significant participation differences between the two groups in states that do not have family coverage expansions. In the multivariate models, for example, there is about a 4 percentage point difference between the participation rates of TANF and poverty-related children in the states with family coverage which is not statistically significant. This contrasts with an 8.8 percentage point difference in states without family coverage expansions, which is statistically significant.

Finally, when we use multivariate methods to net out the underlying differences in participation across states with and without family coverage we find that participation rates for children eligible under the poverty-related expansions are approximately 20 percentage points higher in states that cover the parents of these children under either a state-funded program or the Medicaid program, than in states that do not cover the parents of these children.[24] Thus, these cross-sectional analyses indicates that family-coverage expansions do raise participation levels among already eligible children and that the estimated effect is substantial.

The Massachusetts Before and After Comparison. In this analysis we contrast changes in Medicaid coverage for children in Massachusetts before and after implementation of family coverage with changes in Medicaid coverage for children over this period in the rest of the nation. We also contrast changes in private coverage and in the uninsurance rate in Massachusetts with changes in the rest of the nation in order to assess whether the observed increases in coverage are due do reductions in the uninsurance rate or the substitution of public for private coverage. This difference-in-difference approach explicitly uses trends in insurance coverage for the rest of the nation as a control for what would have happened in Massachusetts in the absence of the family

coverage expansions.[25,26] This methodology was used extensively to examine the impact of previous Medicaid expansions for children on insurance coverage (Dubay 1999; Dubay and Kenney 2000).

As with the prior analysis, we focus on children eligible for Medicaid under the poverty-related expansions and conduct both descriptive and multivariate analyses.[27,28] The multivariate analysis includes the same control variables used in the cross-sectional model. We conduct this analysis with and without controls for offers of insurance coverage. This is because in theory, offers of insurance could be affected by the broad-based expansion of coverage in Massachusetts through the MassHealth Program, making inclusion as a control variable endogenous. At the same time, family premiums per enrolled employee increased by 13.6 percent over this period (AHCPR 2000a; AHCPR 2000b). This trend in premiums may have affected employers' willingness to offer coverage and individuals' willingness to take up ESI even absent the coverage expansion. Importantly, analyses that have examined the issue of whether employers responded to the Medicaid expansions for children and pregnant women have found no evidence of an employer response (Cutler and Gruber 1996; Shore-Sheppard et al. 2000). Estimating

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[24] See Appendix I for the specification of this model.
[25] See Appendix I for the specification of this model.
[26] In fact, three other states implemented family coverage during this time period: Missouri, Rhode Island, and the District of Columbia. We do not treat these states like Massachusetts because there are few observations on the NSAF in these states. In addition, other states had expanded coverage for families prior to 1997. We do not exclude these states from the rest of the nation. We do conduct sensitivity analysis to assess whether our results are sensitive to the exclusion of states that are over sampled on the NSAF and had family coverage prior to 1997 from the rest-of-the-nation group. These results are presented in Appendix II.
[27] We also estimate models for the TANF related group. If we observe similar results for this group of children we would be concerned that the results for the poverty related group were due to some other factors occurring in Massachusetts other than the family coverage expansion, since these children should not have been affected importantly by this change. In fact, we do not observe similar trends for the TANF-related group, which supports the notion that the family coverage expansion in Massachusetts are responsible for the findings.

separate models that both exclude and include a variable measuring offers of employer sponsored insurance coverage, yields upper and lower bound estimates of the extent to which any increase in Medicaid coverage was due to the substitution of private coverage. Given the lack of evidence of an employer-response under previous expansions, we give greater emphasis to the results that control for offers of employer-sponsored insurance.

The Massachusetts experience confirms the finding from the comparison of state groups that expanding coverage to parents leads to greater participation among children. Table 7 compares changes in insurance coverage between 1997 and 1999 for children eligible for Medicaid under the poverty- related expansions in Massachusetts and in rest of the nation. As can be seen, coverage under Medicaid rose from 42.3 percent to 63.6 percent of these eligible children in Massachusetts, a 21.3 percentage point increase. While Medicaid coverage also rose in the rest of the nation, the increase was a much smaller 3.6 percentage points. Private coverage for this group fell by 11.6 percentage points in Massachusetts compared to 4.4 percentage points in the rest of the nation. Finally, the uninsurance rate for children eligible for Medicaid under the poverty-related expansions fell by 9.7 percentage points in Massachusetts but remained unchanged in the rest of the nation.

Turning to the regression adjusted difference-in-difference estimates, we find that the Medicaid coverage in Massachusetts increased by 14.7 percentage points relative to the change in the rest of the nation. Massachusetts also saw a decline in the uninsurance rate for these children that was 11.0 percentage points greater than those observed elsewhere. Both these differences are statistically significant. While these eligible

[28] While the parents of some SCHIP eligible children in Massachusetts are eligible for Medicaid we do not include these children in the analysis because we cannot disentangle the effects of the expansion in

children lost private coverage at a somewhat higher rate in Massachusetts relative to the rest of the nation, the difference of 3.2 percentage points was not statistically significant.

Most of the increased Medicaid participation was due to reductions in uninsurance rather than substitution of private coverage. The difference-in-difference results indicate or the lower bound estimate for the substitution of 22.5 percent of private coverage. When we do not control for offers of employer-sponsored coverage, we derive an upper bound substitution effect of 39.6 percent. The actual substitution rate was likely somewhere between these two estimates.

IV. Policy Implications

The findings here make it clear that expanding the Medicaid and SCHIP programs to include parents presents a very promising policy opportunity. As with most promising opportunities, however, the opportunities come with challenges.

Opportunities. Of the 10.6 million uninsured parents, 8.7 million have incomes that fall below current Medicaid and SCHIP income thresholds for children and, of these, 7.4 million could qualify for coverage. Fully covering those parents would, thus, reduce the group of uninsured parents to a fraction of its current size. Evidence also indicates that such coverage would provide significantly greater access to health care for low-income parents, because the currently uninsured parents who could qualify under Medicaid/SCHIP income guidelines experience more access problems and receive fewer health services than parents currently covered by Medicaid.

Further, such expansions are likely to provide benefits to children as well, because family coverage policies lead to greater participation in Medicaid and lower uninsurance

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coverage for the children from the effects of the expansion of coverage to parents.

rates among eligible children. In 1999, for example, children eligible for Medicaid under the poverty-related expansions participated in Medicaid at a rate that was over 20 percentage points higher in states that expanded coverage to parents than in states that did not. In Massachusetts, implementation of family coverage led to a 14.2 percentage point increase in Medicaid coverage and a 11 percentage point reduction in uninsurance among children eligible for Medicaid under the poverty-related expansions, relative to the rest of the country. By covering parents, states may achieve the dual goals of increasing Medicaid and SCHIP coverage of eligible but uninsured children and extending new coverage to parents.

Challenges. The policy challenges have to do with making these coverage increases happen. For the roughly 3 million parents who have children enrolled in Medicaid or SCHIP, the policy problem is the relatively straightforward one of expanding coverage to include the parents of children already covered. But over half of all uninsured parents who meet Medicaid or SCHIP income thresholds have children who are uninsured despite meeting those thresholds. Increasing Medicaid/SCHIP participation by eligible children hinges on raising awareness and understanding of the programs and their benefits, improving enrollment systems, and addressing barriers related to other program dimensions (Kenney and Haley 2001; Kenney et al. 2001). However, as indicated above, expansions themselves may lead states to enroll more of the eligible children who are uninsured.

But all parents who meet the income thresholds are not eligible. If all policy steps enumerated in the previous paragraph were adopted, it might be possible to reach the 6.3 million uninsured parents who are citizens and have incomes that fall below current

Medicaid and SCHIP thresholds for children. But 2.3 million of the uninsured parents who meet the income eligibility thresholds are not U.S. citizens. Current rules would leave an estimated 1.2 million without insurance, because federal law prohibits use of federal dollars to cover undocumented aliens and even certain legal aliens. Thus, significantly reducing uninsurance rates among uninsured parents who are not citizens would require changes in federal eligibility rules or use of state-only funds. Since non-citizens constitute over a quarter of all uninsured parents who meet the Medicaid/SCHIP thresholds for children, current law represents a major barrier to eliminating the problem of uninsurance among low-income parents. Even among non-citizens who qualify for coverage under existing rules, anecdotal evidence strongly suggests that fears around public charge issues are acting as a strong deterrent to applying for Medicaid, as well as for other government programs to which specific immigrants are entitled (Lake Snell Perry & Associates 1998).

The final challenge is the possibility that expanding coverage will draw some parents in who were not in fact uninsured but were paying for private coverage—the substitution problem so much discussed when program expansions are on the table. Policy makers need to come to terms with the inevitable fact that covering whole families may lead to some substitution of public for what was previously privately financed coverage. Results from Massachusetts suggest that the extent of substitution will be small—about the magnitude observed under the Medicaid expansions for children (Dubay 1999)—with most of the increased coverage coming from real reductions in the number of uninsured children. Coverage expansions to parents with higher incomes than those examined here can be expected to increase the amount of substitution, while

coverage expansions directed at lower-income parents should result in lower levels of substitution. It is important to note, however, that substituting public for private insurance may yield large benefits to the low-income families who choose the public option—not only in reduced premiums, copayments, and deductions, but also in better benefits, including broader coverage of routine and other preventive care (Dubay and Kenney 2001). Some substitution may be the price society has to pay to achieve health insurance for the almost 40 million Americans currently uninsured.

Several states have expanded eligibility to parents since 1999. New York's recently approved expansion under a Medicaid waiver and California's proposed expansion using an SCHIP waiver have the potential to reach many uninsured parents. HCFA's apparent willingness to approve waivers under Medicaid and SCHIP provides states considerable flexibility to expand coverage to parents, although it is not clear whether any new federal funds will be made available for such expansions (Guyer 2001, Rosenblatt 2001). Ultimately, states' abilities and willingness to solve the problem of uninsured parents will depend on the political will to cover parents, the budget and economic situation facing states, and the federal resources that are available to help defray the cost of coverage expansions.

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Exhibit 1
Expansions In Coverage to Parents Beyond Welfare Thresholds

	Eligibility Threshold for Parents		Eligibility Threshold for Parents	
	1997	1997	1999	1999
	Medicaid	Separate Program	Medicaid	Separate Program
Delaware	100%		100%	
District of Columbia			200%	
Hawaii	100%		100%	
Massachusetts[1]	133%		133%	
Minnesota[2]		275%		275%
Missouri			100%	
Oregon	100%	100-170%	100%	100-170%
Rhode Island			185%	
Tennessee[3]	100%		100%	
Vermont	150%		150%	
Washington		200%		200%
Wisconsin[4]			185%	

[1] Massachusetts implemented its family coverage expansion in July of 1997. MassHealth also covers adults at higher incomes under certain circumstances, including: parents employed by small businesses that offer insurance coverage; and individuals eligible for unemployment benefits.

[2] In October of 1999, Minnesota began receiving federal matching payments for adults covered under Minnesota Care.

[3] TennCare also covers some parents at higher incomes who were enrolled when income thresholds for parents were higher.

[4] Wisconsin implemented its family coverage expansion in July of 1999.

Table 1: Insurance Distribution of Parents by Income, 1999

	All Parents		Low-Income Parents[a]		High-Income Parents[a]	
	Number (Millions)	Percent	Number (Millions)	Percent	Number (Millions)	Percent
Medicaid/State	4.1	6.3%	3.7	17.5%	.4	1.0%
Private/Other	51.0	77.6	9.8	46.7	41.2	92.2
Uninsured	10.6	16.1	7.6	35.9	3.0	6.8
Total	65.8		21.1		44.7	

[a] Low-income is defined as less than 200 percent of the federal poverty level (FPL) and high-income is defined as more than 200% of the FPL.

Source: Urban Institute Tabulations of 1999 National Survey of America's Families (NSAF)

Table 2: Potential Eligibility of Uninsured Parents for Medicaid or SCHIP

	Unadjusted Millions	Adjusted Millions	Unadjusted Percent	Adjusted Percent
Potentially Eligible for Medicaid/SCHIP	8.6	7.4	81	70
Citizen	6.3	6.3	59	59
Non-Citizen	2.3	1.1	22	11
Not Eligible for Either Program	2.0	3.2	19	30
Total	10.6	10.6	100%	100%

Source: Urban Institute Tabulations of 1999 NSAF, based on Medicaid and SCHIP rules in place for children in July 2000.

Note: Numbers may not sum because of rounding error. Unadjusted estimates treat foreign-born parents who are not citizens as potentially eligible if their incomes fall below the income thresholds for Medicaid and SCHIP coverage of children. The adjusted estimates assume that 52.2% of non-citizen uninsured parents are undocumented and thus not eligible for Medicaid and SCHIP.

Table 3: Classification of Uninsured Parents with Medicaid/SCHIP Eligible Children, According to Insurance Coverage of Children

	Uninsured Parents		Uninsured Parents By Citizenship			
	Millions	Percent	Citizen (Millions)	Percent	Non-Citizen (Millions)	Percent
Parent Potentially Eligible for Medicaid/SCHIP						
Child Enrolled in Medicaid/SCHIP	3.1	36%	2.3	36%	.9	38%
Child Uninsured	4.8	56%	3.4	54%	1.4	58%
Child with Private/Other Coverage	.7	8%	.6	10%	.09	4%
	8.6	100%	6.3	100%	2.3	100%

Source: Urban Institute tabulations of 1999 NSAF, based on Medicaid and SCHIP rules in place for children in July 2000.

Note: Numbers may not sum because of rounding error.

Table 4: Access to Care Among Parents with Medicaid/SCHIP Eligible Children By Insurance Status of Parent, 1999

Outcome	Uninsured Parents	Medicaid Covered Parents		Regression-adjusted difference[a] Medicaid vs. Uninsured[b]	
Usual source of care					
No usual source of care of ER as usual source	36.6%	17.4%	***	15.50%	***
Unmet or delayed health needs					
Not getting or postponing medical or surgical need	13.1%	9.7%	**	-6.9%	***
Not getting or postponing any needed care[c]	28.4%	28.8%		-7.1%	***
Confidence					
Not confident about obtained needed care	20.4%	10.2%	***	-10.7%	***
Access to care					
Any physician visits	42.93%	71.08%	***	19.0%	***
Any dental visits	37.23%	56.55%	***	7.46%	***
Breast examination[d]	33.11%	46.59%	***	10.8%	***

[a] The regression models control for health status (excellent, very good, good, fair, poor) activity limitations, age (18-23, 24-33, 34-43, 44-53, 54-64) race and ethnicity (Hispanic, black/non-Hispanic, white non-Hispanic), education (less than high school, high school college +), birthplace (US born, naturalized citizen, alien), family income as a percentage of poverty, geographic location, work status (full time, part time, or not working), and state. Uninsured parents.

[b] These numbers reflect regression-adjusted percentage point differences in the outcome between Medicaid insured and uninsured parents.

[c] Any unmet need includes postponing or forgoing medical or surgical care, dental care, or prescription drugs.

[d] Question asked of female respondents.

*** Significantly different from Uninsured at the 0.01 level.
** Significantly different from Uninsured at the 0.05 level.

Source: 1999 National Survey of America's Families

Table 5: Medicaid Participation Rates for Children Eligible Under the Poverty-Related Expansions by Family Coverage Status, 1999[1]

		Difference[2]	Regression-Adjusted Difference[2,3]
No Family coverage	57.1		
Family coverage under state-funded program[4]	78.5*	21.4*	21.9*
Family coverage under Medicaid program[5]	80.8*	23.6*	24.0*

[1] Participation rates exclude children with private insurance coverage and Medicare only coverage.

[2] Differences are measured between states with no family coverage and states with family coverage.

[3] Regression models control for age, race, and health status of child, education and nativity of parents, and income, number of children and welfare history of the family.

[4] Includes Minnesota and Washington

[5] Includes Oregon, Vermont, Delaware, Hawaii, Tennessee, Missouri, Massachusetts, District of Columbia and Rhode Island

* Significantly different than rate for children in states with no family coverage at the 0.05 level.

Source: 1999 National Survey of America's Families

Table 6: Medicaid Participation Rates for TANF-Related and Poverty-Related Eligible Children by Family Coverage Status, 1999

	No Family Coverage	Family Coverage State-Funded Program	Family Coverage Medicaid Program
Poverty-Related Eligibles	57.1	78.5	80.8
TANF-Related Eligibles	77.0	79.5	81.8
Difference Across Family Coverage Types[1]			
Poverty-Related			
Unadjusted		21.4 [a]	23.6 [a]
Adjusted[2]		23.6 [a]	24.0 [a]
TANF-Related			
Unadjusted		2.5	4.9
Adjusted		3.5	4.6
Difference Between Poverty-Related and TANF-Related within Family Coverage Type[3]			
Unadjusted	-19.8 [b]	-1.0	-1.1
Adjusted	-8.8 [b]	4.3	3.7
Difference Across Family Coverage Types Net of Underlying Differences Across States[4]			
Unadjusted		18.9 [c]	18.7 [c]
Adjusted		20.0 [c]	19.5 [c]

[a] Rate is significantly different than rate for those in states with no family coverage at the 0.05 level.

[b] Rate for poverty-related eligibles is different than the rate for TANF-related eligibles in the same family coverage type at the 0.05 level.

[c] Rate for poverty-related eligibles in states with family coverage is significantly different than rates for those in TANF-related at the 0.05 level.

[1] Represents participation rates for children in states with family coverage minus participation rates from children in states with no family coverage.

[2] Regression model controls for age, race and health status of child, work status, education and nativity of parent, income, number of children, and welfare history of children.

[3] Represents participation rate for poverty-related children minus participation rate for TANF-related children among states with the same family coverage type.

[4] Represents difference in participation rates between states with family coverage and states with no family coverage for poverty-related children minus same difference for TANF-related children.

Source: 1999 National Survey of America's Families

Table 7: Changes in Insurance Distribution of Children Eligible Under the Poverty-Related Expansions, Massachusetts and the Rest of the Nation, 1997-1999

	Massachusetts		Rest of the Nation		Difference-in-Difference		
	1997	1999	1997	1999	Unadjusted	Regression Adjusted with offers[1]	Regression Adjusted without offers[2]
Medicaid	42.3	63.6	30.3	33.9	17.7*	14.2*	15.4*
Uninsured	18.1	8.4	21.7	22.6	-10.6*	-11.0*	-9.3*
Private	39.3	28.0	48.0	43.6	-7.1	-3.2	-6.1
Crowd-Out Estimate						22.5%	39.6%

[1] Regressions include controls for year, year* Massachusetts, Massachusetts, age, race, and health status of child, work status, education and nativity of parent, and income, number of children, welfare history of the family, and whether the parents have an offer of employer sponsored coverage.

[2] Regressions include above mentioned controls and but do not control for whether the parents have an offer of employer sponsored coverage.

* Changes in rate for Massachusetts is significantly different than changes in the rate for the rest of the nation at the 0.05 level.

Source: 1997 and 1999 National Survey of America's Families

Appendix I :Model Specification

The effects of family coverage on Medicaid participation rates net of state-specific participation effects are estimated using the following equation:

$$Medicaid = b_o + b_1 pov + b_2 fcsp + b_3 fcmp + b_4 fcsp * pov + b_5 fcsp * pov + b_6 child + b_7 parent + b_8 family + b_9 state$$

Where: Medicaid = 1 if the child participates in Medicaid
Pov = 1 if child is eligible for Medicaid under the poverty-related expansions and 0 if child is eligible for Medicaid under TANF-related rules.
fcsp = 1 if the state covers parents under a separate program
fcmp = 1 if the state covers parents under the Medicaid program
child = a vector of child characteristics
parent = a vector of parent characteristics
family = a vector of family characteristics
state = a vector of state indicator variables

Using this specification, the coefficients on fcsp*pov and fcmp*pov represent the increase in Medicaid participation that occurs in states with family coverage net of underlying differences in participation across the states.

We estimate the effects of family coverage in Massachusetts on insurance coverage of children using the following models:

$$\text{Medicaid} = b_0 + b_1 Mass + b_2 Year + b_3 Mass * Year + b_4 Child + b_5 Parent + b_6 Family$$

$$\text{Private} = b_0 + b_1 Mass + b_2 Year + b_3 Mass * Year + b_4 Child + b_5 Parent + b_6 Family$$

$$\text{Uninsured} = b_0 + b_1 Mass + b_2 Year + b_3 Mass * Year + b_4 Child + b_5 Parent + b_6 Family$$

Where: Medicaid = 1 if child participates in Medicaid
Private = 1 if child has private coverage
Uninsured = 1 if child is uninsured
Mass = 1 if child resides in Massachusetts
year = 1 if year is 1999
child = a vector of child characteristics
parent = a vector of parent characteristics
family = a vector of family characteristics
state = a vector of state indicator variables

Using this specification the coefficients on Mass*year in each equation represent the difference-in-difference estimate of the effect of family coverage on insurance coverage. The share of the increase in Medicaid participation attributable to reductions in uninsurance is the ratio of $\$_3$ the equation predicting uninsurance to $\$_{3M}$ in the equation predicting Medicaid participation.

Appendix 2: Changes in Insurance Distribution of Children Eligible Under the Poverty-Related Expansions, Massachusetts and the Rest of the Nation (Excluding Minnesota and Wisconsin), 1997-1999

	Massachusetts		Rest of the Nation		Difference-in-Difference		
	1997	1999	1997	1999	Unadjusted	Regression Adjusted with Offers[1]	Regression Adjusted without Offers[2]
Medicaid	42.3	63.6	30.5	34.2	17.5*	13.8*	15.0*
Uninsured	18.1	8.4	22.5	23.6	-10.8*	-11.0*	-9.4*
Private	39.6	28.0	47.0	43.3	-6.8	-2.8	-5.6
Crowd-Out Estimate						20.3%	37.3%

[1] Regressions include controls for year, year* Massachusetts, Massachusetts, age, race, and health status of child, work status, education and nativity of parent, and income, number of children, welfare history of the family, and whether the parents have an offer of employer sponsored coverage.

[2] Regressions include above mentioned controls and but do not control for whether the parents have an offer of employer sponsored coverage.

* Changes in rate for Massachusetts is significantly different than changes in the rate for the rest of the nation at the 0.05 level.

Source: 1997 and 1999 National Survey of America's Families