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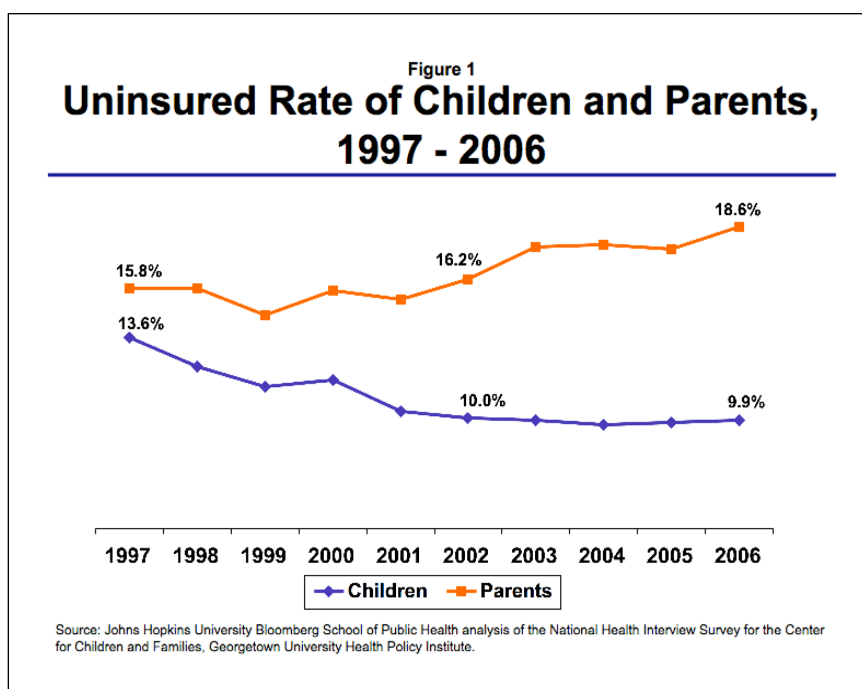
Family Coverage: Covering Parents Along with Their Children

Summary

While much progress has been made over the last decade in lowering the rate of uninsured children, the uninsured rate for parents remains significantly higher than for their children—and it has been growing rather than declining (Figure 1). The primary reason for these very different coverage rates is that while employer based coverage has eroded for both children and their parents, publicly funded coverage programs (Medicaid and the State Children's Health Insurance Program; SCHIP) have more than offset the declines for children. States, however, can take steps similar to those that have been taken on behalf of children to expand coverage to parents and to ensure that those who are eligible are enrolled. With increased interest at the state level on finding solutions to the health care crises, covering parents is a logical "next step" for many states.



Framing the Issue

As the Institute of Medicine concluded in a major report it issued in 2002, health insurance is "a family matter."[1]

- **Family coverage promotes child and family well-being.** Parents without health care coverage are less able to access care.[2] When parents lack the medical care they need their ability to work, support their families, and care for their children is compromised.

- **Parent coverage promotes children's coverage.** Studies and state experience have consistently shown that covering parents promotes coverage and access to care for children.[3] Low-income families with uninsured parents are three times as likely to have uninsured children compared to parents with private coverage or Medicaid.[4]

With the cost of private insurance rising far more rapidly than earnings, parents with a full-time, full-year job no longer have any guarantee of coverage through their employer. This is especially

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true for lower-wage earners, who are often employed at small firms or at the type of jobs that are less likely to offer coverage. Employer-based insurance has been declining for all wager earners, but the steepest declines over the past six years have been among the lowest-income workers.[5]

Medicaid and SCHIP have been very successful in reducing the uninsured rate among low-income children, and Medicaid can help states achieve positive results for their uninsured parents as well.[6] Federal Medicaid funding is available to states to cover parents—no waiver is required.

Data

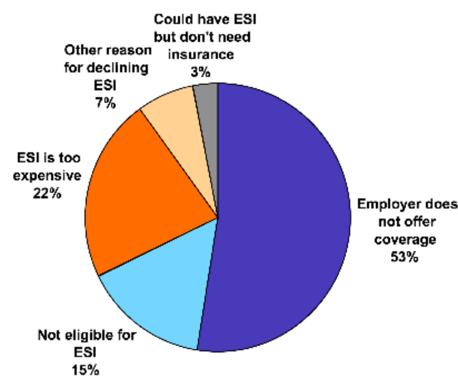
Nationwide, parents account for nearly a quarter of the 47 million uninsured Americans. According to a 2005 survey:[7]

- Nearly four out of every 10 low-income parents (39 percent) lacked health insurance in 2005. The vast majority (82 percent) of low-income parents without coverage have at least one full-time worker in the family.

- The high uninsurance rate among low-income parents comes about due to a lack of both private and public insurance options. Among low-income uninsured parents in employed families, nearly 90 percent either had no offer of insurance or the insurance was too expensive to take up (Figure 2). The private coverage rates are low because so many low-wage parents are employed in small firms and at the kinds of jobs (construction, service sector, and agriculture) that are far less likely to offer health insurance. At the same time, many of these low-income parents do not qualify for publicly-funded coverage because the Medicaid income eligibility levels for parents is very low in many states.

Figure 2

Access to ESI for Uninsured Low-Income Parents in Working Families



Note: Parents in families where no one is working for an outside employer are excluded from this analysis. Other reasons for declining coverage include difficulties with paperwork, only recently becoming eligible, and coverage not being comprehensive enough.

Source: K. Schwartz, "Spotlight on Uninsured Parents: How a Lack of Coverage Affects Parents and Their Families," Kaiser Commission on Medicaid and the Uninsured (June 2007), based on Kaiser Low-Income Coverage and Access Survey, 2005.

Where States Stand

Eligibility

State Medicaid eligibility levels for parents are quite low in most states, but some states have moved forward to expand coverage for parents. As of January 2008:[8]

- A parent who is employed but whose total family income still leaves them below the federal poverty level (FPL) would be ineligible (i.e., over income) for Medicaid in 27 states. (The federal poverty level is equivalent to annual income of $17,600 for a family of three in 2008.)

- On the other hand, several states have taken advantage of federal options to expand coverage for parents through Medicaid. Full Medicaid coverage is available to parents with incomes at or above the poverty line in 16 states; an additional eight states have extended more limited (sometimes very limited) coverage to parents at this income level through waivers or state funds.[9]

(See http://ccf.georgetown.edu/index/medicaid-and-schip-programs for parent eligibility levels by state.)

Simplification
Most, if not all, of the enrollment/renewal simplification steps that states have taken to boost participation rates for children in Medicaid and SCHIP can be taken with respect to parents. However, in many states, the simplification measures adopted for children have not been applied to family-based coverage. As of January 2008:[10]

- Only 28 states had a simplified family coverage application similar to the simplified applications that virtually all states use for children;

- 40 states had dropped the application interview requirement for parents compared to 46 for children;

- 22 states had dropped their asset test for parents, compared to 46 states that have no asset test for children; and

- Renewal procedures also differ in some states for parents as compared to their children; for example, New Hampshire and North Carolina have 12-month renewal periods for children but 6-month renewal periods for parents.

(See http://ccf.georgetown.edu/index/medicaid-and-schip-programs for parent Medicaid/SCHIP simplification measures by state.)

Legislative Authority

Eligibility
States have the option under federal Medicaid law to expand coverage for parents above federal minimum standards. It is particularly important for states to exercise this option because the federal Medicaid *minimum* coverage requirements for parents are much lower than for children.

- **Children:** At a minimum, states must cover children in Medicaid with incomes below 100 percent of the FPL for children age six and over and below 133 percent of the FPL for children under age six.

- **Parents:** The federal minimum eligibility level for parents is tied to each state's 1996

eligibility levels in the former cash assistance program, Aid to Families with Dependent Children (now known as TANF). In almost every state, this minimum eligibility level is well below the federal poverty level. In some states, it is below 20 percent of the federal poverty level.

States have the legal authority to expand eligibility for parents above these minimum requirements.

- **Under a federal option, states can raise their income eligibility levels for parents to whatever level they choose.**[11] There is no cap on the eligibility levels states can adopt, as long as states are able to provide the matching funds. Some states that have expanded eligibility for parents have adopted the same income level for parents and children, while others have not gone quite as high for parents as they have for children. For example, as of January 2008, Arizona and Maine cover parents and children up to 200 percent of the FPL, while Connecticut covers parents up to 185 percent of the FPL and children up to 300 percent of the FPL.

- **Some states have used waivers instead of the regular legislative option to expand coverage for parents.** In general, states that have relied on waivers have done so either because they wanted to narrow the scope of eligibility (for example to just cover parents whose employers contribute toward the cost of coverage) or because they wanted to use some of their federal SCHIP funds to cover parents. SCHIP funds normally cannot be used to cover parents but under the Clinton and Bush administrations some states were granted waivers to cover parents with SCHIP funds at the more advantageous "enhanced" matching rate.[12] However, in August 2007, the Secretary of Health and Human Services announced that he would no longer approve or renew SCHIP parent waivers.[13] As parent waivers come up for renewal, funding for coverage is generally moved from SCHIP to Medicaid.

Benefits

Federal Medicaid law accords states more discretion in designing the benefit package for adults as compared to children. Under the basic federal benefit rules governing adult coverage, states must cover certain "mandatory" benefits while other benefits are "optional." Once a state decides to cover a benefit, it must assure that the scope of coverage is sufficient to meet minimum federal standards.[14] Federal Early Periodic Screening Diagnostic and Treatment (EPSDT) requirements, which require that states cover regular preventive screening and all medically necessary services, apply only to children.

New federal rules adopted as part of the federal Deficit Reduction Act of 2005 (DRA) further expanded state flexibility to design benefit packages for adults, allowing states to adopt what are referred to in the law as "benchmark" benefit packages.[15] In general, these benchmarks are similar to the benchmarks that apply in separate SCHIP programs. It is important to note, however, that the adults covered under Medicaid expansions generally have much lower incomes than the children covered through SCHIP. Parents with income this low have little ability to afford care that is not covered as part of the benefit plan. The DRA also gives states the authority to design different benefit plans for different groups of adults.

Cost sharing

As is true for benefits, states have greater flexibility to charge parents premiums and cost sharing than they do for children, although recent changes adopted in the DRA have narrowed the differences somewhat. (See http://ccf.georgetown.edu/index/strategy-center for a discussion of the children and parent cost sharing rules.)

Strategies and Considerations

Cost issues

As a state considers whether or not to expand coverage for parents, cost considerations are likely to arise. Some issues to consider include the following:

- **Often the "most expensive" adults are already covered.** As a state considers the cost of a parent coverage expansion, it is important to take into account other eligibility groups that the state is already covering. Typically, states are already providing coverage to some of the most expensive groups of adults at higher incomes (e.g., pregnant women and adults with disabilities), so when they expand coverage to parents they are not picking up these costly individuals. In developing cost estimates, it is important to "back out" the cost of the more expensive groups of adults that the state is already covering (including those in state high-risk pools).

- **A more comprehensive benefit package can bring in federal funds for services the state might otherwise pay for with state dollars**. Over the years, states have added optional benefits to their adult coverage packages in part because without this coverage the state might be providing some of these health care services through public clinics or hospitals. By including these services as part of the Medicaid benefit plan for adults, states can draw down federal matching payments for health care services that parents need and that otherwise might be financed with only state or local funds. In addition, states have often covered optional services, like prescription drugs and targeted case management, for adults because coverage of these services can help avoid more costly "mandatory" care, such as in-patient hospital care.

Crowd out

Issues relating to publicly-funded coverage substituting for (or "crowding out") private coverage often arise when states are considering Medicaid or SCHIP coverage expansions. (See http://ccf.georgetown.edu/index/strategy-center for a discussion on crowd out.) Given how low current Medicaid income levels are for parents in most states, however, crowd out concerns should be less of an issue for parent expansions. The likelihood of crowd out is much less at lower income levels because of the very limited availability of private insurance. For instance, one study found that three-quarters of child SCHIP enrollees live in families in which at least one parent is not covered by employer-sponsored insurance.[16]

Reaching Eligible but Unenrolled Parents

Beyond cost issues there is the question of how states can assure that they are reaching eligible parents. As is true with children, raising eligibility levels is only the first step to covering parents. Whether or not a state expands parent eligibility, federal law permits states to have simplified Medicaid application and renewal procedures for family/parent coverage. Most of the simplification steps that have been taken on behalf of children can be carried over to parents.

For example, states can:

- Drop (or liberalize) the asset test requirement;
- Use short, simplified mail-in applications and renewal forms;
- Eliminate requirements for face-to-face interviews at application or renewal;
- Limit paperwork requirements for verification of eligibility (subject to the citizenship documentation requirements that apply to most parents as well as to children);
- Renew eligibility every 12 months (instead of more frequently); and
- Conduct outreach to inform parents that they (as well as their children) may be eligible for Medicaid. States can receive federal matching payments to help defray the cost of outreach.

There are two main differences in federal law regarding simplification options for children and parents; however, states can take steps to minimize these differences.

- The **continuous eligibility** option does not explicitly apply to parents, but states have the flexibility to effectively obtain the same result by opting to disregard changes in income that occur between renewal periods. (See http://ccf.georgetown.edu/index/strategy-center for a discussion of continuous eligibility). For example, to promote continuity in family coverage (and reduce administrative costs) a state can decide to disregard all changes in earnings or changes in earnings that do not exceed a certain level (e.g., $100 per month) between renewals.[17]

- **Presumptive eligibility** is also not explicitly permitted for parents under federal Medicaid laws. The option for children allows states to authorize health care providers, community-based organizations, and other "qualified entities" to temporarily enroll children who appear eligible into Medicaid so that they can receive coverage while the agency determines eligibility. Under the option, the federal government guarantees federal matching payment for coverage during the presumptive eligibility period even if the child is later not found to be eligible. A state could effectively extend the option to family-based coverage by allowing qualified entities to presumptively enroll parents as well as children. The state would receive federal matching payments for services provided to parents during the presumptive eligibility period *if* the parent were ultimately found eligible as part of Medicaid's retroactive coverage provision. If the parent were ultimately not found eligible the cost of the presumptive eligibility period for the parent would have to be covered with state funds.

Premium Assistance

Family coverage expansions sometimes prompt states to consider premium assistance since it is more amenable to family coverage than to child-only coverage. Premium assistance is when states cover individuals by buying into private insurance coverage, usually employer-based plans. Medicaid law allows states to use Medicaid funds for premium assistance under certain circumstances, namely if the investment is cost effective. The possibility of covering families by subsidizing private insurance may help build political support for a Medicaid expansion but it also raises some complex issues.

- Premium assistance has potential advantages. To the extent that the state is subsidizing and supplementing an insurance plan to which an employer is contributing, premium

assistance can potentially reduce the cost of Medicaid coverage,[18] as the employer's contribution reduces both the state and the federal shares of the costs. In addition, premium assistance can potentially open up access to providers that may not be participating in Medicaid.

- Some investments in private insurance, however, may not be cost effective and the costs per person could be higher than they might appear. Private insurance plans generally pay providers at higher rates than Medicaid so the cost of covering a parent by subsidizing a private policy might be higher than Medicaid, particularly when cost sharing and the scope of benefits covered under the private plan are taken into account. Cost effectiveness will also be affected by the size of the employer's contribution and the state's administrative costs, which can be significant particularly in light of relatively low take up.

In most states that have adopted premium assistance programs, actual enrollment in the plans has been quite modest.[19] Depending on a state's Medicaid eligibility levels, eligible parents may have very little access to cost-effective private insurance.

Resources

- Center for Children and Families Website http://ccf.georgetown.edu/index/resource-center: parent eligibility levels and enrollment procedures, resources on private coverage, including cost data, and resources on premium assistance.
- Kaiser Commission on Medicaid and the Uninsured, "Fact Sheet: Health Coverage for Low-Income Parents," (February 2007).
- Government Accountability Office, "State Children's Health Insurance Program: Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States that Cover Adults," (November 2007).
- K. Schwartz, "Spotlight on Uninsured Parents: How a Lack of Coverage Affects Parents and Their Families," Kaiser Commission on Medicaid and the Uninsured (June 2007).
- S. Rosenbaum & R. Perez Trevino Whittington, "Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature," First Focus (June 2007).
- S. Artiga & C. Mann, "Family Coverage Under SCHIP Waviers," Kaiser Commission on Medicaid and the Uninsured (May 2007).
- L. Ku & M. Broaddus, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities (October 20, 2006).
- Institute of Medicine, Health Insurance Is a Family Matter, (National Academies Press: Washington, DC; September, 2002).

Endnotes

[1] Institute of Medicine, Health Insurance Is a Family Matter, (National Academies Press: Washington, DC; September, 2002).
[2] Kaiser Commission on Medicaid and the Uninsured, "Fact Sheet: Health Coverage for Low-Income Parents," (February 2007). Sixty-nine percent of uninsured low-income adults had no preventive care in the previous 12 months and half of uninsured low-income adults in fair or poor health had not had visited a doctor's office within a year (compared to 27 percent of low-income insured adults with similar health problems).
[3] S. Rosenbaum & R. Perez Trevino Whittington, "Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature," First Focus (June 2007); and L. Ku & M. Broaddus, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities (October 20, 2006).
[4] K. Schwartz, "Spotlight on Uninsured Parents: How a Lack of Coverage Affects Parents and Their Families," Kaiser Commission on Medicaid and the Uninsured (June 2007).
[5] E. Gould, "The Erosion of Employment-based Insurance," Economic Policy Institute (November 2007).
[6] For example, see L. Dubay & G. Kenney, "Addressing Coverage Gaps for Low-Income Parents," *Health Affairs*, 23: 225-234 (2004).
[7] *Op. cit.* (4).
[8] D. Cohen Ross, A. Horn & C. Marks, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," Kaiser Commission on Medicaid and the Uninsured (January 2008).
[9] In the states with limited coverage, either the eligibility is constrained, for example because the parent can only qualify if his or her employer contributes, and/or the benefits are limited. In some cases, this coverage is financed with state only funds.
[10] *Op. cit.* (8).
[11] The family coverage option that allows states to expand coverage to parents above federal minimum standards is found at section 1931 of Title XIX of the Social Security Act; see also M. Birnbaum, "Expanding Coverage to Parents Through Medicaid Section 1931," State Coverage Initiatives (May 2000).
[12] S. Artiga & C. Mann, "Family Coverage Under SCHIP Waviers", Kaiser Commission on Medicaid and the Uninsured (May 2007); and Government Accountability Office, "State Children's Health Insurance Program: Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States that Cover Adults," (November 2007).
[13] See letter from Secretary Michael O. Leavitt, Department of Health and Human Services, to Senator Chuck Grassley, Ranking Member of the Finance Committee (July 31, 2007).
[14] See Kaiser Family Foundation, The Medicaid Resource Book (July 2002).
[15] 72 *Fed. Reg.* Number 36 (February 22, 2008). See also Centers for Medicare and Medicaid Services, "Deficit Reduction Act;" J. Guyer, C. Mann, & J. Alker, "The Deficit Reduction Act: A Review of Key Medicaid Provisions Affecting Children and Families," Center for Children and Families (March 2006); and Kaiser Commission on Medicaid and the Uninsured, "Deficit Reduction Act of 2005: Implications for Medicaid," (February 2006).
[16] G. Kenney & A. Cook, "Coverage Patterns among SCHIP-eligible Children and Their Parents," The Urban Institute (February 2007).
[17] Centers for Medicare and Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," (July 2001).
[18] For example, see National Academy for State Health Policy, "Premium Assistance Toolbox for States," (2004).
[19] For example, see J. Alker, "Choosing Premium Assistance: What Does State Experience Tell Us?," Kaiser Commission on Medicaid and the Uninsured (May 2008).

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