Intra-Family Differences in Health Insurance Coverage

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Abstract

Public programs are an increasingly important way for children to obtain health insurance coverage. In 2009, over one third (35.2 percent) of insured children age 18 and under were covered by Medicaid, the Children's Health Insurance Program (CHIP), or other means-tested public coverage programs (Mach and Blumenthal, 2010). However, program eligibility criteria and procedures for parents and children can differ, leading to intra-family differences in health insurance coverage (discordant coverage). Literature suggests that intra-family discordant coverage may hinder children's access to care or reduce the utility of their coverage (Ku and Broaddus, 2000; Davidoff et. al, 2003; Minkovitz et. al, 2002). In addition, the propensity of families to substitute CHIP for private health insurance (crowd-out) is a growing concern for policymakers since the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Blewett and Call, 2007; Gruber and Simon, 2008; U.S. GAO, 2009).

This national and state-level analysis uses the 2009 American Community Survey (ACS) to estimate within-family differences in health insurance coverage by discordant coverage status and type. From these estimates, we create a crude measure of child crowd-out at the state level. Our national-level analysis focuses on the socioeconomic characteristics of children covered by Medicaid or CHIP whose parents are uninsured or privately covered. Generally, states with more family-inclusive Medicaid/CHIP policies have more cohesive intra-family public coverage. Few states meet our child crowd-out hypothesis, and we find little evidence that states with more family-inclusive policy are more likely to have crowd-out. The results suggest that child crowd-out may not be as relevant as family crowd-out: states make decisions that may induce the whole family to substitute public coverage in place of employer-based insurance.

Keywords: Medicaid, CHIP, Health Insurance Coverage, ACS, crowd-out

INTRODUCTION

Between 2008 and 2009, children were losing private health insurance and gaining public coverage. The net effect was an increase of 1.1 million children with coverage in the United States (Mach and Blumenthal, 2010). Adults were more likely to be uninsured than children, primarily due to loss of employer-based health insurance (authors' own calculations based on 2008 and 2009 American Community Surveys).

While employer-based coverage declined for adults and children, not all parents had the same insurance coverage status and type as their children. There are a variety of ways these differences can occur. For example, after losing a job and the health insurance it provides, a parent may become uninsured while the child obtains public coverage (Czajka, 2000; Holahan, 2009). Even those parents that remain employed and insured can nonetheless lose the benefit of family coverage, and use the public insurance safety net for the children. However, some employed parents will drop employer-based family coverage, but maintain their individual coverage, and enroll their children in public health insurance (Blewett and Call, 2007; Cutler and Gruber, 1996). The substitution of public health insurance for private insurance is termed "crowd-out".

The prominent public insurance programs for those under age 65 are Medicaid and the Children's Health Insurance Program (CHIP). These programs target low-income children as well as adults with disabilities. The definition of "low-income" varies from state to state. All states offer public insurance to children's parents, but often only if they meet more restrictive, low-income criteria. The parents of children who qualify for Medicaid or CHIP are not always eligible themselves (Ross et. al, 2009).

These differences in child and parent eligibility for Medicaid and CHIP can cause a child to have a different insurance coverage type than the parents. Hereafter, we call this phenomenon "discordant" coverage (intra-family differences in type of health insurance), and we refer "Medicaid or other means-tested public coverage" as just "Medicaid".

This paper gives a tabular analysis of the characteristics of Medicaid children and parents that have discordant coverage. We shed light on the socioeconomic characteristics of children covered by Medicaid or other means-tested public coverage. In addition, at the state level we examine Medicaid children by child-parent discordant coverage rate as well as by parent discordant coverage type (i.e., privately covered parents or uninsured parents). We then use these measures to create a crude measure for state crowd-out potential.

LITERATURE REVIEW

Discordant child-parent coverage can negatively impact the efficacy of public insurance programs. Specifically, parent coverage status has an effect on children's coverage status, access to care and regularity of care. Even among insured children, those with an uninsured parent are less likely to visit a medical provider than those with insured parents (Davidoff et. al, 2003). Pertaining to Medicaid-and CHIP- eligible children, literature finds that offering Medicaid coverage to parents increases children's program participation and reduces the number of uninsured children (Ku and Broaddus, 2000; Dubay and Kenney, 2003). There is also evidence that parent familiarity with a child's health care provider may affect a child's health care ulitization, supporting the notion that children sharing the same coverage type as their parents (i.e. both privately insured) have increased health care utilization (Minkovitz et. al, 2002).

While uninsured parents may inhibit Medicaid children from reaping the full benefit of coverage, Medicaid children with privately covered parents pose a potential crowd-out risk for policymakers. Crowd-out in this context is the propensity of families to drop their children's private health insurance and enroll income-eligible children in lower-cost means-tested public coverage (i.e., CHIP). Estimates of child crowd-out vary from 0 to 60 percent. To combat this issue, the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 only allowed states to expand their CHIP income-eligibility thresholds if they implemented rules to prevent crowd-out (U.S. GAO, 2009; Gruber and Simon, 2008; Blewett and Call, 2007).

For Medicaid and CHIP, eligibility and renewal rules and procedures vary by state, and are enforced at varying intervals. For instance, some states enforce child income-eligibility tests only at application and for annual renewal; other states require an income test after four months of enrollment. Some requirements for obtaining and maintaining coverage include: waiting periods (requiring children to be uninsured for a duration before enrollment), income tests, face-to-face interviews and asset tests (Ross et. al, 2009).

Parents can be eligible for Medicaid or CHIP under certain circumstances. The income-eligibility threshold (a percentage of the Federal Poverty Line [FPL]) for parents is always lower than for children; however, working parents have a higher income-eligibility threshold than non-working parents. Some states alleviate the burden of the Medicaid/CHIP application process on parents by offering a coordinated family application. States with a coordinated family application allow parents to apply for coverage at the same time they apply their child for coverage. A parent fills out one application form for the entire family (all parents and children) for Medicaid and CHIP coverage (Ross et. al, 2009).

We approach our state-level results through the lens of three program eligibility and procedural policies that vary by state: child income eligibility; working-parent income eligibility; and the availability of a coordinated family application. These measures serve multiple purposes in our

analysis. Child income eligibility informs us of state program generosity and crowd-out risk; working-parent income eligibility, and the difference between a state's child and working-parent income-eligibility thresholds highlights a state's potential for discordant coverage; and the coordinated family application option represents a state's effort to promote family coverage.

AMERICAN COMMUNITY SURVEY

This research uses data from the 2009 1-year American Community Survey (ACS). The ACS's annual sample of approximately 3 million addresses nationwide provides demographic, social, economic and housing data for the nation, states and sub-state localities every year. In addition to its robust sample, the ACS measures both household-level and person-level attributes, and features the relationship variables necessary to study within-family health insurance coverage differences.

The ACS has included a question on health insurance coverage since 2008. The question asks respondents about their current health insurance coverage at the time of the survey and classifies their responses into any of seven coverage categories. Indian Health Service, one of the seven health insurance coverage types, is not considered to be health insurance covering a wide array of medical services (SHADAC, 2005). The remainder of these coverage options is broadly defined as either public coverage or private health insurance.

The private health insurance types are employer-based health insurance, direct-purchase health insurance, and TRICARE or other military health coverage; the public coverage types are Medicare, Medicaid or other means-tested public coverage (i.e., CHIP), and VA Health Care. A person can have both public and private coverage (e.g., Medicare and employer-based insurance). Respondents who indicate that they have no health insurance coverage are considered uninsured. In this analysis, we look at the broad categories of public coverage, private coverage, and no coverage (uninsured) for both parents and children; and specifically at Medicaid or other means-tested public coverage for children only.

The ACS does not create within-family relationship pointers to identify family relationships, so we must create child-parent pointers within each household using assumptions based on age and the householder's relationship identifiers. The easiest child-parent pointer is a householder with related children. For subfamilies, it becomes more difficult. If there is a daughter of the householder and there is a grandchild of the householder, we assume that the sub-family consists of the daughter and grandchild. This is an assumption because the grandchild does not necessarily belong to the daughter of the householder. In multiple, related sub-families, the ACS makes its best guess based on auxiliary information.

For non-relative relationship categories, we cannot distinguish within-category familial relationships; e.g., if both parents and their children are categorized as "roomer/boarders" or "other non-relatives" in a household, they will not be recognized as a family unit. Since the survey cannot recognize familial relationships from within the respondent's generalized classifications, these cases are discarded.

METHODOLOGY

For our analysis, we create a universe of children age 18 and under, living at home with at least one parent, and assign parent attributes to the children. In addition, we take into account the incidence of primary (reference)-family children who are parents in sub-family units (teenage parents). We classify the teen parent as both a child in the householder's family unit and as a parent in a sub-family unit. Subsequently, every parent-child family unit includes at least one child and either one or two related parents. The previously explained caveat applies when creating family units – the ACS does not have child-parent pointers.

With child-parent relationships identified, we create a children-only dataset and assign parent and family attributes to related children. These parent characteristics include: number of children, number of working parents, and parent health insurance status and type of coverage. Since the unit of measurement is the child (not the family or parent), parent-attributed variables from a family unit apply to every child in that family unit. This means that while a child occurs only once in the analytical sample, parent attributes may reoccur in the sample if the parents have more than one child.

People can be covered by both private and public health insurance. For example, a person on Medicare can also be covered by insurance provided through their employer. In an effort to simplify our analysis of intra-family (child-parent) differences in health insurance coverage, we use three mutually exclusive insurance coverage categories to determine the coverage type of the child and the parent unit: private (only), public, and uninsured. In the case of a child living with two parents, parent public coverage means that at least one parent has public coverage; private coverage means that at least one parent has a private plan and no parent has public coverage; and uninsured means that both parents are uninsured. When we use phrases such as "parent coverage status/type," we are referring to the parent coverage categories defined above.

A limitation of our approach's parent coverage definition is that it does not take into account those parents who reside outside of the child's household. If a child obtains health insurance through a non-resident parent, that corresponding coverage may not be identified in the parent coverage type, unless the residing parent is also a dependant on the non-resident's plan (or coincidentally shares the same coverage type).

The term "concordance" is used in this paper to refer to the degree of similarity of health insurance coverage within child-parent pairs. The concordance of a child-parent pair can be either concordant or discordant. Discordant coverage occurs when (1) an uninsured child has a publicly or privately covered parent unit, (2) a publicly covered child has an uninsured or privately covered parent unit, or (3) a privately covered child has an uninsured or publicly covered parent unit. This analysis concentrates on discordant family coverage type (2): when a publicly covered child (i.e., on Medicaid) has parents who are privately covered or uninsured.

We define child crowd-out as the possibility that a family substitutes a child's private insurance for public insurance, which we also associate with high rates of publicly covered (i.e., Medicaid) children with privately covered parents. We do not discuss the possibility that the whole family substitutes public coverage for private insurance; if that were the case, low discordant coverage might be the result of whole family crowd-out.

The analysis relies on tabular results. We use Fay's Balanced Repeated Replication (BRR) method (U.S. Census Bureau, 2010) to calculate variances. The socioeconomic characteristics examined in this analysis incorporate child, parent and family-level measures:

- Child's health insurance coverage (i.e., uninsured, privately covered or publicly covered/on Medicaid)
- Parent(s)' working status and health insurance coverage (i.e., uninsured, privately covered or publicly covered)
- Family income-to-poverty ratio and family structure (number of parents and children)

TABULAR RESULTS

National Level

In our descriptive analysis at the national level, we initially look at child-parent discordant coverage patterns for all children, and then focus specifically on the characteristics of Medicaid children's family structure, family income and parent working status.

Child-parent health insurance discordance (all children).

One in five (15 million) children have a different coverage type than their parents (See Table 1a). Over half of this intra-family discord is from the 8.2 million (54.3 percent) insured children whose parents are uninsured. Of these insured children with uninsured parents, 7.1 million (87.1 percent) are publicly covered (See Table 1b). Another 5.7 million cases of discordant coverage occur among children whose parents are privately covered when the children are not; of these children, 4.3 million (76.0 percent) are publicly covered, and 1.4 million (24.0 percent) are uninsured. Discordant coverage occurs in the remainder of children when parents are publicly covered but the children have no public coverage (1.2 million).

Of all intra-family discordant coverage, 75.9 percent occurs among publicly covered children. However, when we look exclusively at publicly covered children, the majority of them (51.3 percent) have parents who are also on public coverage (concordantly covered). Less than one fifth (18.2 percent) have privately covered parents, and this is the population in which child crowd-out potentially occurs at the national level.

Family structure of Medicaid children versus all children.

As Table 2 shows, Medicaid children are over-represented among children from single-parent families and under-represented among children from two-parent families. That said, a surprising 42.6 percent of Medicaid children do live with two parents.

While most children overall live with two parents (66.4 percent), most Medicaid children live with only one parent (57.4 percent). Over half of all children in single-parent families are on Medicaid (53.3 percent), while only one fifth of all children in two-parent families are on Medicaid. More Medicaid children live in single-parent families with siblings than any other family arrangement. They are least likely to be an only-child in a two-parent family (6.1 percent of Medicaid children, compared to 13.1 percent of all children).

Family income of Medicaid children.

Income level is the most important indicator of eligibility for Medicaid or CHIP. Even though children's income eligibility thresholds range from 100 to 400 of the FPL (depending on the child's age and state of residence), Medicaid children are more likely to be in poverty than in any other income bracket, and 80.1 percent of Medicaid children's incomes fall below 200 percent of the FPL.

As shown in Table 3, when the family income-to-poverty ratio increases (as a percentage of the FPL), Medicaid children's parents are more likely to have private insurance. This supports prior crowd-out literature (Blewett and Call, 2007; Gruber and Kosali, 2008; U.S. GAO, 2009). Medicaid children in families that are not in poverty are at least three times more likely to have a parent with private coverage than those children in poverty (below 100 percent of the FPL).

Medicaid children in poverty have the highest rate of concordant public coverage with their parents (6.7 million, 62.1 percent), whereas those children who are not in poverty have concordance rates below the Medicaid average (51.5 percent). This speaks to the fact that the discrepancy between child and parent income eligibility thresholds tends to be larger in states with more generous child income thresholds (StateHealthFacts.org, 2009). Following other income patterns, we expected children at or above 300 percent of the FPL to be the least likely to have publicly covered parents (41.5 percent); when in fact, children between 200-299 percent of the FPL were least likely (38.8 percent) to have publicly covered parents. However, there are also more children within 200-299 percent of the FPL (2.8 million) than at higher income-to-poverty ratios (1.8 million at or above 300 percent of the FPL).

The highest percentage of Medicaid children with uninsured parents is among those that are within 100-199 percent of the FPL (32.0 percent); the lowest is among those children at or above 300 percent of the FPL (22.8 percent).

These results are not surprising. Medicaid and CHIP income-eligibility thresholds differ for parents and children; the difference between states' child income-eligibility thresholds and working-parent thresholds averaged 156 percentage points in 2009 (child income threshold minus working-parent threshold) (StateHealthFacts.org, 2009).

Employment/Working status of the parents of Medicaid children.

Medicaid children are most likely to have working parents when their parents are privately covered, as these families should have better access to employer-based insurance. There are similar patterns in employment between single-parent and two-parent family households of Medicaid children (See Table 4). In both parent scenarios, children are more likely to have working parents; however, the likelihood that a child's parents do not work is significantly greater among children from single-parent families (44.7 percent) than those from two-parent families (13.2 percent).

Among Medicaid children in single-parent households, children whose parents are publicly covered are more than five times more likely to have a non-working parent (57.5 percent) than those with a privately covered parent (9.7 percent). Single-parent children with an uninsured parent are more likely to have a working parent (62.1 percent) than those with a publicly covered parent (42.5 percent).

Among Medicaid children from two-parent family households, we see analogous parent employment trends. Two-parent children with publicly covered parents are almost nine times more likely to have two non-working parents (20.6 percent) than those with privately covered parents (2.4 percent). These results are expected because children with working parents are more likely to have employer-based coverage; crowd-out is most likely to occur in this sub-group.

State Level

At the state level, we look solely at Medicaid children. Because states have different child income-eligibility standards, we chose to make comparisons of uninsured parent and privately covered parent rates for only the subset of children below 200 percent of the FPL who represent the majority of the Medicaid population (similar to the restriction used by Davidoff et. al, 2001). In addition, since only a handful of states offer coverage to working parents above the 200 percent of the FPL income threshold, and only four states have child income eligibility below it, applying this cut-off makes comparisons of child-parent coverage patterns more equitable across states.

As we would expect, focusing on Medicaid's lower-income population tempers state-level discordant coverage, because parents in this income bracket are more likely to be eligible for state programs (these children are more likely to have concordantly covered parents). Further, we would anticipate that the discord that does exist is more likely due to parent uninsurance than parent private coverage, which is generally the case.

We make comparisons to the national average for state (1) child-parent discordant coverage, (2) uninsured parent, and (3) privately covered parent rates. In comparing the inter-dynamics of

these three estimates, we search for relationships between the family inclusiveness of state program-eligibility policy and state crowd-out potential. We consult three policy measures to provide perspective on the implications of state policy on the data: (1) working-parent income-eligibility threshold, (2) child income-eligibility threshold, and (3) availability of a coordinated family application.

Discordant Coverage: Medicaid children whose parents do not have public coverage.

Although examining discordance rate alone does not show a state's crowd-out potential, state discordance rate can highlight whether uninsured and/or privately covered parent rates could feed into an over-arching intra-family discordance issue (which could correlate with restrictive Medicaid or CHIP policy). If we look at a state's uninsured parent or privately covered parent rate independently, the implications are unclear. For instance, if we look only at state discordance and parent private coverage rates, we may conclude that states with rates above the national average have high crowd-out potential. But if we know that the state's uninsured parent rate is above the national average as well, the state's intra-family discordance better implicates stringent parent income-eligibility policies than child crowd-out.

When a state's Medicaid child population has a discordance rate above the national average, we would expect the state to (1) have a higher likelihood of child crowd-out, (2) have restrictive working-parent income eligibility for Medicaid or CHIP, (3) show a large difference between the child and working-parent income-eligibility thresholds, and/or (4) not offer a coordinated family application.

Table 5 (as well as Map 1) shows Medicaid children's intra-family discordant coverage rates, by state. Availability of a coordinated family application correlates with below national average discordance rates. Among the 26 states and the District of Columbia that offer a coordinated family application, 13 states and the District of Columbia have discordant coverage rates below the national average (45.6 percent), nine states are above the average, and four are not statistically different from the national average. Of the 24 states that do not offer a coordinated family application, 17 states have discordance rates above the national average, five states are below, and two are not statistically different from the national average.

Of our three policy measures, working-parent income eligibility has arguably the strongest correlation with discordant coverage rates. Table 5 (and Map 1) shows that most of the states with more generous income-eligibility rules for working parents have lower child-parent discordance. Sixteen of the 17 states with working-parent income-eligibility thresholds at or above 100 percent of the FPL have discordant coverage rates below the national average (one is not statistically different from the average).

Coordinated Family Applications: Uninsured parent versus privately covered parent rates.

Table 6 (as well as Map 3) shows that of the states with coordinated family applications (26 states and the District and Columbia), 14 states and the District of Columbia have parent uninsured rates below the national average (national average is 31.3 percent), eight states are above the national average, and four are not statistically different from the uninsured parent national average. Looking at parent private coverage rates (Table 6 as well as Map 2), 12 of

these states are below the national average (national average is 14.3 percent), eight are above the average, and seven are not statistically different from the national average of children with privately covered parents.

Of the 24 states that do not offer a coordinated family application, 12 states have parent uninsured rates above the national average, six states are below the average, and six are not statistically different from the national average of children with uninsured parents. For parent private coverage rates, 14 states that do not offer a coordinated family application are above the national average, five states are below the average, and five are not statistically different from the national average of children with privately covered parents.

Medicaid children's income-eligibility generosity: Uninsured parent versus privately covered parent rates.

New Jersey and New York are the states with the most generous income-eligibility thresholds for children. As Table 6 shows, these two states' rates are below the national average for both parent uninsurance and private coverage. Idaho and Oklahoma have two of the least generous income-eligibility thresholds at 185 percent of FPL (exceeding only Alaska's 175 percent and North Dakota's 160 percent thresholds), and they have rates above the national average for both Medicaid children with privately covered, and uninsured, parents. The most common income-eligibility threshold was around 200 percent (Colorado uses 205 percent). For those 20 states, uninsured and private coverage parent rates are above the national average for nine states, five states are below the parent private coverage average, and six states are below the uninsured parent national average.

While working-parent income eligibility is the most influential of the three policy factors on discordance at the state level, child income eligibility is most important for crowd-out (children at higher income levels are the most likely to have privately covered parents). Although we may expect the states with more generous child income thresholds to have higher rates of parent private coverage, that doesn't hold true. In fact, of the 27 states and the District of Columbia with child income threshold generosity above the median 235 percent of the FPL, there are just as many states with below-average parent private coverage as there are above.

Integrating state results to measure potential for crowd-out effects.

Applying these estimates to the concept of Medicaid child crowd-out, we expect that those states with (1) below-average parent uninsurance and (2) above-average parent private coverage will have higher rates of crowd-out than other states; this is a crude measure for potential for child crowd-out. We also take note of states' Medicaid/CHIP policy rules and procedures to see how they correlate with our crowd-out measure.

According to Tables 5 and 6, 18 states and the District of Columbia have discordance rates below the national average (45.6 percent), and all of these states' uninsured parent rates are below the national average as well (31.3 percent). Of these below-average discordance states, 14 states and the District of Columbia have parent private coverage rates below the national average (14.3 percent), and three states' private coverage rates are not statistically different from the

national average. Only Pennsylvania has a parent private coverage rate above the national average (16.5 percent).

Twenty-six states have above-average discordance rates. Of those states, 20 states have uninsured parent rates above the national average, and six states are not statistically different from the national average. Twelve of those states with above-average discordance and parent uninsurance states are also above the national average for parent private coverage.

Only three states match our crowd-out hypothesis (uninsured parent rate below 31.3 percent national average, and parent private coverage rate above 14.3 percent national average): Iowa, Pennsylvania and Maryland. To search for policy patterns, we refer to each state's policy regulations and compare them to the median income threshold generosity levels across the states. For child income eligibility, the median income threshold is 235 percent of the FPL; for working-parent income eligibility, the median threshold is 64 percent of the FPL; and the average difference between states' child and working-parent income-eligibility thresholds is 156 percentage points of the FPL (the average of the differences between each state's child eligibility threshold and its working parent eligibility threshold) (StateHealthFacts.org, 2009).

Iowa's discordance rate is not statistically different from the national average; however, Iowa's parent uninsurance rate is below the national average while its parent private coverage rate is above the national average. Iowa does not offer a coordinated family application; its child income-eligibility threshold is 300 percent of the FPL (above the median 235 percent of the FPL), and its working-parent threshold is 83 percent of the FPL (above the median 64 percent of the FPL). Iowa has a 217 percentage point difference between its child and working-parent income-eligibility thresholds.

Pennsylvania's rate is below the national average for discord, below the national average for parent uninsurance, and above the national average for parent private coverage. The state does offer a coordinated family application, which may contribute to its below-average discord and uninsured parent rates, but it has a child income-eligibility threshold (300 percent of the FPL) above the median, and its working-parent threshold is one of the least generous (34 percent of the FPL) in the country. The difference between Pennsylvania's child and parent income-eligibility thresholds is 266 percentage points.

Maryland's discordance rate is not statistically different from the national average; however, its parent uninsurance rate is below the national average; and its parent private coverage rate is above the national average for Medicaid children. This again fits our child crowd-out criteria. Maryland offers a coordinated family application, its child income-eligibility threshold is 300 percent of the FPL (above the median generosity), and its working-parent threshold is 116 percent of the FPL (above the median generosity)—creating a 184 percentage-point difference between the thresholds.

CONCLUSIONS

State regulations and rules impact whether the parents of Medicaid children are publicly covered, privately covered, or uninsured, and thus have an effect on intra-family (child-parent) discordance at the state level. By looking at where a state's discordance rate falls on the national spectrum in comparison to the positions of the rates for the specific types of discord (uninsured parent and privately covered parent rates), we obtained a more nuanced understanding of how policy decisions correlate with states' intra-family discord and potential for child crowd-out.

We do not see evidence that more generous or family-inclusive policies correlate with child crowd-out. In fact, most states that offer coordinated family applications have below-average discordance, whereas most of those that do not offer family applications have above-average discordance rates. However, the three states that meet our crowd-out hypothesis do have child income eligibility thresholds above the median generosity level across states.

Concerning coordinated family applications, more states that do the application have below-average uninsurance rates than those that do not offer family applications. Additionally among states that offer family applications, more of them have below-average parent private coverage rates than above-average rates. With respect to working-parent income-eligibility thresholds, states with more generous working-parent thresholds generally have lower rates of intra-family discordant coverage than those with less generous working-parent income-eligibility thresholds.

Pennsylvania, Maryland and Iowa meet the child crowd-out hypothesis, but the inclusiveness of their state policies is inconsistent overall. Future research should model child crowd-out at the person-level and refine the functional definition of child crowd-out. The results suggest that child crowd-out may not be as relevant as family crowd-out. States make decisions that may induce the whole family to substitute employer-based insurance for public coverage.

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TABLES AND MAPS

Table 1a: Children By Discordant Coverage Status By Child/Parent Coverage Type (numbers in thousands)
Universe: Children age 18 and under living with a parent – Household Population

DISCORDANT COVERAGE STATUS / COVERAGE TYPE	Count	Margin of Error	Percent	Margin of Error
Total:	**74,175**	**65**		
Children with Concordant Coverage (child and parent(s) share same coverage type)	59,130	104	79.7	0.1
Children with Discordant Coverage (child and parent(s) have different coverage type)	15,045	102	20.3	0.1
Children with Discordant Coverage by Child/Parent Coverage Type	**15,045**	**102**		
By Child Coverage Type				
Uninsured Children	1,526	29	10.1	0.2
Publicly Covered Children	11,421	98	75.9	0.3
Privately Covered Children	2,097	30	13.9	0.2
By Parent Coverage Type				
Uninsured Parents	8,170	86	54.3	0.4
Publicly Covered Parents	1,207	27	8	0.2
Privately Covered Parents	5,669	66	37.7	0.4

Table 1b: Children By Coverage Type,
Including Discordant Coverage Status/Type For Publicly Covered Children (numbers in thousands)
Universe: Children age 18 and under living with a parent - Household Population

CHILD COVERAGE TYPE / PUBLICLY COVERED CHILDREN BY DISCORD TYPE	Count	Margin of Error	Percent	Margin of Error
Total:	**74,175**	**65**		
Uninsured Children	6,355	44	8.6	0.1
Publicly Covered Children	23,438	83	31.6	0.2
Privately Covered Children	44,381	79	59.8	0.2
Publicly Covered Children By Discordant Coverage Status/Type	**23,438**	**83**		
Concordant Coverage, Publicly Covered Parents	12,017	96	51.3	0.3
Discordant Coverage, Uninsured Parents	7,112	84	30.3	0.3
Discordant Coverage, Privately Covered Parents	4,309	54	18.4	0.2

Source: U.S. Census Bureau, 2009 American Community Survey

Table 2: Children By Family Structure & Medicaid Status -
All Children & Medicaid Children (numbers in thousands)
Universe: Children age 18 and under living with a parent - Household Population

FAMILY STRUCTURE / MEDICAID STATUS	ALL CHILDREN				MEDICAID CHILDREN			
	Count	Margin of Error	Percent	Margin of Error	Count	Margin of Error	Percent	Margin of Error
TOTAL:	**74,175**	**65**			**23,145**	**134**		
Number of Parents								
Living with One Parent	24,908	136	33.6	0.2	13,276	111	57.4	0.3
Living with Two Parents	49,266	111	66.4	0.2	9,869	73	42.6	0.3
Presence of Siblings								
Only Child	17,594	142	23.7	0.2	4,890	48	21.1	0.3
Siblings Present	56,581	178	76.3	0.2	18,254	153	78.9	0.3
Medicaid Status								
Not on Medicaid	51,030	110	68.8	0.2	-	-	-	-
On Medicaid	23,145	134	31.2	0.2	-	-	-	-
LIVING WITH ONE PARENT:	**24,908**	**136**			**13,276**	**111**		
Presence of Siblings								
Only Child	7,876	62	31.6	0.3	3,468	41	26.1	0.4
Siblings Present	17,032	166	68.4	0.3	9,808	118	73.9	0.4
Medicaid Status								
Not on Medicaid	11,633	78	46.7	0.3	-	-	-	-
On Medicaid	13,276	111	53.3	0.3	-	-	-	-
LIVING WITH TWO PARENTS:	**49,266**	**111**			**9,869**	**73**		
Presence of Siblings								
Only Child	9,717	98	19.7	0.2	1,422	22	14.4	0.2
Siblings Present	39,549	100	80.3	0.2	8,446	76	85.6	0.2
Medicaid Status								
Not on Medicaid	39,398	123	80	0.1	-	-	-	-
On Medicaid	9,869	73	20	0.1	-	-	-	-

Source: U.S. Census Bureau, 2009 American Community Survey

Table 3: Medicaid Children By Income-to-Poverty Ratio By Parent Coverage Type (numbers in thousands)

Universe: Medicaid children age 18 and under living with a parent – Household Population

PARENT COVERAGE TYPE	INCOME-TO-POVERTY RATIO									
	All Medicaid Children		Below 100% FPL		100%-199% FPL		200%-299% FPL		At or Above 300% FPL	
	Count / Percent	Margin of Error	Count / Percent	Margin of Error	Count / Percent	Margin of Error	Count / Percent	Margin of Error	Count / Percent	Margin of Error
NUMBER										
Total:	**23,145**	**134**	10,729	111	7,818	69	2,789	40	1,808	27
With Uninsured Parents	**7,003**	**81**	3,305	55	2,505	42	781	23	413	14
With Publicly Covered Parents	**11,918**	**97**	6,666	81	3,420	50	1,082	23	751	21
With Privately Covered Parents	**4,223**	**53**	759	27	1,893	35	926	26	644	16
PERCENTAGE										
Total:	**100.0**	-	46.4	0.3	33.8	0.2	12.1	0.2	7.8	0.1
With Uninsured Parents	**30.3**	**0.3**	30.8	0.4	32	0.5	28	0.7	22.8	0.7
With Publicly Covered Parents	**51.5**	**0.3**	62.1	0.4	43.7	0.5	38.8	0.7	41.5	0.9
With Privately Covered Parents	**18.2**	**0.2**	7.1	0.2	24.2	0.4	33.2	0.7	35.6	0.7

Source: U.S. Census Bureau, 2009 American Community Survey

Table 4: Medicaid Children By Parent Coverage Type By Parent Working Status

Universe: Medicaid children age 18 and under living with a parent – Household Population

PARENT COVERAGE TYPE	WORKING STATUS	LIVING WITH ONE PARENT		LIVING WITH TWO PARENTS			
				Both Working / Both Not Working		One Working	
		Percent	Margin of Error	Percent	Margin of Error	Percent	Margin of Error
Total (All Medicaid Children):	Parent Working	55.3	0.4	31.1	0.4	55.6	0.4
	Parent Not Working	44.7	0.4	13.2	0.3		
With Uninsured Parents	Parent Working	62.1	0.6	29.4	0.8	60.2	0.8
	Parent Not Working	37.9	0.6	10.4	0.4		
With Publicly Covered Parents	Parent Working	42.5	0.5	22.7	0.5	56.7	0.7
	Parent Not Working	57.5	0.5	20.6	0.5		
With Privately Covered Parents	Parent Working	90.3	0.5	50.2	0.9	47.3	0.8
	Parent Not Working	9.7	0.5	2.4	0.2		

Source: U.S. Census Bureau, 2009 American Community Survey

Table 5 (Accompanies Map 1)

Percent Of Medicaid Children Below 200 Percent of the FPL With Discordant Coverage From Parents

Sorted by States' Medicaid/CHIP Federal Income Eligibility Thresholds for Working Parents

Universe: Medicaid children age 18 and under with family income below 200% FPL, living with a parent - Household Population

SORTED BY MEDICAID/CHIP INCOME ELIGIBILITY THRESHOLD (% FPL) FOR WORKING PARENTS* (highest to lowest)	DISCORDANT COVERAGE FROM PARENTS			STATE OFFERS COORDINATED FAMILY APPLICATION?*
	Percent	Margin of Error	Comparison to National Average (45.6%)	
UNITED STATES (Median: 64% FPL)	**45.6**	**0.3**	-	-
181% - 215% FPL				
Minnesota	21.3	2.1	BELOW	Yes
District of Columbia	6.0	2.6	BELOW	Yes
Maine	14.0	2.8	BELOW	Yes
New Jersey	32.0	2.2	BELOW	Yes
Wisconsin	13.5	1.4	BELOW	Yes
Connecticut	20.1	2.7	BELOW	
Vermont	22.2	4.6	BELOW	Yes
Illinois	36.3	1.4	BELOW	Yes
Rhode Island	12.4	3.6	BELOW	Yes
100% - 150% FPL				
New York	24.1	1.0	BELOW	Yes
Massachusetts	10.3	1.6	BELOW	Yes
Tennessee	37.7	2.0	BELOW	
Delaware	29.4	6.9	BELOW	Yes
Maryland	45.9	3.1	-	Yes
Arizona	27.5	2.0	BELOW	Yes
California	41.8	0.9	BELOW	
Hawaii	29.1	5.3	BELOW	
50% - 90% FPL				
Ohio	26.6	1.3	BELOW	Yes
South Carolina	50.1	2.5	ABOVE	
Nevada	50.3	4.5	ABOVE	
Iowa	47.1	2.9	-	
Alaska	41.4	5.5	-	Yes
Washington	49.1	2.2	ABOVE	
New Mexico	52.8	3.8	ABOVE	
Colorado	49.1	3.2	ABOVE	Yes

(Continues on page 20)

Table 5 – continued (Accompanies Map 1)

Percent Of Medicaid Children Below 200 Percent of the FPL With Discordant Coverage From Parents Sorted by States' Medicaid/CHIP Federal Income Eligibility Thresholds for Working Parents				
Universe: Medicaid children age 18 and under with family income below 200% FPL, living with a parent - Household Population				
SORTED BY MEDICAID/CHIP INCOME ELIGIBILITY THRESHOLD (% FPL) FOR WORKING PARENTS* (highest to lowest)	DISCORDANT COVERAGE FROM PARENTS			STATE OFFERS COORDINATED FAMILY APPLICATION?*
	Percent	Margin of Error	Comparison to National Average (45.6%)	
50% - 90% FPL (continued)				
Michigan	35.3	1.6	BELOW	
Kentucky	51.4	2.6	ABOVE	
North Dakota	43.8	7.1	-	Yes
Nebraska	60.0	3.3	ABOVE	
Montana	55.6	5.7	ABOVE	
Florida	52.4	1.6	ABOVE	
South Dakota	55.3	4.8	ABOVE	
Wyoming	65.8	6.9	ABOVE	Yes
Georgia	64.9	1.6	ABOVE	Yes
17% - 49% FPL				
New Hampshire	56.7	6.6	ABOVE	
North Carolina	56.3	1.7	ABOVE	
Oklahoma	68.2	2.1	ABOVE	
Mississippi	53.2	2.8	ABOVE	Yes
Utah	48.1	4.0	-	Yes
Oregon	53.0	2.9	ABOVE	Yes
Pennsylvania	35.9	1.5	BELOW	Yes
West Virginia	48.7	2.9	ABOVE	
Kansas	60.7	3.6	ABOVE	Yes
Virginia	51.0	2.9	ABOVE	
Idaho	66.6	3.5	ABOVE	
Texas	72.2	1.0	ABOVE	
Indiana	47.7	2.4	-	
Louisiana	60.5	2.0	ABOVE	Yes
Missouri	51.7	2.0	ABOVE	Yes
Alabama	59.6	1.8	ABOVE	Yes
Arkansas	70.4	2.5	ABOVE	

Sources:
U.S. Census Bureau, 2009 American Community Survey
*Ross et. al, 2009

Table 6 (Accompanies Maps 2 and 3)

Percent Of Medicaid Children Below 200 Percent Of The FPL With Privately Covered / Uninsured Parents By State, Compared To National Averages -
Sorted by States' Medicaid/CHIP Federal Income Eligibility Thresholds For Children
Universe: Medicaid children age 18 and under living with a parent, with family income-to-poverty ratio below 200% FPL - Household Population

SORTED BY MEDICAID/CHIP INCOME ELIGIBILITY THRESHOLD (% FPL) FOR CHILDREN* (highest to lowest)	PRIVATELY COVERED PARENTS			UNINSURED PARENTS			STATE OFFERS COORDINATED FAMILY APPLICATION?*
	Percent	Margin of Error	Comparison to National Average (14.3%)	Percent	Margin of Error	Comparison to National Average (31.3%)	
UNITED STATES (Median: 235% FPL)	**14.3**	**0.2**	-	**31.3**	**0.3**	-	-
350% - 400% FPL							
New York (400%)	8	0.7	BELOW	16.2	0.9	BELOW	Yes
New Jersey (350%)	9.9	1.4	BELOW	22.1	2	BELOW	Yes
300% FPL							
Alabama	20.6	1.9	ABOVE	39	2	ABOVE	Yes
Connecticut	7.2	1.7	BELOW	12.9	2.3	BELOW	
District of Columbia	2.2	1.5	BELOW	3.8	2.1	BELOW	Yes
Hawaii	18	4.6	-	11.1	4.1	BELOW	
Iowa	22.3	2.2	ABOVE	24.8	2.5	BELOW	
Maryland	18.7	2.4	ABOVE	27.1	2.6	BELOW	Yes
Massachusetts	6.4	1.1	BELOW	3.9	0.9	BELOW	Yes
Missouri	15.9	1.2	ABOVE	35.9	2	ABOVE	Yes
New Hampshire	23.6	5.3	ABOVE	33.1	5.9	-	
Oregon	15.4	2.9	-	37.6	3.5	ABOVE	Yes
Pennsylvania	16.5	1.2	ABOVE	19.4	1.3	BELOW	Yes
Vermont	15.1	4	-	7.1	2.4	BELOW	Yes
Washington	18.8	1.8	ABOVE	30.3	2.4	-	
Wisconsin	4.9	0.9	BELOW	8.6	1.2	BELOW	Yes
235% -275% FPL (250% if not otherwise denoted)							
Minnesota (275%)	8.4	1.2	BELOW	12.9	1.7	BELOW	Yes
California	12.1	0.6	BELOW	29.8	0.9	BELOW	
Indiana	17.4	1.8	ABOVE	30.3	1.9	-	
Louisiana	18.4	1.9	ABOVE	42	2.2	ABOVE	Yes
Montana	15.6	3.6	-	40.1	6.4	ABOVE	
Rhode Island	2.9	1.5	BELOW	9.5	3.3	BELOW	Yes
Tennessee	12.1	1.5	BELOW	25.5	1.8	BELOW	
West Virginia	12.1	2	BELOW	36.7	2.9	ABOVE	
Kansas (241%)	20.6	3	ABOVE	40.2	3.9	ABOVE	Yes
Georgia (235%)	19.2	1.3	ABOVE	45.7	1.5	ABOVE	Yes
New Mexico (235%)	16.3	2.4	-	36.5	3.4	ABOVE	

(Continues on page 22)

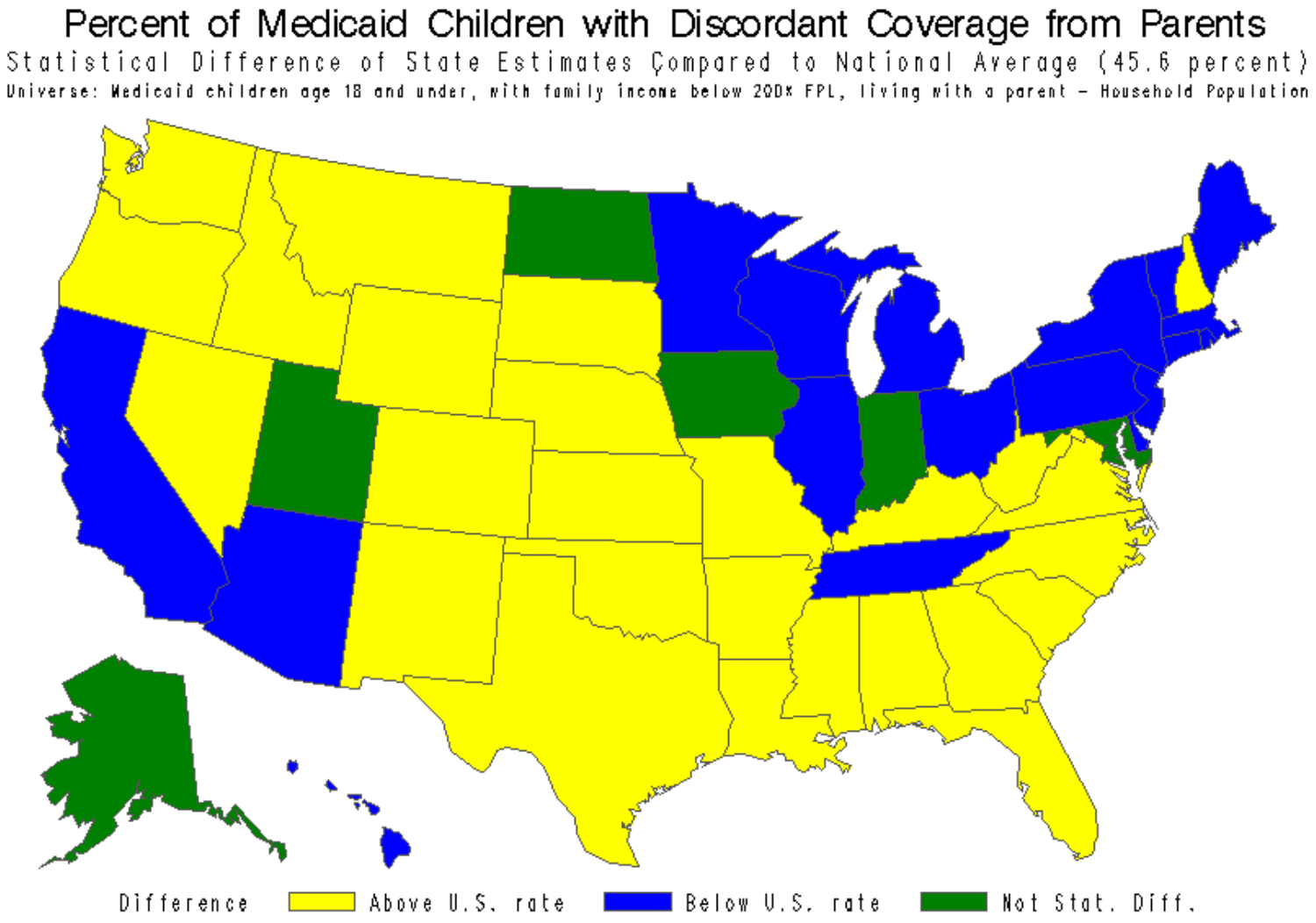
Table 6 - continued (Accompanies Maps 2 and 3)

Percent Of Medicaid Children Below 200 Percent Of The FPL With Privately Covered / Uninsured Parents By State, Compared To National Averages -
Sorted by States' Medicaid/CHIP Federal Income Eligibility Thresholds For Children
Universe: Medicaid children age 18 and under living with a parent, with family income-to-poverty ratio below 200% FPL - Household Population

SORTED BY MEDICAID/CHIP INCOME ELIGIBILITY THRESHOLD (% FPL) FOR CHILDREN* (highest to lowest)	PRIVATELY COVERED PARENTS			UNINSURED PARENTS			STATE OFFERS COORDINATED FAMILY APPLICATION?*
	Percent	Margin of Error	Comparison to National Average (14.3%)	Percent	Margin of Error	Comparison to National Average (31.3%)	
200% FPL (if not otherwise denoted)							
Colorado (205%)	13.9	1.9	-	35.2	3.4	ABOVE	Yes
Arizona	6.7	0.9	BELOW	20.9	1.8	BELOW	Yes
Arkansas	23.6	2.4	ABOVE	46.8	2.6	ABOVE	
Delaware	16.5	5.7	-	12.9	4.1	BELOW	Yes
Florida	14.2	1	-	38.1	1.5	ABOVE	
Illinois	11.3	1	BELOW	25	1.4	BELOW	Yes
Kentucky	16.6	1.9	ABOVE	34.9	2.6	ABOVE	
Maine	6.6	1.9	BELOW	7.4	2.1	BELOW	Yes
Michigan	13	1	BELOW	22.2	1.3	BELOW	
Mississippi	21.8	2.1	ABOVE	31.4	2.6	-	Yes
Nebraska	25.1	3.3	ABOVE	34.8	3.9	-	
Nevada	11.6	3.3	-	38.7	4	ABOVE	
North Carolina	18.4	1.2	ABOVE	37.9	1.3	ABOVE	
Ohio	10.5	0.9	BELOW	16.1	0.9	BELOW	Yes
South Carolina	16.5	1.8	ABOVE	33.6	2.2	ABOVE	
South Dakota	25.9	4.6	ABOVE	29.4	4.2	-	
Texas	16.3	0.8	ABOVE	55.8	1.1	ABOVE	
Utah	14.7	2.8	-	33.4	3.9	-	Yes
Virginia	19.1	2	ABOVE	31.9	2.4	-	
Wyoming	19.1	5.3	-	46.7	6.8	ABOVE	Yes
160-185% FPL							
Idaho (185%)	21.1	3.3	ABOVE	45.4	3.3	ABOVE	
Oklahoma (185%)	23.6	2	ABOVE	44.6	2.4	ABOVE	
Alaska (175%)	10.9	2.9	BELOW	30.6	5.7	-	Yes
North Dakota (160%)	18.6	5.6	-	25.2	7.2	-	Yes

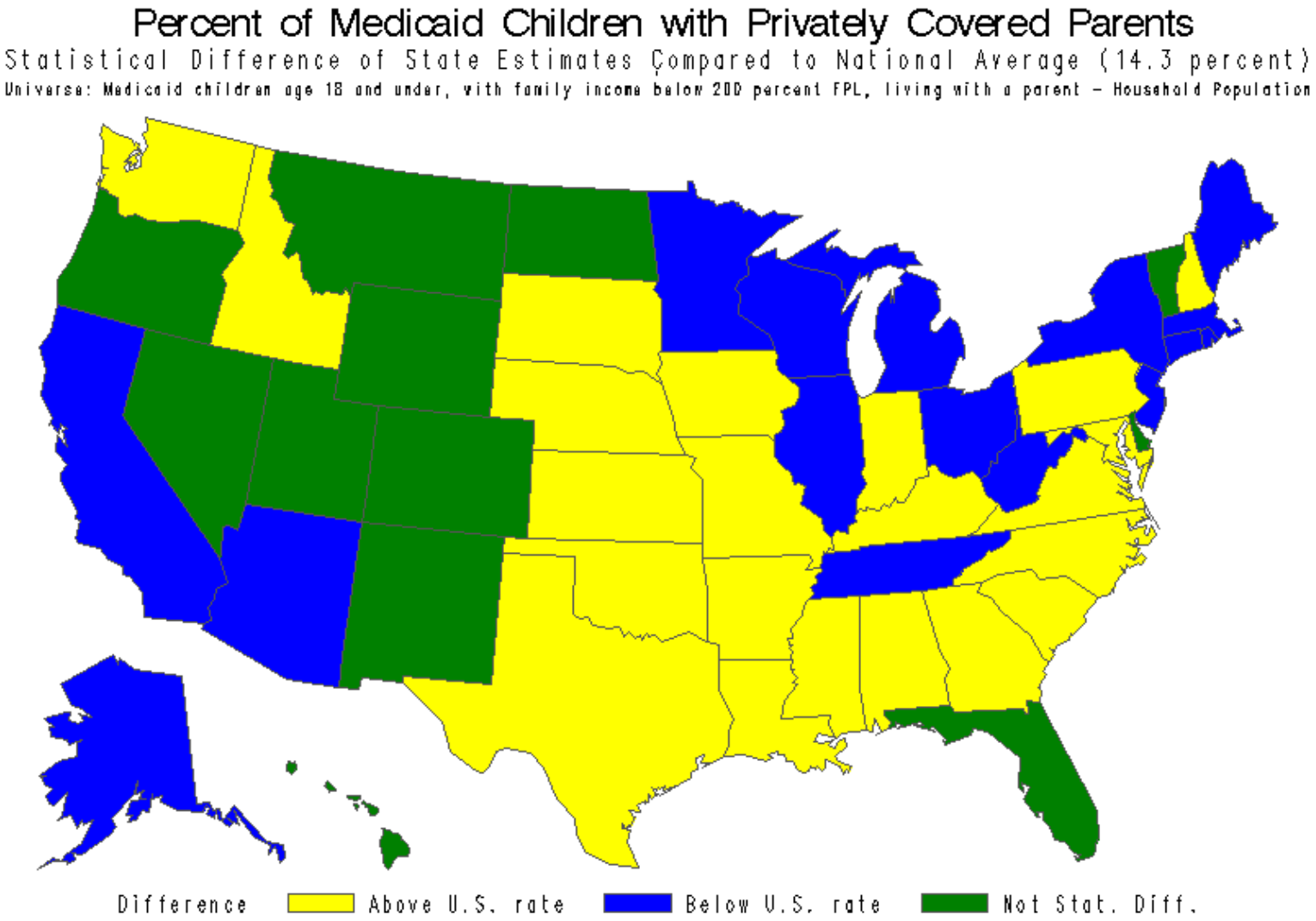
Sources:
U.S. Census Bureau, 2009 American Community Survey
*Ross et. al, 2009

Map 1:



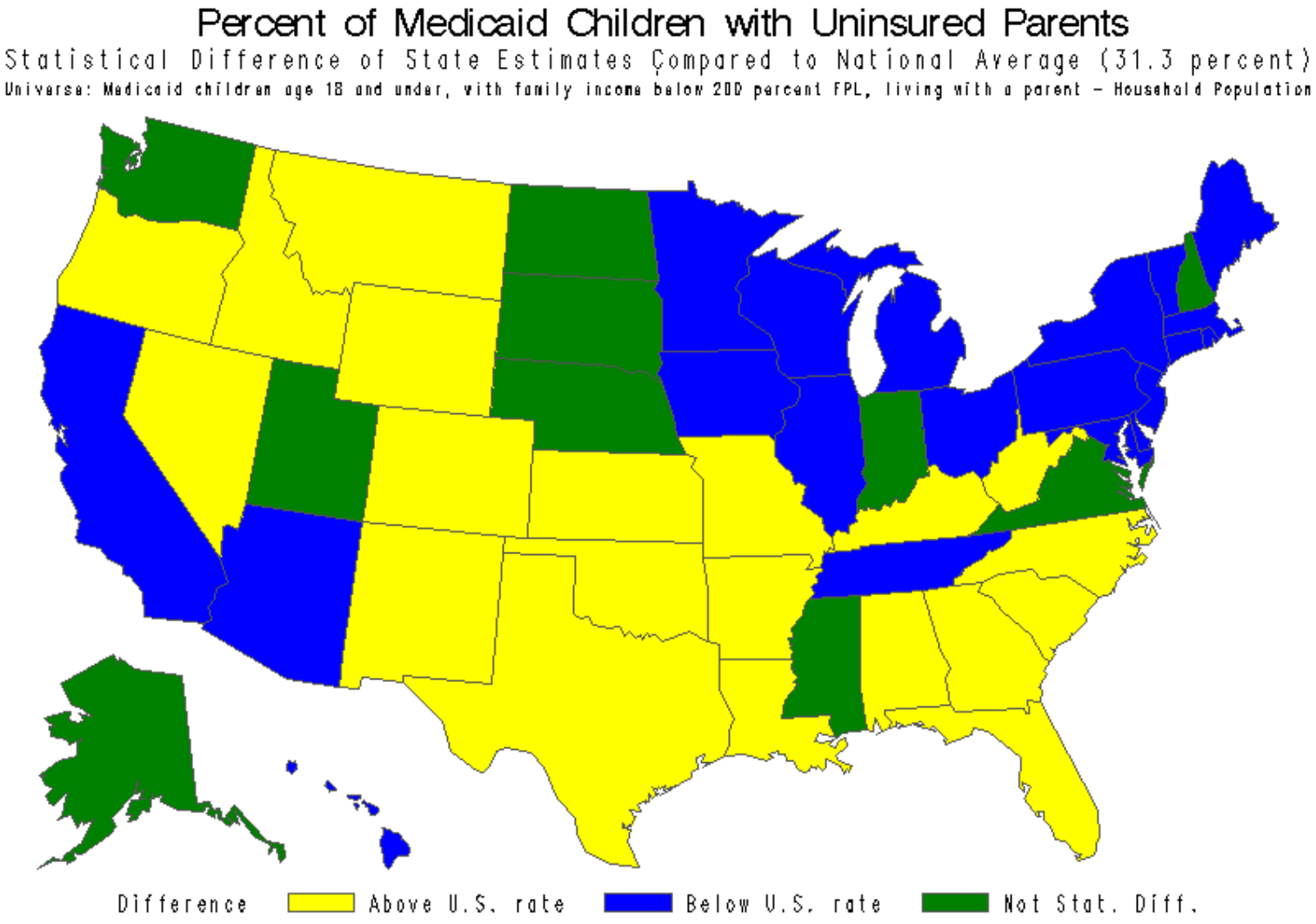
Source: U.S. Census Bureau, 2009 American Community Survey

Map 2:



Source: U.S. Census Bureau, 2009 American Community Survey

Map 3:



Source: U.S. Census Bureau, 2009 American Community Survey