Access to Private Coverage for Children Enrolled in CHIP

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ABSTRACT

OBJECTIVE: To provide updated information on the potential substitution of public for private coverage among low-income children by examining the type of coverage held by children before they enrolled in Children's Health Insurance Program (CHIP) and exploring the extent to which children covered by CHIP had access to private coverage while they were enrolled.

METHODS: We conducted a major household telephone survey in 2012 of enrollees and disenrollees in CHIP in 10 states. We used the survey responses and Medicaid/CHIP administrative data to estimate the coverage distribution of all new enrollees in the 12 months before CHIP enrollment and to identify children who may have had access to employer coverage through one of their parents while enrolled in CHIP.

RESULTS: About 13% of new enrollees had any private coverage in the 12 months before enrolling in CHIP, and most were found to have lost that coverage as a result of parental job loss. About 40% of CHIP enrollees had a parent with an employer-sponsored insurance (ESI) policy, but only half reported that the policy could cover the child. Approximately 30% of new enrollees had public coverage during the year before but were uninsured just before enrolling.

CONCLUSIONS: Access to private coverage among CHIP enrollees is relatively limited. Furthermore, even when there is potential access to ESI, affordability is a serious concern for parents, making it possible that many children with access to ESI would remain uninsured in the absence of CHIP.

KEYWORDS: children; CHIP; crowd out

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WHAT'S NEW

Updated estimates of access to private coverage among low-income children enrolled in the Children's Health Insurance Program suggest limited potential for crowd out, but the share of children with a gap between periods of public coverage suggests room for improvement in renewal processes.

SINCE THE CHILDREN'S Health Insurance Program (CHIP) expanded eligibility for public insurance to children in 1997, there has been concern that the program would encourage families to substitute public coverage for existing employer-sponsored coverage. Concern about such "crowd out" is common to many government programs, but with eligibility extended to families with higher incomes than those traditionally eligible for Medicaid, it has always been particularly pronounced for CHIP. Moreover, policy makers also have feared that employers would reduce the availability of dependent coverage if children of employees had an alternative source of coverage. As a result, the original CHIP legislation required each state to incorporate strategies to limit crowd out. Such strategies include, among others, waiting periods that require children to be uninsured for a minimum number of months before enrolling and cost-sharing structures that mimic private insurance.

Many studies have estimated the extent to which public coverage substitutes for private coverage by using econometric methods to isolate the effects of public coverage expansions on children's health insurance coverage. A common measure of crowd out calculates the decline in private coverage resulting from CHIP eligibility expansions as a share of the increase in public coverage. In one study, LoSasso and Buchmueller found that for every 100 children gaining public coverage under CHIP, approximately 50 children lost private coverage.[1] However, the magnitude of such crowd out estimates is very sensitive to the data source, target population, methodological approach, and treatment of those reporting both public and private coverage.[2] For example, Dubay and Kenney found crowd out estimates ranging from 16% to 44% using the National Survey of America's Families,[3] whereas Hudson and colleagues found estimates ranging from 25% to 70% using the Medical Expenditure Panel Survey.[4] As a result, it is difficult to draw meaningful conclusions for policy on the basis of these widely varying estimates.

Another approach to understanding the relationship between public and private coverage for low-income children is to examine access to private coverage among CHIP

enrollees. In the first CHIP evaluation mandated by Congress, parents of CHIP enrollees in 10 states were surveyed in 2002 about their child's coverage before enrolling in CHIP. The survey found that 28% of new CHIP enrollees had private coverage in the 6 months before enrolling in the program, but that half of these children reportedly lost their private coverage as a result of a change in parental employment or family structure.[5] The latter suggests that these children no longer had access to private coverage when they enrolled in CHIP. A similar approach was used by Shone and colleagues to examine the movement from private to public insurance in New York in 2000–2001.[6] They found that only 7% of children dropped private coverage in the 6 months before enrolling in CHIP. Using another measure of potential access to private coverage, estimates from the 2002 CHIP survey found that 39% of enrollees had a parent with employer coverage,[7] while a more recent study found that in 2005, 33% of CHIP enrollees had a parent with employer coverage.[8]

Many changes in the health care system over the past 10 years could have affected access to private coverage for CHIP enrollees. Medicaid and CHIP coverage for children has expanded and rates of employer-sponsored coverage have declined among both adults and children.[9] On the other hand, CHIP income eligibility thresholds have increased, which could expand access to private coverage among enrollees. In this study, we provide updated information on access to private coverage among CHIP enrollees based on the most recent Congressionally mandated CHIP evaluation.[10] We consider the type of coverage held by children before they enrolled in CHIP and the reason that coverage ended for those reporting private insurance. We also explore the extent to which children covered by CHIP had access to private coverage while they were enrolled, including new information on whether a parent's employer plan included coverage for dependents. This analysis provides important context as policy makers consider the future of CHIP as well as other issues that may affect the distribution of children's coverage under the Affordable Care Act.

METHODS

The data for this study were drawn from a telephone-based survey of parents of 12,197 CHIP enrollees and disenrollees in 10 states fielded by Mathematica Policy Research from January 2012 through March 2013 as part of the CHIPRA-mandated evaluation of CHIP. The states included were Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. These states were selected because they utilize diverse approaches to providing health insurance coverage for children, represent various geographic areas (including a mix of more rural and more urban states and a variety of races/ethnicities), and each contains a significant portion of uninsured children. In 2012, CHIP enrollees in these states represented approximately 57% of CHIP enrollees nationally.[11]

We used state eligibility and enrollment files to construct the sample frame for each state and randomly selected children (18 years or younger) in 3 strata in each state:

Established enrollees.—Children who had been enrolled in CHIP for 12 or more consecutive months at the time of sampling.

Recent enrollees.—Children who had been enrolled in CHIP for exactly 3 consecutive months, preceded by a gap in public coverage of at least 2 months, at the time of sampling.

Recent disenrollees.—Children who were disenrolled from the program for exactly 2 months, at the time of sampling, and who were previously enrolled for at least 3 months before the month of disenrollment.

Recent CHIP enrollees that transferred from Medicaid ("transfers"), or returned to CHIP after a short gap (3 months or less) in public insurance coverage ("churners") were excluded from the sampling frame. Parents of such CHIP enrollees are often unaware of these coverage transitions and therefore not able to reliably describe health care experiences before their (re)enrollment in CHIP, but we use the state eligibility and enrollment files to identify the public coverage history of these transfers and churners before their most recent enrollment in CHIP.

The final survey data included responses from parents of 5518 established enrollees, 4142 recent enrollees, and 2537 disenrollees. The overall survey response rate was 51% for established enrollees, 46% for recent enrollees, and 43% for recent disenrollees. The survey included a wide range of questions related to the sampled child's current and prior health insurance, health status and needs, and health care use and experiences. Additional details on the survey, including the questionnaire, are available elsewhere.[12] The study was reviewed and approved by the New England Institutional Review Board (NEIRB 12-200).

We relied on both the survey sample of recent enrollees and the administrative records for the population of transfers and churners who were excluded from the survey sample to analyze coverage prior to CHIP enrollment. We dropped 1009 survey observations as a result of incomplete interviews and survey skip patterns. Our final analytic sample included 93,120 transfer and churner records and 3133 survey observations.

For each of the 12 months before their enrollment in CHIP, a recent enrollee was assigned to one of the following coverage values on the basis of their survey response: private, public, uninsured, other, or unknown coverage status. In some cases, we then "corrected" the prior coverage information using the administrative data. Specifically, we overwrote the survey-based coverage value with a value of "public coverage" if the administrative data indicated that the new enrollee was covered by public insurance in a given month. We did not overwrite the survey response if it indicated that the child had private coverage, however, because a child can have both public and private coverage simultaneously, and we wanted to capture any reported private coverage.

We then summed the number of months with each type of coverage and assigned each child to 1 of 4 mutually

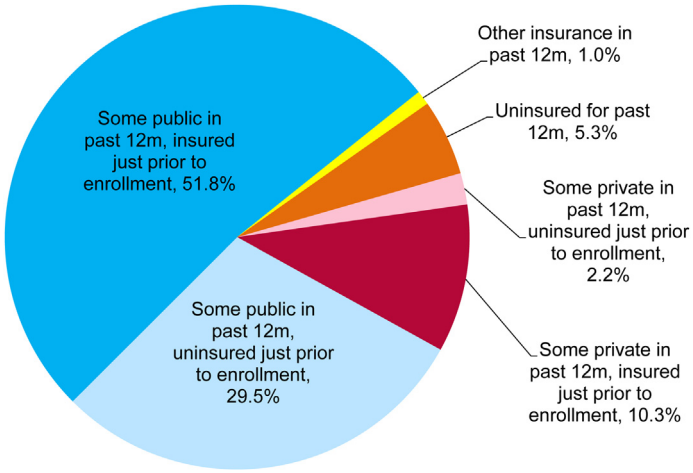

Figure 1. *Coverage of recent Children's Health Insurance Program (CHIP) enrollees during the 12 mo before enrolling. Source: 2012 Congressionally mandated survey of CHIP enrollees and disenrollees. The sample includes recent enrollees who have been enrolled in CHIP for 3 mo after at least 2 mo without CHIP coverage. It comprised 3133 survey cases and 93,120 administrative cases that transferred from Medicaid or returned to CHIP after a short gap in public insurance coverage. The sample has been weighted to represent the outcomes of all recent enrollees across 10 study states.*

exclusive categories according to the following hierarchy: 1) any private coverage in the past 12 months, 2) any public coverage in the past 12 months, 3) any other coverage in the past 12 months, and 4) no coverage in the past 12 months (eg, uninsured for the full year before enrolling). The population of transfers and churners with only administrative records were assigned to category 2. We assigned private coverage to the top of the hierarchy to capture any access to private coverage among CHIP enrollees. For those with private or public coverage before enrolling, we also identified whether the child was uninsured just before enrolling in CHIP (eg, uninsured for 1 or more consecutive months before enrollment). We used survey weights to account for the complex, multistage sampling design of the survey and nonresponse bias; transfers and churners received a weight of 1. The estimates thus reflect the full population of recent enrollees in the 10 survey states.

For recent enrollees who had private coverage in the past year, we also described the reason the child's private coverage ended, as reported by a parent. This information allowed us to consider the likelihood that a child still had access to private coverage at the time of enrollment. In addition to the analysis of coverage before enrolling, we generated 4 measures of access to employer-sponsored insurance (ESI) coverage through a parent: 1) any parent has an ESI policy or an ESI offer, 2) any parent has an ESI policy, 3) any parent has an ESI policy or offer that could cover the child, and 4) any parent has an ESI policy that could cover the child. These estimates of access to ESI coverage for children relied on the survey sample of established CHIP enrollees. We used this sample because it was representative of all established enrollees, while the survey sample of recent enrollees was only representative of those who did not transfer or churn from public coverage. We dropped 778 observations due to incomplete interviews and survey skip patterns; our final analytic sample included 4740 established enrollees.

Results

Recent CHIP enrollees were somewhat younger than established enrollees, with 23.5% under age 6 compared to 15.0% for established enrollees. Recent enrollees were also more likely to have a parent with more than a high school education and were slightly more likely to have a household income greater than 200% of the federal poverty level (Online Appendix Table).

Prior Coverage of Recent CHIP Enrollees

A large majority of recent CHIP enrollees (81.3%) had a period of public insurance coverage in the 12 months before enrolling in CHIP (Fig. 1). Just over half of recent enrollees (51.8%) had Medicaid or CHIP coverage during the 12 month period before they enrolled in CHIP, including just before enrollment. Another 29.5% of recent enrollees had public coverage during the year before but were uninsured just before enrolling.

A much smaller share of recent CHIP enrollees (12.5%) had private coverage for some portion of the 12 months before enrolling in CHIP, including 2.2% that had a gap in coverage before enrolling and 10.3% that enrolled directly after private coverage with no gap in insurance. The rest of the recent enrollees were uninsured the full year before enrolling in CHIP (5.3%) or had other insurance (such as Medicare or military-based coverage) before enrolling (1.0%).

An estimated 69.1% of children who enrolled in CHIP after some period of private coverage were reported to have lost that coverage as a result of a parent's job loss or loss of benefits from an employer (Table 1). An additional 3.2% lost private coverage as a result of a change in family circumstances, such as a death or divorce. Together, these estimates suggest that 72.3% of new enrollees who had access to private coverage in the last year no longer had access to that coverage at the time of enrollment.

Table 1. Reason Private Coverage Ended for Recent CHIP Enrollees With Private Coverage in the Year Before Enrolling

Characteristic	% (SE)
Employment or Benefit Loss/Change	69.1 (2.5)
No longer works for employer, lost/changed jobs	63.2 (2.3)
Employer no longer offers coverage	5.9 (1.1)
Family circumstances	3.2 (0.9)
Parent got divorced	2.1 (0.7)
Child custody changed	1.1 (0.5)
Preference for CHIP/dislike other insurance	5.0 (1.0)
Dropped plan to qualify for CHIP	3.2 (0.9)
Employer plan changed/less desirable/employer switched to less generous plan	0.5 (0.2)
CHIP/Medicaid costs less	1.0 (0.4)
CHIP/Medicaid has better benefits	0.3 (0.1)
Affordability	18.1 (1.6)
Cost of insurance or dependent coverage went up	9.0 (1.1)
Family income changed	5.4 (0.9)
Financial or affordability reasons	3.7 (0.8)
Miscellaneous	4.8 (1.0)
Total	100
Sample size	1352

CHIP indicates Children's Health Insurance Program.

Note: Recent enrollees are those enrolled in CHIP for 3 mo after at least 2 mo without CHIP coverage at the time of sampling.

Source: 2012 Congressionally mandated survey of CHIP enrollees and disenrollees.

Only about 5% of children who had private coverage in the 12 months before enrolling in CHIP appeared to have dropped this coverage for reasons based purely on a preference for CHIP. Another 18.1% of children with a recent history of private coverage were reported to no longer have that coverage for affordability reasons, including a reduction in income, the cost of insurance, or other financial reasons. An additional 4.8% of children lost coverage for other miscellaneous reasons, such as move-related issues and logistical problems with insurance forms. Thus, about 28% of new enrollees with a recent history of private coverage might have maintained access to that coverage after enrolling in CHIP, but it is clear that most did not find that coverage to be affordable.

ACCESS TO EMPLOYER COVERAGE FOR ESTABLISHED CHIP ENROLLEES

Among established CHIP enrollees, an estimated 42.9% had a parent who was either offered ESI or had an ESI policy (Fig. 2). Several factors could prevent the child from being covered by a parent's plan, however. First and foremost, only about 20% of children were reported to have access to a plan that could cover them. Furthermore, among those children with access to dependent coverage, the parents of 56.6% of them said they would be responsible for the entire premium and the parents of 39.4% said they would have to contribute some portion of the premium (Table 2). Of children with access to a dependent ESI policy to which an employer contributed something, the main reasons reported by parents for not joining were that the premiums were too high (55.3%), that CHIP/Medicaid cost less (8.1%), or that out-of-pocket costs in the employer plan were unaffordable (6.9%).

DISCUSSION

Our findings indicate that both recent and established CHIP enrollees had relatively limited access to private coverage. Only 13% of recent enrollees had any private coverage in the 12 months before enrolling in CHIP, and about 72% lost this coverage as a result of a change in parental employment or family structure. Another 18% reported affordability as the reason their private coverage ended. Together, these suggest that most new enrollees with a history of private coverage no longer had access to that coverage at the time of enrollment, and those who did found it unaffordable.

These findings differ from an earlier CHIP evaluation that found that 28% of new CHIP enrollees had private coverage in the 6 months before enrolling and roughly half lost that coverage as a result of job or family circumstances. At least 2 factors likely contribute to this difference. First, the 2012 survey of CHIP enrollees was administered during the sluggish recovery from the recession, which may have contributed to the limited evidence of prior private coverage among these children as

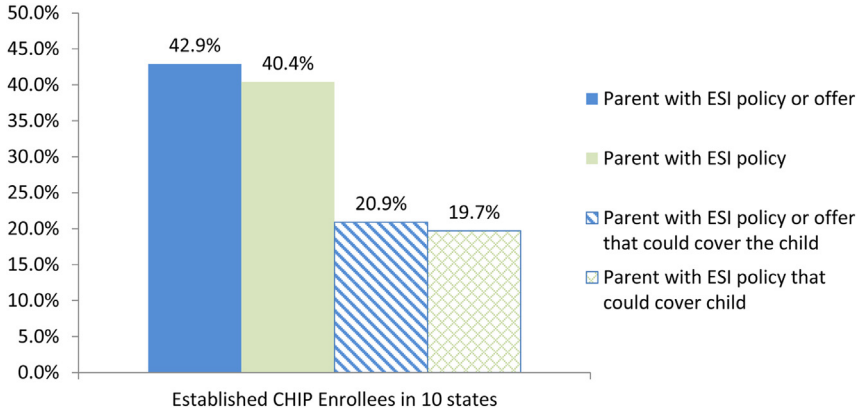

Figure 2. *Potential access to employer-sponsored insurance (ESI) among established Children's Health Insurance Program (CHIP) enrollees. Source: 2012 Congressionally mandated survey of CHIP enrollees and disenrollees. Established enrollees are those enrolled for at least 12 mo at the time of sampling (n = 4740).*

Table 2. Employer Contributions and Reason Child is Not Covered Among Established CHIP Enrollees with Access to Dependent ESI Coverage Through a Parent

Characteristic	% (SE)
Employer contribution to premium for dependent coverage	
Employer pays none for child	56.6 (2.2)
Employer pays some for child	39.4 (2.2)
Employer pays all for child	4.1 (0.8)
Sample size	905
Reason child is not covered by the parent's plan*	
Affordability: premium	55.3 (3.2)
CHIP/Medicaid costs less	8.1 (2.0)
Affordability: out of pocket	6.9 (1.7)
CHIP/Medicaid better benefits	6.2 (1.4)
Cannot see needed providers	0.7 (0.4)
Services do not meet needs	1.4 (0.7)
Other reasons	20.7 (2.6)
Don't know/refused	0.8 (0.4)
Sample size	417

CHIP indicates Children's Health Insurance Program; ESI, employer-sponsored insurance.

Note: Established enrollees are those enrolled for at least 12 mo at the time of sampling.

*Asked of those where employer pays some/all for child.

Source: 2012 Congressionally mandated survey of CHIP enrollees and disenrollees.

well as the prevalence of job loss as a reason for coverage ending. Second, a much larger proportion of children reported public coverage before their most recent CHIP enrollment in the 2012 survey, which is consistent with the growth in the Medicaid and CHIP programs over the past decade.

Our findings suggest that access to private coverage for established enrollees is also relatively limited, but the range of estimates is similar to those from prior studies. For example, compared to our estimate of 40%, the prior CHIP evaluation found that 39% of CHIP enrollees had a parent with ESI. We also found that only 20% of CHIP enrollees had a parent with a policy that could cover the child, but the proportion of parents with ESI reporting that their policy did not provide dependent coverage was lower than what has been reported in surveys of employers. For example, data from the Insurance Component of the Medical Expenditure Panel Survey and unpublished Urban Institute estimates using the 2010-2012 Kaiser/Health Research & Educational Trust Employer Health Benefits Survey suggest that nearly all establishments that offer any insurance coverage also offer dependent coverage.[13] The estimates based on the survey of CHIP families could be lower if the sample of CHIP families was concentrated in firms or jobs that did not offer dependent coverage, such as smaller firms, or if respondents were concerned that their access to CHIP could be at risk if they reported that they had access to ESI for their child. It seems more plausible, however, that respondents may have understood the question to be about whether dependent coverage would have been affordable rather than simply about whether it was offered. Thus, we interpret the estimates of plans that could cover the child with caution and consider the broader estimates of any access to ESI for parents as an upper bound on potential access for children. Our results also show that even when there is potential access to ESI, affordability is a serious concern for parents, making it possible that many children with access to ESI would remain uninsured in the absence of CHIP. Recent research projects that over a million children enrolled in separate CHIP programs, many of whom have access to ESI that would require large premium contributions, would become uninsured without CHIP.[14]

The results from this study should be considered in the context of several strengths and limitations. One advantage is that this survey explicitly distinguished CHIP enrollees from children with Medicaid, which is often not possible on other surveys and thus can speak to the experiences of children with CHIP rather than those with public coverage more generally. At the same time, however, the survey only included children from 10 states, potentially limiting the generalizability of the findings. In addition, our assessment of prior coverage and access to ESI was dependent on parental reports, which are subject to recall and other biases. This may be particularly problematic for recent enrollees who faced a long recall period in reporting prior insurance coverage. Finally, our analysis does not allow us to present an estimate of crowd out that is comparable to most of those found in the literature, but it does provide strong evidence that access to private insurance coverage that families find affordable is quite limited among CHIP enrollees.

These findings have important implications as the major coverage provisions of the Affordable Care Act are implemented. Employees are not eligible for subsidies to purchase marketplace coverage if they have access to an affordable employee-only ESI policy. This provision may make children in low- and moderate-income families more vulnerable to being uninsured when single coverage is deemed affordable but dependent coverage is unaffordable. Moreover, concerns have been raised about the affordability and comprehensiveness of both marketplace and employer coverage available for children in low- and moderate-income families.[15] CHIP is currently a potential source of coverage for children in such families, but CHIP is only funded through fiscal year 2015, raising concerns that children in families who lose eligibility will have more limited coverage options in the absence of CHIP.

Beyond the findings on access to private coverage, our analysis also indicates that many children are cycling in and out of public insurance programs. More than 80% of new CHIP enrollees had public coverage at some point in the 12 months before their most recent enrollment period. This is likely a result of expansions in public coverage over the past decade and substantial efforts to enroll eligible uninsured children. Despite these efforts, roughly 30% of new CHIP enrollees were uninsured just before enrolling after a period of public coverage at some point in the last year. This suggests that improving public program renewal processes and minimizing churning between the marketplace, Medicaid, and CHIP may need to be a priority to reduce periods of uninsurance for low-income children.

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SUPPLEMENTARY DATA

Supplementary data related to this article can be found online at http://dx.doi.org/10.1016/j.acap.2015.02.005.

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