Concerns about Parents Dropping Employer Coverage to Enroll in SCHIP Overlook Issues of Affordability

Timely Analysis of Immediate Health Policy Issues
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Summary

One of the more prominent concerns in the SCHIP reauthorization debate is that many children enrolling in the program could have been insured through their parents' employers. However, concern about parents dropping employer coverage to enroll their children in SCHIP typically ignores the affordability of that coverage. This brief measures affordability as families' out-of-pocket spending burden. The findings suggest that families' spending burden is, on average, lower under public insurance than under employer-sponsored insurance (ESI), especially for the lowest income families. We show that families in which children are insured through ESI have an out-of-pocket spending burden that is greater than the 5 percent cap suggested in a recent directive put out by the Centers for Medicare and Medicaid Services (CMS). For families in which children are covered by Medicaid or SCHIP, out-of-pocket spending is, on average, 4 to 5 percent of their income. However, for families in which children have ESI for a full year, the out-of-pocket spending burden is higher, ranging from 12.9 percent of income for families below 150 percent of FPL to 6.1 percent for families between 250-400 percent of FPL. Families with uninsured children have lower total out-of-pocket spending than families with children on ESI, and similar total out-of pocket spending to families with children who are publicly insured. Public insurance provides protection against high out-of-pocket costs, even as health care needs increase. Total out-of-pocket spending for low-income families who have a child with a chronic health condition is lower when their children are covered by public programs (5.5 percent) as opposed to ESI (11.2 percent).

Background

A decade ago, the State Children's Health Insurance Program (SCHIP) expanded public coverage to children in low-income families who lacked access to affordable health insurance but whose family incomes were too high to make them eligible for coverage under Medicaid. States were not required to implement SCHIP, but all states took advantage of the federal funding and expanded coverage for children. The program covered more than 6 million children at some point during 2006.[1] This program is up for reauthorization this year, a time when many states are preparing to build on SCHIP as a way of covering all children.[2]

As the debate over SCHIP reauthorization and expansion unfolds, one of the more prominent concerns raised is that many children enrolling in the program are actually substituting SCHIP for coverage available through their parents' employers. This is not a new issue for SCHIP and provisions to limit substitution were included in the original legislation. The Congressional Budget Office concluded that 25 to 50 percent of the children enrolled in SCHIP might have had employer coverage if SCHIP coverage were not available.[3] President Bush recently urged Congress not to expand SCHIP to children with higher incomes, saying that "Our goal should be to move children who have no health insurance to private coverage—not to move children who already have private health insurance to government coverage."[4]

Concerns about parents dropping employer coverage to enroll their children in SCHIP typically ignore the affordability of that coverage. However, a recent study showed that about one-half of the children who might have had access to employer coverage enrolled in SCHIP because their parents felt the employer coverage was not affordable.[5] Employer coverage may be unaffordable to low-income families because of required premiums, cost sharing, and an ongoing need to pay for necessary services that may not be covered by the plans available to them. In addition, because both the benefit packages and employer contribution to premiums can vary considerably, the group of families who take up employer-sponsored insurance (ESI) may represent the families with the best ESI offers among those with offers. Therefore, the financial burden of ESI among families who accept employer offers may understate the potential burden of the average ESI offer.

This brief examines family medical spending when children are enrolled in ESI and compares that to the costs families incur when their children are covered by SCHIP or Medicaid or when children are uninsured. The findings show that the financial burden of employer coverage for children is greater for low-income families than it is for higher-income families and that public coverage for children provides a significant amount of financial relief for families with low incomes. The out-of-pocket spending burden for families

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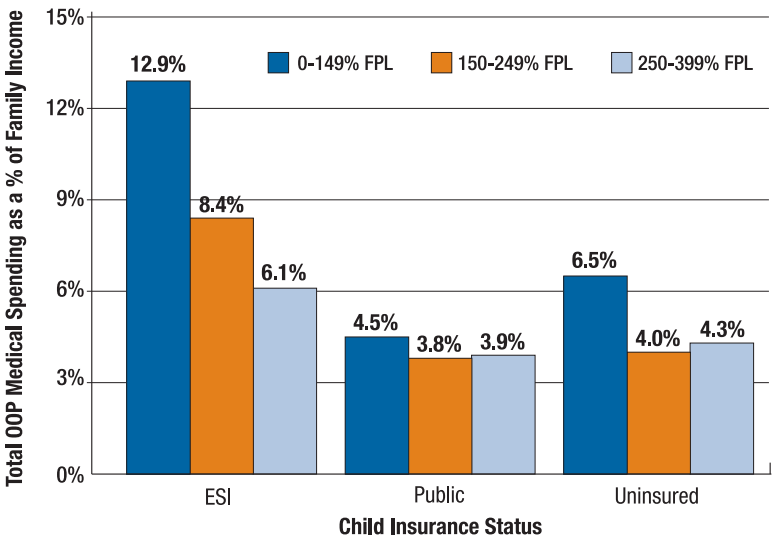
FIGURE 1: Out-of-Pocket Spending Burden, by Children's Insurance and Family Income



Source: 2003 & 2004 Medical Expenditure Panel Survey.

Note: Sample is families with at least one child under age 18 with annual income above $1,000 but below 400 percent of the federal poverty level and no change in insurance status of children during the year. Families in the top 1 percent of total OOP spending in each survey year were dropped from the sample.

with at least one child with a chronic condition is twice as high when children have ESI than when children have public insurance.

Data and Methods

This analysis uses a sample of 5,554 families with children from a pooled sample of the 2003 and 2004 Medical Expenditure Panel Survey—Household Component. The analysis focuses on out-of pocket spending burden, defined as out-of-pocket spending relative to the family's annual income. Out-of-pocket spending includes spending on the worker's share of ESI premiums,[6] plus spending related to co-insurance, deductibles, and uncovered services. To prevent outliers from driving the results, we drop families with less than $1,000 of annual income or out-of-pocket expenditures in the top 1 percent of out-of-pocket spending in each survey year. In the tables, spending is decomposed into premiums and other out-of-pocket spending for adults and children.

We define income groups as families with income below 150 percent of the Federal Poverty Level (FPL),[7] families with incomes from 150 to 249 percent of FPL, and families with incomes from 250 to 399 percent of FPL.[8] We exclude from this analysis families with incomes at or above 400 percent of FPL because these families are rarely included in proposals to expand eligibility to public health insurance.

We group families by the insurance status of their children. For ease of exposition, we limit our sample to families where all children have the same insurance status for the entire year (public coverage, employer coverage or uninsured).[9] Within a type of children's insurance, parents may not have the same coverage,[10] because many families have children who are eligible for public insurance when the parents are not. Among children with public insurance, for example, 9.2 percent have parents with ESI, 26.9 percent have parents with public insurance, 58.3 percent have uninsured parents, and 5.6 percent have parents with mixed, but full-year, coverage; among children with ESI, parental coverage is more homogenous, with 85.1 percent insured through ESI.

Finally, we contrast families that have at least one child with a chronic health condition, such as asthma or diabetes, with other families, restricting the sample to families with incomes less than 250 percent of the FPL. We limit our analysis of families that have at least one child with a chronic health condition to those with income below 250 percent of the FPL because over 90 percent of the children covered by Medicaid and SCHIP have incomes below that level.[11] In addition, only seven states allowed for eligibility above 250 percent of the FPL in 2004.[12] Children with chronic conditions are likely to require more health care services than other children, and this comparison shows how protective insurance can be as utilization increases.

Standard errors are adjusted for the survey design of the MEPS. We use Wald tests to measure for difference in out-of-pocket burden across groups.

Findings

Families' out-of-pocket spending burden is lower under public insurance than under ESI. Figure 1 shows out-of-pocket spending burden by family income and children's insurance status. The first set of bars shows that the average out-of-pocket burden for families in which children have ESI for a full year falls as family income increases.[13] The drop-off is dramatic, going from 12.9 percent of income for families below 150 percent of FPL to 8.4 percent for families between 150–250 percent of FPL to 6.1 percent for families with incomes between 250–400 percent of FPL. Differences in financial burden are much lower for families in these income groups when the children are covered by public coverage for an entire year; this burden is 4.5 percent of income for the lowest income group, 3.8 percent of income for families with incomes between 150–250 percent of FPL, and 3.9 percent for families with income between 250–400 percent of FPL. As income increases, the gap in financial burden between families whose children have public insurance as opposed to ESI shrinks. Moreover, since most states charge higher income families premiums to enroll their

TABLE 1: Out-of-Pocket Spending Burden, by Children's Insurance and Family Income, for Families with Income Below 400 Percent of the FPL

	All Children Public Insurance for Full Year	All Children Employer Sponsored Insurance for Full Year	All Children Uninsured for Full Year
Families with Incomes Less than 150% of Federal Poverty Level			
Total Out-of-Pocket (OOP) Spending/income	4.5%	12.9%[a]	6.5%[b]
OOP Spending on Premiums/income*	0.8%	7.5%[a]	0.8%
Other OOP Spending/income – Adults	3.0%	3.7%	4.6%[b]
Other OOP Spending/income – Children	0.7%	1.7%[a]	1.0%
Families with Incomes 150-249% of Federal Poverty Level			
Total Out-of-Pocket (OOP) Spending/income	3.8%[#]	8.4%[a#]	4.0%[#]
OOP Spending on Premiums/income*	1.3%[#]	5.1%[a#]	0.9%
Other OOP Spending/income – Adults	2.0%[#]	2.0%[#]	2.3%[#]
Other OOP Spending/income – Children	0.4%[#]	1.2%[a]	0.8%[c]
Families with Incomes 250-399% of Federal Poverty Level			
Total Out-of-Pocket (OOP) Spending/income	3.9%	6.1%[a#]	4.3%[#]
OOP Spending on Premiums/income*	1.9%[#]	3.7%[a#]	1.7%[#]
Other OOP Spending/income – Adults	1.7%[#]	1.6%[#]	1.8%[#]
Other OOP Spending/income – Children	0.2%[#]	0.8%[a#]	0.7%[a]

Source: 2003 & 2004 Medical Expenditure Panel Survey.

Note: Sample is families with at least one child under age 18 with annual income above $1,000 but below 400 percent of the federal poverty level with no change in insurance status of children during the year. Families in the top 1 percent of total OOP spending in each survey year were dropped from the sample.

[a] indicates significantly different from public insurance burden at the 1 percent level.

[b] indicates significantly different from public insurance burden at the 5 percent level.

[#] indicates significantly different within insurance and spending category between income groups. Standard errors are adjusted for the MEPS survey design.

* Publicly available MEPS data do not include premium information for public programs, where they exist. The premium numbers shown reflect only private premiums.

children in SCHIP and our data do not capture these premiums, the financial benefits of public coverage for families with incomes between 250–400 percent of FPL is likely smaller than that reported in Table 1.[14] However, across all three income groups, the average financial burden of ESI is above 5 percent—the maximum out-of-pocket burden that is proposed in a recent CMS directive[15] for SCHIP enrollees with incomes at or above 250 percent of the FPL.

Public coverage for children keeps families' out-of pocket burden lower than ESI by limiting payments for premiums and other out-of-pocket spending. Table 1 shows the out-of-pocket spending burden from Figure 1 disaggregated by the source of spending—premiums, adults' other out-of-pocket and children's other out-of-pocket. For the lowest income group, families whose children have public coverage spend only 0.8 percent of their income on premiums compared to 7.5 percent when the children are covered by ESI. Similarly, other out-of-pocket spending for children is 0.7 percent when they have public coverage as opposed to 1.7 percent when they have ESI. For families with incomes between 150 and 250 percent of the FPL, premiums represent a lower burden when the children have public instead of ESI coverage (1.3 versus 5.1 percent); other out-of-pocket spending for children is also lower (0.4 versus 1.2 percent).

Families with uninsured children have lower total out-of-pocket spending than families with children on ESI, but only have higher total out-of pocket spending than families with children who are publicly insured for the lowest income group. The financial burden for families in which the children are uninsured for a full year is highest in the lowest income group, but the level of burden is lower than that of families with similar incomes in which children have ESI (Table 1). Families with uninsured children do not pay premiums for their children, leaving them with a lower total out-of-pocket burden. As a result, premium burdens for families with incomes below 400 percent of the FPL whose children are uninsured are no different than the premium burdens for families with publicly covered children. However, families with incomes below 150 percent of the FPL with uninsured children devote a greater share of their incomes to total out-of-pocket spending than families with children on public coverage.

Public insurance provides protection against high out-of-pocket costs, even as health care needs increase. Children with chronic health conditions have a higher average need for health care services, thereby exposing their families to more financial risk. Table 2 shows that total out-of-pocket spending for families having a child with a chronic health condition and incomes below 250 percent of the FPL is lower when their children are covered by public programs (5.5 percent) as opposed to ESI (11.2 percent). Total out-of-pocket burden is lower for these families as a result of savings related to premiums and other out-of-pocket spending on children. Although public coverage provides financial protection for families that have a child with a chronic condition, it is still the case that these families spend a greater share of their incomes out of pocket than publicly insured families that do not have a child with a chronic condition.

TABLE 2: Out-of-Pocket Spending Burden, by Children's Insurance and Health Status, for Families with Income Below 250 Percent of the FPL

	All Children Public Insurance for Full Year	All Children Employer Sponsored Insurance for Full Year	All Children Uninsured for Full Year
Families without Children with Chronic Conditions			
Total Out-of-Pocket (OOP) Spending/income	4.0%	8.9%[a]	5.1%[c]
OOP Spending on Premiums/income*	0.9%	5.4%[a]	0.8%
Other OOP Spending/income – Adults	2.6%	2.3%	3.5%[c]
Other OOP Spending/income – Children	0.5%	1.1%[a]	0.8%[a]
Families with at Least One Child with a Chronic Condition			
Total Out-of-Pocket (OOP) Spending/income	5.5%[#]	11.1%[a#]	6.6%
OOP Spending on Premiums/income*	1.0%	6.6%[a#]	1.3%
Other OOP Spending/income – Adults	3.3%[#]	2.5%[c]	3.4%
Other OOP Spending/income – Children	1.3%[#]	2.1%[b#]	1.9%[#]

Source: 2003 & 2004 Medical Expenditure Panel Survey.

Note: Sample is families with at least one child under age 18 with annual income above $1,000 but below 250 percent of the federal poverty level with no change in insurance status of children during the year. Families in the top 1 percent of total OOP spending in each survey year were dropped from the sample. [a] indicates significantly different from public insurance burden at the 1 percent level. [b] indicates significantly different from public insurance burden at the 5 percent level. [c] indicates significantly different from public insurance burden at the 10 percent level. [#] indicates significantly different within insurance and spending category between families without children with chronic conditions and families with at least one child with a chronic condition. Standard errors are adjusted for the MEPS survey design.

* Publicly available MEPS data do not include premium information for public programs, where they exist. The premium numbers shown reflect only private premiums.

1 Smith V, Cook J. "SCHIP Turns 10: An Update on Enrollment and the Outlook on Reauthorization From the Program's Directors," Kaiser Family Foundation, May 2007; Kenney G, Yee J. "SCHIP At A Crossroads: Experiences To Date And Challenges Ahead," *Health Affairs*, March/April 2007; 26(2): 356-369.

2 Georgetown Center for Children and Families. "Children's Health Coverage: States Moving Forward." Updated July 20, 2007. Available at http://ccf.georgetown.edu/pdfs/0723smfupdate.pdf.

3 Congressional Budget Office. "The State Children's Health Insurance Program," Pub no. 2970, May 2007. Available at: http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf.

4 President's Radio Address September 22, 2007. Available at: http://www.whitehouse.gov/news/releases/2007/09/20070922.html

5 Sommers A, Zuckerman S, Dubay L, Kenney G. "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation of SCHIP in Ten States," *Health Affairs*, March/April 2007; 26(2): 529-537.

6 Premiums are calculated from the MEPS Person Round Plan Public Use File. All premiums shown are for ESI. Employer contributions to premiums are part of an employee's total compensation; employers' contribution may be lower if they have a higher concentration of low-income workers. Premiums for public programs are not included in the publicly available version of the MEPS, so SCHIP premiums are not represented in our tabulations. This is likely to understate out-of-pocket premium burdens for families with children on public coverage toward the upper end of the income range represented in this brief.

7 http://aspe.hhs.gov/poverty/04poverty.shtml

8 We include children in families with incomes between 250 and 400 percent of the FPL, even though few states have eligibility for public coverage in this income range, because it is common for public coverage to be reported for these children in surveys such as the MEPS or the Current Population Survey

9 This restriction drops 1098 families with mixed coverage among children, 815 of which contain children who experienced at least some uninsurance during the year, and 283 of which contained children with full-year, but not uniform, coverage. Families with children with full-year non-group coverage (79) are included in the former category.

10 This diverges from previous literature, which has restricted insurance categories based on the entire family's coverage (Galbraith AA, Wong ST, Kim SE, Newachek PW, "Out-of-Pocket Financial Burden for Low-Income Families with Children: Socioeconomic Disparities and Effects of Insurance," *Health Services Research*, December 2005; 40(6 Part I): 1722-36).

11 Peterson C, Herz E. "Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees." Washington, DC: Congressional Research Service, March 13 2007.

12 Ross DC, Cox L. "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, A Fifty State Update on Eligibility, Enrollment, Renewal, and Cost-Sharing Practices in Medicaid and SCHIP," Kaiser Commission on Medicaid and the Uninsured, October 2004. Available at: http://www.kff.org/medicaid/upload/Beneath-the-Surface-Barriers-Threaten-to-Slow-Progress-on-Expanding-Health-Coverage-of-Children-and-Families-pdf.pdf.

13 There is extensive variation around these averages, with some families in each income group having burdens that exceed 25 percent.

14 Based on data from Kenney, Hadley and Blavin (2007), we estimate that the out-of-pocket burden for families whose children have public coverage in the 250–400 percent of FPL group is understated by about 1 percentage point. Kenney G, Hadley J, and Blavin F. "The Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003." *Inquiry* Winter 2006/2007; 43(4): 345-361.

15 SHO #07-001, Letter from Dennis G. Smith to State Health Officials, August 17, 2007. Available at: http://www.cms.hhs.gov/smdl/downloads/ SHO081707.pdf

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