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CHIP Expansions to Higher-Income Children in Three States: Profiles of Eligibility and Insurance Coverage

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INTRODUCTION

Recent years have witnessed steady, state-by-state expansions to the availability of public health insurance coverage for children with higher incomes (State Health Access Reform Evaluation, 2009). Illinois, Pennsylvania, and Washington were among the first to enact measures expanding Children's Health Insurance Program (CHIP) eligibility (Table 1). In this issue brief, we provide a descriptive analysis of the experiences of children in these three states over time during the period surrounding the reforms. We look specifically at eligibility for public coverage and health insurance coverage outcomes.

Table 1: Key Features of CHIP Expansions in Illinois, Pennsylvania, and Washington

State	Date	Reform	Premium Cost-Sharing	Legal Status Restrictions
Illinois	July 1, 2006	Eligibility threshold for subsidized public insurance increased from 200 to 400 %FPL; >400% FPL newly eligible for full-cost public coverage	<150% FPL: Free 150-400% FPL: Subsidized 400-500% FPL: Full Cost > 500% FPL: Surchage	None
Pennsylvania	March 1, 2007	Eligibility threshold for subsidized insurance increased from 235 to 300%FPL; >300% FPL newly eligible for full-cost public coverage	<200% FPL: Free 200-300%: Subsidized >300% FPL: Full Cost	Citizens, Legal residents, Refugees
Washington	July 22, 2007	Eligibility for undocumented children extended to 250% FPL (same level already in place for children who are citizens)	<200% FPL: Free 200-250% FPL: Subsidized	None
	February 2009	Eligibility threshold for subsidized coverage increased from 250 to 300% FPL	<200% FPL: Free 200-300% FPL: Subsidized	None

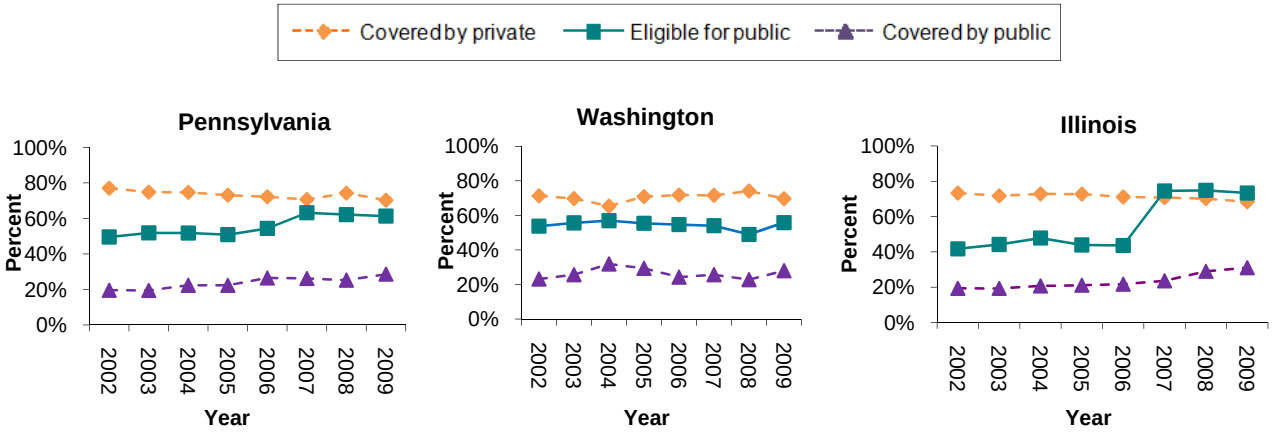
DATA & METHODS

Our data are from the 2002 to 2009 Annual Social and Economic Supplements (ASEC) of the Current Population Survey (CPS). Our sample includes children 17 years old or younger in each of the three study states. We assigned eligibility for subsidized public insurance to each child in the CPS-ASEC using the income eligibility thresholds in place in the particular state and year, which we obtained from annual reports from the Kaiser Family Foundation (Kaiser Family Foundation, 2000, 2002, 2003, 2004, 2005, 2007, 2008, 2009). In assigning eligibility, we accounted for each state's rules regarding income disregards (Cohen Ross et al., 2008), as well as their rules regarding eligibility for immigrant children. While the three study states offered coverage to all legal immigrants and refugees throughout the study period, none of the states offered eligibility to undocumented immigrants prior to the expansions, and only Illinois and Washington made these children eligible through their expansions. Because the CPS-ASEC does not contain information on the legal status of immigrants, we implemented methods developed by Passel et al. (2006) to assign probable legal status to each immigrant child in the data and accounted for legal status of the child in assigning eligibility. It was particularly important to capture legal status for children in Washington, where a key reform was the extension of eligibility to undocumented children.

KEY FINDINGS

Figure 1 depicts changes over time in eligibility for subsidized public insurance coverage, as well as changes in coverage by public and private sources, for all children in Illinois, Pennsylvania, and Washington from 2002 to 2009.

Figure 1: Eligibility and Insurance Coverage among All Children (0-17), 2002-2009



The expansions in these three states brought sea-changes in the availability of subsidized public insurance to children. Not surprisingly, the magnitude of the increase in eligibility across the study states was directly related to the change in income thresholds for eligibility. Thus Illinois, which by raising the eligibility threshold from 200 to 400 percent of the FPL implemented by far the most ambitious expansion, saw the proportion of all children eligible for subsidized public coverage jump from less than one-half to three-fourths. In Pennsylvania and Washington, where the scope of reform was more limited, the proportion of children eligible rose more modestly.

Figure 2: Percent Uninsured among All Children (0-17), 2002-2009

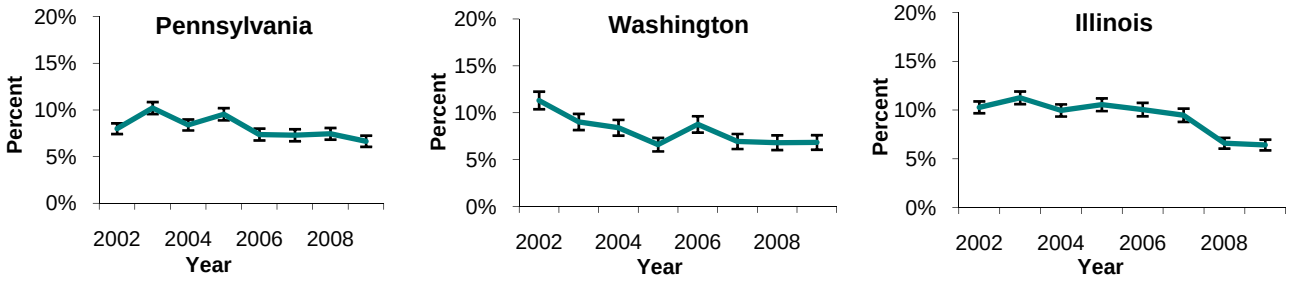
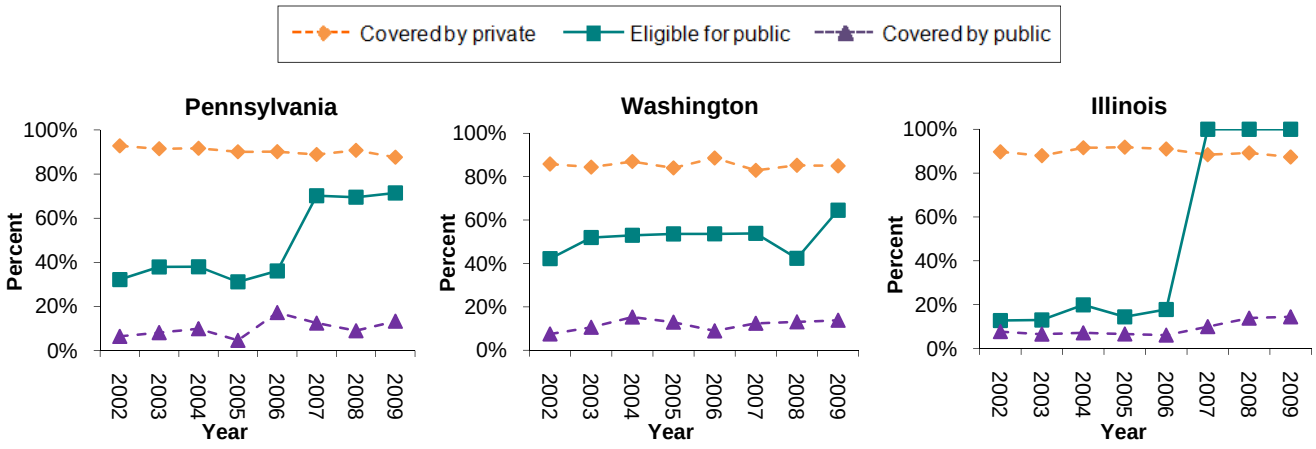


Figure 2 profiles changes from 2002 to 2009 in the percentage of children who were uninsured in each state. Both this and the preceding figure show the overall change in insurance coverage and eligibility for children; however, given the targeted nature of the insurance expansions in the study states, it is important to look at subgroups as well. Since the expansions in the three study states were aimed at increasing eligibility for subsidized public coverage among middle-income children, we repeated our analyses focusing on children in families with incomes between 200 and 400 percent of the FPL (Figures 3 and 4).

Figure 3: Eligibility and Insurance Coverage among Children (0-17) in Families with Incomes Between 200 and 400% FPL, 2002-2009

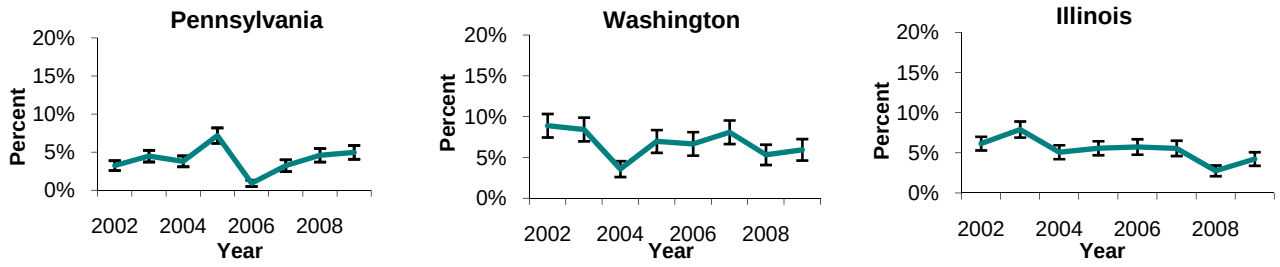


As shown in Figure 3, the percentage of children between 200 and 400 percent of the FPL who were eligible for public coverage jumped from roughly 20 percent to 100 percent in Illinois, reflecting the sweeping scope of its expansion. The percentage of children in this income band also grew considerably in Pennsylvania and Washington, despite their more modest changes in eligibility thresholds.

In Illinois, public coverage increased from between 19 and 22 percent of all children in the pre-expansion period to 31 percent in 2009. The increase was sizable and its timing corresponded to an effect of the expansion with a one-year lag. The rate of public coverage grew during the study period in Pennsylvania as well, but this change occurred more gradually, and the largest one-year increase preceded the state's expansion by more than a year. Finally, in Washington the rate of public coverage fluctuated during the study period.

We found declines during the study period in the rate of private insurance coverage in all three study states, with the largest decline in Pennsylvania and the smallest in Washington. This finding conforms to other reports of a decline in rates of private coverage—especially employer-sponsored coverage—across the nation. Our analyses were not designed to assess the extent to which the declines in private coverage that we observed were due to substitution of public coverage for private coverage—i.e., "crowd-out" (Blewett and Call, 2007).

Figure 4: Percent Uninsured among Children (0-17) in Families with Incomes Between 200 and 400% FPL, 2002-2009



Evidence of a decline in the percentage of uninsured children resulting from expanded eligibility was strongest for Illinois, where the uninsurance rate fell from between 10 and 11 percent in the pre-expansion period to just over six percent in 2009, with the timing again suggesting an expansion effect with a one-year lag. The uninsurance rate among all children fell during the study period in Pennsylvania and Washington as well, but the patterns of decline were not consistent with expansion effects. Our study was not designed to assess other causes of decreases in the rates of uninsurance, or increases in rates of public coverage, among children in the study states. Nonetheless, it is likely that other causes contributed to the coverage patterns that we observed. In particular, growing acceptance over time of public insurance as a source of coverage for higher-income children, coupled with states' efforts to de-stigmatize such coverage, may have been a factor. States' ongoing efforts to simplify application and eligibility-determination processes may have contributed as well.

CONCLUSION

We found strong evidence that Illinois' ambitious July 2006 expansion in children's eligibility for subsidized public insurance coverage resulted in higher rates of public coverage among children and cut the number of uninsured children by almost half. Rates of uninsurance among children generally declined between 2002 and 2009 in Pennsylvania and Washington as well, but our analyses could not tie these declines to the eligibility expansions in those states. A possible reason that this connection could not be made is that the expansions in Washington and Pennsylvania were more recent and more modest than the one in Illinois, making it harder to detect their effects in our data. Additionally, although the expansions may have contributed to the lower uninsurance rates in these states, other factors are likely to have played an important role as well.

Broad-based reforms, like those in Illinois, offer the potential for dramatic changes not only in eligibility but also in increasing coverage and decreasing uninsurance. Future analyses, possibly based on additional CPS data, are required to disentangle the effect of expansions in each state from the potential effects of other factors. A key question related to expansions of public health insurance coverage to individuals and families in higher income groups is the magnitude of the "crowd out" of private insurance; additional analyses of the experiences in these three states will provide insight into this important question as well.

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ABOUT THE SHARE INITIATIVE

SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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