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Parental Eligibility and Enrollment in State Children's Health Insurance Program: The Roles of Parental Health, Employment, and Family Structure

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We examined eligibility and enrollment among parents of children in New Jersey's State Children's Health Insurance Program following expansion of parental eligibility for NJ FamilyCare coverage. Data were from the 2003 NJ FamilyCare Family Health Survey (n=416 families). Parental eligibility was higher in households without a full-time employed parent (odds ratio [OR]=5.50; 95% confidence interval [CI]=2.72, 11.14) and lower among single parents (OR=0.38; 95% CI=0.23, 0.61). Enrollment was higher among single parents (OR=2.24; 95% CI=1.17, 4.31). Roughly one third of eligible parents did not enroll, suggesting the need to increase awareness of parental eligibility and reduce barriers to enrollment. (*Am J Public Health.* 2011;101:274–277. doi:10.2105/AJPH.2010.194654)

Nationally the State Children's Health Insurance Program (SCHIP) has made considerable progress in reducing the number of uninsured children from low-income families, but the lack of insurance among their parents has been a substantial and growing problem.[1] Policymakers in many states have recognized the need to provide affordable coverage options for low-income parents. Child uninsurance is lower when eligibility is extended to parents,[2–7] and retention of children improves when their parents enroll.[8] To enroll and retain more children and improve parental coverage, under an SCHIP 1115 Waiver, in 2000 New Jersey's SCHIP extended eligibility to parents in families with income up to 200% of the federal poverty level who were not covered by other means. Despite much research on the importance of parental eligibility under the SCHIP, little is known about which parents actually enroll in the program. We examined parental eligibility and enrollment in NJ FamilyCare in single- and 2-parent families by parental employment and health characteristics. We hypothesized that families with an ill parent, with no full-time employed parent, and single-parent families would be more likely than would others to be eligible for and to enroll in the SCHIP.

METHODS

We used data from the 2003 NJ FamilyCare Family Health Survey—the most recent available survey data with information to calculate parental eligibility, enrollment status, health, and employment characteristics. Families with children enrolled in NJ FamilyCare (New Jersey's SCHIP) in the year preceding May 2002 were randomly selected for a telephone survey of the adult most knowledgeable about children in the family. The sample was stratified by enrollment status in January 2003, NJ FamilyCare plan level (based on family income), and whether parents were enrolled.[9] The response rate was 52%. Parents were omitted from the sample if their family income was higher than 200% of the federal poverty level at the time their child enrolled, because parents would not qualify under the NJ FamilyCare eligibility criteria (n=246). Among those in the income-eligible range, cases were omitted if parents were employed but temporarily not working (n=21); their child was disenrolled at the time of the survey (n=2); parental demographics were missing (n=4); or family income was missing (n=2). Some cases fit more than 1 exclusion criterion. Final sample size was 416.

We constructed counts of the number of parents in the family who were eligible for NJ FamilyCare, and the number of parents who enrolled in NJ FamilyCare among those who were eligible. Parents with other insurance (employer-sponsored insurance, private,

TABLE 1—New Jersey FamilyCare Eligibility and Enrollment, by Parental Employment, Presence of Health Symptoms, and Household Demographic Characteristics: NJ FamilyCare Family Health Survey, 2003

	Unweighted No.	Weighted %	Households With 1 or 2 Eligible Parents, %	Households With Enrollment of 1 or 2 Parents,[a] %
All	416	100.0	69.3	67.5
Parental employment status				
No full-time employed parent	105	27.4	88.0	76.5
1 or 2 parents employed full-time	311	72.6	62.3	62.8
Presence of serious or morbid symptoms[b] among parents				
No parent has any serious or morbid symptoms	192	44.5	65.7	63.7
1 or 2 parents with ≥1 serious or morbid symptoms	224	55.5	72.2	70.3
Household structure				
1 parent	190	48.8	63.9	77.5
2 parents	226	51.2	74.5	59.2
No. of children enrolled				
1	161	35.3	61.1	59.9
2	121	35.8	74.5	66.5
≥3	134	29.0	72.8	76.3
Family income				
≤133% of the federal poverty level	167	43.3	78.9	73.9
>133%–200% of the federal poverty level	249	56.7	61.6	60.6
Race				
White	163	38.8	75.5	78.8
Non–White	253	61.2	65.4	59.4
Language spoken in the household				
English	349	86.8	71.3	68.6
Non-English	67	13.2	56.2	58.4

[a]Among households with 1 or 2 eligible parents.
[b]Based on reporting of 15 symptoms in a list identified by physicians as highly serious or morbid.[10]

Medicare, or Champus) were classified as ineligible for NJ FamilyCare. Those on Medicaid were counted as eligible under NJ FamilyCare program criteria.[9] Preliminary analysis showed little difference in eligibility or enrollment when parents worked part-time, were unemployed, or were not in the labor force, so employment status differentiated between families with at least 1 full-time working parent or none. Presence of health symptoms among parents was based on reporting of 15 symptoms in a list identified by physicians as highly serious or morbid.[10]

We used SAS version 9.0 (SAS Institute, Cary, NC) to estimate multivariate logistic regressions of (1) whether at least 1 parent was eligible for NJ FamilyCare, and (2) among households with an eligible parent, whether at least 1 parent enrolled in NJ FamilyCare. Estimates were weighted to the universe of children enrolled in NJ FamilyCare on May 31, 2002.[9]

RESULTS

Demographic composition of the sample is shown in Table 1. Table 2 shows that households with at least 1 parent with serious or morbid symptoms had higher odds of NJ FamilyCare parental eligibility (odds ratio [OR]=1.15; 95% confidence interval [CI]=0.74, 1.84), but the association was not statistically significant. Single parents (OR=0.38; 95% CI=0.23, 0.61; $P<.05$) and non–English speakers had lower odds of eligibility (OR=0.40; 95% CI=0.20, 0.77; $P<.01$), whereas households without a full-time employed parent (OR=5.50; 95% CI=2.72, 11.14; $P<.01$) or with incomes up to 133% of the federal poverty level had higher odds of eligibility (OR=1.90; 95% CI=1.14, 3.17; $P<.01$).

Parental employment status and health symptoms were not statistically significantly associated with enrollment in NJ FamilyCare among eligible parents (Table 2). Single parents had substantially higher odds of enrollment (OR=2.24; 95% CI=1.17, 4.31; $P<.01$), as did households with income up to 133% of the federal poverty level (OR=2.37; 95% CI=1.25, 4.50; $P<.01$), or with 3 or more children enrolled (OR=2.10; 95% CI=0.98, 4.47; $P=.06$). Enrollment was lower in households with races/ethnicities other than White (OR=0.28; 95% CI=0.14, 0.55; $P<.01$) and non–English-speaking households (OR=0.42; 95% CI=0.17, 1.08; $P=.07$).

DISCUSSION

Odds of eligibility for New Jersey's SCHIP were much higher among households without a full-time worker. Nearly half of single-parent families and three quarters of 2-parent families

TABLE 2—Estimated Odds of Parental Eligibility and Enrollment in New Jersey FamilyCare, by Presence of Health Symptoms, Parental Employment Status, and Household Demographic Factors: NJ FamilyCare Family Health Survey, 2003

	1 or 2 Parents Eligible (n=416), OR (95% CI)	1 or 2 Parents Enrolled[a] (n=240), OR (95% CI)
Health symptoms		
No parents with symptoms (Ref)	1.00	1.00
1 or 2 parents with ≥1 serious or morbid symptoms[b]	1.15 (0.74, 1.84)	1.18 (0.65, 2.15)
No. of parents in household		
2 (Ref)	1.00	1.00
1	0.38** (0.23, 0.61)	2.24* (1.17, 4.31)
Full-time employed parents		
1 or 2 full-time employed parents (Ref)	1.00	1.00
No full-time employed parent	5.50** (2.72, 11.14)	0.93 (0.43, 1.99)
No. of children enrolled		
1 (Ref)	1.00	1.00
2	1.55 (0.90, 2.66)	1.09 (0.55, 2.17)
≥3	1.50 (0.85, 2.65)	2.10 (0.98, 4.47)
Family income		
>133%–200% of the federal poverty level (Ref)	1.00	1.00
≤133% of the federal poverty level	1.90* (1.14, 3.17)	2.37** (1.25, 4.50)
Race		
White (Ref)	1.00	1.00
Non-White	0.75 (0.45, 1.26)	0.28** (0.14, 0.55)
Household language spoken		
English (Ref)	1.00	1.00
Non-English	0.40** (0.20, 0.77)	0.42 (0.17, 1.08)
Model: Wald χ^2 (df)	53.19* (8)	27.53* (8)

Note. CI = confidence interval; OR = odds ratio.
[a]Among households with 1 or 2 eligible parents.
[b]Based on reporting of 15 symptoms in a list identified by physicians as highly serious or morbid.[10]
*P < .05; **P < .01.

with at least 1 full-time worker had 1 or 2 parents eligible for NJ FamilyCare, underscoring the substantial need for insurance coverage for low-income working parents.

Parents with serious or morbid health symptoms were slightly more likely to be eligible and to enroll in NJ FamilyCare, but the association was small and not statistically significant. This suggests that self-selection of sicker parents is unlikely to drive cost increases in NJ FamilyCare. Ill parents were less likely to work full time, consistent with studies suggesting that disabilities and chronic conditions are associated with reduced labor force participation, fewer work hours, and lower wages,[11] reducing parents' chances of employer-sponsored insurance coverage and ability to afford private coverage.

Enrollment among NJ FamilyCare–eligible parents was 78% in single-parent families and 59% in 2-parent families, demonstrating that a sizeable share of those who could benefit from NJ FamilyCare coverage did not enroll. Possible reasons include a lack of awareness about the criteria for parental eligibility, stigma associated with public health insurance programs, citizenship issues, and other enrollment barriers such as difficulty completing the application and documenting income.[12–14]

Overall, roughly half of income-eligible households had at least 1 parent enrolled in NJ FamilyCare, providing an estimate of the share of parents in low-income families who might enroll in a public health insurance program with their children. Family coverage has several benefits for both parents and children. Parents with Medicaid or SCHIP coverage are more likely than are uninsured parents to receive needed health care without delay, see a physician or dentist, have a usual source of care,[15] and to enroll their children.[16]

Strengths and Limitations

One strength of this study is that the data are from households in which children were enrolled in New Jersey's SCHIP, providing a targeted sample of parents who were potentially eligible for NJ FamilyCare. Limitations include the small sample size, which restricts the number of variables in the multivariate analysis. Also, the sample does not capture parents who might be eligible from families not yet participating in NJ FamilyCare. Third, there is little income variation among those eligible for parental coverage (all families' incomes were less than 200% of the federal poverty level), so we cannot assess relationships among employment, health, and income.

Policy Implications

Our findings suggest that a substantial number of eligible parents did not enroll in NJ FamilyCare in 2003 under the New Jersey SCHIP 1115 waiver. Following increased outreach and administrative simplification efforts in the 2008 New Jersey Health Care Reform Act,[17] many additional parents enrolled in the program, demonstrating the importance of such strategies to increase parental coverage (oral communication via a conference phone call with John Guhl, director, and Valerie Harr, deputy director, Division of Medical Assistance and Health Services, NJ Department of Human Services; September 21, 2009). Nationally, however, enrollment and renewal simplification practices to increase children's participation in Medicaid and SCHIP have not been applied consistently to covering parents.[18]

The recently enacted Patient Protection and Affordable Care Act provides funding to states to expand Medicaid to all adults with family income up to 133% of the federal poverty level, and will provide subsidies for the purchase of private coverage for other low-income individuals above that level, starting in 2014.[19] Under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, no new states will be allowed to cover parents under

the Children's Health Insurance Program, and states currently covering parents under Children's Health Insurance Program will transition their coverage into a separate block grant program beginning in 2012. This will reduce disparities among states in covering the poorest adults, but will require states to rethink approaches to covering uninsured parents with income above 133% of the federal poverty level, who may be more vulnerable during a widespread economic crisis when states are facing budget shortfalls. ■

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Contributors

J.E. Miller conceptualized the study, oversaw the data preparation and analysis, and led the writing. D. Gaboda oversaw the data preparation and analysis, and contributed to the Methods and Discussion sections. C.N. Nugent prepared the data, conducted the analysis, and contributed to the literature review and the Methods section. T.M. Simpson assisted in data preparation and contributed to the literature review. J.C. Cantor assisted in conceptualization of the analysis and contributed to the Discussion section. All authors contributed to the writing and review of the article.

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Note. The authors are solely responsible for the analyses and conclusions herein.

Human Participant Protection

This project was approved by the Human Subjects Review Board of Rutgers, the State University of New Jersey.

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