Evidence for a Uniform Medicaid Eligibility Threshold for Children and Parents

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If you ask children's clinicians to identify the key influencers who help children grow up healthy and resilient, most will place parents at the top of the list. Parents are the navigators and shapers of children's developmentally pivotal experiences, serve as critically important facilitators of timely preventive health care, and provide vital protection and support when children face acute and chronic illnesses.[1]

However, the majority of federal and state programs that provide health coverage to children and parenting adults treat them as if their needs are somehow disconnected. Children and parents typically qualify for government programs, such as Medicaid, on the basis of distinct household income eligibility thresholds, thereby covering tens of millions of children while leaving many parents in the same households without such coverage. This gap in public program coverage across generations leaves a shortfall for parents nationally: As recently as 2016, 89.6% of children had insurance coverage for the last 12 months, whereas only 80.5% of their parents had the same pattern.[2] On the basis of my conservative estimate of the number of parents residing with their minor children in 2016 from the US Census Bureau (ie, ~121.5 million parents overall),[3] the parent coverage shortfall translates to ~11 million uninsured parents living in households with children who themselves have coverage.

One result of within-family disparities in coverage is that children miss opportunities for routine well-child preventive visits that help ensure the timely delivery of preventive services, screening, and management of chronic health conditions. Venkataramani et al's[4] study of Medicaid data from 2001 to 2013 and >50 000 parent-child dyads suggests that children whose parents were newly enrolled in Medicaid (largely as states expanded income-based eligibility) were significantly more likely to have annual well-child visits, independent of the children's own insurance status. Although there are limitations to the study (for instance, it is not possible to tell whether children's health outcomes changed in connection with their parents' gain in coverage, and the years of the study do not include the expansion of Medicaid eligibility for adults under the Patient Protection and Affordable Care Act), this study is among the first to indicate that providing coverage for parents is a boon for their children's health care.

I say it is among the first because of the precedent for parents' opportunities for coverage through the State Children's Health Insurance Program (SCHIP) in the late 1990s and early 2000s. Policy analysts found evidence that covering parents can be beneficial for children's coverage status, suggesting benefits for children's access to timely health care as well.[5,6] Nonetheless, the notion of parents (ie, adults) gaining coverage through a program with the word "children"

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in its name was controversial among federal legislators despite the fact that the bipartisan enabling legislation for SCHIP in 1997 explicitly mentioned family coverage as an option. Consequently, as the federal SCHIP was reauthorized in 2009 and renamed the Children's Health Insurance Program (CHIP), the option to use (S)CHIP funds to offer coverage for parents was phased out.

A subtext to the CHIP policy dialogue 1 decade ago was that there can be bipartisan agreement about covering children but not about covering their parents. This policy distinction raises a key analytic question: Is it surprising that expanding coverage to parents is beneficial for their children? The answer is almost certainly no. Although the mechanism of benefit may not be consistent across families (eg, in some instances, parents' own health care encounters may remind them of health concerns for their children; in other households, the diminished economic risk faced by parents with coverage may help them navigate health care expenses for their children), the basic nature of health care coverage is that it is chiefly a financial tool for individuals and families that helps them manage other economic burdens they face.

In other words, the same principles of insurance benefits in private health plans hold for coverage through government programs, such as Medicaid. The dominant paradigm of coverage in private insurance markets in the United States is that an individual who purchases coverage by paying premiums pays an incremental amount more to cover dependents in the same household. The central rationale for this paradigm is efficiency: family units are groups of individuals who bear the risks for health, and health care expenditures, together.

On the basis of decades of evidence of the benefits of parental coverage for children, it is time for public programs, such as Medicaid and CHIP, to adopt a similarly efficient approach: Offer coverage to parents of children on Medicaid at the same income eligibility thresholds that are applied to their children. After all, the household income used to determine program eligibility is the same for a child and parent. What is different today in the majority of states is the threshold under which a child versus a parent qualifies. If there is bipartisan sentiment that children deserve coverage that safeguards their health and wellbeing, then covering their parents can be an evidence-based way to maximize the value of that coverage. Although skeptics would likely criticize this idea on the grounds of affordability, the benefits for children and improvements to their preventive health care use might surprise the doubters and benefit the children's parents as well.

ABBREVIATIONS

CHIP: Children's Health Insurance Program
SCHIP: State Children's Health Insurance Program

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