

**Does Family Health Insurance Coverage Matter for Children's Health?**  
Evidence From Auto-Enrollment in Wisconsin

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**Short Abstract:**

In February 2008, 26,000 adults and 18,000 children who were family members of current beneficiaries of Wisconsin's combined Medicaid/Children's Health Insurance Program were automatically enrolled into the program. Adults in families with incomes above 150% of the federal poverty line were subject to modest premium payments and disenrolled very quickly, while those with incomes below 150% of the federal poverty line tended to stay enrolled. Children were not subject to this premium limit. I use administrative enrollment and claims data from Wisconsin's program and the exogenous differences in parental Medicaid coverage resulting from the auto-enrollment phenomenon in order to determine whether parental enrollment matters for children's health care utilization and health outcomes.

**Extended Abstract:**

In the U.S., social welfare programs have typically benefited parents with dependent children before other nondisabled adults. Medicaid coverage has gradually extended in most states to include the low-income parents of children on the program. While this may represent a desire on the part of policymakers to reduce uninsurance rates through simply extending benefits to those easiest to reach, it is also possible that there are family level benefits from allowing parents to be covered along with their children. Parental contact with the health care system has been found to be correlated with on-time pediatric visits and immunizations (Hanson, 1998). Medicaid-enrolled children whose parents have Medicaid are more likely to have a well child visit compared to those with uninsured parents (Gifford et al. 2005).

The difficulty in studying how parental insurance coverage affects children's health care outcomes is that parental and child coverage decisions are generally made together at the family level, and a child's own coverage is a more important determinant of health care outcomes. Naïve comparisons of, for example, outcomes of children with Medicaid coverage with parents on Medicaid versus those of children with Medicaid coverage with parents who are uninsured or have private coverage would not account for underlying differences in those family decision-making processes that resulted in different coverage decisions. Coverage decisions are likely to be made with health care outcomes in mind. Without an exogenous determinant of either child or parental coverage, estimates of the impact of parental coverage on children's health care usage and health will be biased.

Wisconsin expanded its public health insurance programs in 2008, and the particular implementation of the expansions provides an exogenous determinant of parental coverage. In February 2008, 26,000 adults and 18,000 children who were family members of current beneficiaries of Wisconsin's combined Medicaid/Children's Health Insurance Program were automatically enrolled into the program. Of these, 6,389 adults were in families with incomes above 150% of the federal poverty line (FPL) and were subject to modest premium payments. The auto-enrollment process occurred in conjunction with the state level reform initiative and applied new program eligibility criteria to previously ineligible individuals for whom there was current information in the state's administrative program eligibility database.

Compared both with adult auto-enrollees in lower-income households and with other adult February enrollees who were not auto-enrolled, auto-enrolled adults required to pay premiums were much more likely to exit and did so very quickly, within the first few months of enrollment. Children were not subject to this premium limit. This phenomenon created two groups of children: those in families below 150% FPL whose automatically enrolled parents were likely to stay enrolled, and those in families above 150% FPL whose automatically enrolled parents were likely to exit. I compare the health care utilization of these two groups of children in order to determine whether parental enrollment matters for children's health outcomes.

I employ two empirical strategies in order to identify these effects. First, I note that a simple pre-post design would make use of the fact that auto-enrolled parents in families with incomes below 150% FPL are likely to be similar to auto-enrolled parents in families with incomes above 150% FPL. Taken to the limit, this argument implies that a regression discontinuity design will give the causal effect of parental enrollment. This strategy is preferred because it does not require me to assume that auto-enrollment was exogenous, only that whether family income is just above or just below 150% FPL is exogenous.

However, sample sizes are relatively small for this exercise, especially given the incidence rates of some of the outcomes of interest. In order to address this issue I use a difference-in-differences empirical strategy which allows me to make use of data farther away from the 150% threshold. The difference-in-differences compares the outcomes for children in families above and below 150% FPL for those with auto-enrolled parents and for those with non-auto-enrolled parents. This strategy removes concerns about average differences in the composition of the group of children above and below 150% FPL, assuming that there is nothing unobservably different about children with non-auto-enrolled parents.

DeLeire et al. (2012) provide a descriptive analysis of Wisconsin's auto-enrollment process. The motivation for the use of auto-enrollment was to reach those residents who were eligible for the state's health insurance programs but were not currently enrolled. Studies have shown that requiring people to opt out of programs rather than opt in results in higher rates of program participation (Remler & Glied, 2003; Choi et al. 2004). Dague (2012) shows that Wisconsin's premiums, which begin at \$10 per month, have a direct and important causal effect on overall enrollment, with those required to pay premiums 11-15 percentage points more likely to exit within six months of enrollment.

The data for this project are administrative enrollment and claims data from Wisconsin's combined Medicaid/Children's Health Insurance program, called BadgerCare Plus. These data allow me to connect adults and children within the same household and to follow their enrollment status (and health care utilization, if enrolled) for a period of up to three years. I have access to data on health care utilization beginning in 2008 and data on program enrollment beginning in 2006. The data include basic demographic information in addition to detailed claims for outpatient visits, emergency department visits, and hospital admissions. Preliminary results indicate that children whose parents stayed enrolled were more likely to themselves stay enrolled in the program; results on utilization outcomes are pending.

### References

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