State Children's Health Insurance Program (SCHIP) Expansion:
Will increasing income eligibility limits for children increase insurance coverage?

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Abstract:

The State Children's Health Insurance Program (SCHIP) was established to provide health insurance coverage to children whose families cannot afford private coverage and whose incomes are too high to qualify for Medicaid. Currently, a majority of states limit SCHIP eligibility to children with family incomes at or below 200% of the federal poverty level (FPL), while four states have set the eligibility threshold at 250% of FPL. Our paper employs a difference-in-difference model that exploits these differences in eligibility thresholds to determine if higher eligibility thresholds have a positive impact on insurance coverage. We find no evidence that extending eligibility for SCHIP to families above 200% of FPL has contributed to increased insurance coverage for children in this higher eligibility range. These results suggest that future efforts to increase insurance coverage for low-income children should focus on increasing enrollment among children already eligible for Medicaid and SCHIP and not on extending eligibility for public insurance to higher-income groups.

I. Introduction

Passed into law with bipartisan support as part of Title XXI of the 1997 Balanced Budget Act, the State Children's Health Insurance Program (SCHIP) was established to provide health insurance to children whose families could not afford private coverage but whose incomes were too high to qualify for Medicaid. SCHIP has been praised for successfully increasing insurance coverage for low-income children, and in 2006, approximately 6.7 million children were enrolled in SCHIP (Kenney, 2008).

Congress initially appropriated over $40 billion in federal matching funds over 10 years that states could use to expand Medicaid eligibility, establish separate SCHIP programs, or to combine new SCHIP programs with Medicaid. SCHIP is a means tested program with eligibility thresholds measured in terms of family income as a percent of the Federal Poverty Level (FPL). Title XXI allowed states to extend eligibility for public insurance to children with family incomes up to 200% of the federal poverty level (e.g. $42,054 for a family with two parents and two children in 2007) with the exception that those states with Medicaid eligibility levels already above 200% could extend eligibility to higher levels. Currently, the number of states that set eligibility at, above and below 200% of the FPL are 28, 14 and 8, respectively.

SCHIP came up for renewal in 2007, and Congress was required to reauthorize funding to continue the program. Since SCHIP was recognized as being successful at increasing insurance coverage among children, many SCHIP supporters urged Congress to expand the program by appropriating more federal funds and increasing the maximum eligibility threshold. Although Congress passed legislation to extend funding for SCHIP for five additional years, President Bush vetoed comprehensive reauthorization bills

twice. In addition to renewing previous funding levels, this legislation authorized additional funds for outreach and enrollment efforts, but did not raise eligibility thresholds. After much debate, a compromise was finally reached in December of 2007 to temporarily extend SCHIP for 18 months. Critics, such as President Bush, argue that raising the eligibility threshold will do little to increase overall insurance coverage for children because children in the upper income eligibility range are likely to already have private coverage. SCHIP will again come before Congress in 2009, and it is likely that they will again consider expanding funding and eligibility levels (Kenney, 2008). A Democratic presidential victory in 2008 would likely place SCHIP reauthorization high on the agenda since the two remaining Democratic presidential candidates have made expansion of SCHIP a key component of their health care reform packages. Even with a Republican in the White House, SCHIP will continue to attract bipartisan support.

Given the goals of SCHIP and continued efforts to increase the number eligible for the program, it is imperative to know if expanding eligibility thresholds will lead to an increase in coverage. Early research has shown that SCHIP contributed to the decline in the percent of low-income children that are uninsured from 23 percent in 1996 to 18.6 percent in 2002 (Selden et al., 2004). It has been hailed for its success in increasing coverage and improving access to care for low-income children (Cunningham et al., 2002; Kenney and Cook, 2007; Quinn and Rosenbach, 2005). The success of SCHIP in increasing coverage is affected by take-up rates, or the percent of eligible children that actually enroll. SCHIP take-up has risen since the initial years of the program, and is now around 60% (Selden et al., 2004). Our estimates show that higher-income families are

less likely to take-up SCHIP, and so take-up will likely be lower if eligibility is expanded further.

SCHIP can only increase insurance coverage rates if new enrollees are coming from the ranks of the uninsured. A primary criticism of SCHIP is that it leads to "crowd out," or children dropping private insurance coverage to enroll in SCHIP. If crowd out rates are large, expanding public insurance does little to impact overall insurance rates. Estimates of SCHIP crowd out vary and are sensitive to data sources and specifications, with some authors finding that 50-60% all enrollees switch from private insurance (Lo Sasso et al. 2004; Gruber and Cutler, 2007) and others finding more modest effects of 7-15% (Wooldridge et al., 2005).

Given less than 100 percent take up and the potential for crowd out, it is not known whether expansions of the program will increase insurance coverage. In this paper, we exploit variation across states in SCHIP eligibility rules to test whether higher income eligibility thresholds contribute to higher insurance rates for children. As noted above, a majority of states limit SCHIP eligibility to children whose family incomes are at or below 200% of FPL. In contrast, four states (California, New York, Washington and Rhode Island) have set the eligibility threshold at 250% of FPL. Among the four states with more generous SCHIP eligibility rules, we would expect to see higher insurance coverage for those with incomes between 200 and 250% of FPL than those with incomes between 150 and 200%. Some of this difference is due to expansions of the SCHIP program to higher-income groups, but some will also be due to the fact that insurance rates for children tend to rise with family income. Looking at insurance coverage rates for the less generous states as a control, the difference in insurance rates

between the higher (200 to 250% of FPL) and lower (150 to 200% of FPL) eligibility

states provides an estimate of the change in insurance coverage that would occur in the

four more generous states had there not been an expansion in coverage. The difference in

these differences is then an estimate of what expansion of the program to high income

groups has done to insurance coverage rates. We find no evidence that extending

eligibility for SCHIP to families above 200% of the FPL has contributed to an increase in

insurance coverage for children in this higher eligibility range. These results suggest that

future efforts to increase insurance coverage for low-income children should focus on

increasing enrollment among children already eligible for Medicaid and SCHIP and not

on extending eligibility for public insurance to higher-income groups.

II. Empirical Methodology

A. Data

The data for this study comes from the March Current Population Survey (CPS).

The CPS is a monthly survey of roughly 50,000 households that has been conducted for

more than 50 years by the U.S. Census Bureau for the Bureau of Labor Statistics.[1] The

survey is representative of the civilian noninstitutional population. A series of questions

regarding labor force and demographic characteristics are asked monthly with detailed

questions regarding income, poverty, and health insurance status asked in March as part

of the Annual Demographic File and Income Supplement.

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[1] http://www.census.gov/cps/

Data is obtained through the Integrated Public Use Microdata Series (IPUMS) for the CPS.[2] IPUMS-CPS is an integrated set of data spanning 1962-2007 for the March CPS where data elements have been harmonized for comparability over time. Data is available at both the individual and household level.

We use individual data for the years 2001-2007. The primary reason for beginning in 2001 is that it was the first year a verification question was added at the end of the series of insurance questions. The verify question asks: "Does the person with no coverage reported previously have any coverage?" If yes, the respondent was then able to choose up to six types of health insurance for the previous calendar year. This "verify" estimate greatly reduced the estimated number of persons without health insurance (about 8% of persons previously classified as not having health insurance). The March 2001 CPS was also the first to include a Medicaid follow up question on whether individuals 18 and under were covered by SCHIP. This variable cannot be used exclusively to determine the number of children enrolled in SCHIP because of the way the survey structures insurance questions. We return to this point in detail below.

The key outcome variables included in our analysis are indicators for whether an individual child is covered by any insurance, private insurance, and public insurance. The variable any insurance indicates the individual reported coverage through Medicaid, Medicare, military health insurance, Civilian Health and Medical Program of the Department of Veterans' Affairs, Indian Health Service, SCHIP, group coverage, private coverage, or through the verify question. Individuals are categorized as having private insurance if they report being covered by private insurance or group insurance. People

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[2] Miriam King, Steven Ruggles, Trent Alexander, Donna Leicach, and Matthew Sobek. *Integrated Public Use Microdata Series, Current Population Survey: Version 2.0*. [Machine-readable database]. Minneapolis, MN: Minnesota Population Center [producer and distributor], 2004. <cps.ipums.org/cps>.

are classified as having public insurance, if they report having Medicaid or SCHIP. Other forms of public insurance, including Medicare, were not included in the public insurance variable because the main criteria for eligibility in these programs is not income, but other requirements such as age, disability status, and veteran status.

Eligibility for SCHIP is determined by family income in relation to the federal poverty level, which is itself a function of family size. We impute the income eligible for inclusion in a child's poverty level calculation using rules developed by the U.S. Census Bureau. According to these definitions, all related family members within a household have the same poverty status, and so the incomes from all related family members are included when calculating a family's poverty status.[3] Since the March CPS collects information for the previous calendar year, we use poverty thresholds that are lagged one year (i.e. the 2007 March CPS poverty thresholds are based off 2006 U.S. Census Bureau poverty thresholds).

Our sample consists of children aged 0-18, the age eligibility range for SCHIP. We omit non-U.S. citizens from our sample because they are ineligible. We are not able to include foster children and other children living with non-relatives because family income data is not available for them. Our sample is also confined to children with incomes between 150-250% of FPL, which is the subgroup relevant for our difference-in-difference model.

B. Econometric Model

We estimate a difference-in-difference model by grouping states into a low eligibility control group and a high eligibility treatment group. States in the low eligibility group use the most common eligibility threshold, covering children with family incomes

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[3] http://www.census.gov/hhes/www/poverty/threshld.html

up to 200% of FPL. We use all low eligibility states that use similar income eligibility requirements to form the control group in our model.[4] Four states grant eligibility to children with incomes up to 250% of FPL, and these four states form the treatment group where the "treatment" is expanded eligibility for SCHIP. Table 1 lists all states in the treatment group, and Table 2 lists all states in the control group. States with eligibility levels other than 200 and 250% are not included in our sample. In addition, we exclude four states because they operate separate state programs in which eligibility for public coverage exceeds SCHIP eligibility levels. All states not included in our sample are described in Table 3.

Children in our sample are divided into two groups based on family income. Children in the lower-income group have incomes 150-200% of FPL. Kids in this group are eligible for SCHIP in both treatment and control states. Therefore, any difference in insurance coverage between lower-income kids in treatment and control states is due to secular differences between low eligibility control states and high eligibility treatment states. Children in the higher-income group have incomes 200-250% of the FPL. Higher-income kids living in treatment states are eligible for SCHIP but those living in control states are not eligible. The difference in insurance coverage between higher-income kids in treatment and control states are a result of both secular differences between treatment and control states and eligibility for SCHIP. Since we can identify the secular effect as the difference between lower-income kids in treatment and control states, subtracting this

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[4] States are given the flexibility to set their own rules for income attribution and exemptions, enrollment policies, and other program features in separate SCHIP and SCHIP combination programs. We use only those states that use income attribution rules which are identical or very similar to Medicaid rules in an attempt to pool states with the most similar programs and to minimize the variation in what types of income can be counted in determining SCHIP eligibility across states. We also tried running our model for all states with 200% eligibility, excluding states with separate programs that finance children above SCHIP levels, but did not find large enough changes for us to abandon using only states with Medicaid rules.

difference from the difference between higher-income kids in treatment and control states will give the effect of SCHIP eligibility on insurance coverage for higher-income kids. Table 4 provides summary statistics for treatment and control groups. As noted before, the sample consists of U.S. citizens aged 0-18, with incomes ranging 150-250% of FPL.

The visual results from the difference-in-difference model are graphically represented in Figures 1-3. In Figure 1, we report the fraction of children with any health insurance in states with 200 and 250% cutoff levels. In both groups of states, children with incomes below 200% of the FPL are eligible for SCHIP and notice that as incomes rise, the change in insurance status increases at about the same rate in both state groups. If expanding eligibility to 250% has increased insurance coverage for children in this higher income range, we should see a break in the trend line of the 250% states at the 200% threshold. In particular, the trend line should jump upward if SCHIP eligibility is causing more kids with incomes 200-250% to be insured. However, the graphs show no such breaks at the 200% threshold for any of the insurance outcomes. This suggests that expanded eligibility is not having an impact on insurance coverage.

In Figures 2-3, we repeat the exercise with the two other key outcomes: whether the child has private and public insurance, respectively. In both of these graphs, we see similar insurance rates for the children below 200% of the FPL and no appreciable change in the vertical distance between the graphs in the 200 to 250% ranges. Again, these figures, especially Figure 3, provide visual evidence that expanded SCHIP eligibility in the four states listed in the treatment group does not appear to have changed public insurance enrollment rates above what we would expect in states that do not cover these children.

The basic difference-in-difference regression model estimated for a child (i) from state (s) in year (t) follows the form of

(1) $$Y_{ist} = \beta_0 + \beta_1 T_{ist} + \beta_2 A_{ist} + \beta_3 T_{ist} A_{ist} + \varepsilon_{ist}$$

where $Y_{ist}=1$ if the child is insured (by any, private, or public policy) and zero otherwise. We begin with a limited set of covariates. We identify $T_{ist}=1$ if the observation belongs to a treatment state with a 250% eligibility cutoff; $A_{ist}=1$ for an individual in the higher income group of 200-250% of FPL (the treatment period); $T_{ist}A_{ist}$ is the interaction of living in a treatment state with an income 200-250% of the FPL. β_3 is the coefficient of interest, interpreted as the effect of SCHIP eligibility on insurance coverage for children in the 200-250% income range. The variable ε_{ist} is a random error.

As the numbers in Table 5 indicate, there are some potential differences in demographic characteristics across states that could potentially contaminate a simple model like Equation 1. Therefore, we need to control for a denser set of covariates than reported in Equation 1.

(2) $$Y_{ist} = \beta_0 + \beta_1 T_{ist} + \beta_2 A_{ist} + \beta_3 T_{ist} A_{ist} + \beta_4 X_i + u_{is} + \lambda_{it} + \varepsilon_{ist}$$

where $Y_{ist}=1$ if the child is insured (by any private or public policy) and zero otherwise, $T_{ist}=1$ for the treatment states, $A_{ist}=1$ for an individual with income 200-250% of the FPL (the treatment period), $T_{ist}A_{ist}$ is the interaction of living in a treatment state with an income 200-250% of the FPL. β_3 is, again, the coefficient of interest, interpreted as the effect of SCHIP eligibility on insurance coverage for children in the 200-250% income range. X_i is a vector of individual characteristics. Included are sex, age, the interaction of age and male, Hispanic, white, black, and Asian. Looking at Figure 1, there is a pronounced positive relationship between the FPL and insurance status. Although the

relationship can be approximated by a linear function, we allow for a possible non-linear relationship between FPL and insurance status by including a squared and a cubic term in the FPL into the regressions. We allow for the possibility that the treatment states are not randomly assigned (i.e. 250% states have higher eligibility thresholds by choice) by including state effects. State and year effects are represented by u_s and λ_t respectively, and ε_{ist} is a random error term.

A key assumption of the difference-in-difference model is that the change in insurance coverage in the control states between lower and higher income groups represents the change in coverage that would occur in the treatment groups in the absence of any expansion of SCHIP beyond the 200% level. For example, suppose that expanding the eligibility of SCHIP to higher levels of FPL increases children's insurance coverage, but insurance coverage is changing at a higher rate in higher eligibility states compared to lower eligibility states. In this case, the difference-in-difference model will overstate the effect of increased eligibility rates. While we cannot verify that the outcomes would have been the same in the absence of intervention, Figures 1-3 provide some evidence that this assumption is valid. Note that the change in insurance coverage as one moves from 150 to 200% of FPL within each of these groups is nearly identical. For all insurance and private insurance, insurance coverage gradually increases with higher FPL. For public insurance, children's insurance coverage gradually decreases with higher FPL.

III. Results

Table 5 reports mean insurance coverage rates for four different groups: states with high (250% of FPL) and low (200% of FPL) SCHIP income eligibility cutoffs and individuals with higher (200-250% of FPL) and lower (150 to 200% of FPL) incomes. Looking at the 'treatment' states with more generous coverage (columns (4) and (3)), we see that insurance coverage rates are 2.5 percentage points higher for children in the higher-income group in high eligibility states. However, among states without any SCHIP coverage for children in the 200 to 250% of the FPL range, there is also only a 2.4 percentage point difference in insurance coverage rates between the high and low income groups. The small difference in these means (column (7)) confirms the visual evidence in Figure 1 that expanding SCHIP to the higher-income group of children appears to have had little impact on insurance coverage rates. The numbers indicate a slight decrease in public insurance and slight increase in private insurance for 250% states, but neither of these estimates is qualitatively large.

Our complete regression estimates are reported in Table 6. We estimate three models for three different outcome variables. The outcome variables are indicators for if an individual is covered by any insurance (1), covered by private insurance (2), and covered by public insurance (3). The coefficient of interest is for the interaction term "Above 200% Federal Poverty Level*States with Cutoff at 250% of Federal Poverty Level", which gives the effect of living in a high eligibility state on the probability that a child with income 200-250% FPL will have insurance. This coefficient is essentially the difference-in-difference means given in Table 5 adjusted for demographic characteristics and state and year effects. The estimated coefficient for the any insurance model is not

statistically different from zero, which corresponds to the small difference in means discussed above. The interpretation of this result is that a higher-income child is not more likely to have insurance as a result of being eligible for SCHIP.

The estimated coefficient for public insurance is also not statistically different from zero, with the interpretation that SCHIP also has a negligible impact on public insurance coverage for children with incomes 200-250% of the FPL. This would imply very low take-up rates for children in this income range. The estimated effect on private insurance is positive and statistically significant at the 5 percent level. The interpretation is that expanded SCHIP eligibility increases the probability that children with incomes 200-250% will be privately insured. The magnitude is small, but the positive sign of this result is counterintuitive because being eligible for public coverage should have the effect of decreasing private coverage if it has any effect at all. One plausible explanation for this result is that people are misreporting public insurance coverage as private coverage in the CPS. This nonsampling error concern is discussed in more detail below.

We have tried numerous other ways to specify the data and create accurate measures. One method employed throughout the research process was an alternative method of computing family income. An income was constructed using only the mother and father's income (if living with the child) because we were concerned that families did not actually report the incomes of all related family members when applying for SCHIP. Since these results differ very little from our published results, we have not included them, but they can be provided upon request. Another method used was including all states with 200% of the FPL in the control group, excluding the states with SCHIP

programs financed past those levels. Again, the results did not differ drastically and we feel that our closer specification of income criteria produces more credible results.

Accuracy of estimates depend on the extent of sampling error and nonsampling error. Sampling error occurs because of differences between sample values, which are estimated for a subset of the total population and the true population values. Standard errors should account for sampling error. Nonsampling error refers to the difference from the true population value that would occur if the entire population was sampled. The aspect of nonsampling error of greatest concern is that the March CPS being a self-reported survey. Respondents may not recall their previous year's income correctly or may misunderstand a question. Respondents may have problems remembering previous health coverage or may have switched and neglected to report all previous forms of insurance. In addition, often people on Medicaid or SCHIP are issued a health insurance card from Blue Cross/Blue Shield or another private insurer. Respondents may be confused about whether their coverage is in fact public or private insurance. The Census Bureau attempts to control for problems by electronically changing the name of the Medicaid program to match the state's terms. Various other precautions are also taken to limit nonsampling error.

We feel the biggest problem in our research is that the income measures we generate do not exactly simulate incomes used to determine eligibility for Medicaid and SCHIP. Factors such as child care expenses, alimony, and outgoing child support payments are not reported in the CPS but are used as income exemptions when applying for Medicaid and most SCHIP programs. Variation exists in how states determine SCHIP eligibility, and it is not always clear how states calculate the types of income that are

relevant for eligibility. We try to limit these errors by only including states that exactly or very closely follow Medicaid eligibility rules so we can at least be certain that all states in our sample are using the same rules. However, we cannot be certain that the incomes we generate are identical to ones actually used to determine eligibility in all cases.[5]

IV. Discussion and Conclusion

Our results show that expanding SCHIP eligibility beyond 200% of the FPL has no discernable impact on the probability that a child with family income 200-250% of the FPL will be insured. Thus, we conclude that expanding eligibility thresholds over 200% of the FPL has had a negligible impact on insurance coverage. These results are not entirely unexpected considering that crowd-out is greater and take-up rates are lower for higher-income groups. Our results provide suggestive evidence that further expanding SCHIP eligibility levels will do little to impact uninsurance rates and that proposed SCHIP expansions to extend eligibility to families with incomes of 300% or more of the FPL will be an inefficient use of resources.

Nearly three-quarters of uninsured children are already eligible for public insurance (Dubay et al., 2002). Therefore, lack of eligibility is not the primary problem policymakers must grapple with in their efforts to decrease the number of uninsured children. Policies intended to increase insurance coverage for low-income children should instead focus on increasing the enrollment of eligible children. Haley and Kenney (2001) find that lack of knowledge about the SCHIP program was the primary barrier to enrollment for one-third of uninsured children. Administrative difficulties were responsible for another 10%, while 22% of uninsured kids' parents said they did not want

or need public insurance; 18% of those surveyed had had Medicaid or SCHIP at some point in previous year but hadn't re-enrolled for various reasons.

Simplifying eligibility procedures, community-based outreach and application options, as well as integrating enrollment for Medicaid and separate SCHIP programs would help expand enrollment (Ross and Hill, 2001). Grants to decrease barriers to enrollment through features such as automatic enrollment, premium assistance programs, and translation services have the potential to increase insurance coverage for high poverty and near poverty children. Federal grants for implementing these programs were included in the proposed legislation vetoed by President Bush in 2007, but not in the temporary extension bill that expires in 2009. Enrolling eligible children for Medicaid should also be a top priority. Currently states receive lower federal matching rates for Medicaid than for SCHIP, which may partly explain greater state efforts to enroll children in SCHIP than Medicaid. Increasing Medicaid payments would go a long way toward increasing enrollment and access to care for high poverty children (Kenney, 2008).

Providing the nation's estimated 9.4 million uninsured children with an adequate source of regular care should be a top priority for policymakers. The results of our study do not diminish the role that SCHIP has played in providing coverage to its target population, children below 200% of the FPL. Rather, they demonstrate that extending eligibility beyond the 200% threshold is not the best way to target uninsured children. The literature suggests that states have been reasonably effective in expanding coverage for low-income children currently eligible for SCHIP. Future SCHIP expansions should seek to build on this success by giving states more resources to increase enrollment of uninsured children below 200% of FPL.

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Figure 1

Percentage of Children with Any Insurance

Figure 2

Percentage of Children with Private Insurance

Legend: 250% States, 200% States

X-axis: % of the Federal Poverty Level
Y-axis: Percent Privately Insured

Figure 3

Percentage of Children Age 0-18 with Public Insurance

Y-axis: Percent Publidy Insured

X-axis: % of the Federal Poverty Level

Legend:
- 250% States
- 200% States

Table 1
200% States' SCHIP Eligibility Levels as a Percent of the Federal Poverty Level

State	Type[1]	Medicaid Income[2]	2000	2001	2002	2003	2004	2005	2006
Alaska	E	Y	200	200	200	175	175	175	175
Arizona	S	Y	200	200	200	200	200	200	200
Arkansas	E	Y	200	200	200	200	200	200	200
Colorado	S	Y	185	185	185	185	185	185	200
Delaware	C	Y	200	200	200	200	200	200	200
D.C.	E	Y	200	200	200	200	200	200	200
Hawaii	E	Y	200	200	200	200	200	200	200
Indiana	C	Y	200	200	200	200	200	200	200
Kansas	S	Y	200	200	200	200	200	200	200
Louisiana	E	Y	150	200	200	200	200	200	200
Maine	C	Y	200	200	200	200	200	200	200
Michigan	C	Y	200	200	200	200	200	200	200
Mississippi	S	Y	200	200	200	200	200	200	200
North Carolina	S	Y	200	200	200	200	200	200	200
Ohio	E	Y	200	200	200	200	200	200	200
Utah	S	Y	200	200	200	200	200	200	200
Virginia	C	Y	185	200	200	200	200	200	200
West Virginia	S	Y	150	200	200	200	200	200	200
Wisconsin	E	Y	185	200	200	200	200	200	200
Wyoming	S	Y	133	133	133	185	185	185	200

[1]Indicates whether the state chose to implement SCHIP as a separate program (S), an expansion of its current Medicaid program (E), or a combination of the two (C)

[2]Indicates yes (Y) if the rules for attributing family income are identical or very similar to Medicaid income determination regulations

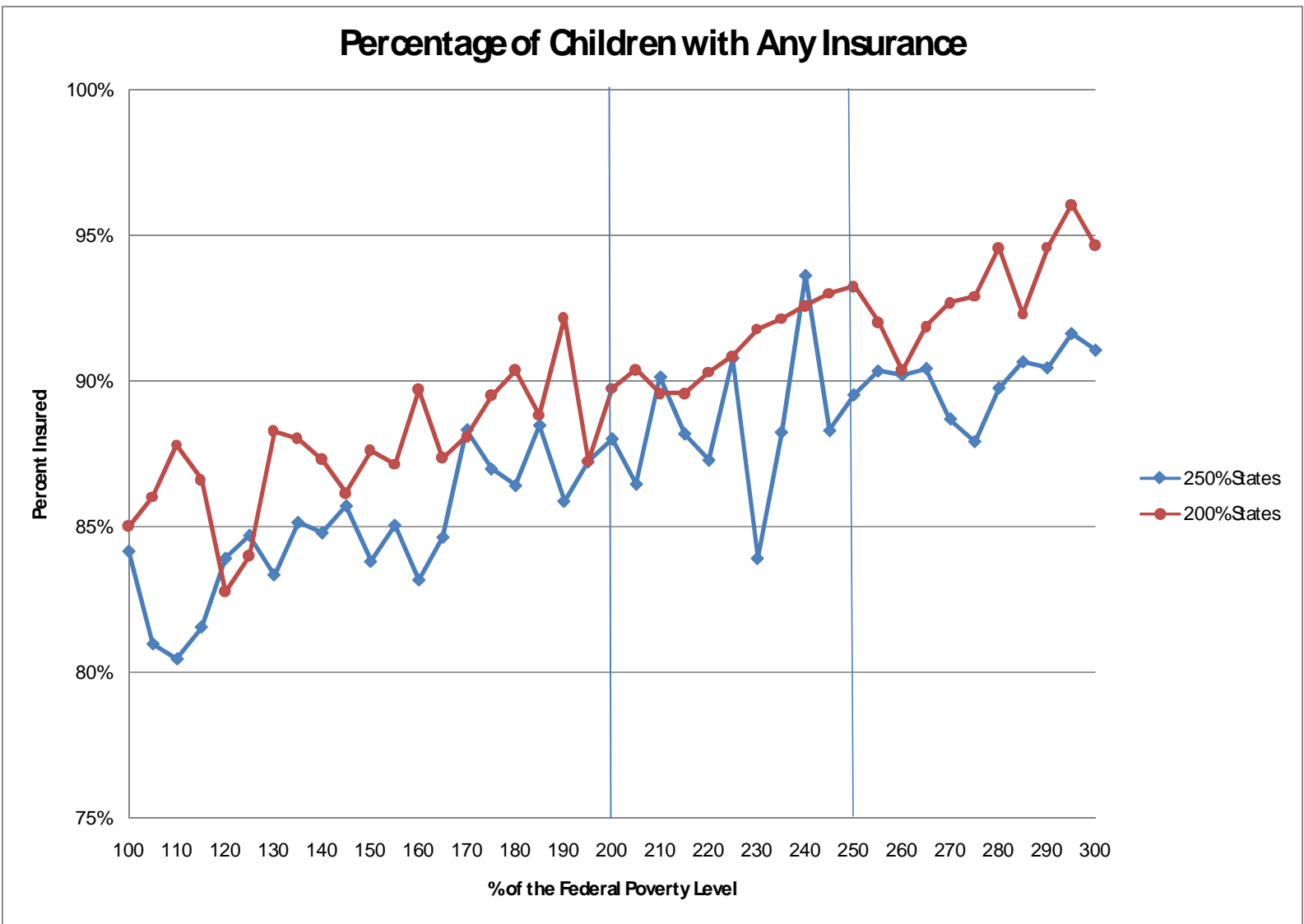*A separate state program finances insurance for children in families with incomes exceeding SCHIP levels
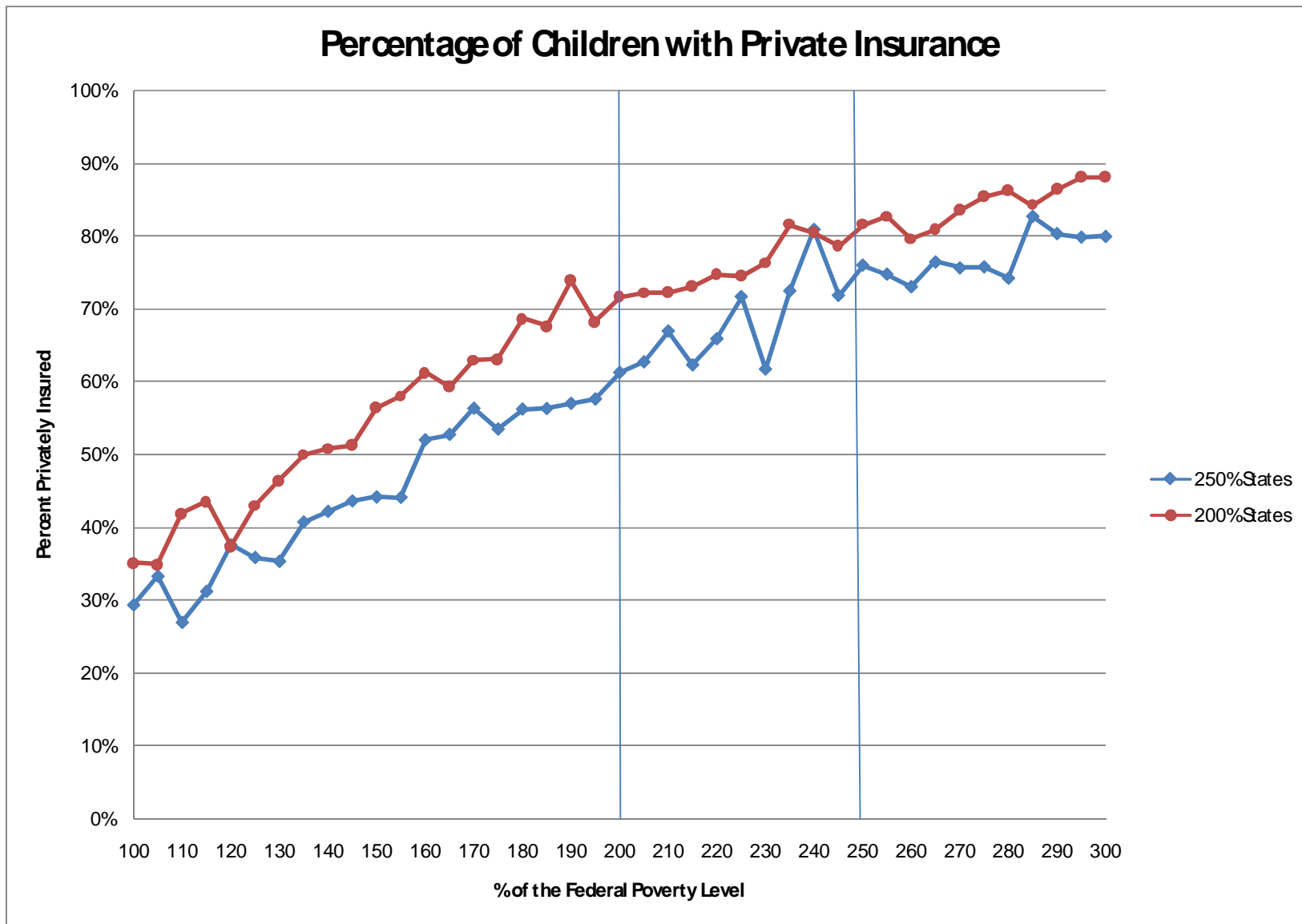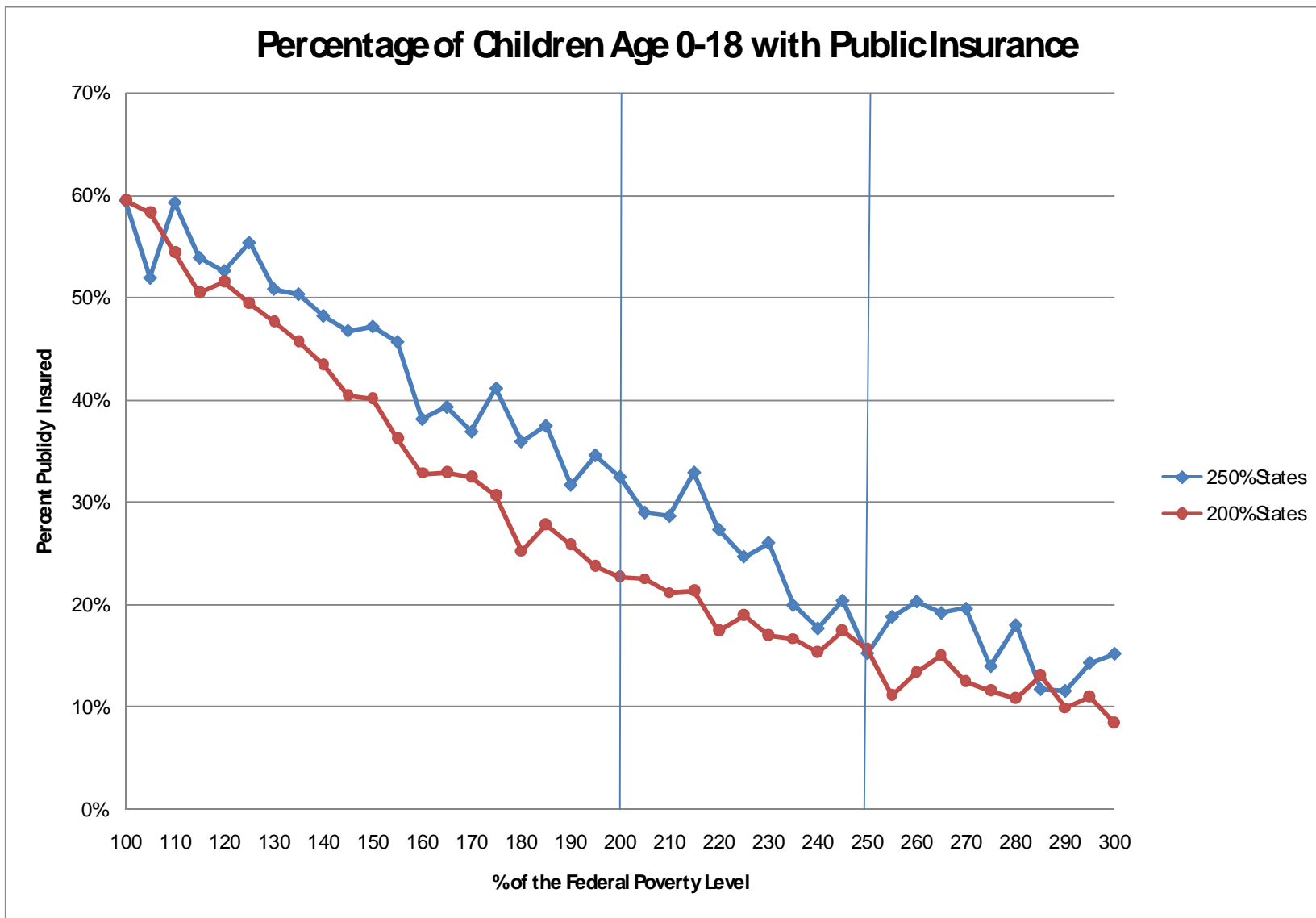
Table 2
250% States' SCHIP Eligibility Levels as a Percent of the Federal Poverty Level

State	Type[1]	Medicaid Income[2]	2000	2001	2002	2003	2004	2005	2006
California	C	N	250	250	250	250	250	250	250
New York	C	N	250	250	250	250	250	250	250
Rhode Island	E	Y	250	250	250	250	250	250	250
Washington	S	N	250	250	250	250	250	250	250

[1]Indicates whether the state chose to implement SCHIP as a separate program (S), an expansion of its current Medicaid program (E), or a combination of the two (C)

[2]Indicates yes (Y) if the rules for attributing family income are identical or very similar to Medicaid income determination regulations

*A separate state program finances insurance for children in families with incomes exceeding SCHIP levels

Table 3

Remainder of States' SCHIP Eligibility Levels as a Percent of the Federal Poverty Level

State	Type[1]	Medicaid Income[2]	2000	2001	2002	2003	2004	2005	2006
Alabama	S	N	200	200	200	200	200	200	200
Connecticut	S	Y	300	300	300	300	300	300	300
Florida	C	N	200	200	200	200	200	200	200
Georgia	S	N	235	235	235	235	235	235	235
Idaho	E	Y	150	150	150	150	185	185	185
Illinois*	C	Y	185	185	185	200	200	200	200
Iowa	C	N	200	200	200	200	200	200	200
Kentucky	C	N	200	200	200	200	200	200	200
Maryland	C	N	200	300	300	300	300	300	300
Massachusetts*	C	Y	200	200	200	200	200	200	200
Minnesota	E	Y	275	275	275	275	275	275	275
Missouri	E	N	300	300	300	300	300	300	300
Montana	E	Y	150	150	150	150	150	150	150
Nebraska	E	Y	185	185	185	185	185	185	185
Nevada	S	N	200	200	200	200	200	200	200
New Hampshire	C	Y	300	300	300	300	300	300	300
New Jersey	C	N	350	350	350	350	350	350	350
New Mexico	E	Y	235	235	235	235	235	235	235
North Dakota	C	Y	140	140	140	140	140	140	140
Oklahoma	E	Y	185	185	185	185	185	185	185
Oregon	S	N	170	170	170	185	185	185	185
Pennsylvania*	S	N	200	200	200	200	200	200	200
South Carolina	E	Y	150	150	150	150	150	150	150
South Dakota	C	N	140	200	200	200	200	200	200
Tennessee*	S	Y	133	133	133	133	133	133	250
Texas	S	N	200	200	200	200	200	200	200
Vermont	S	Y	300	300	300	300	300	300	300

[1]Indicates whether the state chose to implement SCHIP as a separate program (S), an expansion of its current Medicaid program (E), or a combination of the two (C)

[2]Indicates yes (Y) if the rules for attributing family income are identical or very similar to Medicaid income determination regulations

*A separate state program finances insurance for children in families with incomes exceeding SCHIP levels

Table 4

Summary Statistics of Descriptive Characteristics for children in states that have SCHIP Eligibility Levels (as indicated in Table 1 and Table 2) 200% and 250% of the Federal Poverty Level

Variable	Mean	Standard Deviation	Variable	Mean	Standard Deviation
States that cover children up to 200% of the Federal Poverty Limit			**States that cover children up to 250% of the Federal Poverty Limit**		
Male	0.515	0.500	Male	0.505	0.500
Hispanic	0.111	0.314	Hispanic	0.451	0.498
White	0.753	0.431	White	0.798	0.401
Black	0.150	0.357	Black	0.095	0.294
Asian	0.021	0.144	Asian	0.045	0.207
Insured	0.900	0.300	Insured	0.872	0.334
Private Insurance	0.702	0.458	Private Insurance	0.606	0.489
Public Insurance	0.245	0.430	Public Insurance	0.320	0.467

Note: Summary statistics for variables calculated using all related individuals in the house to determine the federal poverty limit cutoff. Sample consists of children 0-18, citizens, and with income between 150-250% of the Federal Poverty Limit.

Table 5

Percentage of children having any insurance, private insurance, and public insurance before and after the 200% federal poverty limit

	200% States		250% States		Difference		Difference in difference
	Below 200% (1)	Above 200% (2)	Below 200% (3)	Above 200% (4)	Difference [(2)-(1)] (5)	Difference [(4)-(3)] (6)	[(6)-(5)] (7)
Insured	0.889	0.913	0.861	0.886	0.024	0.025	0.001
	(0.003)	(0.003)	(0.004)	(0.004)	(0.004)	(0.006)	(0.003)
Private Insurance	0.647	0.764	0.536	0.692	0.118	0.156	0.038
	(0.004)	(0.004)	(0.006)	(0.006)	(0.006)	(0.008)	(0.005)
Public Insurance	0.300	0.184	0.383	0.243	-0.116	-0.140	-0.024
	(0.004)	(0.003)	(0.006)	(0.005)	(0.005)	(0.008)	(0.004)
Sample Sizes:	13963	12281	7769	6295	26244	14064	40308

Notes: Standard errors are in parentheses. The states with public insurance coverage up to 200% above the Federal Poverty limit constitute the treatment group. The control group is states with public insurance coverage up to 250% above the Federal Poverty limit. Income limits calculated based on all related family members in the household.

Table 6

Regression impact of higher eligibility on increased insurance rates, private insurance, and public insurance for children 0-18

Dependent Variable	All forms Insurance (1)	Private Insurance (2)	Public Insurance (3)
Male	0.003	-0.001	0.013
	(0.007)	(0.011)	(0.010)
Age	-0.003	0.002	-0.006
	(0.001)	(0.001)	(0.001)
Age*Male	0.000	0.000	-0.001
	(0.001)	(0.001)	(0.001)
Hispanic	-0.053	-0.171	0.122
	(0.006)	(0.008)	(0.007)
White	0.015	0.108	-0.077
	(0.010)	(0.013)	(0.012)
Black	-0.002	0.021	0.007
	(0.011)	(0.015)	(0.014)
Asian	0.016	0.105	-0.080
	(0.014)	(0.021)	(0.019)
Federal Poverty Level	0.025	0.025	-0.018
	(0.014)	(0.020)	(0.019)
Federal Poverty Level^2	0.000	0.000	0.000
	(0.000)	(0.000)	(0.000)
Federal Poverty Level^3	0.000	0.000	0.000
	(0.000)	(0.000)	(0.000)
Above 200% of the Federal Poverty Level	-0.004	-0.029	0.013
	(0.011)	(0.015)	(0.014)
Above 200% Federal Poverty Level *States with Cutoff at 250% of Federal Poverty Level	-0.002	0.025	-0.009
	(0.008)	(0.011)	(0.010)
Constant	-0.762	-1.575	2.033
	(0.916)	(1.285)	(1.211)
Sample Size	40308	40308	40308
R^2	0.017	0.072	0.064

Notes: The dependent variable is (1) insurance (2) private insurance or (3) public insurance. Standard errors are in parentheses. The omitted race is other.