

NHPF Issue Brief

No.795 / November 13, 2003

**NATIONAL
HEALTH
POLICY
FORUM**

Sailing SCHIP through Troubled Waters

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OVERVIEW — *As the State Children's Health Insurance Program (SCHIP) enters its sixth year of operation, states have continued their commitment to children's coverage and to reaching out to the uninsured. This issue brief explores the current status of SCHIP in light of fiscal pressures that have been created by the state budget crisis. It highlights some of the key successes in the program thus far and notes several examples of state initiatives to serve particularly vulnerable populations and collect outcomes data and information about access to care.*

Sailing SCHIP through Troubled Waters

As the state budget crisis continues into a fourth year, good news about health insurance coverage has become increasingly scarce. Recently released Census Bureau data held the alarming news that, between 2001 and 2002, the number of individuals without health insurance grew from 41.2 million to 43.6 million, while, at the same time, the corresponding availability of private coverage decreased. The state budget shortfall for 2003 totaled at least \$70 billion, forcing virtually all states to implement cost-containment measures in their Medicaid programs. Reducing provider payments and access to prescription drugs has been the most common strategy, but many states have also resorted to restricting eligibility and benefits and increasing beneficiary cost sharing.¹ Many states have also discontinued the outreach efforts and removed the enrollment simplification measures that spurred enrollment in the State Children's Health Insurance Program (SCHIP) and Medicaid in the late 1990s.

Despite the tight economy, however, SCHIP so far has largely escaped programmatic cuts. In fact, overall declines in the proportion of children covered by private insurance (which fell from 68.4 percent in 2001 to 67.5 percent in 2002) were entirely offset by increases in Medicaid and SCHIP enrollment.² SCHIP-funded programs covered an additional 693,000 children in 2002.³ Consequently, uninsurance rates for children did not change significantly from 2001 to 2002. Although enrollment increases signal the continued success of the SCHIP program, today's reasons for growth lie more with the growing number of people living in poverty and the increasing demand for publicly financed coverage than with successful outreach and enrollment efforts.

EVALUATING SCHIP'S SUCCESS

Since its enactment in 1997, SCHIP has helped states make significant strides in providing health coverage to children in the United States. Between 1997 and 2003, the percentage of uninsured children has decreased significantly (from 13.9 percent to 9.1 percent) and the number of low-income uninsured children has decreased by about one-third.⁴ (Figure 1) Analysts agree that this decrease is due almost entirely to the success of SCHIP and corresponding advances in Medicaid.

Expanding Coverage

The stated goal of the SCHIP statute was to provide health insurance coverage to low-income, uninsured children under age 19. Because

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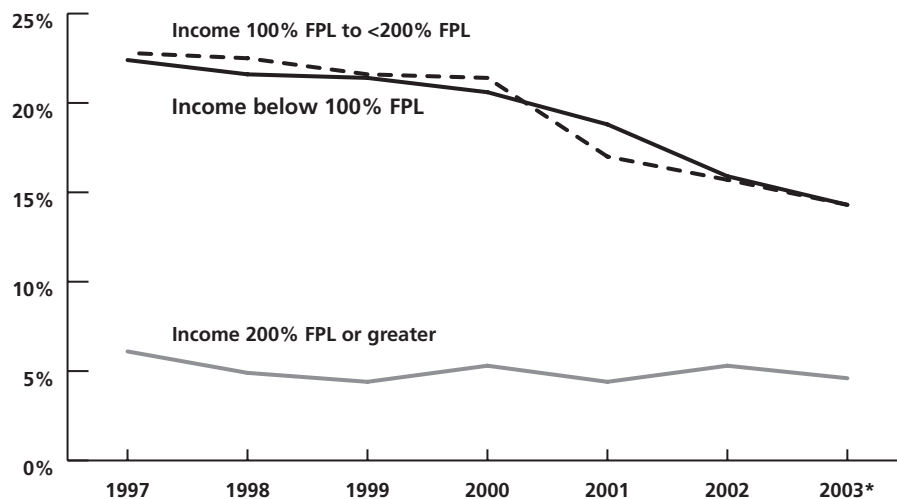
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lower-income children are three times more likely to be uninsured than higher-income children, the theory was that SCHIP could help reduce the overall uninsurance rate for children and, six years later, that theory has proven out. States used the enhanced federal matching funds provided by the SCHIP statute to expand coverage for children and to simplify the processes through which families could apply for that coverage. These simplification strategies combined with targeted outreach campaigns simultaneously changed the public face of the Medicaid program in many states, significantly improving enrollment across the board. In 2002, nearly 28 percent of children in the United States received health insurance coverage through the Medicaid or SCHIP programs.⁵

FIGURE 1
Uninsurance Rates for Children, 1997–1st Quarter 2003,
by Poverty Status



*First quarter federal fiscal year 2003.

Source: Centers for Disease Control and Prevention, U.S. Public Health Service, National Health Interview Survey, September 2003.

Examples of states' achievements through SCHIP include the following:

- Thirty-nine states provide SCHIP/Medicaid coverage for children with incomes at 200 percent of the federal poverty level (\$30,520 for a family of three in 2003) or higher.
- Thirty-four of 35 states with separate SCHIP programs use a single application form for both Medicaid and SCHIP.
- Forty-one states provide 12 months of continuous eligibility.

- Twelve states use “self-declaration” of income (that is, they do not require families to provide pay stubs or other verification of their income when determining eligibility).
- Forty-six states no longer require a face-to-face interview in applying for coverage.⁶

Improving Access to Care

A second major question in evaluating the success of the SCHIP program is just beginning to be answered. Now that enrollment efforts have proven successful, the question of access to care is receiving more focus. Does SCHIP coverage guarantee access to comprehensive health care services? Recent evidence suggests that while the majority of uninsured children enrolling in SCHIP had a regular source of health care prior to enrollment, more than one-third of them had unmet health care needs. These needs most frequently included mental health care, specialty services, dental and vision care, and prescription drugs.⁷

By 2002, the Urban Institute concluded that children covered by Medicaid/SCHIP were about 1.5 times more likely than uninsured children to receive well-child care, office visits, and dental care. Further, the proportion of children enrolled in SCHIP receiving those services increased significantly between 1999 and 2002.⁸ Although the results are preliminary, the evidence is beginning to suggest that SCHIP is having a positive impact on the overall health of low-income children.

A slightly different aspect of improving access to care is the policy recently adopted by the Centers for Medicare and Medicaid Services (CMS) that allows states to provide SCHIP coverage and prenatal care to pregnant women who are not otherwise eligible for Medicaid. To date, six states have received approval to provide this coverage, which enables women with somewhat higher incomes (states' eligibility levels range from 185 percent to 275 percent of the federal poverty level) to gain access to prenatal care. Because the coverage is technically tied to the unborn child, this option also allows states to receive SCHIP matching funds for providing coverage to immigrant women whose children will be U.S. citizens.

Addressing Racial and Ethnic Disparities

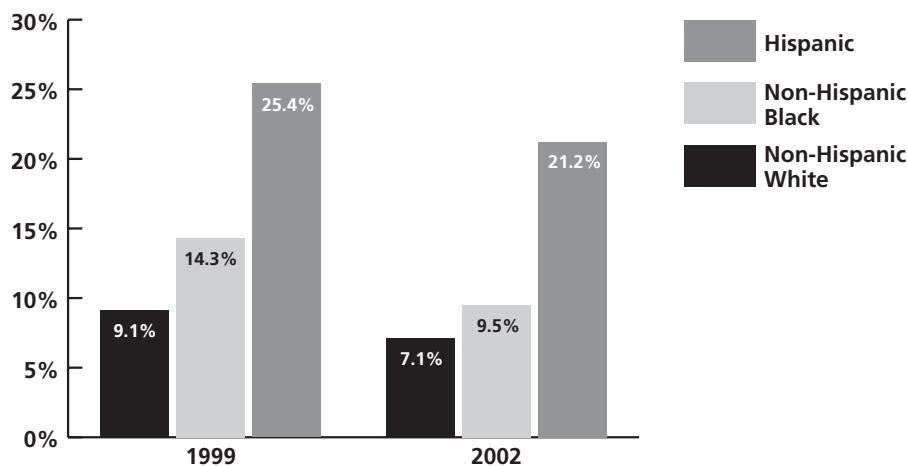
A recent survey of demographic characteristics of SCHIP enrollees in several states found that African American and Hispanic children who enrolled in the program were more likely to lack a regular source of health care and report poorer health status than white children. Minority children who did have prior health coverage were most likely to have been enrolled in Medicaid.⁹

SCHIP-funded efforts have helped narrow the racial and ethnic disparities in health coverage. Uninsurance rates for African American and Hispanic children declined by 4.8 percent and 4.2 percent, respectively, between 1999

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and 2002 (Figure 2), and, by 2002, 43.2 percent of African-American children and 35.6 percent of Hispanic children were covered by Medicaid or SCHIP.¹⁰ However, disparities persist and many states have taken steps to further bridge the gaps in coverage and access to care.

FIGURE 2
Rates of Uninsurance for Children, by Race/Ethnicity,
1999 and 2002



Sources: 1999 and 2002 National Survey of America's Families, Urban Institute.

STATE PERSEVERANCE

Despite ongoing fiscal pressures, states continue to strive to cover as many children as possible; most states have sustained and, in some cases, continued to expand their SCHIP programs. Examples of continued innovation include the following:

Alabama

Alabama is one of a few states that have specifically targeted efforts at serving children with special health care needs. In 1999, the state received approval for a third phase of its SCHIP program, ALL Kids Plus. The ALL Kids Plus program supplements the basic ALL Kids benefit package to serve children with special health care conditions/needs (broadly defined to include children and youth with developmental disabilities, mental retardation, genetic disorders, serious emotional disorders, ongoing orthopedic disorders, or any of the diverse chronic illnesses that affect children and adolescents). Alabama also continues

to allow self-declaration of income when determining eligibility for the ALL Kids programs. However, budget constraints have recently led the state to implement a waiting list for children eligible for the separate SCHIP program.

Illinois

On July 1, 2003, the governor of Illinois signed legislation expanding the state's KidCare and FamilyCare programs to cover an additional 20,000 children and 65,000 working parents in the first year. The state received CMS approval to expand eligibility for children from 185 percent to 200 percent of the federal poverty level and the legislature has also decided to expand coverage for pregnant women and parents of children enrolled in KidCare. Illinois plans to provide coverage to 300,000 more adults over the next three years. States are increasingly testing the theory that enrolling parents will result in more children having coverage under SCHIP.

Mississippi

Mississippi experienced a large increase in SCHIP enrollment in 2001, with more than 30,000 children enrolling during the calendar year, 40 percent of whom were enrolled continuously throughout the year. In addition, a study of quality of care in Mississippi rated access to care for children as excellent, noting that 93 percent of children between the ages of one and two had at least one primary care visit within the year. Corresponding access rates for 2- to 6-year-olds and 7- to 11-year-olds were 85 percent and 94 percent, respectively. Nationally, only about 65 percent of uninsured children see a health care provider at some point during the year.¹¹ An analysis conducted by the state's health department found a 90 percent immunization completion rate for two-year-olds enrolled in SCHIP.

Overall, governors and state legislatures have maintained their strong commitment to the SCHIP program and to the goal of providing health coverage to low-income children. Although the far-reaching effects of the state budget crisis cannot yet be measured, it appears that states will continue to go to great lengths to sustain children's coverage and access to care.

Ninety-three percent of one- and two-year-olds in Mississippi had at least one primary care visit in 2001.

ENDNOTES

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