Georgetown University Health Policy Institute
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FAMILY COVERAGE MATTERS

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A Success Story: Closing the Insurance Gap for America's Children Through Medicaid and SCHIP

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Over the past few years, as rapidly rising health care costs and fiscal pressures turned the spotlight on Medicaid spending, another story – a success story – has been buried by the headlines. For decades, the nation has looked to Medicaid as the way to close the insurance gap for children. With the enactment, in 1997, of Medicaid's smaller companion program – the State Children's Health Insurance Program (SCHIP) – the commitment to covering children deepened. Just as efforts to expand and improve coverage for children began to take hold, however, the economy soured and attention turned to budget cuts, first at the state level and now in Congress. As debate on the future of Medicaid and SCHIP unfolds it is important to assess their track record in covering children.

Key Findings

- ***Medicaid and SCHIP have been remarkably successful in closing the coverage gap for children.*** Since 1997, Medicaid and SCHIP have been the driving force in reducing the uninsured rate of low-income children by one third – from 23 percent to 15 percent.

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- ***Medicaid is the backbone of the public coverage system for children,*** covering more than 27 million children. An additional four million children are covered through separate SCHIP programs.
- ***Children enrolled in Medicaid and SCHIP are generally able to secure the care they need.*** Almost all children covered by Medicaid (96 percent) have a usual source of care, and they are far less likely than their uninsured counterparts to face unmet medical and dental needs. Even compared to low-income children with private coverage, they are more likely to have well-child care and dental visits.
- ***The coverage provided to children through Medicaid and SCHIP is relatively cost-effective.*** Covering a child through Medicaid is 31 percent less costly than private insurance, yet the coverage provided is comprehensive and affordable to families.

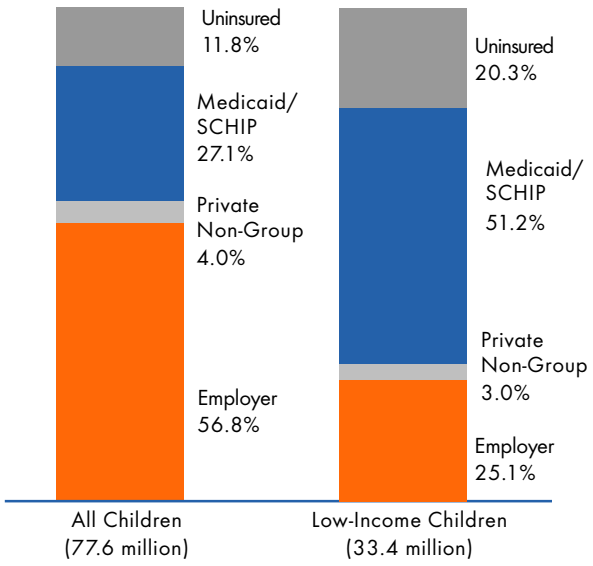
In the period ahead, it will be important to take note of this progress and identify the key elements that contributed to this success. More needs to be done to maintain these gains and to extend coverage to the remaining nine million uninsured children. Any changes to Medicaid and SCHIP should strengthen their ability to keep the nation moving in the right direction.

Background

The goal of ensuring that all children have access to health insurance has enjoyed enduring bipartisan support. Most children have coverage through their parents' jobs, but gaps in employer-based insurance leave millions of children – particularly low-income children – without private coverage. In 2003, 25 percent of low-income children had employer-based coverage, compared to 81 percent of higher-income children.[1] Over the years, the nation has committed to fill these gaps through Medicaid and, more recently, SCHIP. Together, Medicaid and SCHIP now cover a little more than one quarter of all children and half of all low-income children in America (Figure 1).[2]

Figure 1

Source of Health Coverage for Children, 2003



Source: Data taken from Hoffman et al, *Health Insurance Coverage in America: 2003 Data Update*, Kaiser Commission on Medicaid and the Uninsured, November 2004. "Medicaid/SCHIP" includes children enrolled in other state coverage programs, the military health care system, and Medicare.

• Medicaid for Children

Enacted in 1965, Medicaid originally focused on children and adults who received welfare. In the late 1980s, Congress broke the link to public assistance for children by gradually extending Medicaid eligibility to children in low-income working families. Today, Medicaid mostly covers children in families with earnings – less than one-third of the children enrolled in Medicaid receive public assistance.[3]

Under current federal minimum standards, nearly all children with family income below the federal poverty line ("FPL" – Table 1) are guaranteed coverage through Medicaid no matter where in the country they may live.[4] Younger children (those under age six) with somewhat higher family incomes (up to 133 percent of the federal poverty line) are also ensured coverage under Medicaid, as are most disabled children who qualify for federal Supplemental Security Income (SSI).[5] In addition, states are guaranteed shared federal financing if they extend Medicaid coverage to children with family incomes above these minimum standards, as almost all do.

Table 1

Key Medicaid and SCHIP Income Thresholds (Based on a Family of 3, 2005)

	Annual Income	Monthly Income
100% of FPL	$16,090	$1,341
133% of FPL	$21,400	$1,783
200% of FPL	$32,180	$2,682

Enactment of SCHIP

In 1997, Congress boosted coverage efforts by enacting SCHIP, which offers states an added financial incentive to narrow the insurance gap for children. States can receive "enhanced" federal funding to extend coverage to additional children either through a separate child health program or through Medicaid. This enhanced federal funding is capped; states can stop enrolling uninsured children who are eligible for a separate SCHIP program at any time if state or federal SCHIP funds fall short of need.

Recent Activities

The enactment of SCHIP gave rise to unprecedented activity aimed at improving children's coverage rates. The vast majority of states (38 and the District of Columbia) now cover children up to 200 percent of the federal poverty line or higher.[6] As important, the enactment of SCHIP focused attention on the need to let families know about available coverage and to make it easier for them to enroll their children in Medicaid and SCHIP. States, localities, and community-based organizations launched extensive outreach campaigns, and coverage barriers were eased as states made it simpler for families to apply for and renew coverage.

More recently, with the economic downturn, substantial numbers of children lost employer-based insurance and the need for publicly-financed coverage grew. At the same time, in many states, budget pressures slowed down efforts to improve public coverage rates of low-income children.

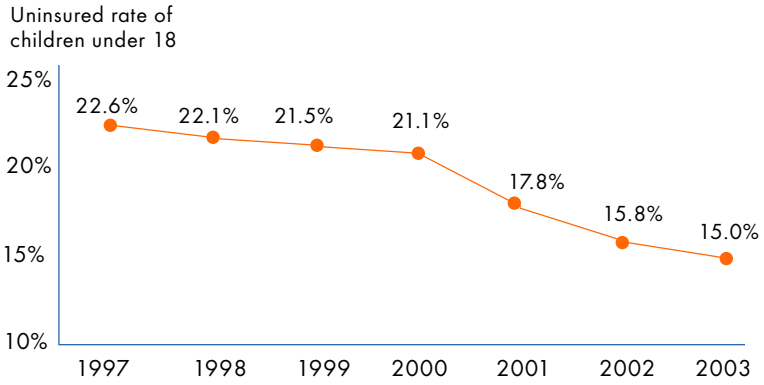
This issue brief summarizes the available evidence to answer three basic questions:

1. What has been the effect of Medicaid and SCHIP on the uninsured rate of low-income children?
2. To what extent have Medicaid and SCHIP provided children with access to needed care?
3. Are Medicaid and SCHIP providing cost-effective coverage?

1. What has been the effect of Medicaid and SCHIP on the uninsured rate of low-income children?

A look at the trends in low-income children's coverage show the pivotal role Medicaid and SCHIP have played in improving the health insurance status of children over the past several years. Between 1997 and 2003, the uninsured rate of low-income children fell by a third, dropping from roughly one in four low-income children to one in seven (Figure 2).[7]

Figure 2
Trends in the Uninsured Rate of Low-Income Children, 1997-2003



Source: CCF calculations based on Cohen, R. et al., *Health Insurance Coverage: Estimates from the National Health Interview Survey, January – September 2004,* Centers for Disease Control, March 2005 and *Trends in Health Insurance and Access to Medical Care for Children Under Age 19 Years: United States, 1998 – 2003*, April, 2005.

Both Medicaid and SCHIP played a critical role in driving these coverage improvements. By extending coverage to children in families with income above Medicaid levels, SCHIP programs were able to enroll significant numbers of children in "near-poor" families – those with incomes between 100 percent and 200 percent of the federal poverty line.

To a surprising degree, however, SCHIP's enactment also helped to increase coverage among poor and near-poor children eligible for Medicaid. This occurred both because many states used SCHIP to expand Medicaid coverage for children and because nearly all states took steps to improve Medicaid participation rates. During the early years of SCHIP implementation, it was not uncommon for state program administrators to report that their SCHIP outreach efforts resulted in enrolling more children in Medicaid than in their separate SCHIP programs.[8] In combination with states' effort to ease the Medicaid application process for families, this "spillover" effect helped to spur a significant jump in the rate at which low-income families enrolled their children in Medicaid. By 2003, the Medicaid participation rate for children had reached an estimated 79 percent.[9]

Today, more than 31 million American children are covered by publicly-financed health insurance, with close to nine in ten securing this coverage through Medicaid. In 2002, the latest year for which detailed data are available, Medicaid covered 27.4 million children and an additional four million children were covered through separate SCHIP programs.[10]

How did Public Programs Serve Children in the Recent Recession?

Recent gains in low-income children's coverage are particularly notable. They occurred even as an economic slowdown and rising health care costs caused a significant jump in the size of the nation's uninsured population. These same factors also led to budget-driven cutbacks in Medicaid and SCHIP coverage. In 2003 and 2004, almost half the states took action to make it harder for families to apply for and renew their children's coverage.[11] Six states froze enrollment in their separate SCHIP programs, at least for a temporary period.[12] Yet even with these setbacks, nationwide, Medicaid and SCHIP protected low-income children during the recent recession. Between 2000 and 2003, the uninsured rate of children actually declined slightly. By contrast, more than five million adults lost coverage and became uninsured during this period.[13]

2. To what extent have Medicaid and SCHIP provided children with access to needed care?

Ensuring that children have health insurance is of value only if it helps children receive appropriate and needed health services. Under Medicaid, children must be provided with a comprehensive benefit package that includes coverage for preventive care (including vision, hearing, and dental checkups), as well as for any other medically necessary services. Cost sharing for children is generally not permitted.[14] Coverage in separate SCHIP programs can be less comprehensive than Medicaid, and states can charge families for premiums and other costs.

Medicaid programs in parts of the country have sometimes had problems enlisting a sufficient number of providers who accept Medicaid payments – particularly for dental care and some specialty services. Nevertheless, while improvements are needed, it is clear that Medicaid and SCHIP increase the likelihood that families have a usual source of care for their children and reduce their unmet medical needs.

Studies examining access to care among children consistently find positive results for those enrolled in Medicaid and SCHIP.

- Poor children covered by Medicaid are more likely to have a usual source of care than their counterparts who are uninsured (96 percent versus 78 percent).[15]
- Children with Medicaid also are more likely than uninsured low-income children to have well-child and dental visits, as well as to have fewer unmet medical needs.[16]
- Even compared with low-income children on private coverage, children insured through Medicaid are more likely to have well-child visits, to have a physician visit, and to see a dentist. [17]
- Although there are fewer SCHIP studies, researchers have found that after enrolling in SCHIP children are more likely to have a regular source of care and to use more preventive care services, as well as to have fewer unmet medical needs.[18]

3. Are Medicaid and SCHIP providing cost-effective coverage?

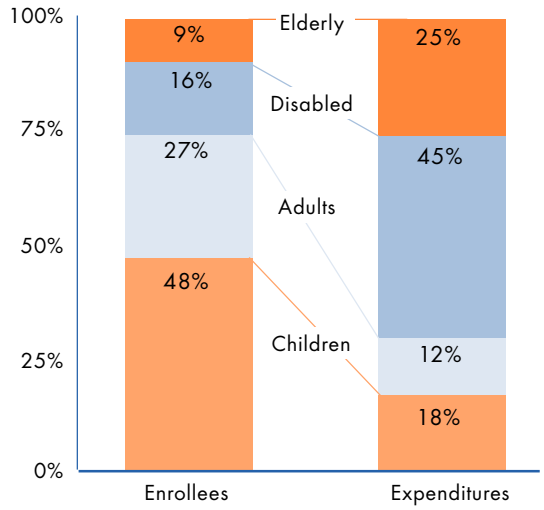
By all measures, Medicaid is a particularly cost-effective way to insure children. Administrative costs for Medicaid are just under seven percent. (This includes the administrative cost of private managed care organizations delivering services to Medicaid beneficiaries.) By contrast, private insurance administrative costs are almost double that – 13.6 percent.[19] Medicaid provider payment rates are also low, typically below the levels used by private insurers.[20] Some would maintain that states (who set these rates) have been aggressive purchasers; others worry that low provider rates dampen access to care. What is not in doubt is that on a per person basis, Medicaid is a much less costly way to cover children than private insurance. A recent study found that children – those with and without disabilities – were covered in Medicaid at a cost 31 percent lower than the cost of covering children with similar health care needs in the private sector.[21]

The major cost pressures in Medicaid do not result from children's coverage. Instead, they are largely due to three factors:

1. ***Medicaid's Role in Financing Long-Term Care:*** Medicaid is the single largest source of payment for long-term care services for the nation's growing population of seniors and people with disabilities.
2. ***Rising Health Care Costs:*** A sharp rise in health care costs has affected all health care payers, including Medicaid. While there is state variation, Medicaid actually has experienced a slower rate of growth in per person health care spending than the private sector in recent years – between 2002 and 2003, Medicaid spending per person grew 7.3 percent while private insurance premiums jumped 13.9 percent.[22]
3. ***Growing Enrollment:*** Medicaid has significantly increased the number of people that it covers. While most of these enrollment gains are due to children, the relatively low cost of covering children means they nevertheless are not the major driver of Medicaid spending growth. Children are the least costly group to cover in Medicaid. In 2005, they are expected to comprise nearly half of the enrollees in Medicaid but to account for only 18 percent of the spending (Figure 3).[23] Medicaid's average per-child cost is estimated at $1,800 as compared to the $13,200 average per-person cost of serving seniors.[24]

Figure 3

Children Account for Almost Half of Medicaid Beneficiaries But Less than 20% of Expenditures



Note: "Disabled" includes children and adults with a disability.

Source: CCF analysis based on CBO March 2005 Medicaid Baseline estimates for 2005. Expenditures exclude spending on DSH payments, administrative costs, and vaccines for children.

Conclusion

The nation has committed to the goal of covering children and assuring that they have access to the care they need. While much more remains to be accomplished – more than 9 million children in this country still lack coverage – and new challenges are arising, the evidence is strong that efforts to reach this goal through Medicaid and SCHIP have been remarkably successful.[25] The uninsured rate of low-income children has declined; children enrolled in public programs receive needed health care services; and publicly-funded coverage programs are providing services in a cost-effective way. Success stories are hard to come by. This one has made a major difference in the lives of families throughout the nation.

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[1] Hoffman, C. et al., *Health Insurance Coverage in America: 2003 Update,* Kaiser Commission on Medicaid and the Uninsured, November 2004. "Low-income" is defined as having income below 200 percent of the federal poverty line.

[2] Ibid.

[3] Urban Institute analysis of the 2001 MSIS prepared for the Kaiser Commission on Medicaid and the Uninsured. This analysis does not consider children who are characterized under MSIS data as eligible for Medicaid based on disability.

[4] With some exceptions, Medicaid does not cover children who are legal immigrants unless they have lived in the country for more than five years, nor does it cover undocumented children.

[5] About a dozen states, known as "209(b) states," do not automatically provide Medicaid to all SSI recipients, but instead rely on their own, more restrictive definition of disability when evaluating people with disabilities for Medicaid eligibility. For details, see Schneider A., et al., *Medicaid Resource Book,* Kaiser Commission on Medicaid and the Uninsured, July 2002.

[6] Cohen Ross, D. et al., *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Commission on Medicaid and the Uninsured, October 2004. Tennessee has expanded coverage to 200 percent of the FPL, but it is not counted among the 38 states because it has closed enrollment for all but select groups of children under its expansion.

[7] CCF calculations based on Cohen, R. et al., *Health Insurance Coverage: Estimates from the National Health Interview Survey, January – September 2004*, Centers for Disease Control, March 2, 2005 and Cohen, R. et al., *Trends in Health Insurance and Access to Medical Care for Children Under Age 19 Years: United States, 1998 – 2003*, Centers for Disease Control, April 15, 2005. Unlike other data in this brief, this finding and the data in figure 2 are for children under age 18.

[8] Rosenbach, M. et al., *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations*, Centers for Medicare and Medicaid Services, 2003.

[9] Selden, T et al., "Tracking Changes in Eligibility and Coverage Among Children, 1996–2002," *Health Affairs*, Volume 23, Number 5, September/October 2004.

[10] CCF calculations using the 2002 MSIS and the fiscal year 2002 SCHIP annual enrollment report, as well as an analysis of the 2001 MSIS conducted by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured. Coverage for roughly 1.3 million of the 27.4 million children on Medicaid was through an SCHIP-financed Medicaid expansion.

[11] Cohen Ross, D. et al., *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Commission on Medicaid and the Uninsured, October 2004

[12] See Cohen Ross, D et al., *Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children*, Kaiser Commission on Medicaid and the Uninsured, December 2003; *Update on the Florida SCHIP Enrollment Freeze*, Kaiser Commission on Medicaid and the Uninsured, July 23, 2004.

[13] Holahan, J. and Ghosh, A, *The Economic Downturn and Changes in Health Insurance Coverage, 2000–2003*, Urban Institute, September 2004.

[14] Some states have imposed cost sharing on children in Medicaid under Section 1115 waivers. For details, see Cohen Ross, D et al., *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Kaiser Commission on Medicaid and the Uninsured, October 2004, Table 11.

[15] Newacheck, P. et al., "The Role of Medicaid in Ensuring Children's Access to Care," *The Journal of the American Medical Association*, Volume 280(20) November 25, 1998, pp 1789-1793.

[16] Dubay, L. and Kenney, G. "Health Care Access and Use Among Low-Income Children: Who Fares Best?," *Health Affairs*, Volume 20, Number 1, January/February 2001.

[17] Ibid.

[18] VanLandeghem K, et al., *Does SCHIP Benefit All Low-Income Children?* CHIRI™ Issue Brief No. 4, AHRQ Publication No. 05-0010, Agency for Healthcare Research and Quality, December 2004. This study evaluated the experiences of children in separate SCHIP programs in three diverse states (NY, FL, KS) after a year of enrollment. The three states accounted for more than 25 percent of SCHIP enrollees in 2001, the year in which the study began.

[19] CCF analysis based on Smith C, et al., "Health Spending Growth Slows in 2003," *Health Affairs*, January/February 2004.

[20] See, for example, Zuckerman, S. et al. "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation," *Health Affairs*, June 23, 2004.

[21] Hadley, J. and Holahan, J. "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry*, Winter 2003-2004 (40):323-342.

[22] See Holahan, J. and Ghosh, A., "Understanding the Recent Growth in Medicaid Spending, 2000-2003" *Health Affairs*, January 26, 2005. Long-term care spending was excluded when the authors calculated the growth in health care spending, per Medicaid enrollee.

[23] CCF analysis based on CBO 2005 Medicaid Baseline.

[24] Ibid.

[25] Data on the number of uninsured children are from Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured based on the March 2004 Current Population Survey. Based on children under the age of 19.

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