CENTER FOR CHILDREN AND FAMILIES
GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

June 2007

Making Real Gains for Children:
Strategies for Reaching the More Than Six Million Uninsured Children Eligible for Medicaid and SCHIP

During SCHIP reauthorization, one of the most important steps that the nation could take in covering America's children would be to reach the over six million uninsured children who already qualify for SCHIP or Medicaid. The families of these children – the vast majority of whom are low-income and employed – are eager to enroll their children in these programs when told about them and given the opportunity to do so.[1] However, some notable barriers to coverage remain for these uninsured children, particularly for the 4.4 million of the 6.1 million who qualify for Medicaid.[2] SCHIP reauthorization offers the opportunity for Congress to adopt policies to help assure that these children can gain the coverage they need and for which they already qualify.

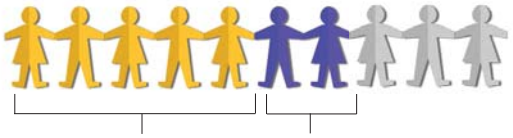
Most Uninsured Children are Eligible for Coverage

The country has made remarkable progress in covering children in recent years, and states are again seeking to move forward to cover more children. A key focus of their renewed efforts has been to conduct outreach and make it easier for eligible children to enroll in and keep coverage. States have focused their efforts on this population for the simple reason that the vast majority of uninsured children are already eligible for SCHIP or Medicaid. Researchers estimate that over six million uninsured children qualify for SCHIP or Medicaid under existing state eligibility rules, representing close to seven in ten of all uninsured children in the United States.[3]

- **Most are eligible for Medicaid.** The majority of already-eligible uninsured children qualify for Medicaid, rather than SCHIP. Of the 6.1 million uninsured children eligible for coverage, 4.4 million are eligible for Medicaid and 1.7 million for SCHIP. In other words, for each uninsured child who is eligible for SCHIP, there are more than two children who are eligible for Medicaid (Figure 1).

FIGURE 1

7 out of 10 Uninsured Children are Eligible But Unenrolled[4]



- **Most come from low-income working families.** More than nine in ten (93 percent) uninsured children already eligible for coverage are "low-income," which is defined as having family income below 200 percent of the federal poverty level, the equivalent of $34,340 for a family of three in 2007. The vast majority (70 percent) have one or more parents who are employed.[5]

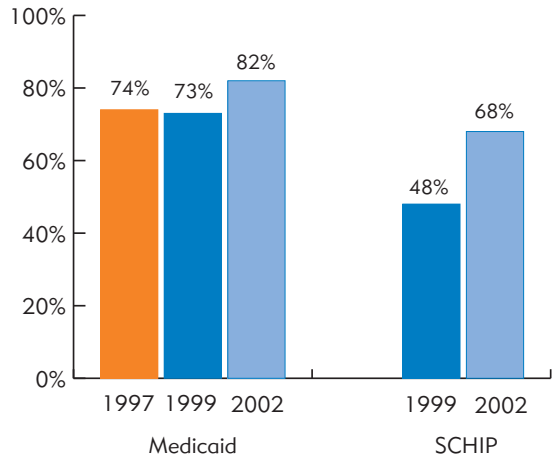
Key Barriers to Covering Eligible Children

As a result of SCHIP's creation in 1997, states across the country moved to take advantage of the opportunity to cover more uninsured children. Every state expanded eligibility levels, but equally important, to reach more eligible children, they conducted outreach and made their application and renewal procedures for child health coverage programs (SCHIP and Medicaid) more family-friendly. States reduced the length and complexity of application and renewal forms, eliminated requirements

that families appear in-person to apply for or to renew coverage, lengthened the time between renewals, and cut back on unnecessary and duplicative documentation requirements. Although some of this progress was reversed or stalled in the early 2000s due to state fiscal pressures,[6] the rate at which eligible uninsured children participate in SCHIP and Medicaid is far above the pre-SCHIP level (Figure 2).

FIGURE 2

Medicaid & SCHIP are Reaching an Increasing Share of Eligible Children



Source: 1997, 1999, 2002 National Survey of America's Families.

Despite the marked progress, a few notable barriers remain to making further gains. Even as states again are looking for ways to cover more children, they face the following issues:

- **Coverage cost concerns.** States recognize that if they succeed in enrolling uninsured children in SCHIP and Medicaid, they will face an increase in their coverage costs. Given that Medicaid serves a much broader group of children than SCHIP, it is not surprising that states have regularly found that efforts to enroll children in SCHIP can result in equal or even greater numbers of children enrolling in Medicaid. This "woodwork effect" has played a significant, positive role in the progress that has been made in covering America's children over the past decade (Box 1). However, it can make it more difficult for states to sustain their successful enrollment efforts, particularly because states pay a higher share of the costs for children enrolled in Medicaid as compared to SCHIP (Box 2).

- **Limitations on state flexibility to adopt family-friendly enrollment systems.** States generally have broad flexibility to establish family-friendly enrollment and renewal systems in both Medicaid and SCHIP, but a few notable barriers remain. Even though millions of uninsured children are already enrolled in other social service programs, such as food stamps, school lunch, and WIC, states often cannot readily use information from these programs to help enroll uninsured children in Medicaid and SCHIP due mostly to modest differences in how the programs define family income.[7] In addition, over the past year, states have faced a new, paperwork intensive federal mandate to document citizenship status in Medicaid, making it difficult for them to sustain simplified mail-in application procedures.[8] Thousands of children have lost or experienced delayed coverage as a result.[9]

BOX 1

Medicaid's Role in Reducing Children's Uninsured Rate

The experiences of states after enactment of SCHIP have shown that eligibility expansions and related outreach efforts bring in many lower-income children already eligible for Medicaid.[10] The resulting growth in Medicaid enrollment has played a vital role in the country's success in covering more uninsured children. Between 1997 and 2005, the uninsured rate of low-income children fell by one-third, and over 70 percent of this decline was driven by coverage gains in Medicaid.[11]

BOX 2

State Coverage Costs Under Medicaid versus SCHIP

In both Medicaid and SCHIP, the federal government and the states share the cost of covering children, with the federal government "matching" states for their spending. To induce states to increase coverage for children, the SCHIP law gives states an "enhanced matching rate" for expanding coverage for children beyond 1997 Medicaid eligibility levels. The enhanced matching rate reduces by 30 percent the share of costs that states must cover for a SCHIP child relative to a Medicaid child. For example, a state with a 50 percent matching rate in Medicaid receives a 65 percent matching rate in SCHIP. If such a state spends $1,000 to cover a child, the federal government will pay $500 of the cost if the child is in Medicaid and $650 if the child is in SCHIP.

Policy Implications

With states again looking for ways to move forward in covering more of America's uninsured children[12] and the public and many policymakers strongly supporting such initiatives, SCHIP reauthorization creates the opportunity to apply the lessons from the past ten years to make the most gains possible to cover uninsured children over the next period of time. Particularly if policymakers are interested in covering the lowest income children in America, experience shows that financing supports and some new tools are needed.

- **Added federal assistance with Medicaid coverage costs in states that are moving forward.** To make progress in covering eligible, uninsured children, the coverage cost concerns of states will need to be addressed. Of particular importance is addressing the additional coverage costs that states sustain as a result of the lower Medicaid matching rate when they succeed in increasing Medicaid enrollment. One of the central lessons of SCHIP is that when the federal government contributes a higher share of coverage costs, states will respond and children will gain coverage. To this end, states could be provided with extra assistance if they adopt "best practice" procedures known to increase enrollment of eligible children and/or if they show improvements in coverage among uninsured but eligible children.

"For every SCHIP child we enrolled, we found two who were Medicaid eligible, so our state office asked us to back off on the outreach... Obviously, we'd like to get out there and do more outreach, but it's breaking the budget on the Medicaid side."

— A Medicaid managed care official in Kentucky, explaining why the state is reducing outreach efforts.[13]

- **New tools for identifying and enrolling eligible uninsured children.** Some of the available tools include an "Express Lane" option that allows states more readily to use financial information from other programs (e.g., school lunch, WIC) to enroll children in Medicaid and SCHIP, as well as relief from the paperwork-intensive federal mandate to document citizenship status in Medicaid. To foster use of the enrollment options, states could also be provided with increased financial assistance for the investment they need to make in their information technology infrastructure to implement Express Lane.

Conclusion

The history of coverage programs for children demonstrates that families are eager to enroll their eligible, uninsured children in SCHIP and Medicaid, and that with a few notable exceptions, states have many of the tools needed to help them do so. If some of the fiscal consequences of successful enrollment efforts are addressed, it will be possible to make significant progress on the very solvable issue of eligible children missing out on coverage. As a result, the country will be much closer to the finish line in covering its children.

Endnotes

1 M. Perry and J. Paradise, *Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Parents*, Kaiser Commission on Medicaid and the Uninsured (May 2007); and G. Kenney, J. Haley, & A. Tebay, *Familiarity with Medicaid and SCHIP Programs Grows and Interest in Enrolling Children Is High*, Urban Institute, Snapshots of America's Families III, no. 2 (July 2003).

2 L. Dubay analysis of March 2005 Current Population Survey using July 2004 state eligibility rules.

3 Ibid.

4 Ibid.

5 J. Holahan, A. Cook, & L. Dubay, *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?*, Kaiser Commission on Medicaid and the Uninsured (February 2007).

6 In 2003, on the heels of the economic downturn of the early 2000s, nearly half of all states made it more difficult for eligible children to acquire or retain public coverage. D.C. Ross and L. Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, October 2004, available at http://www.kff.org/medicaid/7191.cfm. As chronicled in a series of annual reports by Ross and Cox, available online at http://www.kff.org, many of these retrenchments were later reversed.

7 In 2002, 71% of low-income uninsured children lived in families who participated in at least one of three means-tested nutrition program (National School Lunch Program, WIC, or Food Stamps); see S. Dorn & G. Kenney, *Automatically Enrolling Eligible Children and Families Into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers*, The Commonwealth Fund (June 2006).

8 See A. Grady, *Medicaid Citizenship Documentation*, Congressional Research Services (May 16, 2007); P. Shin, B. Finnegan, L. Hughes, & S. Rosenbaum, *An Initial Assessment of the Effects of Medicaid Documentation Requirements on Health Centers and Their Patients*, The George Washington University School of Public Health (May 7, 2007); and National Academy for State Health Policy, *Reauthorizing SCHIP: Principles, Issues and Ideas from State Directors*, (April 2007).

9 See D. Cohen Ross, *New Medicaid Citizenship Documentation Requirement is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up*, Center on Budget and Policy Priorities (March 13, 2007); and Virginia Health Care Foundation, *Unintended Consequences: The Impact of New Medicaid Citizenship Documentation Requirements on Virginia's Children* (May 24, 2007).

10 See Rosenbach, et al., *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations* [Chapter IX, Section B], Mathematica Policy Inc. (March 2003).

11 L. Dubay, J. Guyer, C. Mann, and M. Odeh, "Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward," *Health Affairs*, 26: 370-381 (March/April 2007).

12 See Center for Children and Families, *Children's Health Coverage: States Moving Forward*, (May 2007), available at www.ccfgeorgetown.org.

13 See "SCHIP, Medicaid Outreach Blocked by Some States," *Inside CMS*, vol. 10, no. 7 (April 5, 2007).

Acknowledgements

This report was produced by the Center for Children and Families (CCF). CCF is an independent, nonpartisan research and policy center based at Georgetown University's Health Policy Institute whose mission is to expand and improve health coverage for America's children and families.

This report was developed in collaboration with The Children's Partnership, a national, nonprofit organization working to ensure that all children – especially those at risk of being left behind – have the resources and the opportunities they need to grown up healthy and lead productive lives.

CCF

GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE
CENTER FOR CHILDREN AND FAMILIES

BOX 571444 ■ 3300 WHITEHAVEN STREET, N.W., SUITE 5000
WASHINGTON, DC 20057-1485
(202) 687-0880 ■ FAX (202) 687-3110 ■ WWW.CCFGEORGETOWN.ORG