Medicaid At The Ten-Year Anniversary Of SCHIP: Looking Back And Moving Forward

Medicaid and SCHIP have reduced the number of uninsured low-income children by a third, but much more needs to be done.

by Lisa Dubay, Jocelyn Guyer, Cindy Mann, and Michael Odeh

ABSTRACT: The adoption of the State Children's Health Insurance Program (SCHIP) in 1997 spurred widespread efforts to simplify and revitalize Medicaid coverage for children. To an extent often not recognized, these Medicaid improvements were a key factor behind much of the progress that has been made in covering low-income children: These children's uninsurance rate dropped from 22.3 percent in 1997 to 14.9 percent in 2005, and more than 70 percent of those gains can be attributed to Medicaid. The program, however, faces a number of issues that will need to be addressed if the country is to continue to make progress. [*Health Affairs* 26, no. 2 (2007): 370–381; 10.1377/hlthaff.26.2.370]

As the ten-year anniversary of the enactment of the State Children's Health Insurance Program (SCHIP) approaches, it is important to assess the role that its larger companion program, Medicaid, plays in the coverage system for children and the relationship between the two programs. Designed to sit on the shoulders of Medicaid, SCHIP was focused on covering children whose family incomes are above Medicaid levels but too low to afford private insurance. At the same time, the law that established SCHIP was mindful of Medicaid's role as a key component of the public insurance system for children and included several provisions specifically addressing Medicaid.

Most fundamental is that the law allows states to use their SCHIP funds to expand coverage for children either through Medicaid or through a separate program, and it requires states with separate programs to coordinate enrollment with Medicaid.[1] Coordination was seen as vital to preventing children from falling through the cracks of a two-program system and to assure that Medicaid-eligible children were enrolled in Medicaid.[2] Other provisions of the law—in particular, the "continuous eligibility" and "presumptive eligibility" options—were specifi-

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cally aimed at boosting participation rates for Medicaid-eligible children.[3] In other words, SCHIP's drafters anticipated and intended that the program would have important "spillover" effects for Medicaid.

The reality probably exceeded even these considerable expectations. SCHIP's enactment was followed by unprecedented levels of activity aimed at reducing the uninsurance rate for children, through both Medicaid and SCHIP.[4] Every state took steps to streamline and improve the enrollment process. In addition, education and outreach campaigns were conducted by schools, community organizations, foundations, and states.[5] These efforts represented a fundamental shift with major implications for Medicaid and for children's coverage.[6] Most of these initiatives remain in place today, although some were abandoned or curtailed amid state fiscal pressures in the early 2000s.[7]

Just as SCHIP's implementation offered new opportunities to strengthen Medicaid's role in covering children, SCHIP reauthorization is an occasion to examine Medicaid's coverage role for children over the past ten years and to consider what further improvements might be needed. In this paper we examine the relative roles of Medicaid and SCHIP in providing coverage to children and in reducing the uninsurance rate of low-income children since 1997, as well as Medicaid's role in serving the most vulnerable U.S. children. We provide evidence for the need for additional Medicaid reforms to ensure that Medicaid will continue to meet the needs of low-income children and families, and to do so better.

Study Data And Methods

■ **Data.** Data for this paper were drawn from four nationally representative household surveys in various years: the National Survey of America's Families (NSAF), the Current Population Survey (CPS), the National Health Interview Survey (NHIS), and the National Survey of Children's Health (NSCH), as well as the Medicaid Management Information System (MMIS) and published data.

■ **Eligibility simulations.** In analyses using CPS and NSAF data, we separately identified Medicaid- and SCHIP-eligible children using a detailed eligibility simulation.[8] In analyses using NHIS data, we used a simpler proxy for Medicaid and SCHIP eligibility. Specifically, we considered children in families with incomes below 125 percent of the federal poverty level to be eligible for Medicaid and those with family incomes of 125–200 percent of poverty to be eligible for SCHIP.[9] In both the detailed simulation models and the simpler eligibility measure, we considered children who are served by Medicaid through a SCHIP-financed Medicaid expansion to be SCHIP-eligible.

■ **Insurance coverage trends.** We used NHIS data rather than CPS data for insurance coverage trends because the insurance questions in the former have remained consistent over time and represent a clear point-in-time estimate.

■ **Family characteristics and health status.** We derived data on family characteristics of children covered by Medicaid and SCHIP from the CPS and included the

income of the child's health insurance unit and the composition of adults and children in the child's family. We drew data on health status from the NSCH and included whether the parent reports that the child is in fair or poor health; whether the child is determined to have special health care needs using the Children with Special Health Care Needs (CSHCN) screener; and whether the child is limited or prevented in any way from doing what most children of the same age can do.

Roles Of Medicaid And SCHIP In Insuring Children

Although SCHIP often receives more public recognition, Medicaid is the more important source of public insurance coverage for children: It covers the majority of publicly insured children, including those most vulnerable economically.[10] Based on March 2005 CPS data, 64.5 percent of children eligible for public health insurance coverage are eligible under Medicaid, while 35.4 percent are eligible under SCHIP (Exhibit 1). The distribution of actual coverage in the two programs is even more heavily weighted toward Medicaid. Almost 80 percent of children actually enrolled in public coverage are enrolled in Medicaid. This same pattern is true when administrative data from the MMIS are considered.

■ **Overall trends in coverage.** Medicaid has also played a key role in coverage trends. Much has been written about the increases in public insurance coverage and reductions in uninsurance since SCHIP was implemented. It is difficult, if not impossible, to disentangle the individual effects of SCHIP's financial incentives to expand coverage, the outreach efforts and steps taken to simplify eligibility and renewal procedures after the enactment of SCHIP, concurrent changes in the economy, rising health care costs, and declining rates of employer-based coverage. Nonetheless, examining trends in children's coverage since the implementation of SCHIP provides much insight into the programmatic sources of coverage improvements.

The share of all children with public insurance coverage increased from 18.7 percent in 1997 to 27.0 percent in 2005 (Exhibit 2). This steady increase over time, with the exception of a small dip between 1997 and 1998, is consistent with both

EXHIBIT 1
Distribution Of Eligible And Covered Children, By Program, 2004

	Eligible for public health insurance coverage (CPS) (%)	Covered by public health insurance coverage (CPS) (%)	Covered by public health insurance coverage (MMIS) (%)
Medicaid	65	78	82
SCHIP	35	22	18

SOURCES: Urban Institute analysis of data from the March 2005 Current Population Survey (CPS); and Center for Children and Families analysis of data from the fiscal year 2004 Medicaid Management Information System (MMIS).

NOTE: For the share of children covered by public insurance, children enrolled in State Children's Health Insurance Program (SCHIP)–financed Medicaid expansions are identified as being enrolled in SCHIP.

EXHIBIT 2
Insurance Status For Children Under Age Nineteen, 1997-2005

Poverty level/ coverage source	1997	1998	1999	2000	2001	2002	2003	2004	2005
All children (millions)	74.3	75.1	75.8	76.0	76.2	76.6	76.4	76.8	77.1
Public	18.7%	17.6%	18.2%	19.4%	21.1%	24.3%	25.8%	26.3%	27.0%
Employer	64.0	65.4	66.1	64.9	64.4	62.3	59.7	60.0	59.4
Other	3.8	4.8	4.4	4.0	4.2	3.5	4.7	4.0	3.9
Uninsured	13.5	12.2	11.2	11.7	10.3	9.9	9.8	9.6	9.7
Children <200% FPL (millions)	34.6	33.9	33.9	34.1	33.6	34.4	35.4	35.5	35.2
Public	36.6%	34.7%	36.2%	37.7%	41.3%	46.8%	48.2%	49.3%	50.6%
Employer	38.3	39.8	40.1	38.9	37.5	34.7	32.7	32.5	31.5
Other	2.9	4.0	3.6	3.4	3.3	2.7	3.2	3.0	3.0
Uninsured	22.3	21.5	20.1	20.0	18.0	15.8	15.9	15.2	14.9
Children <125% FPL (millions)	21.2	20.8	19.9	20.1	20.5	21.0	21.6	21.3	21.5
Public	50.5%	47.7%	49.1%	49.5%	52.0%	58.0%	58.8%	61.4%	61.5%
Employer	23.0	25.4	25.8	25.6	25.1	22.9	21.8	20.4	20.4
Other	2.2	3.1	2.9	2.7	2.5	1.8	2.6	2.2	2.4
Uninsured	24.3	23.8	22.2	22.1	20.4	17.3	16.9	16.0	15.7
Children 125–200% FPL (millions)	13.4	13.1	14.0	14.0	13.2	13.4	13.7	14.2	13.7
Public	14.6%	13.9%	17.8%	20.8%	24.7%	29.2%	31.6%	31.3%	33.4%
Employer	62.6	62.7	60.4	58.0	56.7	53.3	50.0	50.7	48.8
Other	3.9	5.5	4.6	4.3	4.4	4.0	4.0	4.1	4.0
Uninsured	19.0	17.9	17.2	16.9	14.2	13.5	14.3	13.9	13.7

SOURCE: Center for Children and Families analysis of data from the National Health Interview Survey, various years.

NOTES: "Public" includes Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), other government, and other public insurance; "employer" includes private coverage obtained through work or a union and military coverage; "other" includes all other types of private coverage; "uninsured" includes those without any insurance, only single service coverage, and Indian Health Service coverage. FPL is federal poverty level.

the implementation of SCHIP and the economic downturn during 2001–2003.[11] The dip was likely due at least in part to program transition issues following enactment of the 1996 welfare law.[12]

Trends in the share of all children with employer-sponsored coverage followed a different pattern. Nearly two-thirds of children had employer-sponsored coverage in 1997, and the share of children with such coverage grew in the early years following SCHIP implementation (Exhibit 2). It began to fall steadily beginning in 2000, dropping to 59.4 percent by 2005. Although some of this decline can be attributed to public coverage expansions that "crowded out" private insurance, much of it likely is due to other factors such as rapid increases in health insurance premiums and the broader economic decline.[13] Evidence of this is found in the comparable decline in employer coverage that was observed for adults during this period, even though public coverage for adults did not change greatly.[14] Notwithstanding the private coverage losses, the rate of unin-surance among all children declined steadily from 1997 to 2005 because of public coverage gains (Exhibit 2).

■ **Changes for low-income children.** Much larger changes occurred for low-income children (those with incomes below 200 percent of poverty) than for high-income children. Between 1997 and 2005, the share of low-income children covered by public programs rose 14.0 percentage points, the share with employer coverage

declined 6.9 percentage points, and the share that were uninsured fell 7.3 percentage points (Exhibit 2). However, different patterns of change applied to Medicaid-eligible than to SCHIP-eligible low-income children. Among Medicaid-eligible children, most of whom were eligible before SCHIP implementation, there was an 11.2-percentage-point increase in public coverage, a 3.3-percentage-point decline in employer coverage, and an 8.0-percentage-point decline in uninsurance. In contrast, SCHIP-eligible low-income children experienced an 18.0-percentage-point increase in public coverage, an 11.6-percentage-point decline in employer coverage, and a 6.6-percentage-point decline in uninsurance (Exhibit 2).

As mentioned earlier, an array of trends, including broad economic forces and rising health insurance premiums, affected the coverage of low-income children. What is clear from the NHIS data, however, is that following implementation of SCHIP, approximately 50 percent of the increase in public coverage among low-income children was due to increases in Medicaid coverage.[15] These data are similar to evidence from administrative data, which suggests that approximately half of the increase in enrollment in Medicaid and SCHIP between 1997 and 2004 was due to increases in Medicaid coverage.[16] Perhaps most striking is the fact that declines in uninsurance among low-income children were driven in large part by declines in uninsurance among Medicaid-eligible children. The gains in Medicaid enrollment between 1997 and 2005 accounted for 73.8 percent of the decrease in uninsurance among low-income children during this period.[17]

■ **Public program participation trends.** Other evidence of the role of Medicaid in coverage trends and the "spillover" effect of SCHIP on Medicaid can be found by examining trends in participation among children eligible for Medicaid since SCHIP was adopted. The three rounds of the NSAF used a detailed eligibility simulation to identify children eligible for Medicaid and SCHIP. Estimates of participation reflect the share of those children who are income-eligible for Medicaid and not covered by private insurance who participate in Medicaid or SCHIP. These patterns varied by eligibility for Medicaid and SCHIP. Participation in Medicaid went from 71.4 percent in 1997 to 78.8 percent in 2002, with a dip to 69 percent in 1999, likely as the result of states' implementation of federal welfare changes.[18] Participation rates also increased for SCHIP-eligible children from 44 percent in 1999 to 63 percent in 2002, but the participation rates lagged behind those of Medicaid in 2002.

Role Of Public Coverage In Serving Vulnerable Children

■ **Economic status.** Along with driving much of the coverage improvement among low-income children over the past decade, Medicaid plays a particularly important role for some of the most vulnerable U.S. children. Because Medicaid and SCHIP are means-tested programs, children with public coverage are more economically disadvantaged than the population as a whole. Moreover, Medicaid serves an even more economically vulnerable population than SCHIP does. Some 76.2 percent of Medicaid-covered children are in families with incomes below poverty, while a

comparable percentage of SCHIP-covered children (77.9 percent) live in families with incomes of 100–199 percent of poverty (Exhibit 3).

■ **Health status.** Children with public coverage also are more vulnerable in terms of their health compared with children who have private coverage and, based on some indicators, with uninsured children. Children with public coverage, the vast majority of whom are covered by Medicaid, are significantly more likely than other groups to be in fair or poor health, to have limits on activities, and to have special health care needs (Exhibit 4). Because of the higher prevalence of poor health status, health conditions, and limitations among children who are publicly insured, Medicaid and SCHIP serve a disproportionate share of these children relative to private insurers. Although about 27 percent of all children are covered by Medicaid or SCHIP, 57 percent of all children in poor health and 47 percent of all children with an activity limitation are covered by Medicaid or SCHIP (Exhibit 5).

Issues Affecting Medicaid's Ability To Serve Children Over The Next Decade

As policymakers consider ways to further narrow the uninsurance gap for children over the next decade, in the context of SCHIP reauthorization, it will be important to examine three key issues facing Medicaid and options for addressing them: enrolling eligible but uninsured children; addressing gaps in coverage; and ensuring children's access to needed, high-quality care.

■ **Enrolling and retaining eligible children.** As detailed above, Medicaid, even more than SCHIP, has had notable success in achieving a relatively high participation rate among eligible children over the past decade. Nevertheless, some 4.4 million uninsured children are eligible for Medicaid (and an additional 1.7 million are eligible for SCHIP).[19] These Medicaid-eligible children account for more than half of all uninsured U.S. children.

Strategies are available to increase Medicaid participation rates: Simplifying application forms, lengthening the time between renewals, adopting continuous eligibility, and eliminating requirements for families to document matters that the

EXHIBIT 3
Children In Medicaid And The State Children's Health Insurance Program (SCHIP), By Family Income, 2005

Family income	All children (%)	Medicaid-covered children (%)	SCHIP-covered children (%)
Less than 100% FPL	23.2	76.2	1.2
100–199% FPL	19.7	21.8	77.9
200–299% FPL	16.4	1.5	19.6
300+% FPL	40.7	0.5	1.3

SOURCE: Urban Institute analysis of data from the March 2005 Current Population Survey.
NOTE: FPL is federal poverty level.

EXHIBIT 4
Rate Of Health Status Indicators Among Children, By Insurance Coverage Status, 2003–2004

	Coverage source (%)		
	Public	**Private**	**Uninsured**
Child is in fair or poor health	6.73	1.37[a]	5.60
Child has activity limitations	9.59	4.04[a]	4.76[a]
Child has special health care needs	21.82	16.81[a]	10.44[a]

SOURCE: National Survey of Children's Health, 2003–2004.
[a] Statistically significant difference from rate for publicly insured ($p \leq 0.05$).

Medicaid agency can verify in other ways have been shown to greatly affect enrollment.[20] However, states do not always pursue these strategies, or they might abandon or curtail them when state budgets are under pressure, because effective strategies will result in additional coverage costs.[21] This is a particular problem for Medicaid, given that the federal government pays a lower share of coverage costs compared with its payments to SCHIP. To address this, federal Medicaid matching rates could be enhanced, as they are in SCHIP. A more modest and targeted approach (that could apply to SCHIP as well) would be to provide performance-based fiscal support to states that succeed in their enrollment efforts. For example, the federal government could provide an enhanced matching rate to states that greatly increase participation rates (in Medicaid and SCHIP) or that consistently maintain high participation rates. Such a strategy would allow states to decide for themselves the best way to enroll eligible children while easing the fiscal concerns that might deter some states from pursuing effective strategies.

States also are coping with a new barrier to simplifying their Medicaid application process for children. Because of a provision included in the Deficit Reduction Act (DRA) of 2005, states now are mandated to require proof of citizenship from U.S. citizens who apply for Medicaid or seek to renew their Medicaid coverage.[22]

EXHIBIT 5
Distribution Of Children, By Health Status Indicators And Insurance Coverage, 2003–2004

	Coverage source (%)			
Health status	**Public**	**Private**	**Uninsured**	**Total**
Population distribution	27.44	63.88	8.74	100.0
Child is in fair or poor health	57.48	27.27	15.25	100.0
Child has activity limitations	46.71	45.90	7.39	100.0
Child has special health care needs	33.95	60.87	5.18	100.0

SOURCE: National Survey of Children's Health, 2003–2004.
NOTE: Distribution of health status indicator is statistically different ($p \leq 0.05$) from distribution of population for all indicators.

Only a limited range of documents are acceptable.[23] State officials have indicated that the requirement, which applies primarily to children and their parents, is creating new barriers to coverage for eligible children whose families might not have the required documents on hand.[24] Of particular concern is that the new requirement makes it difficult for states to continue to allow families to apply for coverage through the mail, a basic step that all but a handful of states have taken to simplify their application processes.[25] One option for easing these stresses is to give states flexibility in determining how best to verify citizenship.

The data also suggest that more needs to be done to increase families' awareness of public coverage programs. Such awareness is up, but, in 2002, more than four in ten parents of low-income uninsured children did not know that their children could participate in Medicaid or SCHIP without receiving welfare. At the same time, among low-income children whose parents had heard of either Medicaid or SCHIP, 81.7 percent of parents said that they would enroll their children if told they were eligible.[26] Experience to date suggests that ongoing education and strategically targeted outreach campaigns, including community-based application assistors, can be effective in increasing awareness, prompting applications, and educating families about the need to renew coverage regularly.[27]

■ **Addressing gaps in coverage.** Between Medicaid and SCHIP, states have broad flexibility to determine the extent to which they will provide publicly subsidized coverage to children. But some notable gaps remain. States are barred from using federal Medicaid (or SCHIP) funds to cover many immigrant children, including many legal immigrants who have lived in the country for less than five years.[28] About one-quarter of all children who are uninsured and otherwise eligible for Medicaid or SCHIP are excluded because of immigration restrictions.[29]Also, research has shown that when all family members are eligible for coverage, children are more likely to enroll and be able to obtain needed care.[30] Most states, however, have much more restrictive coverage policies for parents than they do for children. In all but fourteen states, parents earning wages that are well below poverty have incomes too high to qualify for Medicaid. Some states cover parents at income levels no higher than 10–20 percent of poverty.[31] States have the option to provide family-based coverage, with its attendant benefits for children, but experience with both children's and parents' coverage suggests that in the absence of a federal coverage mandate, additional federal support (such as an enhanced matching rate) will likely be needed to encourage more states to take up this option.[32]

■ **Ensuring children's access to high-quality care.** Over the next ten years, Medicaid also will need to preserve and in some ways strengthen its role in providing comprehensive coverage for children. The program has a history of providing access to care, particularly preventive care, for poor and near-poor children at a rate comparable to that of private coverage and offering even greater protection for families against excessive out-of-pocket costs.[33] The findings of a limited number of studies on Medicaid's role in promoting access among children with special health

care needs are not uniform, but the majority of studies indicate that Medicaid is as good as or often better than private coverage.[34] Increasingly, however, it is clear that it is not appropriate to use privately financed coverage as the benchmark against which Medicaid is judged because of the quality shortcomings of private coverage. A recent Commonwealth Fund study, for example, found that fewer than half of all U.S. children are receiving adequate developmental and psychological surveillance, screening for health risks such as lead exposure, or anticipatory guidance.[35]

Continuity of benefits specific to children. A threshold issue is whether Medicaid will continue to provide its benefit package. Unlike the SCHIP benefit package, which is based in large part on private-sector benefit models designed to cover working adults, Medicaid's benefit package for children is specifically designed for children. It requires children to be provided with regular health, dental, hearing, and vision screening, as well as any care that is medically necessary.[36] Although some SCHIP programs offer a comprehensive benefit package, others are more limited. For example, under federal SCHIP standards, some SCHIP plans limit mental health services, speech and physical therapy, or dental care; they do not cover certain types of services (such as family therapy); or they operate under medical-necessity standards that do not reflect the fact that children have different needs than adults do.[37] In the recent debate over the DRA, policymakers discussed whether to weaken the federal standards governing the Medicaid benefit package for children by bringing them in line with SCHIP. It is possible that during the SCHIP reauthorization debate, this set of questions will arise again.

Provider reimbursement. Also relevant to this debate are concerns about the adequacy of provider reimbursement rates in Medicaid. Rates are set by states, with no federal oversight and few federal standards. In some cases, rates are comparable to commercial rates, and in others, they fall below costs, impeding access and quality initiatives.[38] If they believe that they are underpaid when they treat Medicaid patients, providers might be reluctant to undertake new initiatives on behalf of Medicaid patients or, in some cases, even to take them on as patients.

Accomplishments And Challenges

As intended by the drafters of the original SCHIP statute, Medicaid and SCHIP have generally worked well together over the past decade. Medicaid serves as the backbone of the public coverage system for U.S. children, covering more than eight in ten publicly insured children. It plays a particularly vital role for children with special health care needs and those whose family incomes leave little room for paying for uncovered medical care. SCHIP has touched off widespread and largely successful efforts to revitalize and modernize Medicaid coverage for children. Together the two programs have reduced the uninsurance rate of low-income children by a third, with Medicaid accounting for the majority of the gains.

Medicaid, however, faces important challenges. Over the next ten years, to build on the successes to date, policymakers will need to find ways to enroll unin-

sured children who are eligible for Medicaid; to sustain and strengthen coverage during economic downturns; to fill remaining gaps in state coverage and financing options for discrete groups of children and parents; and to ensure that Medicaid leads the nation in improving the quality of care that children receive.

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NOTES

1. 42 U.S. Code, sec. 2101.
2. 42 U.S. Code, sec. 2102(b)(3)(B).
3. *Balanced Budget Act of 1997* (P.L. 105-33). The continuous-eligibility option allows states to assure that children can stay enrolled in Medicaid, without interruption, for up to twelve months. Presumptive eligibility permits health care providers and other designated people to enroll children who appear to be eligible for coverage while their applications are formally reviewed.
4. P. Cunningham, J. Reschovsky, and J. Hadley, "SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage," Issue Brief no. 59 (Washington: Center for Studying Health System Change, December 2002); and D.C. Ross and I. Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *Future of Children* 13, no. 1 (2003): 81–97.
5. J. Moore, "CHIP and Medicaid Outreach and Enrollment: A Hands-On Look at Marketing and Applications," Issue Brief no. 748 (Washington: National Health Policy Forum, 19 October 1999); and J. Ryan, "SCHIP Turns Five: Taking Stock, Moving Ahead," Issue Brief no. 781 (Washington: NHPF, 15 August 2002).
6. J. Wooldrige et al., "Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress" (Washington: Mathematica Policy Research and Urban Institute, 26 October 2005).
7. 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, http://www.kff.org/medicaid/7191.cfm (accessed 22 January 2007). 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.
8. Eligibility was based on the following models with adjustment for immigrant status but not Medicaid undercount: L. Dubay and G. Kenney, "Assessing SCHIP Effects using Household Survey Data: Promises and Pitfalls," *Health Services Research* 35, no. 5, Part 3 (2000): 112–127; and L. Dubay, J. Holahan, and A. Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* 26, no. 1 (2007): w22–w30 (published online 30 November 2006; 10.1377/hlthaff.26.1.w22).
9. Analyses of the NHIS rely on imputed income data to identify children in different income groups. The NHIS uses a multiple-imputation methodology to impute data. In the absence of a detailed eligibility model, the threshold of 125 percent of the federal poverty level is used to distinguish between Medicaid- and SCHIP-eligible children. This may in fact understate Medicaid's importance, given that 12 percent of Medicaid-eligible children live in families with incomes above 125 percent of poverty (authors' tabulation of detailed eligibility simulation using data from the CPS).
10. For example, see J. Broder, "Health Coverage of Young Widens with States' Aid," *New York Times*, 4 December 2005.
11. The second half of the 1990s continued one of the longest economic expansions in U.S. history; see J. Jermann and V. Quadrini, "Stock Market Boom and the Productivity Gains of the 1990's," NBER Working Paper no. 9034 (Cambridge, Mass.: National Bureau of Economic Research, 2002). This period of profound economic growth ended with the start of a recession in March 2001. NBER, "Business Cycle Expansions and Contractions," 2005, http://www.nber.org/cycles.html (accessed 28 December 2006).
12. B. Garrett, J. Holahan, and A. Yemane, "Unemployment, Welfare Reform, and Medicaid Enrollment" (Abstract, AcademyHealth Services Research and Health Policy Annual Meeting, Washington, D.C., June 2002); C. Burke and C. Abbey, "Managing Medicaid Take-Up, Medicaid Enrollment Trends: 1995–2000" (Albany: Rockefeller Institute of Government, August 2002); and L. Dubay, L. Blumberg, and A. Luque,

"Participation in Public Health Insurance Programs in the Wake of Welfare Reform and SCHIP Implementation" (Washington: Urban Institute, 2006).

13. J.L. Hudson, T.M. Selden, and J.S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry* 42, no. 3 (2005): 232–254; and L. Dubay and G. Kenney, "Estimating the Impact of SCHIP on Insurance Coverage and Access to Care" (Paper presented at the American Public Health Association annual meeting, Washington, D.C., November 2004). Although each of these studies found some evidence of crowding out among the SCHIP population, they found very little among the Medicaid population. Consequently, crowding out is unlikely to be driving the overall declines in employer-sponsored coverage for all children, given the small share of children made eligible under SCHIP. On increases in premiums and broader economic trends, see Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2006 Annual Survey,* September 2006, http://www.kff.org/insurance/7527/index.cfm (accessed 2 January 2007); NBER, "Business Cycle Expansions and Contractions"; and J. Jermann and V. Quadrini, "Stock Market Boom and the Productivity Gains of the 1990's," NBER Working Paper no. 9034 (Cambridge, Mass.: NBER, 2002).
14. Authors' tabulations of data from the NHIS; and J. Holahan and A. Cook, "Changes in Economic Conditions and Health Insurance Coverage, 2000–2004," *Health Affairs* 24 (2005): w498–w508 (published online 1 November 2005; 101377/hlthaff.w5.498).
15. Of the increase in public coverage of 5.2 million low-income children identified in the NHIS, 2.5 million were children in families with incomes below 125 percent of poverty. Some of the change in public coverage was due to shifts in the share of children in each of the two low-income groups. When this is accounted for, the share of the increase attributable to Medicaid rises to 47 percent.
16. The number of people enrolled in SCHIP over the course of a year increased from 0 in 1997 to 6.2 million in 2004, while the number of children enrolled in Medicaid over this same period increased 6.8 million, from 21 million to 27.8 million. SCHIP data are from the Centers for Medicare and Medicaid Services (CMS), and Medicaid data are from the CMS in 1997 and the Congressional Budget Office in 2004. The NHIS and administrative data differ for a number of reasons, including underreporting of coverage on household surveys; the fact that the NHIS represents a point-in-time estimate while the administrative data represent ever covered over the course of the year; and other sources of measurement error in both data sources.
17. Of the 2.4 million decline in the number of uninsured low-income children, 1.8 million was attributable to children with family incomes below 125 percent of poverty. When changes in the distribution of children between the two low-income groups are accounted for, the share attributable to Medicaid declines to 72 percent. Although Medicaid had a larger role than SCHIP did in lowering the uninsurance rate among low-income children, SCHIP also contributed to strengthening coverage rates among children with family incomes above 200 percent of poverty.
18. K. Kronebusch, "Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding," *Health Affairs* 20, no. 1 (2001): 97–111.
19. Urban Institute analysis of data from the March 2005 Current Population Survey.
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the Third Comprehensive Survey of State Children's Health Insurance Programs" (Portland, Maine: National Academy for State Health Policy, September 2006). States with the capacity to conduct data matches with their office of vital statistics and other state agencies may have more success retaining mail-in application and renewal procedures. See L. Ku, D.C. Ross, and M. Broaddus, "Documenting Citizenship and Identity using Data Matches: A Promising Strategy for State Medicaid Programs" (Washington: Center on Budget and Policy Priorities, 1 September 2006).

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31. See D.C. Ross and L. Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Washington: Kaiser Commission, October 2005), Table 3.
32. For proposed legislation, see S. 1843, A bill to amend titles XIX and XXI of the Social Security Act to provide for FamilyCare coverage for parents of enrolled children, and for other purposes (introduced in the U.S. Senate 10 November 2003).
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34. A.E. Jeffrey and P.W. Newacheck, "Role of Insurance for Children with Special Health Care Needs: A Synthesis of the Evidence," *Pediatrics* 118, no. 4 (2006): e1027–e1038.
35. P. Chung et al., "Preventive Care for Children in the United States: Quality and Barriers," *Annual Review of Public Health* 27 (2006): 491–515.
36. Under the SCHIP statute, states have much flexibility to design their benefit packages for separate programs based on a number of benchmarks, including the Blue Cross/Blue Shield preferred provider option provided to federal employees; the health maintenance organization in a state with the largest commercial, non-Medicaid enrollment; any plan offered to a state employee; or coverage approved by the secretary of health and human services. See S. Rosenbaum, A. Markus, and C. Sonosky, "Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP," *Journal of Health and Biomedical Law* 1, no. 1 (2004): 1–47; and A.H. Fox and P. McManus, "A Fifty-State Analysis of Medicaid Benefit Coverage for Children without EPSDT" (Memorandum to the March of Dimes and National Association of Children's Hospitals), September 2005, http://www.mchpolicy.org/publications/medicaid.html (accessed 29 January 2007).
37. C. Mann and E. Kenney, "Differences That Make a Difference: Comparing Medicaid and the State Children's Health Insurance Program Federal Benefit Standards," Family Coverage Matters, Issue Brief (Washington: Center for Children and Families, Georgetown University Health Policy Institute, 2005).
38. The American Academy of Pediatrics (AAP) has estimated that Medicaid (and SCHIP) payment rates are 65 percent of private-pay and 70 percent of Medicare rates. See AAP, "2006 Pediatric Medical Cost Model," http://www.aap.org/research/pedmedcostmodel.cfm (accessed 28 December 2006). Many states rely on managed care organizations to deliver care to children in Medicaid, but here, as well, rates can vary widely across states, and some managed care companies report less satisfaction with Medicaid than with SCHIP. J. Holahan and S. Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001," *Health Affairs* 22, no. 1 (2003): 204–218; and M. Gold et al., "Participation of Plans and Providers in Medicaid and SCHIP Managed Care," *Health Affairs* 22, no. 1 (2003): 230–240.