

Reauthorization of the State Children's Health Insurance Program (SCHIP): A Key Step to Covering All Kids

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EXECUTIVE SUMMARY



The State Children's Health Insurance Program (SCHIP) was established in the Balanced Budget Act of 1997. The act outlined that states could cover children in families not eligible for Medicaid with incomes up to 200 percent of the federal poverty level, with the option to cover children of higher incomes. Ultimately, SCHIP was to serve as a mechanism through which children who did not have access to private health insurance or Medicaid could be insured. To fund this new children's health insurance program, \$40 billion was authorized in federal funds over a 10-year period.¹ At the time of the passage of the Balanced Budget Act, the program was expected to cover approximately 40 percent of the then-estimated 10 million uninsured children.¹

Ten years after its creation, SCHIP provides health coverage to 6 million children.² As it was originally authorized for 10 years, the program is scheduled to be reauthorized in 2007. The program's reauthorization presents Congress with an opportunity to make a key

step to give every child in the United States the health coverage he or she needs to grow up healthy and strong. Although the program has been successful during the past decade in reducing the percentage of low-income children who are uninsured and improving their health status and outcomes, the future of the program is now in jeopardy as current funding levels are insufficient even to maintain the coverage of children currently enrolled.

Ultimately, if fully funded and improved, SCHIP has the potential, along with Medicaid, to cover roughly three-quarters of the nation's uninsured children. Funding SCHIP should not be at the expense of the Medicaid program, which complements SCHIP and covers 28 million children.³ In addition to providing ample funding to cover all children eligible for but not enrolled in SCHIP and Medicaid, SCHIP reauthorization needs to address the quality and adequacy of the health coverage that children in SCHIP have and make changes that are necessary to ensure that they have a

By The Numbers: A Portrait of the Nation's Uninsured Children—Potential for Improving Access

9 million	Number of uninsured children in the United States. ¹¹
74	Percentage of uninsured children eligible for SCHIP or Medicaid but not enrolled. ¹²
11	Percentage of uninsured children in families not eligible for Medicaid or SCHIP with incomes below 300 percent of the federal poverty level who cannot afford to purchase private health coverage. ¹²
15	Percentage of uninsured children in families with incomes over 300 percent of the federal poverty level who are ineligible for Medicaid and SCHIP. ¹²
90	Percentage of uninsured children that come from families where at least one parent works. ¹³
50	Percentage of two-parent families of uninsured children in which both parents work. ¹³
3.4 million	Number of uninsured children who are white, non-Hispanic. ¹³
1.6 million	Number of uninsured children who are black. ¹³
3.3 million	Number of uninsured children who are Hispanic. ¹³
670,000	Number of uninsured children of other racial and ethnic backgrounds. ¹³

comprehensive, prevention-focused benefits package. Ultimately, the SCHIP reauthorization and congressional budget processes need to include the following policy and legislative recommendations:

- Provide at least \$60 billion in new funds over five years for SCHIP reauthorization. This amount would be enough to cover all current enrollees, enroll most of the children currently eligible for but not enrolled in SCHIP and Medicaid and provide coverage to pregnant women and legal immigrant pregnant women and children.
- Strengthen the federal standard for SCHIP benefits packages to make it comparable to the Medicaid benefits package, which includes coverage of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.
 - Provide adequate funding and give states the option to cover pregnant women and legal immigrant pregnant women and children in their SCHIP programs.
 - Make revisions to federal law to give states the flexibility to deem children eligible for and enroll them in SCHIP or Medicaid based on information from other means-tested programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children and the National School Lunch Program.
 - Allow states the flexibility to determine the citizenship status of Medicaid and SCHIP applicants.



Background

Unlike Medicaid, SCHIP was funded as a 10-year capped block grant to states rather than as an individual entitlement program. Under SCHIP, each state is given a certain amount of money per year, determined by a formula that was established by Congress upon the program's creation. A state only receives federal matching funds up to its annual allotment, and is able to use this money over a three-year period. After the three-year period, unspent funds are redistributed to states that spent their entire allotments. If these states are unable to spend the redistributed funds within a certain period of time, they are returned to the United States Treasury. Additional funding is only available if some states do not spend their entire allocations. Unfortunately, not all children eligible for SCHIP receive coverage, nor are they entitled to a federally defined set of benefits as with Medicaid. Also, the current funding structure of SCHIP has become insufficient, with 14 states — Alaska, Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, Rhode Island and Wisconsin — anticipating funding shortfalls in fiscal year 2007.⁴

To give states incentives to cover these children, the federal government provides states with an enhanced matching rate in comparison to Medicaid. The matching rates of SCHIP range from 65 percent to 84 percent of total program costs — about 30 percent higher than those under Medicaid.⁵ These enhanced matching rates, when coupled with political will on the state level, has helped to protect most SCHIP-eligible children from cuts in eligibility during the past decade — especially throughout the economic downturn following Sept. 11, 2001.^{6,7,8}

States also have had the flexibility to determine which model they will adopt to cover these children,

such as offering a separate stand-alone program, expanding their Medicaid program, or a combination of both of these approaches. If states chose to create a separate stand-alone program, they could put forward a different benefits package, choosing among the private health maintenance organization plan that has the largest commercial, non-Medicaid enrollment in the state; the standard Blue Cross/Blue Shield preferred provider option under the Federal Employee Health Benefits Plan; any state-administered plan for state employees; or a plan that has been approved by the Secretary of Health and Human Services. These private benefit plans have different benefits than Medicaid, which guarantees children access to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, a comprehensive benefit plan specifically catered to child health and development. Separate programs could also include cost sharing — enrollment fees, premiums, deductibles and co-pays.¹

SCHIP provides health coverage to 6 million children during the course of a year and roughly 4 million at any point in time.² Eighteen states have separate SCHIP programs, 11 states and the District of Columbia have expanded their Medicaid programs and 22 states have a combination of both approaches.⁹ Overall, about 30 percent of children enrolled in SCHIP are enrolled in Medicaid expansion programs and therefore generally have more comprehensive coverage that includes EPSDT services.¹⁰ As of July 2006, 26 states cover children with incomes up to 200 percent of the federal poverty level (FPL), which is equivalent to \$2,767 in monthly income for a family of three. Fifteen states have adopted income eligibility limits above and 10 have adopted limits below 200 percent FPL.⁹

SCHIP Successes

SCHIP is an example of a federal and state joint program that has been successful in both reducing the number of the nation's uninsured children and improving the health status and outcomes of those children enrolled in the program. The final congressionally mandated evaluation found the program to be very successful in effectively providing health coverage to the population it was meant to cover.¹ Its demonstrated success means it should be prioritized in future congressional funding decisions and an increased investment should be made during its reauthorization, coupled with sustaining coverage of children in the Medicaid program.

Overall, the percentage of low-income children who are uninsured has decreased by one-third since SCHIP's inception in 1997.¹¹ Between 2000 and 2004, together with Medicaid, it more than made up for the declines in employer-sponsored coverage, which could have left thousands of children uninsured. In this time frame, the rate of employer-sponsored insurance for low-income children dropped from 36.1 percent to 30.6 percent — over 5 percentage points. During this same time period, coverage under Medicaid or SCHIP for this population increased by 8 percentage points, from 36.5 percent to 44.7 percent. Ultimately, Medicaid and SCHIP lowered the percent of low-income children who were uninsured by 2 percentage points.¹⁴ However, there was only

SCHIP Improves Children's Health Outcomes: Findings of the Final Congressionally Mandated Evaluation of SCHIP

The Balanced Budget Refinement Act (BBRA) of 1999 required the Secretary of Health and Human Services to conduct an independent evaluation of SCHIP. The BBRA stipulated that the evaluation was to include 10 states that represented varying SCHIP program designs, geographic diversity and a large percentage of the low-income, uninsured children in the United States. The final report, building off of an interim report sent to Congress in 2003, was funded by the Office of the Assistant Secretary for Planning and Evaluation. The 10 states that constituted the primary focus of the final evaluation, representing 60 percent of SCHIP enrollees, were California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina and Texas.

The final evaluation of the program found that:

- 91 percent of SCHIP beneficiaries had a usual source of medical care — a medical home.
- Parents of 81 percent of children in the program were confident they could meet their children's health needs.
- Established SCHIP beneficiaries were 21 percentage points more likely than recent enrollees who had been uninsured to have a usual source for medical care.
- Established SCHIP enrollees were 31 percentage points more likely to have a usual source for dental care compared to the recent enrollees who were uninsured for the six-month period before they enrolled.
- SCHIP enrollees were 13 percentage points less likely than uninsured recent enrollees to have unmet needs for prescription drugs as well as care provided by a hospital, specialist, physician or dental professional.¹

a negligible increase in Medicaid and SCHIP coverage for children in 2004–2005, which was not enough to offset the erosion in employer-sponsored insurance during this time period.¹⁵ Therefore, the number of uninsured children increased. This underscores the importance of fully funding SCHIP reauthorization and not cutting Medicaid.

This success in reducing the uninsurance rates for low-income children could not have been achieved without the states designing and simplifying the application and enrollment processes to improve enrollment and retention rates in their Medicaid and SCHIP programs. During the past decade, states have used several strategies to make enrollment and retention in the programs as simple as possible. Successful outreach and enrollment strategies have included:



SPOTLIGHT: New York

New York's State Children's Health Insurance Program has significantly reduced racial and ethnic health disparities. Examples of the program's success include:

- Before SCHIP in New York, a greater proportion of white children had a usual source of care compared with black or Latino children. During SCHIP, all had a usual source of care.
- Black children had significantly greater levels of unmet need relative to white children before SCHIP was created. During SCHIP, racial/ethnic disparities in unmet need between these populations were eliminated.
- Before SCHIP, more white children in New York made all or most visits to their usual source of care compared to black or Hispanic children. During SCHIP, all populations improved their utilization rates of their usual source of care with no remaining disparities.²¹

SPOTLIGHT: SCHIP Enrollment Cap in North Carolina

In 2001, North Carolina capped its SCHIP enrollment — the first state to do so. The state instituted the cap after concluding that SCHIP funding levels were not sufficient to keep up with increasing enrollment in the program. Enrollment in North Carolina's SCHIP program in January 2001 was at 72,024 children. By October of 2001, program enrollment had dropped 29 percent to 51,294 children. During the course of the cap, the state kept a waiting list of those children who were eligible for but could not be enrolled in the program. At one point during the cap, more than 34,000 children's names were on the list.²⁴

using a single application form for both SCHIP and Medicaid; allowing families to “self-declare” their income and not requiring them to submit pay stubs or other verification of their income when determining eligibility;¹⁶ and not requiring a face-to-face interview to apply for coverage, which served as a major obstacle to families with limited access to private or public transportation.⁷

SCHIP Improves Access to Preventive Care

SCHIP beneficiaries overall receive more preventive care, have fewer unmet needs and have better access to and communication with providers than recent enrollees in the six months before they enrolled. They are more likely to visit the doctor, receive preventive medical and dental checkups, and have access to specialist or mental health services than children who had no insurance in the six months before they enrolled. Children enrolled in SCHIP also have increased access to specialty and primary care providers, which is acutely important to children with chronic conditions, who in SCHIP have experienced fewer unmet health care needs.¹⁸

SCHIP Contributes to Reducing Racial/Ethnic Health Disparities

SCHIP has contributed to reducing racial/ethnic health disparities by providing children of varying racial and ethnic backgrounds needed health coverage, which improves their access to care and ultimately improves health outcomes. The diverse populations covered by SCHIP were highlighted in the 10 states that were studied in the final congressionally mandated evaluation of the program. In these states, 49 percent of SCHIP beneficiaries were Hispanic, 32 percent were white, 12 percent were black and 6 percent were Asian. Nearly 50 percent of SCHIP enrollees in these states had at least one parent born outside of the United States. More than 25 percent of children enrolled in SCHIP in the states studied lived in families that spoke primarily Spanish at home.¹ The findings of the final congressionally mandated evaluation were similar to those of previous studies on the diversity of populations served by the SCHIP program.^{19,20}

SCHIP Reauthorization: Key Issues and Recommendations

Fully Fund SCHIP Reauthorization

PROVIDE ENOUGH FUNDING TO MAINTAIN CURRENT LEVEL OF POPULATIONS AND SERVICES COVERED IN SCHIP

In recent years, states have experienced shortfalls in federal SCHIP funding. As the number of states experiencing shortfalls has increased year to year, it is already apparent that funding levels for SCHIP are inadequate to keep the current number of children in the program. And state SCHIP officials have indicated that they expect SCHIP enrollment growth to continue.²² Ultimately, shortfalls lead states to reduce their outreach efforts, implement strategies to make enrollment more difficult and cap enrollment in the program. From 2001 to 2006, eight states imposed enrollment caps.¹⁰ Also, at the time of the SCHIP program administrator survey in 2003, 39 percent of administrators participating reported that, due to budgetary restraints, they had reduced their outreach efforts, and 16 percent reported they had introduced or planned to introduce enrollment caps or limits.¹ In 2004, budget shortfalls prompted many states to tighten SCHIP eligibility, causing children to become disenrolled from the program and uninsured.²³

In fiscal year 2006, 38 of 50 states used more federal SCHIP matching funds than they received in their annual allotments.²⁵ Although states experiencing shortfalls have used unspent funds from past years and funds not spent by other states to make up for their shortfalls, these strategies should not be counted on for the long term as there will be more shortfall states and a smaller amount of unspent funds to be redistributed.

Congressional budget rules limit the amount of annual funding set aside for SCHIP reauthorization to

its fiscal year 2007 funding level of \$5.04 billion. If Congress reauthorizes SCHIP at this level, it is estimated that there will be shortfalls ranging from \$12.7 billion to \$14.6 billion over five years, between fiscal years 2008 and 2012.^{26,27} If Congress does not take the necessary steps during SCHIP reauthorization to make up for this shortfall, approximately 24 states will face a shortfall of roughly \$1.6 billion in 2008,²⁶ an amount that would otherwise provide insurance for nearly 989,000 low-income children.²⁷ At the end of the five-year period, in FY 2012, the number of states experiencing SCHIP shortfalls is expected to increase to 36, with the size of the shortfall increasing from \$3.5 billion to \$4.3 billion,²⁶ equivalent to the amount of funding needed to insure up to 2.1 million low-income children.²⁷

To take a real step to ensure that there will not be any shortfalls in the next five years and ensure that all children currently insured by SCHIP can retain their coverage and current benefits package, Congress must allocate over \$14.6 billion over the next five years, as there is no guarantee that funds will be perfectly targeted to the states to fully cover their respective shortfalls under any federal funding formula as long as SCHIP remains a capped block grant versus an entitlement program. In the end, without this allocation, there is likely to be a significant increase in the number of uninsured children, reversing and undermining the successes of Medicaid and SCHIP over the past decade.

ALLOCATE FUNDING TO COVER ALL CHILDREN ELIGIBLE FOR BUT NOT ENROLLED IN SCHIP AND MEDICAID

Nearly 75 percent of all uninsured children are eligible for Medicaid or SCHIP.¹² To take a major step toward covering all children in the United States, Congress should provide funding sufficient to cover all children currently eligible for but not enrolled in SCHIP or Medicaid. If states are given enough dollars to cover all eligible but unenrolled children, then states will not be discouraged from reaching out to find and enroll them. To give states an increased incentive, states that successfully cover more uninsured children in SCHIP and Medicaid could receive an increased federal match in coverage costs based on their performance.

Strengthen Federal Standard for SCHIP Benefits Packages to Include EPSDT

SCHIP reauthorization needs not only to include a focus on increasing the number of children enrolled in the program; it needs to also address the quality of coverage enrolled children have. For SCHIP programs that are separate from Medicaid, or those that are combination programs, the benefits package can be less comprehensive than Medicaid benefits for children, which include EPSDT. Under these programs, states have the flexibility to change benefits packages to control costs.²⁸

For state SCHIP programs that are not solely Medicaid expansions, the benefits packages they offer need to meet a limited federal standard. Well-child care,

immunizations and emergency health services must be covered in state SCHIP programs. However, outside of these mandates, the coverage of other services is for the most part up to the states, as long as the plan itself offers the same benefits as or is actuarially equivalent to a benchmark plan. SCHIP benchmark plans have been defined as the standard Blue Cross/Blue Shield preferred provider option under the Federal Employee Health Benefits Plan, any plan that is offered to state employees that is administered by the state, the plan offered by the health maintenance organization that has the largest commercial, non-Medicaid enrollment in the state or a plan has been approved by the Secretary of HHS. This is especially a concern as some states are offering catastrophic coverage plans to state employees, and therefore, this coverage plan would meet the limited federal standard and could be offered to children enrolled in SCHIP.²⁹

Although SCHIP has made major strides in improving the health status and outcomes of those enrolled, the variations in benefits packages provided in states have resulted in some SCHIP enrollees still having unmet health care needs. For example, of the children in the SCHIP programs of the 10 states studied by the final congressionally mandated evaluation of the program, fewer than 20 percent of them had an unmet need for any type of care, and 3 percent had more than one unmet need. Twelve percent reported an unmet need for dental services, which are optional in SCHIP. About one in 10 SCHIP enrollees in these states had at least one reported unmet need for prescription drugs, specialty care, physician services or hospital care.¹

Ultimately, the limited federal SCHIP benefits standard leads to program beneficiaries, including those with special needs, sometimes having coverage that is not focused on their developmental and health needs. For example, states are not required to cover speech or physical therapy and therefore the coverage of these services — vital to the health of children with developmental problems — is limited. States are also not required to cover mental health, dental, vision or hearing services.²⁹ States are not required to cover services that are medically necessary, which is a requirement under EPSDT. In fact, a recent study of 15 separate SCHIP programs shows that only six of these states have adopted a medical necessity standard that is comparable to that in Medicaid for children.²⁹

State SCHIP programs should be encouraged and given incentives to offer children in the program the same comprehensive benefits package offered to Medicaid-enrolled children that includes EPSDT. EPSDT allows the provision of health and developmental services necessary for optimal child development, not a “watered down” version of adult services. Under EPSDT, children have access to comprehensive health care, including preventive health care services and follow-up services after treatment for a health problem. EPSDT provides Medicaid-enrolled children under age 21 access to comprehensive preventive care, including but not limited to immunizations, physical exams, dental and vision care, and mental health and hearing screenings.³⁰





WHY EPSDT?

COVERAGE OF PREVENTIVE DENTAL SERVICES AND TREATMENT OF DENTAL PROBLEMS IS REQUIRED UNDER EPSDT

Tooth decay is the most common chronic disease in childhood.³¹ If SCHIP children were to have the guarantee of EPSDT, the “T” of EPSDT would ensure that eligible children have access to services to restore their teeth and medically necessary interventions to relieve children of pain and infections. Due to the infectious nature and early onset of dental caries, and the success of early interventions, there is a need for children enrolled in SCHIP to have access to such services. Untreated dental caries can result in abscesses, cellulites and systemic spread of disease. Also, lack of treatment increases the probability of premature loss of primary molars. Untreated dental caries can also contribute to a decrease in affected children’s quality of life. Children with dental problems lose an estimated 52 million school hours annually, with poor children, including Medicaid and SCHIP beneficiaries, experiencing nearly 12 times as many restricted activity days from dental disease as children from higher-income families. In the long haul, lack of treatment has the potential to affect speech, nutrition, economic productivity and quality of life.³²

EPSDT PROVIDES COMPREHENSIVE COVERAGE OF MENTAL HEALTH SERVICES

The mental health screening provided under EPSDT is essential to effectively detect and treat childhood mental illness. States under EPSDT are required to screen children for mental health and substance abuse disorders under the program.³³ This is important because one in 10 children suffers from a serious mental health problem that causes impairment, and low-income children have more mental health problems than other children.^{34,35} Children enrolled in Medicaid and SCHIP experience the highest prevalence of mental health problems among all children ages 6–17.³⁶ SCHIP coverage of mental health screening and treatment under EPSDT would contribute to reducing the disparities in the use of mental health services among children.

One of every five children and adolescents has a mental disorder, with one in 10 having a serious emotional disturbance that affects daily functioning. Early intervention and treatment in this arena can minimize negative consequences for children and their families, as well as costs to society.³⁷ Early intervention and treatment for mental disorders and illnesses has proven to be cost-effective and reduce the need for more costly interventions and outcomes such as welfare dependency and juvenile detention.³⁸ Also, early intervention and treatment in this area have the potential to improve school readiness, health status and academic achievement, and reduce the need for grade retention and special education services and welfare dependency.^{39,40} If mental disorders are left untreated, the consequences are severe, ranging from an increased likelihood of alcohol and drug use to suicide.⁴⁰ Social and economic consequences of no treatment also include higher school dropout rates and increased probability of landing in the juvenile justice system or jail.⁴⁰

EPSDT GUARANTEES TREATMENT OF HEARING DEFECTS

Under EPSDT, children enrolled in SCHIP would gain access to treatment methods for defects in hearing, including hearing aids. Also, corrective services provided by a speech pathologist are covered. Otitis media with effusion, the most common cause of acquired hearing loss in children, has been associated with delayed language development and behavioral problems. Studies have shown that earlier treatment for otitis media is positively correlated with a reduction in behavioral problems.⁴¹

In general, if congenital or acquired hearing loss remains untreated, lifelong deficits in speech and language acquisition, poor academic performance, personal-social maladjustment and emotional difficulties can result.⁴² Providing this coverage under SCHIP would positively impact the health status and outcomes of enrollees. Early language therapy and intervention leads to better speech and language development.^{43,44,45} Earlier surgical intervention of hearing problems offers a more expeditious improvement of performance without increasing the risks for complications.⁴⁶ In fact, in the case of cochlear implants, pediatric surgery has been demonstrated to be cost-effective. Studies have shown that there is a net cost savings ranging from \$30,000 to \$100,000 per child, even when the full cost of the cochlear implant is included. Savings resulting from education costs alone range from \$30,000 to \$40,000. Such surgery also improves overall quality of life — the quality-adjusted life year (QALY) gain associated with the surgery has been calculated to be 16.33; the cost per undiscounted QALY gain has been estimated to be \$2,153.12 and the cost per discounted QALY gain has been estimated to be \$16,525.60.⁴⁷

EPSDT COVERS TREATMENT OF LOSS OF VISION AND OTHER VISION PROBLEMS

If SCHIP children were guaranteed coverage of EPSDT-related services, they would receive treatment for defects in vision, including eyeglasses. Visual impair-

ment affects approximately 20 percent of children in the United States.⁴⁸ Amblyopia, more commonly known as lazy eye, is the most common cause of visual impairment in childhood. Studies have shown that treatment for the condition is most effective in younger children.⁴⁹ In fact, the United States Preventive Services Task Force found that early treatment of amblyopia and amblyogenic risk factors can improve visual acuity.⁵⁰

Provide Funding for States to Implement Improved Outreach and Streamlined Enrollment Activities

If states have the resources necessary to cover all children eligible for but not enrolled in SCHIP, reaching these children and making sure they enroll in the program is very much dependent on the scope of outreach initiatives undertaken by states and the ease of the enrollment process. Ultimately, resources for outreach are key to a successful state SCHIP program. Current law stipulates that states are allowed to use up to 10 percent of the amount that they spend on their SCHIP programs for administrative costs, outreach and other initiatives related to child health.⁵¹ Despite state successes in conducting SCHIP outreach campaigns and making enrollment in the program as easy as possible, misconceptions still exist regarding SCHIP. Approximately 45 percent of parents of eligible but uninsured children who have heard of Medicaid or SCHIP believe that they need to be receiving welfare assistance in order to enroll in these programs.⁵² There are also parents of uninsured children who are not aware of Medicaid or SCHIP, even if their child is eligible. If Congress provides adequate funding for states to cover all children eligible but not enrolled in SCHIP and Medicaid, then states should be equipped with the funding necessary to make parents aware of Medicaid and SCHIP and how they could enroll their children in the programs. States must ensure that their outreach strategies are culturally competent to effectively reach disadvantaged populations, including racial and ethnic minorities and families in rural areas and inner cities.

However, outreach campaigns will only be effective if the processes to enroll and stay in these programs are as simple as possible. In general, nearly 90 percent of parents of uninsured children who had heard of Medicaid or SCHIP would enroll their child in these programs if they knew their child was eligible.⁵² States must build on approaches that have proven to be successful during the past decade, including providing 12 months of continuous eligibility in the program, using a single application form for Medicaid and SCHIP, allowing parents to declare their own income and using mail-in applications versus requiring face-to-face interviews.

Offering parents of eligible but uninsured children multiple options to enroll their children is essential. For example, parents of children should be given the option to enroll their children in Medicaid or SCHIP at school, at a community health care facility and at the same venues at which they could apply for other means-tested programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children

SPOTLIGHT: California's Express Lane Eligibility Program

During its process of implementing new and innovative measures to increase enrollment in Medi-Cal (California's Medicaid Program) and Healthy Families (the state's SCHIP program), California targeted the 800,000 uninsured children in the state who were already participating in public programs, ranging from the school lunch program to those in families eligible to receive food stamps. By streamlining the enrollment processes for Medicaid and SCHIP, using information that parents of eligible children already provided for enrollment in related public programs, the Express Lane Eligibility Program had two positive outcomes. Parents of eligible children found it much easier to apply for Medicaid and SCHIP, and it reduced the workload of state agencies by eliminating duplication of efforts. The program, implemented in the 2003-2004 school year, now allows children in families who qualify for the free school lunch program and the food stamp program to be rapidly enrolled in the state's Medicaid or SCHIP program.⁵⁶ However, federal law has created obstacles to the most effective possible use of these strategies. Because non-health programs use slightly different technical rules for measuring income (such as the definition of household), Medicaid must evaluate each individual's income, even though another public agency has already determined the individual's income level. In addition, limited information technology resources in California and resulting incompatible computer systems made it more costly and cumbersome to transfer information between means-tested programs.

(WIC) program. States should also make it as easy as possible for children to stay in the program without any interruptions in coverage because as many as 3 million children leave Medicaid and SCHIP each year and become uninsured, despite continuing eligibility.⁵³ In fact, according to recent survey results, confusion about the renewal process is a primary contributor to children disenrolling from the program — 38 percent of parents did not know that they had to renew at all.⁵⁴

STATES SHOULD BE GIVEN THE FLEXIBILITY TO DEEM CHILDREN ELIGIBLE FOR AND ENROLL THEM IN SCHIP OR MEDICAID BASED ON INFORMATION FROM SUCH PROGRAMS AS WIC AND THE NATIONAL SCHOOL LUNCH PROGRAM

Currently, federal law prohibits states from determining Medicaid and SCHIP eligibility based on the findings of other means-tested programs that conclude that families have low enough incomes to qualify. This federal prohibition has led parents of SCHIP- and Medicaid-eligible children to have to complete a second application to qualify for health coverage, although the applications for other means-tested programs are quite similar. This repetitive process has high administrative costs for states, and, ultimately, can serve as an obstacle to eligible children being enrolled in these programs.

States should be given the opportunity to take advan-



tage of the reality that there is a considerable overlap in the populations that qualify for Medicaid or SCHIP and those who qualify for other means-tested programs such as free or reduced-priced school lunches, food stamps and the WIC program. More than 70 percent of low-income, uninsured children — 4.4 million — live in families that receive benefits through these programs. It has been estimated that nearly 6 million uninsured children could be reached through these programs.⁵⁵ To do so, states should be given the flexibility to consider low-income children eligible for and automatically enroll them in Medicaid or SCHIP when they qualify for one of these means-tested programs. Federal funding also needs to be provided to ensure that states have the appropriate information technology infrastructure needed to make this happen.

ALLOW STATES THE FLEXIBILITY TO DETERMINE THE CITIZENSHIP STATUS OF APPLICANTS

The Deficit Reduction Act of 2005 requires families of children applying or reapplying for Medicaid and SCHIP-funded Medicaid expansion programs to produce documentation, such as a passport or birth certificate, proving they are U.S. citizens. This new requirement makes the process of enrolling in these programs more complicated and undermines state efforts to streamline enrollment in the programs. States should therefore be able to ascertain how best to determine citizenship of eligible children applying or reapplying for coverage so children who are citizens do not fall through the cracks.

Limit Cost Sharing

Current law stipulates that a family's total cost sharing in SCHIP is to be no more than 5 percent of the family's income.⁵⁷ For children in families with incomes below 150 percent of the federal poverty level, their SCHIP monthly premiums cannot be more than \$16, and their co-payments cannot be more than \$5 per service. If families of SCHIP-enrolled children do not pay their required co-payments, providers are allowed to deny services. Families of enrolled children are ultimately responsible for keeping track of their expenses associated with cost sharing to determine when they hit the 5 percent cap.¹⁰

Although currently a state option, increasing cost sharing — even if it is still below the 5 percent cap — causes some beneficiaries to lose coverage. Therefore, cost sharing in SCHIP should not be depended on as a source of revenue or an offset for program spending. A study of Washington's Basic Health Plan, Minnesota's Minnesota Care and Hawaii's Quest programs showed that participation in the programs dropped from 57 percent to 18 percent as premiums rose from 1 percent to 5 percent of family income. Results of this study suggest that adding a premium to SCHIP that costs only 1 percent of family income for a family of four living at the federal poverty level would decrease enrollment by 16 percent.⁵⁸ The same was found to be true in Texas, a state that recently experienced a 29 percent reduction in

program enrollment less than a year after increasing premiums, adding a 90-day waiting period for benefits and reducing the enrollment period from 12 months to six months.⁵⁹ A study of SCHIP beneficiaries in Yuma County, Ariz., concluded that a \$10 increase in monthly premiums would cause 10 percent of SCHIP children to disenroll, resulting in a 6 percent increase in public expenditures.¹⁷

Provide States with New Coverage Options

SCHIP reauthorization should be used to expand coverage to new populations, not to cut populations from the program and cause them to become uninsured. The first step should be for states to enroll every child currently eligible for SCHIP or Medicaid in these programs. Current law governing the coverage of parents in state SCHIP programs should not be changed, as studies time and time again have shown that providing health insurance to low-income parents is associated with increased enrollment among children.⁶⁰ The states that were approved by HHS to cover childless adults in their SCHIP programs should be allowed to continue to do so until Medicaid eligibility rules change to allow states to cover all adults with incomes below the federal poverty level in the Medicaid program. In the spirit of using SCHIP reauthorization to reduce the number of uninsured people in the United States, states should be given the ability to directly provide coverage to two populations in their SCHIP programs — pregnant women, and legal immigrant pregnant women and children — and receive federal matching funds.

ALLOW STATES TO COVER PREGNANT WOMEN

Under current law, states do not have a clear path to cover pregnant women in their SCHIP programs. States are permitted to extend SCHIP coverage to pregnant women, with the unborn child as the true beneficiary. Therefore, pregnant women oftentimes are left with incomplete coverage, as in many states SCHIP coverage only extends for care directly related to the health of the unborn child, such as prenatal care, and therefore any care following delivery may not be covered. Also, pregnant women may not be covered for all of the medical care needed before and during delivery. For example, they may not have coverage for anesthesia needed during delivery.⁶¹

Ultimately, states should be given the flexibility and funding necessary to provide SCHIP coverage to pregnant women that does not rely on the coverage of the unborn child. This coverage should be comprehensive and cover medically necessary services administered before, during and after delivery.

ALLOW STATES TO COVER LEGAL IMMIGRANT CHILDREN AND PREGNANT WOMEN

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which barred legal residents from enrolling in Medicaid during their first five years in the United States. This ban

extended to SCHIP upon its creation in 1997.⁶² States therefore only have the option to cover this population using state-only funds. In 2004, 22 states and the District of Columbia provided coverage to immigrants who were not eligible for Medicaid and SCHIP.⁶³

Legal immigrants pay taxes and should be able to enroll in public programs, regardless of how long they have been in the country. Without this coverage, approximately 400,000 children and 60,000 pregnant women who are perfectly eligible for Medicaid or SCHIP but cannot enroll⁶⁴ are left behind. This affects school readiness, birth outcomes and complications, economic productivity, and ultimately, the health of the people with whom they interact every day.

States should be given the option to enroll legal immigrant children and pregnant women in their Medicaid and SCHIP programs. Taking this action will greatly close the gap in health insurance coverage and health status and outcomes that exists between the citizen and non-citizen populations. Immigrants are currently less likely than citizens to have a usual source of medical care, to access preventive health services and to have had a physician visit in a given year.⁶⁵

Improve the Availability and Use of Children's Health Quality Measures and Data

Once children are enrolled in SCHIP and Medicaid, states and the federal government are in need of mechanisms through which they can measure the quality of health care that children are receiving through the programs, and how their coverage affects their health status and outcomes, school readiness and eventual work productivity. Despite progress made in developing quality measures for children's health and development, they still are dwarfed by those for adults.⁶⁶ Ultimately, a comprehensive set of quality measures for children will yield more support for the programs that serve them and aim to improve their access to care, health status and outcomes.

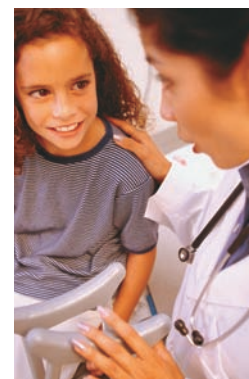
Therefore, Congress should also strive to improve the quality of children's health care during SCHIP reauthorization. First, HHS should be given funding for and required to implement a child health quality initiative, through a collaborative process involving states, to develop quality measures for child health and development, fund demonstration projects and provide its findings to Congress and the public. On the state side, states should be required to report to HHS and Congress on the performance of their Medicaid and SCHIP programs, based on data from core child health quality measures, jointly developed by the federal government and states. Improved partnerships on the state level between state Medicaid and SCHIP programs and entities that receive Title V Maternal and Child Health Block Grant funds can make this data collection and reporting more comprehensive, efficient and effective. To fund this effort, Congress should provide states with enhanced administrative matching funds.

Conclusion

The reauthorization of the State Children's Health Insurance Program presents Congress with the opportunity to not only continue a very successful program, but to make great strides in covering the nation's uninsured children. The reality that approximately 75 percent of uninsured children are eligible for but not enrolled in Medicaid or SCHIP demonstrates the need for an increased federal investment.

Outside of proving to be a cost-effective health insurance provider, SCHIP, along with Medicaid, has provided low-income children with access to essential preventive and primary health services, which reduces their unmet health care needs and improves their health status and outcomes. Insuring children through SCHIP and Medicaid does not only affect the health and well-being of those children enrolled; it impacts the health of the population on the whole, by lessening disease transmission rates and improving community, school and occupational health.

The purpose of the State Children's Health Insurance Program is to provide health coverage to low-income children not eligible for Medicaid or private insurance. SCHIP reauthorization should strive to promote and protect the health of current SCHIP beneficiaries, while providing the funding necessary to cover children eligible for but not enrolled in Medicaid and SCHIP, pregnant women and legal immigrant pregnant women and children. SCHIP beneficiaries, regardless of the state in which they reside, should be guaranteed a prevention-focused, comprehensive benefits package that leads to positive health outcomes and the receipt of high quality care. Ultimately, a goal of SCHIP reauthorization should be to reduce the number of uninsured and underinsured children in the United States and maintain the program's role in narrowing the nation's health disparity gap.



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