

**State Children's Health Insurance Program:
Insuring a Better Future for Children**

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“There is no worse fear for a parent than to know that if your child got hurt, you wouldn’t be able to afford good help,” said Tony Morris, a divorced father of two. Tony was facing great financial difficulties when he was laid off from the local automotive plant after 24 years of work. His biggest concern became the lack of health insurance for his children until he signed up for Tennessee’s Child Health Insurance Program.

“CoverKids is a blessing...there is just no way to describe how much this program means to me. The burden that is lifted off of my shoulders is just huge.” CoverKids has enabled Tony to take his children to preventative annual checkups and given him a peace of mind so that he can “finally let [his] kids be kids again.” (Cover the Uninsured: The Success of SCHIP 13).

Lina Ortiz was 9 years old when she was diagnosed with asthma. Her father was self-employed and could not afford the monthly bill of \$1200 for Lina’s medications. Then a school nurse told the Ortiz family about CHP+, Denver’s SCHIP program. They immediately signed up, paid the enrollment fee of \$35 and now pay only \$12 per month for Lina’s medications. Without CHP+, the Ortiz family would have gone bankrupt. Now, Lina is a 16-year-old high school student with her asthma under control (2).

“If I didn’t have Mass Health, my daughter would be blind,” says Dedra Lewis, the mother of Alexsiana. When Alexsiana was diagnosed with an eye condition called uveitis, which requires constant medical care, Dedra cut back on her work hours to take care of her daughter and lost her medical coverage. She then signed up for Mass Health, the SCHIP program in Massachusetts, which allowed Dedra to pay for necessary appointments and treatments for her daughter to keep her eyesight (7).

SCHIP enrollment has improved the lives of each of these families. With the help of SCHIP, parents are able to access much needed medical care, prescription drugs, and annual check-ups to meet their child's health needs. Across the country, over 6 million children are enrolled in SCHIP, and many of these families have similar tales of how SCHIP allowed them to secure vital health services and improve child health outcomes. However another 9 million children remain uninsured, among which 6 million currently qualify for public health insurance.

I. Background

The State Children's Health Insurance Program (SCHIP) was created as part of the Balanced Budget Act of 1997 and enacted as Title XXI of the Social Security Act (NCSL 119). SCHIP was not created to replace Medicaid for children; rather, it was intended to supplement Medicaid by extending coverage to a greater number of children who fall above the poverty line. SCHIP is similar to Medicaid in that the federal government matches state spending for program beneficiaries. However, SCHIP differs from Medicaid in that it is a capped entitlement program through which Congress allocated over \$40 billion through the year 2007¹. Whereas there are no pre-set limits on federal matching funds for Medicaid, SCHIP funds are capped and allocated to each state, rendering it vulnerable to saturation (State Children's Health Insurance Program (SCHIP): Reauthorization History 1).

SCHIP allows individual states considerable latitude in their individual implementation of the program. States have three options for SCHIP: as a Medicaid expansion, as a state designed private plan offering equivalent coverage, or as a

¹ A capped entitlement program is an entitlement on which an overall annual funding limit is placed, and the funding is distributed by a formula. CHN Budget Glossary 2007. <http://www.chn.org/pdf/budgetglossary.PDF>.

combination of both Medicaid and private plans. Therefore, great variation exists among different states in the format of SCHIP and its specific eligibility requirements. Presently, the future of SCHIP remains uncertain as President Bush has vetoed recent Congressional legislation that would have expanded it. A temporary extension maintains current SCHIP funding until March 2009 (Ross et al. 1).

This paper commences with a comparison of health outcomes and quality of care between uninsured children and those who have either public health insurance or private health insurance. Not surprisingly, access to either private or public health insurance strongly correlates with a variety of positive child and maternal health outcomes. Next, I identify barriers that may prevent families from accessing or retaining SCHIP coverage. These problems of access include enrollment, eligibility, and quality. Subsequently, this paper examines the current policy debate on SCHIP reauthorization along the same three parameters. I conclude by offering some policy recommendations in light of the challenges facing SCHIP.

II. Benefits of SCHIP

Marci Ruff is a mother of two: 11-year-old Jensi and 6-year-old Graham. Marci's husband works as a full time mechanic, yet he cannot afford his employer's health insurance. When Jensi was 9, her vision began to fail, she experienced severe headaches, and her grades began to drop. Concerned, Marci applied for Iowa's SCHIP program, Hawk-I, which allowed her to take her children to see doctors and specialists... When Marci took Jensi to the ophthalmologist, he diagnosed her with amblyopia (lazy eye). Fortunately, through Hawk-I, Marci was able to get her eyes corrected. She is now headache free and is excelling in school. Marci's son, Graham, has also benefited from

Hawk-I. When the Ruff family was uninsured, they bounced from doctor to doctor, lacking continuity of care. Graham, being shy, always felt uneasy about speaking to different doctors at each visit. With Hawk-I, the family is able to maintain consistent doctor-patient relationships with a primary care physician. This relationship has helped both Jensi and Graham receive the best care possible (Cover the Uninsured: The Success of SCHIP 6).

As the Ruff family illustrates, children who have health insurance, whether it be public or private insurance, enjoy better over-all health and more frequent doctor visits. Like Jensi, insured children are more likely to access specialists and expensive drugs in times of need. They, like Graham, are also more likely to have a usual source of continuous care on which they can depend. Therefore, insured children experience better health and educational outcomes.

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Preventative Care

The American Academy of Pediatrics recommends eight well-child pediatric check-ups within the first two years of life and an annual physical examination for children over 2 years of age (The Urban Institute 1). However, the lack of health insurance prevents many low-income parents from taking their children to regular, well-child check-ups. Instead, poor parents frequently rely on visits to the Emergency Room for medical needs, resulting in a greater incidence of inadequate, delayed, and/or discontinuous medical diagnosis and treatment for their children.

Uninsured children are much less likely to receive the recommended number of well-child pediatric check-up. Using data from the 2002 National Health Interview Survey, The Urban Institute found that 48% of uninsured children did not receive their

yearly examination compared to 26% of publicly or privately insured children (1) ². Furthermore, the gap between insured and uninsured children widened for older children. Whereas between the ages of 0 to 1, 12% of insured vs. 18% of uninsured children did not receive a well-child checkup, this 6% gap between the insured and the uninsured increased to 25% for children between the ages of 14 to 17 (2). Thus older, uninsured children are least likely to receive preventative healthcare.

The gap between insured and uninsured children's access to well-child examinations is especially pronounced among low-income parents making less than 200% of the poverty line. The same study found that while 52% of low-income uninsured children did not have a well-child examination, only 27% of their low-income insured counterparts did not receive such an exam (The Urban Institute 2).

Just as CoverKids helped single father Tony Morris obtain regular appointments for his children, SCHIP enrollment is an effective method of increasing preventative health check-ups. A study of New York SCHIP enrollees from 2000 to 2001 found that the proportion of children who received a preventative care visit increased from 74% to 82% following a one year participation in the SCHIP program (Szilagyi et al. 396).

In addition to well-child checkups, immunizations are another critical aspect of preventative care, and SCHIP enrollment increases the likelihood of timely immunizations. A survey of SCHIP participants found that children with SCHIP or Medicaid are much more likely to have received a complete set of immunizations at the age of 19 and 24 months, compared to uninsured peers. Complete immunization at this age includes multiple doses against diphtheria-tetanus, pertussis, polio, measles-mumps-rubella, *Hemophilus influenzae* type b, and hepatitis B. Seventy-six percent of privately

² This Urban Institute study did not distinguish between privately and publicly insured children.

insured and 70% of publicly insured children received this complete regiment of immunizations, compared to 47% of uninsured children and 65% of discontinuously insured children (Smith et al.1).

Therapeutic Care

For children with chronic and serious medical conditions, SCHIP plays a vital role in increasing accessibility to necessary medical attention. SCHIP helps children like Lina Ortiz, whose family could not have afforded her expensive asthma medication, pay for costly and extensive treatments.

Uninsured children are three times more likely than insured children to report an unmet medical need (Necochea 1). Disturbingly, the Urban Institute found that for children with asthma, a chronic condition with potentially severe consequences if left untreated, 38% of uninsured children did not receive the annual check-up compared to less than 25% of their insured counterparts. SCHIP participation has been shown to reduce unmet needs for specialty and acute care by 15.5% and 10.1%, respectively (Szilagyi et al. 2).

Uninsured children also fall behind their insured peers in accessing prescription drugs. An Urban Institute Study found that 16% of uninsured children reported an unmet need for prescription drugs in 2002, compared to 3% of insured children (5). Children without insurance are four times more likely to experience delays in treatment due to cost (Necochea 1). The inability of uninsured families to pay for cost-prohibitive drugs can exacerbate the health of these children. Therefore, even if uninsured children are able to procure a doctor's visit and a prescription for medication, the cost of the medication itself might be too burdensome for financially struggling families.

Continuity of Care

The story of Graham and Jensi Ruff of Iowa reflect the difficulty low-income, uninsured families experience in order to secure a consistent, stable source of medical care. The Urban Institute found that 31% of low-income children without insurance lacked a usual source of care compared to only 4% of their low-income, insured counterparts. A study of the SCHIP program in the state of New York found that the proportion of children who had a usual source of care increased from 86% to 97% after enrollment in SCHIP (Szilagyi et al. 396). The same study found that in the year following SCHIP enrollment, the proportion of children who used their usual source of care for most or all health-related visits increased from 47% to 89%. These findings suggest SCHIP enrollment effectively improves the continuity of care for low-income children.

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Quality of Care

Uninsured children are nearly four times more likely than insured children to delay treatment due to cost (Necochea 1). Since the quality of health outcomes strongly correlates to the immediacy of care, delay negatively impacts the health of an already ill child. Enrollment in SCHIP has been linked with improvements in the quality of care that SCHIP children receive.

A survey of SCHIP participants found that after a year of enrollment in this program, several indicators of health care quality improved (Szilagyi et al. 401). The results of the survey demonstrated that SCHIP participation led to improvements across all 4 indicators listed by the Consumer Assessment of Health Plans Survey: providers listening to parents, explaining things in an understandable way, respecting what parents

have to say, and spending enough time with parents. The same study found that fewer SCHIP parents worried about their child's health after enrollment. Eighty percent of the parents reported that they were more satisfied with their child's doctor, and 74% were more satisfied with the quality of medical care for their children after SCHIP enrollment.

Racial and Ethnic Disparities

SCHIP participation has also led to reductions in racial disparities, thereby removing some of the pre-existing racial and ethnic differences in accessing quality health care for children from low-income families. A 2002 Urban Institute report found that the lack of health insurance correlates to a decreased likelihood of receiving well-child checkups and having continuity of care across all races examined: White, African-American, and Hispanic (3). However, among uninsured children, racial disparities in child healthcare still exist.

A study of NY State SCHIP enrollees from the period of 2000 to 2001 revealed the significant impact of participation across two parameters: unmet need and continuity of care. Prior to SCHIP enrollment, white uninsured children were more likely than Hispanic and black uninsured children to have continuous source of care. Black uninsured children were more likely to report an unmet medical need compared to white and Hispanic uninsured children (Shone et al. 698). Shone found that enrollment in SCHIP completely eliminated racial differences in incidences of unmet need. Children from all three racial groups reported a 19% unmet need rate following SCHIP participation, compared to black (38%), white and Hispanic (27-29%) rates of unmet need prior to enrollment. Similarly, Shone found that SCHIP also dramatically reduced racial disparities in terms of accessing a continuous source of care. Prior to SCHIP, the

percentage of uninsured children having a continuous source of care varied among white (61%), Hispanic (54%), and black children (34%). Following one year of enrollment, access to continuous care improved across all races, such that 87% white, 86% Hispanic, and 92% black children obtained continuity of care. This study illustrates the dramatic impact of SCHIP at reducing racial disparities as measured by unmet need and continuity of care.

Summary: The Benefits of Child Health Care Insurance

The Urban Institute Study demonstrated that uninsured children were worse off than their insured counterparts across these factors: ability to attend the recommended annual well-child check-ups, receiving annual check-ups in the case of asthma, having a usual source of care, and fulfilling prescription drug needs. The SCHIP enrollment studies from the state of New York indicate that the quality of care, parent satisfaction, and the continuity of care all improved with SCHIP enrollment. Furthermore, SCHIP enrollment also reduces pre-existing racial healthcare disparities.

III. The Effects of SCHIP on Health and Educational Outcomes

Health Outcomes

Despite sparse research on the direct effects of Medicaid/SCHIP in the reduction of child mortality and the length of illnesses, we can still draw some conclusions from studies on child immunizations and asthma.

Immunizations are vital for children; they prevent debilitating and deadly diseases. Without vaccinations, the projected annual child disease and mortality in the United States would be: 10,000 paralyzed from polio, 4 million measles infections, leading to 3,000 deaths, 15,000 meningitis infections from *Hemophilus influenzae* type b with the

potential of permanent brain damage, and many more mortalities from pertussis (whooping cough) and diphtheria (Madison Department of Public Health 3). Therefore, health coverage that improves the rate of pediatric immunizations would also reduce disease risk and mortality

The increased rate of immunizations for SCHIP-insured children demonstrates that SCHIP plays a crucial role in reducing the risk of serious illnesses and mortality for children of low-income families (Smith et al. 1). Therefore, SCHIP directly improves health outcomes by reducing the risk of disease.

The correlation between SCHIP and better health outcomes can also be seen in children with asthma. Parents who enrolled their children in the SCHIP program in New York reported that the quality of asthma care and asthma severity were “better or much better” than when they were uninsured (Szilagyi et al. 491). The same report found fewer incidents of asthma-attacks (from 9.5 to 3.8) and fewer hospitalizations (11% to 3%) following enrollment in SCHIP. Parents attributed these improvements to lower costs of medication and more accessible medical care with insurance. Another study that compared the health outcomes among asthmatic children covered by SCHIP, Medicaid, or private insurance found no differences in health outcomes among these three forms of health insurance (Kemp et al. 1020).

Educational Correlations

Alexisana and her uveitis eye condition illustrates how the lack of health insurance can directly impact the ability of uninsured children to succeed in school. The American Medical Student Association reports that the state of Florida found that uninsured children are 25% more likely to miss school, and in Pennsylvania, nearly one

in five uninsured children experienced untreated vision problems (AMSA 1). Since school absences and vision problems are likely to cause children to fall behind their peers, uninsured children are more likely to experience academic problems.

Although the lack of health insurance may not be the only factor that causes school absences—other factors such as family instability and neighborhood safety may also influence school attendance—it is very likely that the lack of continuous and quality medical care nonetheless plays a prominent role in many of these school absences. If a child is unable to receive proper and timely diagnosis followed by appropriate medical treatment, he or she is at risk for contracting serious and chronic illnesses that may keep him or her out of school for extended periods of time.

Summary of SCHIP Outcomes

The strong correlation between the lack of health insurance and a whole host of negative outcomes conveys the importance of SCHIP for children. When children do not receive timely vaccinations or treatment for chronic illnesses such as asthma, they are at risk of suffering a myriad of consequences of ill health, which can even impact their ability to learn in school. Hence, SCHIP and other health care policies should address the 9.4 million children who are currently uninsured.

IV. Problems of Access

During my summer internship at PACT Therapeutic Nursery in Baltimore, Maryland, I met a two-year-old, bright-eyed girl named Anna³. Anna lived in a homeless shelter, as did her two sisters and her mother, and she had never been to a pediatrician. Young children are especially vulnerable to colds and ear infections, but the crowded conditions at the shelters exacerbated Anna's risk of contracting head lice and tapeworm.

³ Name has been changed to protect anonymity.

When Anna gets sick, her mother brings her in to the nurse at the Nursery, who then administers simple medications. In all of Anna's life, she has only been to the doctor once, and it was an emergency room visit when the Nursery happened to be closed. Anna and her sisters qualified for public health insurance, but, they were among the two-thirds of those who qualify who are not enrolled in either Medicaid or SCHIP.

SCHIP, when combined with Medicaid, allows more than three-fourths of all uninsured children access to public health insurance (Haley & Kenney 1). However, actual participation in both SCHIP and Medicaid remain low for eligible families. Of the 9 million children currently uninsured, more than 6 million children, like Anna, are eligible for SCHIP or Medicaid but are not enrolled (Families USA 2007). This presents a serious public health concern since uninsured children are almost three times as likely to have an unmet health need, and they are almost four times as likely to delay treatment due to cost (Necochea 1). In addition to enrollment, the problems of accessing SCHIP also include eligibility, quality of care, and funding.

Enrollment

According to a survey of eligible low-income families, 88% have heard of Medicaid and/or SCHIP, but only 24% of those who have heard of either program actually inquired about applying. After inquiring, only 66% actually applied for the program (Haley & Kenney 3). Therefore, only about 20% of all of the eligible families in this survey had heard of SCHIP and/or Medicaid, inquired about it, and then applied for it. A staggering 80% did not take advantage of this program. Therefore, a pressing issue regarding SCHIP involves the problem of take-up: how to increase enrollment among families whose income levels are below 200% of the poverty line.

Several barriers may contribute to the problem of take-up and prevent families from enrolling in SCHIP. These include: lack of knowledge, administrative hassles, parental perception of need, and retention difficulties.

Knowledge gaps constitute a primary barrier for about one third of all low-income, uninsured parents in SCHIP (Haley & Kenney 1). Research found that 12% of low-income uninsured families had never heard of either Medicaid or SCHIP. Parents who are aware of the program often cited confusion with the eligibility requirements and uncertainty over the application procedure as reasons for not applying for SCHIP. Haley and Kenney conclude that the removal of knowledge-gaps would be an effective mechanism for increasing enrollment.

In addition to the lack of knowledge, a burdensome SCHIP application procedure can deter families from applying. Although states have great discretion over how they establish their eligibility rules and application procedures, many have instituted tough restrictions to prevent crowd-out and abuse of the system. Crowd-out is the phenomenon in which families who could pay for private insurance decide to enroll in “free” public insurance instead. Some states require a face-to-face interview during the application process, and other states require children to remain uninsured for a given amount of time (3 to 6 months) before they become qualified for SCHIP (Necochea 1). While these guidelines are meant to screen out families who can afford private health insurance, they have become a major hassle in the application process, and they may prevent truly needy families from accessing SCHIP. The Deficit Reduction Act of 2005 further complicated the application process by requiring documentation proving identity and citizenship (Discussion with Medicaid Directors, The Kaiser Commission on Medicaid and the

Uninsured 6). The stringent requirement of documentation, extensive application procedures, and face-to-face interviews all serve as barriers to SCHIP enrollment.

Furthermore, a small proportion of parents, despite knowledge of the SCHIP program and reasonable accessibility to applying, still refrain from enrolling their children. Nearly 7% of uninsured children from low-income households reported that their children do not need insurance (Blumberg et al. 346). Blumberg points out that the actual percentage of parents who do not perceive need is variable, and the 1999 National Survey of America's Families found the percentage to be considerably higher, at 22%. Although research demonstrates that parents who do not perceive a need for health insurance generally have healthier children, uninsured children are also less likely to receive annual well-child pediatric check-ups and preventative visits to the doctor and dentist. Instead, they are more likely to visit the emergency department, be hospitalized due to emergencies, and have delayed or inaccurate diagnoses of diseases. Finally, out of pocket medical expenses are likely to be higher for uninsured children (Necochea 1). Under the health care plans proposed by both of the potential Democratic presidential candidates, child health care would be mandated for all children. Thus, the parental perception of need would no longer remain a barrier to healthcare access.

Finally, problems of retention cause many families to receive discontinuous SCHIP care. According to the 1999 National Survey of America's Families, 18% of children who were previously enrolled in Medicaid or SCHIP are no longer enrolled in the following year (Haley & Kenney 6). Examining data from four states, Robert Wood Johnson Foundation found that only 26 % to 48% of children who apply for renewal of SCHIP were approved for continued eligibility (Necochea 3). There are several possible

contributing reasons for this drop-off. Family income may have risen above the SCHIP income eligibility level so that the family no longer ~~qualifies~~qualifies for SCHIP. Or, family income may have fallen enough to render the family eligible for Medicaid coverage in lieu of SCHIP. However, Neochea points out that concerns remain regarding the ten to forty percent of parents who do not respond to renewal notices or submit renewal applications.

Eligibility

The second main concern over SCHIP involves income eligibility cutoffs. Two main questions emerge: first, should the family income eligibility be increased to greater than 200% of the poverty line? Secondly, should the children of immigrants be allowed to enroll in SCHIP? The issue of eligibility would be moot if either Senator Obama or Senator Clinton is elected to the Presidency and enact their proposed policy of mandating child health insurance.

The main argument against expanding SCHIP eligibility is concern over crowd-out. The detractors of SCHIP eligibility expansion are worried that if states raise income eligibility levels to 300% or 400% of the poverty line, many lower-middle class families who could pay for private insurance will opt-out of paying for insurance in order to take advantage of SCHIP.

Experts agree that as income levels of families increase to above 200% of the poverty line, the likelihood of crowd-out increases. However, the actual amount of crowd-out that occurs is difficult to gauge since the definition of “crowd-out” is subjective and highly variable among different researchers and policy-makers. As the Robert Wood Johnson Foundation points out, low-income parents may have access to

employer-based private insurance but may not be able to afford the high cost of private insurance. Under these circumstances, parents often substitute SCHIP for private insurance, but their under-utilization of cost-prohibitive private insurance should not necessarily be defined as “crowd-out” (Davidson et al. 7).

Given the distinction between affordability and availability of private insurance, crowd-out should be separated into two categories: broad and narrow. *Narrowly defined* crowd-out accounts for two factors: the *availability* of private insurance and its *affordability*. If private insurance is *both available and affordable*, then a family has engaged in narrowly-defined crowd-out if it opts for SCHIP rather than private insurance. However, mere availability of private insurance, without affordability, would not constitute narrowly defined crowd-out in the example of a family choosing SCHIP because it cannot afford cost-prohibitive private insurance.

Broadly defined crowd-out does not account for the affordability of private insurance; it is solely gauged based on the *availability* of such insurance. Under *broadly defined* crowd-out, crowd-out occurs whenever private insurance is available and a family chooses to enroll in SCHIP rather than paying for private insurance. Regardless of whether the private insurance was cost-prohibitive, the broad definition counts each instance of private insurance under-utilization as an instance of crowd-out.

In a study of crowd-out under the Healthy Kids SCHIP Program in Florida, researchers surveyed 930 SCHIP families for their access to and participation in employer-based private insurance prior to enrolling in SCHIP. Only 5% of the families bought employer-based coverage prior to substituting it with SCHIP. Twenty-six percent had access to employer-based coverage but remained uninsured due to cost prohibitive

private insurance. For these families, coverage would have cost on average 13% of their incomes (Shenkman et al. 507). Thus the authors conclude that only 5% of SCHIP families fit under the *narrow* definition of crowd-out, meaning they dropped affordable private insurance for public insurance. Whereas 31% (26% plus 5%) of the families fall under the *broad* definition of crowd-out, which does not account for the affordability of private insurance.

Although the extent of the relationship between SCHIP eligibility and crowd-out has not been conclusively demonstrated, many states have implemented policies aimed at discouraging crowd-out. Seventeen states require a waiting period of 6 to 12 months before enrollment in SCHIP for families who have recently dropped private insurance. Additionally, 24 states gear application questions toward the availability of private insurance in an attempt to screen-out crowd-out applicants. Eight states require verification of insurance status that must demonstrate a lack of employee-provided insurance (Davidson et al. 10). The same study goes on to state that no evidence has been found on the effectiveness of waiting periods in the prevention of crowd-out, and waiting periods constitute a major barrier to participation in SCHIP.

The issue of insuring immigrant children further complicates the issue of SCHIP eligibility. Currently, immigrant children who have resided for less than five years in the United States are ineligible for SCHIP (Center for Children and Families 1). Expanding healthcare coverage to children of recent immigrants is so controversial that even Medicaid Directors cannot agree upon a common solution (Discussion with Medicaid Directors, The Kaiser Commission on Medicaid and the Uninsured 8). Currently, seven

states provide prenatal care through SCHIP for pregnant immigrant women (Kaiser Commission 2).

Quality of Care and Funding

The quality of care under public health insurance is directly related to physician participation and government funding. Twenty percent of U.S. pediatricians refuse to see Medicaid/SCHIP patients, and 40% limit the number of such patients (Currie 49). Low reimbursement, excessive paperwork, and unpredictable payments were the three most common reasons cited by pediatricians as reasons for limiting their participation in Medicaid and or SCHIP (Yudkowsky et al. 1). Because the public health insurance reimbursement rate is only about 50% of private insurance reimbursement, physicians are less likely to accept patients under public health coverage, as they tend to be higher risk cases with lower reimbursement rates (Currie 52). Janet Currie also found that increasing the reimbursement rate reduces infant mortality for Medicaid mothers, as a result of the greater likelihood of these patients to obtain care and the higher quality of care that they receive. Applying the same tenet to SCHIP, increasing physician reimbursement would improve the quality of care for more SCHIP-insured children.

SCHIP funding and quality are strongly correlated. As a federally funded program, SCHIP is not immune to changes in federal budget pressures. In Fiscal Years 2002 to 2004, an “SCHIP Dip” occurred when federal funds decreased by 25% (NCSL 123). The tightening of federal spending on SCHIP increased pressure on states to tighten eligibility requirements, increase premiums and cost sharing, or change enrollment procedures (Smith et al. 2). Therefore, the federal budget directly affects both SCHIP accessibility

and quality, and a dip in funding results in restrictions in accessibility and a reduction in the quality of care.

Current debate over the reauthorization of SCHIP could have significant impact on the quality of care received under SCHIP. If the proposed increase of \$50 billion dollars over the next 5 years passes, many states would see an increase in SCHIP funding, which could lead to improvements in quality and enrollment rates. However, if the national funding is frozen for the 2008 to 2012 period, then projected budget shortfalls would threaten the quality of SCHIP. States could face an overall federal funding shortfall of \$12.7 billion to \$14.6 billion, and 24 states could face a combined shortfall of roughly \$1.5 billion in 2008 alone. By 2012, the projected shortfall for 36 states increases to between \$3.5 billion and \$4.3 billion (Missouri Foundation for Health FACT SHEET 2007)

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V. SCHIP Reauthorization Debate

When SCHIP was created in 1997, it was intended as a ten-year program requiring reauthorization in 2007. The road to reauthorization has not been easy, as both defenders and detractors of SCHIP policy have come to a virtual standstill. With the upcoming presidential race, the topic of healthcare reform has resurfaced as a critical issue, and SCHIP policy has been pushed to the forefront of national attention.

At the heart of the debate lay a few fundamental questions: who SCHIP is really helping—the lower middle class or the truly impoverished? Should SCHIP eligibility be expanded to cover a greater percentage above the poverty line? Finally, how can we improve enrollment among those who currently qualify for SCHIP or Medicaid? The three main categories of contention are: eligibility, enrollment, and quality.

Eligibility and Enrollment

In the ten year period following the creation of SCHIP, twenty-four states expanded coverage to beyond 200% of the federal poverty line (Families USA 2007). However, with funding falling short of demand in several states over the past few years, much of the reauthorization debate has revolved around the issue of proposed SCHIP expansion.

In response to concerns of crowd-out as states raise income eligibility, the Center for Medicare and Medicaid Services (CMS) issued new SCHIP and Medicaid guidelines to State Health Officials in August 2007. First, this federal directive required states to show that they have enrolled 95% of eligible children who are under 200% of the poverty line. A second CMS condition requires states to prove that private insurance coverage for lower income children has not declined by more than 2% during the prior five years before they are allowed to consider increasing eligibility above 250% of poverty line (Kaiser Commission on Medicaid and the Uninsured 2). Although this policy was aimed at increasing participation among the most needy (<200% poverty) and reducing private insurance crowd-out, these stipulations have made it virtually impossible for states to consider increasing eligibility levels. Without a federal mandate for child health insurance, such as the type of policy promoted by Presidential candidates Obama and Clinton, reaching a 95% enrollment rate seems impossible under current conditions (Rosenbaum 872).

Current policies tend to view take-up and crowd-out as antagonist problems: the higher the eligibility levels are raised, the more likely crowd-out will occur and the less likely that the poorest children will experience take-up into SCHIP enrollment. The CMS

Federal Directive aimed to concomitantly address the issue of crowd-out and take-up. Critics of this approach, however, have cited that it is virtually impossible to reach the 95% take-up rate that CMS calls for in order to expand income eligibility requirements (Discussion with Medicaid Directors, The Kaiser Commission on Medicaid and the Uninsured 4).

Instead of linking crowd-out reduction with take-up increase, Janet Currie offers an alternative solution to improving take-up: removing the barriers to participation. She advocates continuous coverage, simplification of the application process, and hospital guided enrollment (43-49). Hospitals have a strong economic incentive to enroll families in public health coverage, since enrollment offsets the costs of care incurred by uninsured patients from emergency room visits. Rather than allowing hospitals to enroll patients only for the sake of reimbursement rates, Currie suggests that this system can be capitalized to encourage families to enroll in continuous SCHIP/Medicaid care.

Quality and Funding

Beginning in February of 2007, President Bush proposed a budget for FY 2008 that maintains the current level of SCHIP spending at \$5 billion per year with an additional amount of \$4.8 billion dollars over the next five years. The CBO estimated that this proposal would create a shortfall of \$4.6 billion over the next five years, which would significantly reduce the accessibility and quality of SCHIP services. To address the concerns over potential SCHIP budget shortfalls, Congress responded to the President's proposal with its own budget resolution to create a reserve fund of up to \$50 billion dollars over 5 years (Rosenbaum 871). Further, it passed two bills, HR 976 and HR 3963, that would increase federal SCHIP spending.

HR 976, the Children's Health Insurance Program Reauthorization Act (CHIPRA), passed Congress with bi-partisan support. This bill called for an additional \$35 billion in SCHIP spending beyond the \$25 billion baseline, with funds coming from increases in tobacco tax. President Bush vetoed this bill, believing that it would "federalize health care" (MSNBC October 3, 2007). When Congress failed to override this veto, it drafted a new bill, HR 3963, that essentially called for the same increase in federal budget but with more stringent conditions. HR 3963 prevented adults from joining, excluded children of illegal immigrants, and placed a <300% poverty cap on income eligibility (Kaiser Commission on Medicaid and the Uninsured 2). HR 3963 was again vetoed by President Bush for the same reasons as the first veto, and it failed to be overridden by Congress.

Both the House and the Senate continue to be very active in drafting and debating bills related to SCHIP. Currently, two bills, HR 3162 and S 1893 are being debated in Congress. Both bills would significantly expand SCHIP coverage through increasing federal funding (Kaiser Commission on Medicaid and the Uninsured 2).

The Value of Investing in Children's Healthcare

Children who are covered by public health insurance are more likely to visit their doctors than the Emergency Room, lowering the expenditures that tax payers pay for emergency services. In the state of Florida, when parents were encouraged to sign up for public health insurance, ER visits dropped by 70%, saving Florida taxpayers \$13 million dollars (American Medical Student Association 1). The higher rate of immunizations of insured children also saves society the costs of medical care that would have been spent to treat un-immunized children. Every dollar spent on immunizing children saves society

14 dollars of healthcare costs from treating these preventable diseases (Madison Department of Public Health 2).

The value of insuring children cannot be measured in dollars and savings alone. Access to adequate health care is a fundamental right of every child. Just as the United States government promises educational opportunities for all children, so should children's healthcare be a guaranteed right. Leaving low-income children uninsured predisposes an entire segment of our society to the detrimental effects of ill health, which can spillover to negatively affect their quality of life, ability to learn in school, capacity to participate in the workforce, and opportunity to rise above poverty. The absence of health insurance renders low-income children, through no fault of their own, vulnerable to a whole host of negative consequences, and it further perpetuates the cycle of poverty.

SCHIP is a valuable program both from the economic standpoint of saving societal costs and from the ethical perspective of fulfilling our duty to children. The reauthorization process provides an opportunity for SCHIP to improve its quality, coverage, and funding. I make the following policy recommendations:

- States should be given the option of raising their SCHIP income eligibility cut-offs if they can demonstrate an yearly improvement in take-up among those who fall 200% below the poverty line. Instead of aiming for the virtually impossible standard of enrolling 95% of children whose families fall below 200% of the poverty line, as stipulated by the CMS, states should strive for a steady increase in take-up. A demonstration of improving enrollment trends among families below 200% of the poverty-line should be sufficient proof that states are making strides

to enroll families who need SCHIP the most; therefore, states should be allowed to increase eligibility limits above the 250% poverty line as they see fit.

- Circumvent the problem of crowd-out by allowing families whose incomes fall above the state's eligibility level but who cannot afford private insurance to buy-into SCHIP on a sliding scale (American Academy of Pediatrics 2007).
- National funding should be adequate to cover demonstrated need for every state. SCHIP is an entitlement program and should not be "capped" since the very notion of a "capped entitlement" is oxymoronic.
- Provide basic primary care for all children, regardless of immigration status. This provision is financially viable since primary care is less expensive than critical or specialty care, and it would allow all children to access both well-child-checkups and non-critical doctor visits, which are imperative for maintaining the healthy development of children.
- Improve SCHIP enrollment and retention by removing barriers to participation such as administrative hassles and extensive waiting periods.
- As recommended by Janet Currie, hospitals should be utilized as locations of SCHIP and Medicaid enrollment (43-49). Further, specialized hospital Medicaid and SCHIP staff should encourage clients to maintain continuous enrollment in public health insurance, which would reduce the administrative labor of re-enrolling former participants.
- Outreach programs to parents and children can increase public awareness of SCHIP and Medicaid and reduce knowledge gaps. Furthermore, educating parents

- about the importance of regular health-check-ups can improve the parental perception of need and motivate uninsured parents to enroll in public health care.
- Make SCHIP participation worth a pediatrician's time. Measures need to be taken to address the administrative hassles, low reimbursement rates, and unpredictable nature of SCHIP payments. If public health insurance falls short of its private counterpart in these aspects, then it would be unfair to expect physicians to take up the additional burdens of treating publicly-insured children.

Epilogue: The Future of SCHIP

After extensive political debate over the fate of SCHIP, President Bush signed a stopgap measure, HR 6111, into law in December of 2007 . HR 6111 will provide \$300 million to lessen the projected SCHIP shortfall of over \$900 million. Additionally, President Bush has signed the Consolidated Appropriations Act for FY 2008 and the Extension Bill, S 2499. These measures will maintain current federal funding while preparing \$1.6 billion dollars for shortfalls in FY 2008. Therefore, SCHIP has been extended until March 31, 2009 for further reauthorization debate.

While the future of SCHIP remains uncertain, the importance of healthcare is at forefront of the current Presidential campaign. The election of Senator Obama or Senator Clinton could dramatically alter the landscape of national healthcare. We, as a nation, are now charged with the noble and challenging task of examining and revamping our healthcare system, which could vastly improve the health of our families and of our children.

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