

Historical Overview of Children's Health Care Coverage

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SUMMARY

America's public health insurance programs reflect a deeply rooted commitment to caring for low-income families and children. This article chronicles the evolution of Medicaid and the State Children's Health Insurance Program (SCHIP), two public programs designed to provide free or low-cost health coverage to low-income children who do not have access to private health insurance. Such a historical overview is key to understanding where the programs come from and the challenges that policymakers must grapple with in order to effectively provide health coverage to children.

Depression-era maternal and child health programs created the foundation for Medicaid. Expansions of the program during the 1980s and 1990s made Medicaid the largest single insurance provider for children in the United States. In 1997, SCHIP boosted these efforts by filling the gap between Medicaid and employment-based coverage. In addition to expanding coverage, SCHIP also motivated efforts to address obstacles to coverage such as applica-

tion and enrollment procedures. Together, SCHIP and Medicaid have made significant progress in providing health coverage to children in low-income families. They are the primary sources of coverage for children in low-income families.

In a discussion of major challenges to providing public health coverage to children, the authors highlight some important issues that threaten current progress, such as rising health care costs and falling state revenues, gaps in coverage, and remaining barriers to enrollment and retention.

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America's commitment to assuring health care for its poorest children has developed over several decades. Rooted in the maternal and child health programs of the Depression era, health coverage became an entitlement for low-income children with Medicaid's enactment in 1965 and subsequent expansions in Medicaid coverage for children in the 1980s and 1990s. The 1997 creation of the State Children's Health Insurance Program (SCHIP) boosted these efforts by further expanding federal financing and state options for coverage of low-income children.

The development of publicly funded health coverage for children reflects an effort to fill in a significant gap in the privately based health system: Although most Americans have access to health insurance through their jobs or through the jobs of family members, not all children have access to employer-based coverage. Nationally, more than two-thirds of all children have some type of private health insurance coverage, with most (63%) obtaining their coverage from an employer-sponsored group health plan offered to their parents in the workplace. For low-income children who do not have private coverage, public coverage plays a critical role. One in every five children (20%) and 41% of low-income children are covered by Medicaid or SCHIP.¹ Yet, 12% of children remain without any coverage at all.²

Whether publicly or privately sponsored, health insurance improves children's access to care, enables them to benefit from early preventive and primary care, and contributes to improved health status. On any measure of access to care, uninsured children persistently lag behind those with public or private coverage.³ As these disparities have become more apparent, there have been renewed efforts to assure coverage for all children.

This article provides an overview of the evolution of publicly sponsored coverage over the past four decades through Medicaid and, most recently, SCHIP; the current state of health coverage for children; and remaining challenges. It concludes with a discussion of lessons learned from experiences with Medicaid and SCHIP that can inform future efforts to improve health coverage for America's children.

The Evolution of Public Health Coverage for Children

While the most recent developments in coverage for children were prompted by the adoption of SCHIP in 1997, public health insurance for children has a long history (see Box 1). Much of this history is inextricably linked to the development of cash assistance programs to support low-income families with children. For the past two decades, however, broad, consistent political support for health coverage for children has extended publicly funded coverage for children well beyond traditional welfare populations. Today, most low-income children are eligible for coverage through Medicaid or SCHIP.

Depression-Era Maternal and Child Health Programs

Assisting families with dependent children was among the priorities leading to the enactment of the Social Security Act in 1935. In response to the Great Depression, the act not only established the nation's retirement benefit and unemployment insurance systems, but it also created the nation's public assistance system. As part of the public assistance provisions, states were permitted to provide additional funds to families receiving welfare to help cover the cost of medical care. Not until the Social Security Amendments of 1950, however, could states make direct payments to providers for medical care delivered to welfare recipients.⁴

Title V of the Social Security Act of 1935 also established "Grants to States for Maternal and Child Welfare." Based on the work of the 1912 Children's Bureau, these grants provided states with funds for direct services to children.⁵ Funds were provided based on a formula, with fixed allocations to each state. States generally used Title V funds to provide traditional public health programs—such as immunization and infant mortality prevention—and to provide services to children with special health care needs.⁶

Medicaid and Medicaid Expansions

The enactment of Medicaid as part of the Great Society program was a major advance in providing medical coverage to low-income Americans. Medicaid, or Title XIX of the Social Security Act, was enacted in 1965 as companion legislation to the Medicare program for the elderly. Building on the model of the earlier Kerr-Mills program for the medically indigent aged population, Medicaid was structured as a joint federal-state pro-

gram.⁷ The federal government provides matching funds—or payments to states for a share of the costs they incur for services provided to Medicaid beneficiaries—and sets broad guidelines for eligibility and scope of coverage. The states administer the programs and make specific decisions about eligibility and benefits. State participation in Medicaid is voluntary, but states that choose to participate and receive federal funds must meet federal guidelines. Federal law also allows flexibility by giving states the option to expand their programs' eligibility or to offer benefits beyond the minimums, and by granting states broad discretion to set provider payment rates and establish health care delivery systems. The federal government currently pays about 57% of program costs.⁸

Medicaid was designed to give federal financial support to states to help provide medical assistance to families, the aged, and disabled individuals who were receiving welfare. For families with children, eligibility for Medicaid was primarily based on receipt of cash assistance through the Aid to Families with Dependent Children (AFDC) welfare program. Enacted during the Depression as part of the original Social Security Act of 1935, AFDC provided states with federal matching funds for cash assistance to needy children and their parents.⁹ In general, a family was eligible for AFDC if it had a “dependent” child and an income below its state’s “need standard” (also called an income-eligibility standard), the level of

income and assets the state determined a family needed to live. Most families who qualified were single-parent households with little or no income.

Amendments to the Social Security Act adopted in 1967, just two years after the enactment of Medicaid, made significant changes to the program. One change gave states the option to cover low-income children who were not receiving cash assistance. This option laid the groundwork for the later expansion of Medicaid’s role to provide health coverage based on income, not welfare status.

The 1967 amendments also included provisions to broaden beneficiaries’ access to care. Most significant for children was the creation of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program within Medicaid.¹⁰ EPSDT extended Medicaid’s role from paying for health services to assuring that children receive comprehensive preventive care and follow-up for health problems. With the addition of EPSDT, Medicaid not only entitled children to the basic Medicaid services (for example, hospital, physician, laboratory, and nursing home services), but it also required states to provide health screenings at regular intervals.¹¹ Later amendments further strengthened Medicaid’s role for children. Under Medicaid’s original rules, services were available to children with very limited contributions from families toward the cost of care. Amendments adopted in 1982 eliminated cost sharing for children, assuring that health services for children would be

Box 1

Medicaid and SCHIP Coverage of Children: Legislative History, 1965–2001

This summary outlines the major changes in publicly funded coverage for children enacted by Congress since the initiation of the Medicaid program in 1965. This legislative history is not comprehensive; it includes only the most significant of the changes in Medicaid eligibility, benefits, and financing policy for nondisabled children, and the enactment of the State Children's Health Insurance Program. It does not include references to major changes that affected other groups of Medicaid beneficiaries or proposals that were debated by Congress, but not enacted, such as the Medicaid block grant proposals of 1981 and 1995.

Social Security Amendments of 1965

(Public Law 89-97)

- ▶ Enacted Medicaid as an individual entitlement with open-ended federal matching payments to states
- ▶ Required states that participated in Medicaid to cover children receiving Aid to Families with Dependent Children (AFDC) cash assistance
- ▶ Gave states the option to cover other children with incomes below AFDC income standards ("Ribicoff" children)

Social Security Amendments of 1967

(Public Law 90-248)

- ▶ Enacted Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, requiring regular periodic health screens for children
- ▶ Required states to allow Medicaid beneficiaries to use any providers who accepted Medicaid payment

Omnibus Reconciliation Act of 1981 (OBRA 81)

(Public Law 97-35)

- ▶ Limited AFDC eligibility, including restrictions in eligibility for families with earnings, which automatically limited eligibility for Medicaid
- ▶ Enacted the Section 1915(b) "freedom of choice" waiver to allow mandatory managed care in Medicaid

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

(Public Law 97-248)

- ▶ Allowed states to impose nominal cost sharing on certain Medicaid beneficiaries and services, but exempted children and pregnant women, among other groups

Deficit Reduction Act of 1984 (DEFRA)

(Public Law 98-369)

- ▶ Required coverage for children born after September 30, 1983, up to age five, in families meeting state AFDC income and resource standards (approximately 40% of the federal poverty level)
- ▶ Required coverage for first-time pregnant women and pregnant women in two-parent unemployed families meeting state AFDC income and resource standards
- ▶ Required nine months of "transitional medical assistance" for families who became ineligible for welfare due to earnings or child support
- ▶ Made infants born to mothers covered by Medicaid automatically eligible for one year of coverage

Consolidated Omnibus Budget Reconciliation Act of 1985

(COBRA) (Public Law 99-272)

- ▶ Required coverage for pregnant women in two-parent families meeting state AFDC income and resource standards (that is, dropped the AFDC unemployed-parent criteria)
- ▶ Required coverage of children up to age five in families meeting AFDC income and resource standards

Omnibus Reconciliation Act of 1986 (OBRA 86)

(Public Law 99-509)

- ▶ Allowed states to cover pregnant women and young children up to age five in families with incomes at or below 100% of the federal poverty level (resource standards could be dropped)
- ▶ Allowed states to use presumptive eligibility and continuous eligibility for pregnant women

Omnibus Reconciliation Act of 1987 (OBRA 87)

(Public Law 100-203)

- ▶ Allowed states to cover pregnant women and infants with family incomes at or below 185% of the federal poverty level
- ▶ Required coverage for children up to age eight with family incomes below AFDC standards and allowed states to cover these children up to 100% of the federal poverty level

Box 1

(Continued)

Medicare Catastrophic Coverage Act of 1988 (MCCA)

(Public Law 100-360)

- ▶ Required the phase-in of coverage for pregnant women and infants with family incomes below 100% of the federal poverty level (retained when MCCA was repealed)

Family Support Act of 1988

(Public Law 100-485)

- ▶ Extended transitional Medicaid coverage to 12 months to families leaving AFDC due to earnings
- ▶ Required coverage of two-parent families meeting the AFDC unemployed eligibility test with incomes below AFDC income and resource standards, even if the state did not cover such families under AFDC
- ▶ Allowed states to cover pregnant women and children (among other groups) beyond minimum standards

Omnibus Budget Reconciliation Act of 1989 (OBRA 89)

(Public Law 101-239)

- ▶ Required coverage of pregnant women and children under age six in families with incomes at or below 133% of the federal poverty level
- ▶ Expanded the EPSDT benefit for children under age 21 to include diagnostic and treatment services that could be covered under Medicaid, even if the state Medicaid program did not cover these services for adult beneficiaries
- ▶ Required coverage of services provided by federally qualified health centers

Omnibus Budget Reconciliation Act of 1990 (OBRA 90)

(Public Law 101-508)

- ▶ Required phase-in (by 2002) of coverage of children ages 6 through 18 in families with incomes at or below 100% of the federal poverty level

Omnibus Budget Reconciliation Act of 1993 (OBRA 93)

(Public Law 103-66)

- ▶ Established the Vaccines for Children program, providing federally purchased vaccines to states

Personal Responsibility and Work Opportunity

Reconciliation Act of 1996 (PRWORA)

(Public Law 104-193)

- ▶ Repealed the AFDC program and replaced it with a block grant to states (Temporary Assistance for Needy Families) and severed the linkage between eligibility for cash assistance and for Medicaid
- ▶ In lieu of the AFDC link, established the Section 1931 “family coverage” category, requiring coverage of families with children meeting July 16, 1996, AFDC income and resource standards and family composition rules and allowing higher eligibility thresholds at state option
- ▶ Barred Medicaid coverage for five years for most legal immigrants who entered the United States on or after August 22, 1996; allowed coverage after the five-year ban at state option

Balanced Budget Act of 1997 (BBA 97)

(Public Law 105-33)

- ▶ Established the State Children’s Health Insurance Program, providing capped federal matching payments to states for coverage of uninsured, low-income children with incomes above March 1997 Medicaid standards (enhanced matching rate relative to regular Medicaid rate)
- ▶ Allowed states to require most Medicaid beneficiaries to enroll in managed care organizations (MCOs) without states obtaining Section 1915(b) “freedom of choice” waivers
- ▶ Allowed presumptive and continuous eligibility for children in Medicaid

Sources: Congressional Research Service for the Subcommittee on Health and the Environment. *U.S. House of Representatives Medicaid source book: Background data and analysis (1993 update)*. Washington, DC: CRSSHE; Committee on Ways and Means, U.S. House of Representatives. *1998 green book*. Washington, DC: U.S. Government Printing Office. May 19, 1998; Committee on Ways and Means, U.S. House of Representatives. *2000 green book: Background data and data on the programs within the jurisdiction of the Committee on Ways and Means*. Washington, DC: U.S. Government Printing Office. October 2000; The Library of Congress. Thomas: Legislative information on the Internet. Available online at <http://thomas.loc.gov/>.

available at no cost to families. In 1989, further amendments required states to provide treatment for problems detected during EPSDT screenings.

Enrollment grew rapidly in the early years as states chose to participate in the Medicaid program and began covering eligible groups.¹² From the mid-1970s to the mid-1980s, however, enrollment of children slowed, and enrollment among poor children actually declined, largely because of the decline in AFDC eligibility.¹³ Between 1972 and 1990, AFDC eligibility was restricted, and the real-dollar value of the AFDC income-eligibility standard fell by more than 40%.¹⁴ Because eligibility standards for parents' and children's Medicaid coverage were largely linked to receipt of AFDC (rather than to a family's income relative to the federal poverty level [FPL]), decreases in AFDC eligibility automatically translated into reduced Medicaid eligibility for children and their families.

The reductions in Medicaid coverage resulting from Medicaid's ties to AFDC, along with reports of rising infant mortality rates, prompted congressional efforts in the early 1980s to improve pregnant women's and children's access to Medicaid and to sever the direct link between receipt of welfare and Medicaid eligibility for these two groups. Through omnibus budget bills, major federal legislative changes affecting Medicaid coverage of pregnant women and children were enacted each year beginning in 1984 and continuing through 1990.¹⁵ Most notably, these changes began to base children's eligibility on family income, not welfare status, and opened up the program to children in two-parent families. For pregnant women and children, the federal minimum eligibility requirements adopted during this period still apply.¹⁶

- ▶ Under 1989 legislation, states participating in Medicaid were required to cover pregnant women and children under age six with incomes below 133% of the FPL.
- ▶ Under 1990 legislation, states participating in Medicaid were required to cover older children (ages 6 to 18) with incomes up to the FPL. This coverage was phased in over time by extending coverage to older children each year.

These legislative changes also gave states the latitude to cover children at higher income levels and still receive

federal funding to help cover the cost of their care. At the same time, standards for physician payment were implemented in order to assure adequate provider availability for the covered population.

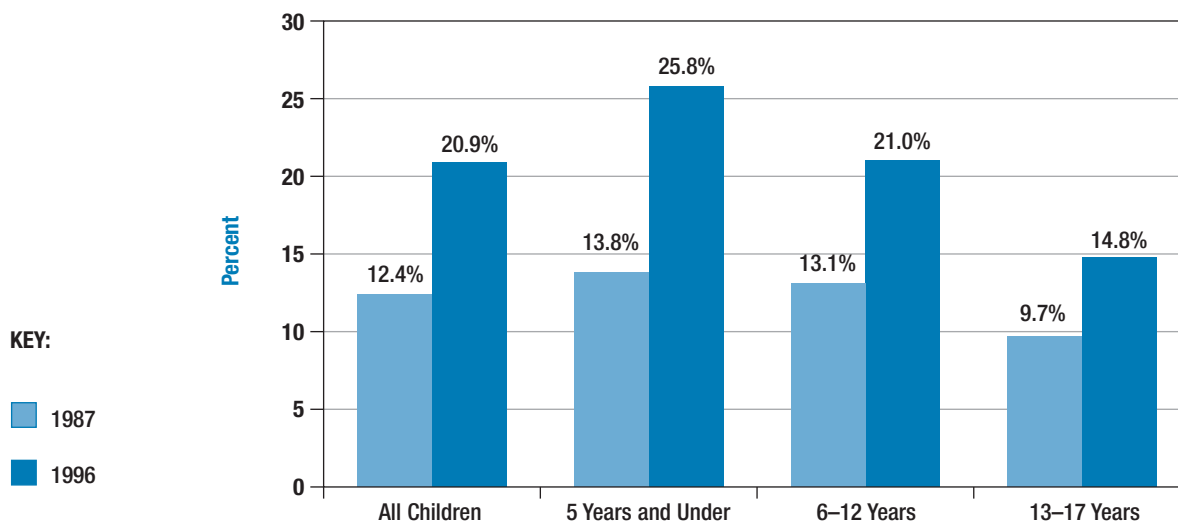
The establishment of federal minimum eligibility standards that were no longer tied to AFDC represented a major step forward for children. In 1992, only one state (Washington) covered children at all ages with incomes up to the FPL. Effective September 30, 2002, all children under age 19 with incomes below the FPL had to be covered under Medicaid in every state. Partly as a result of the new federal requirements and states taking up the option to cover children at higher income levels, the number of children enrolled in Medicaid grew steadily throughout the late 1980s and early 1990s. The most substantial increases occurred for younger children, who were the subject of the earliest federal mandates and options (see Figure 1).

As eligibility expansions increased the number of children covered by Medicaid, states grew concerned about rising program costs and the availability of Medicaid providers to serve new beneficiaries. With predictable costs through prepaid health care and the potential to tap into new provider networks, managed care became an appealing way to contain costs and enhance access to care for Medicaid beneficiaries. States soon began to transition from providing care on a fee-for-service basis to enrolling Medicaid beneficiaries—primarily children and their parents—in managed care plans. Increasing use of managed care in the private sector and easing of federal restrictions on the use of prepaid health plans in Medicaid¹⁷ facilitated this shift in service delivery. Throughout the 1980s, Medicaid managed care grew steadily, and during the 1990s, enrollment increased more than sixfold.¹⁸ In 1997, the use of managed care in Medicaid was made easier by the Balanced Budget Act, which allowed states to require most beneficiaries to enroll in managed care without states first obtaining special permission from the Secretary of Health and Human Services (as had previously been the case).

The passage of the 1996 federal welfare law (the Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA) completed the delinking of Medicaid eligibility and cash assistance for children that had begun in the late 1960s.¹⁹ PRWORA repealed AFDC, replacing it with the Temporary Assistance for Needy Families

Figure 1

Percentage of Children Enrolled in Medicaid, by Age



Source: Weigers, M.E., Weineck, R.M., and Cohen, J.W. *Children's Health 1996. MEPS Chartbook No. 1*. Rockville, MD: Agency for Health Care Policy and Research, 1998.

(TANF) block grant. In an attempt to assure that welfare changes would not result in the loss of Medicaid coverage, PRWORA severed the final eligibility link between Medicaid and cash assistance for families with children and replaced it with a new Medicaid eligibility category, referred to as Section 1931. Families with children now qualified for Medicaid on the basis of their income and resources, not on their status as welfare recipients.²⁰ Although implementation problems contributed to a decline in Medicaid coverage in the first years following welfare reform, PRWORA provided an important step forward in changing Medicaid from a welfare program into a health insurer for low-income families.

The delinking of Medicaid eligibility for children and their families from eligibility for welfare both increased the number of children covered and changed the composition of Medicaid beneficiaries. In 1975, 9.6 million children under age 21 were enrolled in Medicaid, and 88% of them were also receiving welfare assistance.²¹ By 1995, 17 million children were enrolled in Medicaid, and just over half of them were receiving welfare.²² In 1998,

only 37% of children with Medicaid coverage were also receiving welfare.

Through a combination of incremental eligibility expansions, provisions to facilitate access to care, and the separation of health coverage from welfare, Medicaid made great progress in extending health insurance to low-income children in the United States. In its first three decades, the program evolved from an adjunct to an existing welfare program into the largest single insurer of children in the nation. Studies show that Medicaid's expanding role positively impacted the health status of American children.²³ Despite these advances, particularly for poor children and young children at incomes somewhat above poverty, coverage of near-poor children remained limited in many states. States had the option to extend Medicaid to children with family incomes beyond federal minimums and still receive federal matching funds, but as of 1997, less than one-third of states had taken this option.²⁴ Recognizing the effectiveness of public coverage and limits on its availability, policymakers and children's advocates began to explore how to further expand coverage.



State Children's Health Insurance Program

In the aftermath of welfare reform and the failure to implement comprehensive health care reform in the mid-1990s, pressure grew to move incrementally to broaden coverage for at least children. Alternative strategies were debated: Some advocated expanding Medicaid to cover more low-income children, while others advocated a federal block grant that would give states virtually unlimited flexibility. The result was a compromise approach and the enactment in 1997 of SCHIP.

SCHIP provides \$40 billion in additional federal financial support over 10 years to encourage states to offer coverage to uninsured children with family incomes above 1997 Medicaid eligibility levels. To assure that SCHIP funds would be used to extend coverage to currently uninsured children, the law included a number of provisions designed to prevent SCHIP from supplanting either employer-based coverage or Medicaid coverage.

The design of SCHIP reflects the fact that the legislation was the product of a political compromise between those

advocating for a new health care block grant with little or no federal standards and those who supported a new Medicaid expansion for children. Unlike Medicaid, which provides open-ended federal financing, SCHIP is funded through a block grant—a capped amount of federal funds—that states can use to provide coverage to children. Like Medicaid, SCHIP requires states to contribute to the cost of care, but the federal government pays for a higher share of spending under SCHIP than under Medicaid (the “enhanced federal match” is 30% higher under SCHIP than under Medicaid).²⁵

Though SCHIP was funded through a block grant, a compromise in the design of the coverage expansion allows states three options for structuring their programs: They may use their federal SCHIP funds to create or expand a separate child health program, expand Medicaid, or use a combination of both types of programs. As of July 2002, 16 states had elected to develop separate SCHIP programs with no Medicaid expansion, 16 states (including the District of Columbia) relied on Medicaid to expand coverage, and 19 states used a combination approach.²⁶

States that choose to create separate child health programs generally have broad discretion in designing their programs. As part of the political compromise, however, states must cover a specified level of services and limit the costs that beneficiaries have to pay to receive those services (cost sharing). SCHIP requires that states' separate programs meet a "benchmark" benefit package, generally tied to a commercial plan available in the state or to the state employees' health benefit package. Cost sharing (including premiums, co-payments, and deductibles) must be nominal for children with incomes below 150% of poverty. For children in families with higher incomes, cost sharing must not exceed 5% of total family income. (See the article by Wysen, Pernice, and Riley in this journal issue.) In addition, in part because SCHIP does not provide open-ended federal financing, children have no federal entitlement to coverage under a separate SCHIP program. States can limit costs and coverage by capping or freezing enrollment at any time, even if a child meets the eligibility standards for coverage.

States that choose to use their SCHIP funds to expand their Medicaid programs must follow all Medicaid program rules, including those regarding benefits and cost sharing. Because Medicaid is an entitlement, and the state is required to enroll all children meeting the eligibility criteria, states may not cap or freeze enrollment under Medicaid expansions. Under both Medicaid and separate SCHIP program options, however, states can roll back or even eliminate their SCHIP-funded expansions at any time. If costs exceed the capped SCHIP allotment in a Medicaid expansion state, the state can use regular federal Medicaid matching funds to cover the additional costs.

SCHIP's passage in 1997 came at a fortuitous time. The economy was strong, and many states were experiencing revenue surpluses. The fiscal situation, the enhanced federal matching payments available under SCHIP, and the broad political support for children's coverage combined to make SCHIP-funded expansions almost irresistible at the state level. Every state took advantage of SCHIP and expanded coverage for children within the first two years of the program. The scope of coverage and program structure varies widely across the states, but nationwide, SCHIP has the potential to cover millions of low-income, uninsured children.

Health Coverage for Children after 1997

By 2000, Medicaid and SCHIP together covered 24 million children, with Medicaid covering 21 million poor and near-poor children, and nearly 3 million near-poor children assisted by SCHIP through either separate or Medicaid-operated programs. Medicaid and SCHIP had become the primary sources of health coverage for children from low-income families (those with incomes below 200% of the FPL, or \$27,476 for a family of three in 2000): In 2000, 41% of low-income children were covered by Medicaid or SCHIP.²⁷

The implementation of SCHIP was significant not only because it expanded eligibility to nearly all low-income children, but also because it ushered in a movement to get eligible children enrolled by addressing obstacles to coverage. Medicaid application and enrollment procedures were rooted in welfare application procedures. Long application forms with extensive questions and documentation requirements regarding work history, assets, and personal information; use of welfare offices and personnel for processing enrollment; and requirements of in-person interviews discouraged many applicants, particularly those who were not also applying for welfare, from initiating or completing the process.

Recognizing that the complexity and intrusiveness of the enrollment process often deters participation, many states sought to eliminate these barriers when designing their separate SCHIP programs. In the late 1990s, states developed short application forms, limited documentation requirements, streamlined the application process, and encouraged enrollment in SCHIP through outreach.²⁸ Over time, a growing number of states adopted these same simplification strategies in their Medicaid programs, dramatically improving the enrollment processes for children in Medicaid. The majority of states now use simplification strategies in both their Medicaid and SCHIP programs. Forty-four states have dropped the asset test for children's coverage, forty-seven states no longer require a face-to-face interview for children's coverage, and many states have eliminated most documentation requirements and renew coverage on an annual basis.^{29,30}

Studies have examined whether these expansions have helped improve access to health care, reduce financial stress, and improve health outcomes for children.

Research studies consistently show higher levels of preventive care and greater likelihood of a usual source of care among children with public coverage compared with their uninsured counterparts (see Figure 2).³¹ Among low-income children, research shows that public coverage through Medicaid is comparable to private insurance in securing access to care.³² Medicaid coverage, and now SCHIP, helps give children a regular source of care and access to early preventive and primary care.

In addition, a growing body of evidence suggests that having insurance has a positive effect on health outcomes.³³ For example, Medicaid expansions were shown to reduce the number of acute health conditions, bed days, and restricted activity days among children.³⁴ As data and evaluations become available, comparable effects for children now covered by SCHIP who were previously uninsured may be documented. For example, an evaluation of the separate SCHIP program in Iowa

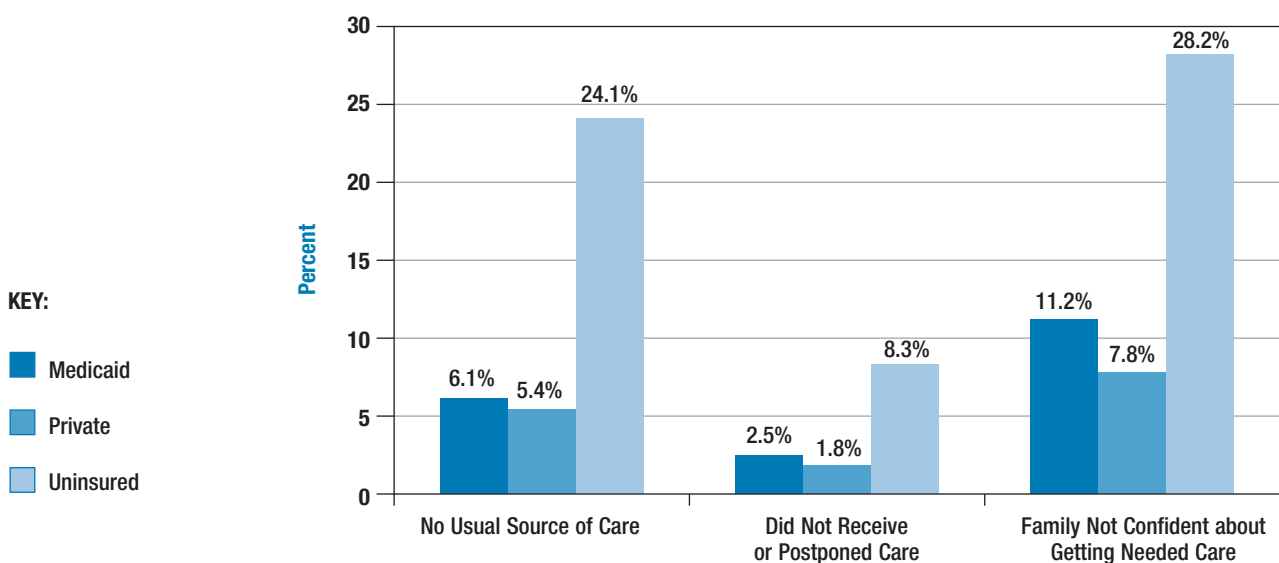
(called Hawk-I) found that SCHIP coverage for children helped improve health status, reduce family stress, and promote access to care.^{35,36} Ongoing research will provide additional evidence about the impact of these programs on children’s access to health care and overall health status.

Current Challenges: Continuing the Progress

While Medicaid and SCHIP have created a strong foundation for providing health coverage to the nation’s low-income children, an estimated 6.5 million low-income children remain uninsured.³⁷ (See the article by Holahan, Dubai, and Kenney in this journal issue.) This section discusses challenges facing public health insurance programs for children, including rising health care costs and falling state revenues, gaps in coverage, and remaining barriers to enrollment and retention of children.

Figure 2

Access to Care among Low-Income Children by Insurance Status, 1997

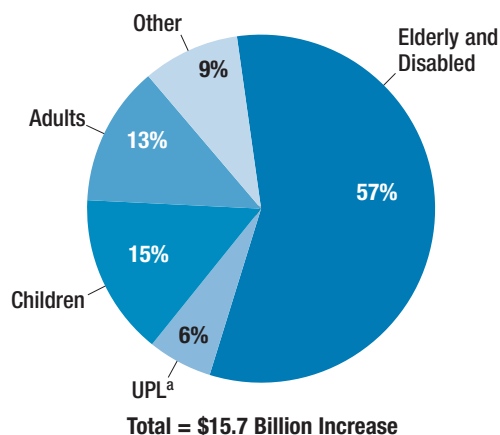


Source: Dubai, L., and Kenney, G.M. Health care access and use among low-income children: Who fares best? *Health Affairs*, January/February 2001, Vol. 20(1), pp. 112–21.

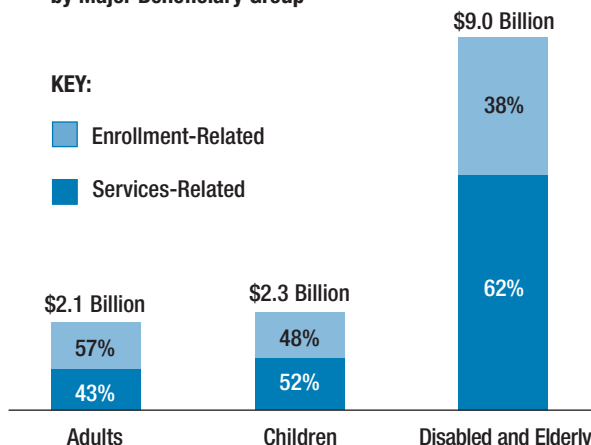
Figure 3

Sources of Growth in Federal Medicaid Expenditures, 2001–2002

Share of Expenditure Growth, by Beneficiary Group



Enrollment vs. Services-Related Expenditure Growth by Major Beneficiary Group



^aUPL = Upper Payment Level

Source: Kaiser Commission on Medicaid and the Uninsured. Analysis of Congressional Budget Office Medicaid baseline data. March 2002.

Rising Health Care Costs and Falling Revenues

Just when the groundwork for covering all low-income children has been laid, and a blueprint for how to successfully identify and enroll eligible children has begun to emerge, fiscal pressures threaten to stall or even reverse this progress. The tasks of closing the gap between eligibility and enrollment and assuring that children receive the quality care they need once they are covered will be considerably more difficult in light of the downturn in the economy and rapidly rising health care costs. In an economic downturn, more children turn to Medicaid and SCHIP as their families lose income and health insurance coverage. Downturns, however, lower state revenues, making it more difficult for states to afford their share of Medicaid and SCHIP costs. Nationwide, state tax revenues are falling more sharply than they have in more than 10 years.

Adding to the problem of greater need and lower revenues is the rising cost of health care services. The cost of private health insurance premiums is climbing at a rate of

11% to 12% per year.³⁸ Medicaid spending is growing at rates that are similar although not quite as steep. In March 2002, the Congressional Budget Office estimated that federal Medicaid costs would grow by an average of 9% per year between 2001 and 2012.³⁹ Although, as shown in Figure 3, children’s coverage is not a major driver of these cost increases, all spending is subject to reexamination when states face large budget shortfalls.

In Medicaid, federal financial support grows as costs and enrollment increase, but states may need even greater assistance from the federal government to avert cutting back on coverage and care. Federal SCHIP funds are capped, and while federal caps and related SCHIP financing rules do not pose an immediate threat to children’s coverage, unless some changes are made, several states will hit those caps over the next few years. According to projections by the federal Office of Management and Budget, this situation could lead to the loss of coverage for nearly 1 million children.⁴⁰

Remaining Gaps in Coverage

These fiscal challenges make it even more difficult to address remaining gaps in coverage. Although most low-income, uninsured children are now eligible for coverage through Medicaid or SCHIP, some poor and near-poor children still do not qualify for coverage due to limits on income eligibility in some states and limits on coverage of immigrants. In addition, many parents of children who are eligible for Medicaid and SCHIP are themselves uninsured. Coverage gaps for children and parents might also widen if a weakening economy and fiscal pressures push states to roll back eligibility standards for children, freeze enrollment in separate SCHIP programs, or impose premiums for children that may be difficult for their families to manage.

Immigrant Children

As considered more fully in the article by Lessard and Ku in this journal issue, legally present immigrant children who entered the United States after August 1996 are generally barred from Medicaid and SCHIP for their first five years in the country, regardless of their income. Over time, the ban will affect a growing number of children who are in the country legally. In addition, undocumented children have always been barred from enrolling in Medicaid, except to receive emergency services.

The five-year ban creates barriers to care and adds to the fiscal pressures facing state and local governments and safety net institutions. Children who are not eligible for public health coverage because of their immigrant status are more likely to be uninsured and thus less likely to receive the health care they need.⁴¹ If they do receive care, it is often because either state or local government is paying the cost of that care without the benefit of federal payments, or local safety net institutions are bearing the burden without any direct reimbursement. Either way, ongoing care for these children is at risk, particularly in light of pressure to cut services that do not qualify for federal matching payments from state budgets and the fiscal stress that most safety net providers are experiencing.

Family Coverage

Many parents of children eligible for Medicaid and SCHIP are uninsured. In light of research showing that family coverage improves opportunities to enroll children and helps assure that they will get needed services, efforts to extend coverage to children in low-income families have focused attention on covering parents as well.⁴²

In contrast to the policies that apply to children, there is no uniform federal eligibility standard for Medicaid coverage of parents, nor is there a consistently available source of enhanced federal matching payments to help states expand coverage to parents. The delinking provisions adopted by Congress in 1996 offer states new options to broaden coverage for low-income parents, and many states have taken advantage of these options, at least until the most recent economic downturn. In addition, some states have obtained waivers to federal rules that enable them use of SCHIP funds to lower the state cost of covering parents.⁴³ Not all states, however, have available SCHIP funds to redirect to parents.

As shown in Figure 4, parents' coverage standards in most states remain below the FPL and well below the standards for children. As of July 2002, only 18 states covered parents with earnings at or above the FPL. In 13 states, parents with incomes at 50% of the FPL are "over income" for Medicaid. Two states (Missouri and New Jersey) that had covered parents up to or above the FPL rolled back that coverage in the summer of 2002 because of state budget pressures.⁴⁴ As a result of low Medicaid eligibility levels for parents and limited opportunities for low-wage workers to obtain employer-based coverage, one out of every three low-income parents was uninsured in 2000.⁴⁵

Eligibility Rollbacks, Enrollment Caps, and Premiums

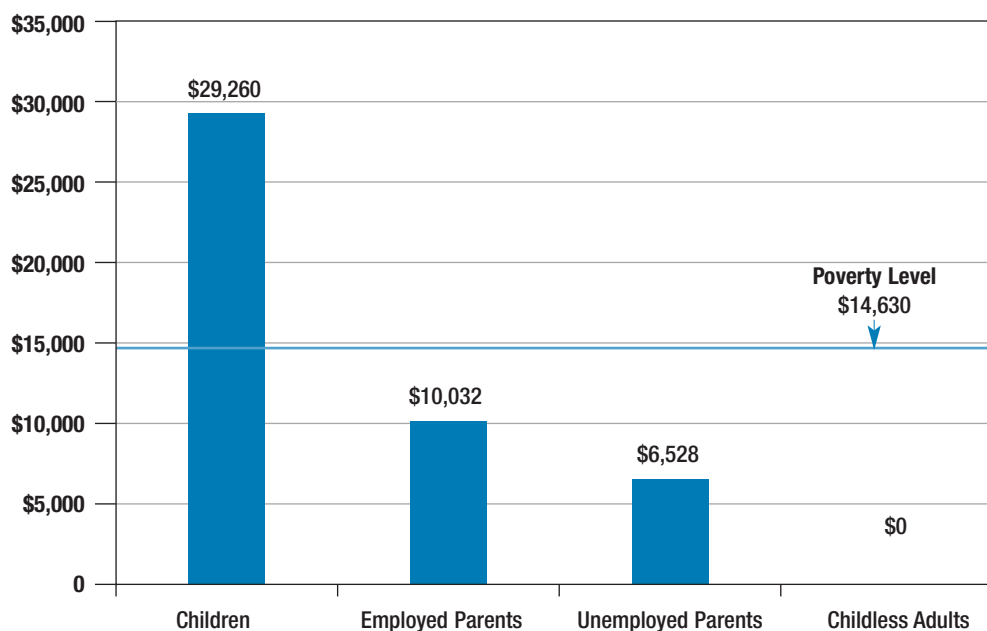
Because separate SCHIP programs are not entitlement programs for children, states can stop enrollment and create waiting lists for coverage. Shortfalls in state funding for SCHIP have already prompted freezes in enrollment in some states. As of August 2002, three states (Montana, North Carolina, and Utah) stopped enrolling children in their separate SCHIP programs for some period of time. Several other states have imposed caps on the number of children they will enroll (or on the amount of dollars they will spend), but they had not reached those caps and had not stopped enrolling children in SCHIP. A preliminary analysis of families affected by the enrollment freeze imposed in North Carolina in 2001 shows that the enrollment cap caused parents to delay necessary care for children and imposed considerable debt on low-income families.⁴⁶

Because Medicaid is an entitlement, states may not cap enrollment in their Medicaid programs, at least not without special permission from the Secretary of Health and

Figure 4

Income-Eligibility Thresholds for Children and Parents under Medicaid and SCHIP, 2001

Annual Median Family Income-Eligibility Threshold



Note: Based on a family of three. The eligibility threshold for working parents takes into account states' earnings-disregard policies, while the threshold for children does not.

Source: Guyer J. Low-income parents' access to Medicaid five years after welfare reform. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002, p. 5.

Human Services (obtained through a waiver of federal Medicaid rules). While some states have been granted waiver authority to cap enrollment for adults (including parents), no state had a waiver that would allow an enrollment cap for children.⁴⁷

States can roll back their eligibility standards in either Medicaid or SCHIP without a waiver, however, as long as they continue to cover children who fall below the federal Medicaid minimum eligibility standards. Rollbacks, like enrollment freezes, reduce the coverage available to children, but they do so based on family income rather than on a first-come, first-served basis. While a few states considered rolling back children's eligibility under SCHIP and Medicaid as they prepared budgets for 2003,

no state had actually taken that step as of June 2002.⁴⁸ Yet, budget analysts and state Medicaid agencies predicted that many states would have to revisit their 2003 budgets soon into the year to address shortfalls.⁴⁹ It remains to be seen whether the eligibility standards for children that were in place in 2002 will represent the high-water mark for children's coverage, at least for the next several years.

In addition to eligibility rollbacks and enrollment caps, coverage may be at risk if budget pressures prompt states to impose premiums that are difficult for some families to manage. In the absence of a waiver, states cannot charge premiums for children's coverage in Medicaid (except for families with children who are eligible under the "transi-

The vast majority (84%) of the nation's 6.5 million low-income, uninsured children are now eligible for public coverage.

tional medical assistance" coverage category. See Box 1, DEFRA provisions). Premiums for children are allowed under SCHIP, within federal guidelines. Over the past year, as a result of budget pressures, a few states have imposed new premiums or increased premiums for children in both Medicaid and SCHIP.⁵⁰ Research has shown that premiums will reduce participation rates among low-income people, but it is too early to know whether the new premium charges will impose too heavy a toll on low-income families and reduce participation among otherwise eligible children.⁵¹

Promoting Enrollment and Retention of Eligible Children

The vast majority (84%) of the nation's 6.5 million low-income, uninsured children are now eligible for public coverage, according to analyses based on 2000 state eligibility levels. Most (60%) are eligible for Medicaid, and 24% are eligible for SCHIP (either through separate SCHIP programs or through SCHIP-funded Medicaid expansions).⁵² While much progress has been made in promoting enrollment of eligible children in recent years, continued efforts will be needed to eliminate remaining barriers to enrollment and retention and to coordinate enrollment between Medicaid and separate SCHIP programs.

Removing Barriers to Coverage

Barriers to enrollment and retention, including a lack of information about eligibility, have been long-standing problems in Medicaid. Some of these problems, particularly in the area of retention, have arisen in SCHIP as well. However, strategies adopted by many states to improve participation rates in public programs have demonstrated that both SCHIP and Medicaid can be designed to encourage enrollment and retention, consistent with federal rules.⁵³ (See the article by Cohen Ross and Hill in this journal issue.) Nonetheless, although the policy levers are in place, several states still have more burdensome procedures in Medicaid than in SCHIP, and many states have not carried over to family applications and renewals all the simplification strategies implemented for children.

Eligibility renewals continue to pose a challenge to assuring continuity of coverage, and they create a risk point

where eligible children often lose their coverage.^{54,55} Moreover, some children and families experience difficulty in keeping their Medicaid coverage when they leave welfare. An estimated 1.7 million children lost Medicaid coverage as a result of welfare reform, and many of the children who lost Medicaid (50%) were uninsured.⁵⁶ The Medicaid/TANF delinking issue received a good deal of attention in 1999 and 2000 and resulted in considerable efforts by states to remedy the problems that had been identified.⁵⁷ Yet, some problems may still be unresolved. Nationally, enrollment of children in regular (non-SCHIP) Medicaid has rebounded after declines following the enactment of the 1996 welfare law, but there are significant variations across states, suggesting that problems may persist in some states.⁵⁸

Over the next few years, state and local delinking systems will face a new test. TANF rolls have risen in many states as a result of the downturn in the economy, but when the economy picks up again, families will find jobs and leave welfare. In addition, over the next few years, more children will be reaching their TANF time limits (the five-year maximum that their families may receive cash assistance). Effective and updated automated eligibility systems, staff training, and continued efforts to inform families of continued Medicaid eligibility will help prevent the loss of Medicaid or SCHIP among eligible children whose TANF benefits end.

Creating Seamless Systems of Coverage

Two-thirds of the states now have two separate publicly funded health coverage programs for low-income children: Medicaid and SCHIP. The other states have Medicaid expansion SCHIP programs. Unless the two programs function effectively as a unified system of providing coverage for children, children will inevitably fall through the cracks, and states will fall short of their coverage goals.

Families often do not know if their children are eligible for Medicaid or for SCHIP. Without coordination at the enrollment stage, children applying for the "wrong" program could be left uninsured. Similarly, children cross in and out of eligibility for Medicaid and SCHIP because their family circumstances tend to be fluid. In some

states, because eligibility rules are tied to a child's age, children must transfer from Medicaid to SCHIP when they “age out” of Medicaid, even with no change in their family circumstances.

Without systems that assure seamless transitions between programs at the application and renewal stages, normal life-cycle changes will put continued coverage of eligible children at risk. Limiting the instances when a program transfer requires families to switch providers can promote continuity of care. For some families, the need to change providers can be the most negative aspect of a transition between coverage programs.⁵⁹

Coordinating Public and Private Coverage

States face a number of challenges as they look to coordinate public and private coverage. In the past few years, a number of states have pursued ways to use SCHIP and Medicaid funds to purchase employer-based coverage and in some cases also to purchase coverage available on the individual market. The goal is to promote reliance on private coverage systems and in some cases to reduce public costs. Medicaid rules allow states to subsidize private coverage if states find it cost-effective to do so, but SCHIP rules are more limited, in part because of the concern, when SCHIP was created, that subsidies for employer coverage would result in employers pulling back their contributions (referred to as “crowd-out”). A few states administer premium-assistance programs, but in general enrollment has been quite limited, largely because so few low-income families have access to employer-based coverage. (See the article by Curtis and Neuschler in this journal issue.)

Premium-assistance programs are strongly favored under the Bush administration's Health Insurance Flexibility and Accountability (HIFA) waiver initiative. According to administration guidance, all HIFA waivers must have a premium-assistance component. Already, several states have applied for waivers or have had waivers approved to subsidize private coverage with Medicaid and SCHIP funds. These waivers generally do not assure children supplemental coverage to bring cost sharing and benefits up to the minimum Medicaid or SCHIP federal standards. It remains to be seen whether these efforts will prove to be a cost-effective way to deliver coverage that meets low-income children's needs.

Improving Access to Care

Enrollment is only the first step to receiving care. Benefit packages and access to doctors, hospitals, and other health care providers are critical components of the children's coverage story.

Benefits

Now that initial implementation of SCHIP is over, the scope and quality of the care that children receive once they are enrolled in SCHIP and Medicaid are attracting more attention. The scope of benefits offered to children under Medicaid and separate SCHIP programs can differ substantially under the rules established by federal law, although in many states the benefit packages are quite similar.⁶⁰ Budget pressures, however, may result in fewer benefits being available through both programs.

As described previously, Medicaid EPSDT rules are intended to assure that poor and near-poor children eligible for Medicaid receive regular preventive care, health screenings, and all necessary treatment. While questions about the cost of EPSDT arise periodically, children covered under Medicaid continue to be the lowest-cost group of Medicaid beneficiaries.⁶¹ In some cases, because of low provider rate payments, states incur fewer costs covering children in Medicaid than in separate SCHIP programs, even though federal SCHIP rules do not require states to provide EPSDT to children.⁶² Nonetheless, budget pressures and new waiver policies at the federal level will inevitably focus renewed attention on EPSDT. For example, Tennessee, a state facing budget shortfalls and long-standing problems ensuring that its managed care organizations actually delivered EPSDT services, recently obtained a waiver from the federal government eliminating the EPSDT requirement for children covered at state option.⁶³

Separate SCHIP programs do not have to comply with EPSDT requirements, but many states have adopted benefit packages that are broader than typical commercial plans.⁶⁴ In other states, benefits provided under separate SCHIP programs are more limited in scope,⁶⁵ raising questions about how well children with mental health problems and special health care needs are faring in separate SCHIP programs.⁶⁶ Estimates suggest that as many as 17% of children eligible for SCHIP

Limited access to providers willing to see Medicaid patients has intermittently plagued the Medicaid program since its inception.

have disabilities or chronic illnesses.⁶⁷ Some states, such as Connecticut and North Carolina, have addressed the needs of these children by offering supplemental coverage to children with special health care needs. One of the challenges facing states, however, is effectively identifying these children so that they are able to get the care they need.⁶⁸

To the extent that states are providing benefits in separate SCHIP programs that exceed federal minimum standards, budget pressures may result in benefit reductions. At least one state (Utah) eliminated dental services for children in its separate SCHIP program in 2002 as a result of fiscal constraints. In addition, as mentioned previously, fiscal pressures are prompting some states to increase the amount families must pay through co-payments and coinsurance requirements to access services under SCHIP. Although cost sharing is not allowed for children under Medicaid, a few states are seeking waivers that would allow them to impose such costs. Cost sharing by families may reduce the state and federal costs of providing Medicaid and SCHIP and allow states to keep benefit packages intact. However, cost sharing also can interfere with children's access to care, depending on the costs imposed and the income level of families who are required to pay them.⁶⁹

Access to Providers

Limited access to providers willing to see Medicaid patients has intermittently plagued the Medicaid program since its inception. Several factors contribute to provider access problems, including the lack of certain types of providers in some parts of the country and relatively low provider payment rates. The American Academy of Pediatrics has identified low provider rates and burdensome paperwork imposed on providers as the two main reasons for low rates of pediatrician participation in Medicaid.⁷⁰ Similarly, the federal Centers for Medicare and Medicaid Services (which oversees the Medicaid program at the federal level) has noted a link between low provider payment rates for dentists and limited access to children's dental services.⁷¹ Limited information is available concerning the adequacy of providers for children enrolled in separate SCHIP programs.

Budget pressures at the state level threaten to worsen provider access problems. In a preliminary review of state budget actions taken in Medicaid and SCHIP in their Fiscal Year 2003 budgets, 28 states reported that they were cutting or freezing their Medicaid provider payment rates. Hospitals, physicians, nursing homes, and managed care organizations were most heavily affected by these rate changes.⁷² Co-payments and coinsurance charges also could affect provider participation in Medicaid because providers often view these charges as reductions in Medicaid or SCHIP payment rates. In July 2002, one of the largest drugstore chains in Massachusetts, reportedly serving one-third of all Medicaid beneficiaries in the state, threatened to withdraw from the Medicaid program, largely because of rate cuts and new Medicaid and SCHIP pharmacy co-payments imposed by the state.⁷³

Federal Financing Issues

In light of state budget pressures and the "dip" in federal SCHIP funding that was built into the original authorization of the program, federal financing issues could have a profound effect on states' ability to continue to provide coverage and a broad set of benefits to low-income children. Still unknown is the extent to which SCHIP waivers that redirect SCHIP spending to other populations will impact children's coverage.

The SCHIP "Dip"

In the formula for distributing SCHIP funds, there is a mismatch between the timing of the availability of federal funds and states' need for those funds. SCHIP was enacted at the same time Congress was trying to reach its balanced-budget goals at the federal level. As a result, the total amount of federal SCHIP funding dropped in 2002 and will not reach its pre-2002 levels until 2005. The drop in funding came after the initial SCHIP start-up period, when enrollment was growing at a strong pace.

The dip in federal SCHIP funds prompted the federal Office of Management and Budget to project a significant decline in SCHIP enrollment beginning in federal Fiscal Year 2004 (see Figure 5). (The lag in the impact of the dip stems from the fact that states have three years to spend their SCHIP funds; carryovers will help most states keep enrollment intact for a few years after the dip

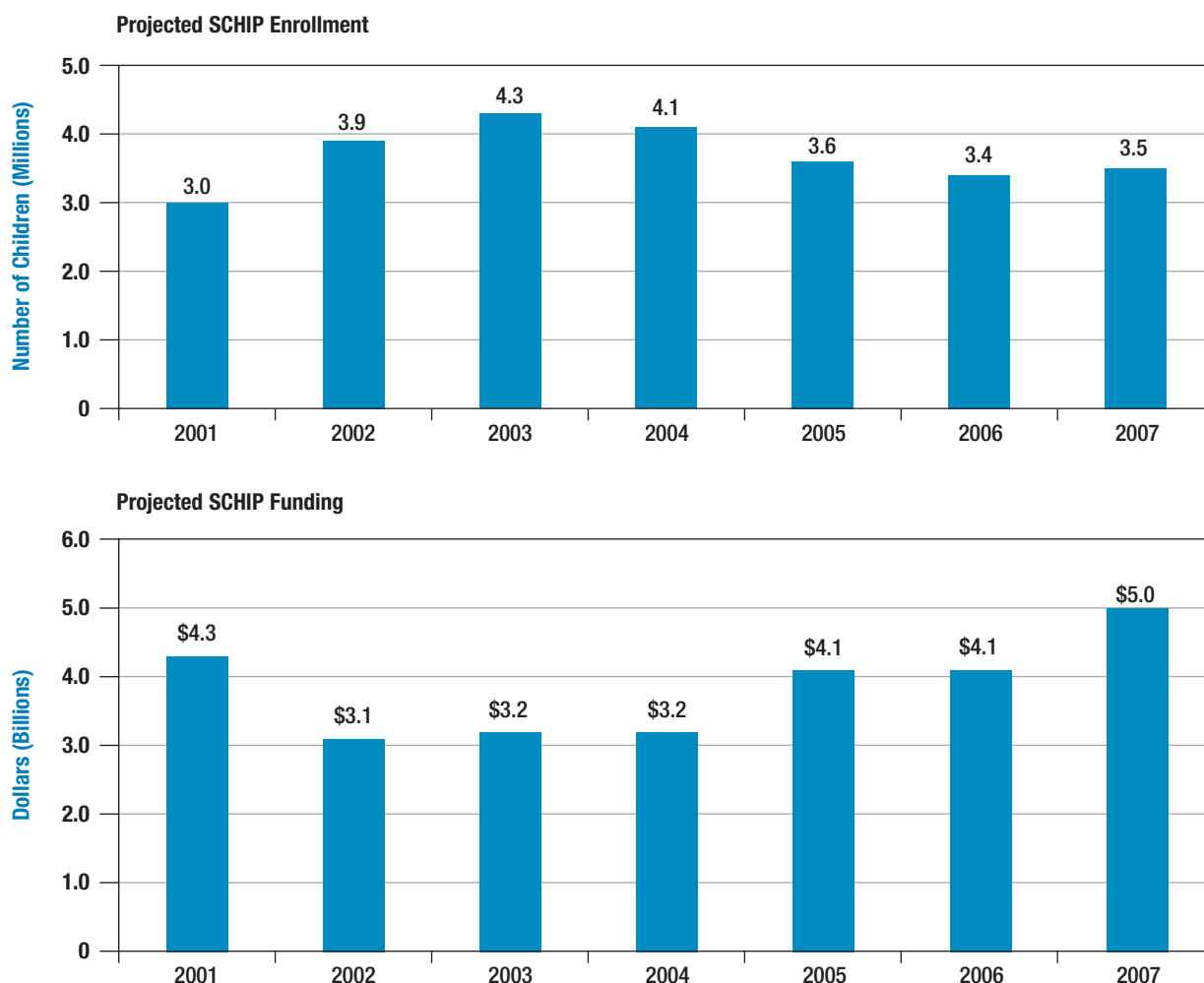
begins.) SCHIP funds that were unspent in the program's early years (Fiscal Years 1998 and 1999) could have helped address this dip, but under SCHIP funding rules, these funds reverted to the Treasury (that is, became unavailable to states to cover children) at the end of federal Fiscal Year 2002.

SCHIP Waivers

SCHIP waivers will also impact SCHIP funding, although it is difficult to predict the extent of the impact. As noted above, waivers have allowed states to use SCHIP funds to cover populations other than children. In July 2000, federal waiver policy allowed states to use SCHIP funds to

Figure 5

Projected SCHIP Enrollment and Funding, 2001–2007



Note: Office of Management and Budget SCHIP projections are based on average annual enrollment.

Source: Office of Management and Budget. Analytical Perspectives, Budget of the United States Government, Fiscal Year 2003. Table 15-3, p. 297.

cover parents and pregnant women under certain circumstances.⁷⁴ This policy was expanded under HIFA guidelines announced in August 2001.⁷⁵ Under HIFA guidelines, states may use SCHIP funds to cover childless adults as well as parents and pregnant women.

These waiver opportunities may help states expand coverage or maintain current coverage for low-income adults. Because SCHIP funds are capped overall, however, waiver spending will reduce the amount of funds some states might receive to cover children. Under the SCHIP funding formula, SCHIP funds that are unspent after three years are reallocated to other states that have fully spent their SCHIP funds. (States have one year to spend the reallocated funds. At the end of the year, the funds revert to the Treasury.) More waiver spending will result in less money moving to other states through the reallocation process. The extent to which SCHIP waiver policy affects children's coverage will depend on many factors, including the level of SCHIP waiver activity in the states, states' needs for SCHIP funds to cover children, and whether federal legislation restores the funds that reverted to the Treasury and addresses the dip in federal SCHIP funds.

Medicaid Financing

Federal Medicaid funds are the largest source of federal grants to states, accounting for 42% of all federal grants to states in 2000.⁷⁶ However, given the fiscal pressures faced by states generally and in their Medicaid programs particularly (because of rising health costs), states are looking to the federal government to increase the level of federal financial participation in Medicaid, at least for as long as the economic downturn continues.⁷⁷ In the long term, policymakers may need to consider whether it makes fiscal or policy sense to have a higher federal matching rate for the children states cover through SCHIP than for the children states cover through Medicaid. Greater levels of federal financial support for children's coverage could be made available to states by raising the matching rate for children in Medicaid to the higher SCHIP matching rate.

Lessons Learned

Despite the challenges that remain and the strains likely to occur with a weaker economy, Medicaid and SCHIP together provide an important vehicle for providing coverage to many of the nation's low-income children. Experience with the recent expansions in publicly sponsored

coverage shows that families value coverage, but efforts are needed to inform them about available coverage and allow them to access that coverage without undue burden.⁷⁸ The recent experience with expansions in coverage for children also shows that reliable, substantial federal financial participation and federal coverage standards are critical to efforts to close coverage gaps. The steady growth in the number and percentage of children covered by Medicaid from the mid-1980s until welfare reform, in contrast to the decade before, reflects the availability of federal matching funds for expansions in children's coverage as well as the influence of federal requirements. In the absence of federal standards, many children would have remained uninsured, and coverage would have varied markedly across states. For example, while states had the option to cover pregnant women and infants with family incomes up to 133% of the FPL before 1990, 31 states did not expand coverage up to this income level until federal law made it a requirement in April 1990.⁷⁹ The recent experience with SCHIP shows that in a strong economy, enhanced federal funding can boost coverage considerably above federal requirements. (See Box 2 for a state and federal perspective on lessons learned from SCHIP.) The impact of a weakening economy and rising costs on state coverage options, even with an enhanced matching rate, remains to be seen.

While it is clear that predictable and substantial federal funding is critical to children's coverage, it is not clear how the differences between the Medicaid and SCHIP financing systems will affect coverage over time. SCHIP and Medicaid offer two distinct models of financing. In Medicaid, federal dollars follow the beneficiary. If more children are enrolled, more federal funds are automatically available to the state to help cover the cost of the coverage. Then, if per-child costs rise for any reason, more federal dollars are automatically available to share those added costs. This open-ended financing system allows the program to operate with certain guarantees: Children are guaranteed coverage as long as they meet the state's eligibility rules; providers are guaranteed payment for services rendered; and the state is guaranteed its federal share of all Medicaid expenditures.

By contrast, the federal government's commitment under SCHIP is capped, and the amount of funds any state will receive is difficult to predict, given that some portion of a state's federal funding depends on how much other states

Box 2

Views from Debbie I. Chang: A Federal and State Perspective

Within the last 20 years, child health policy in this country has dramatically evolved, fueled by innovations at the state level and by federal actions to modify the existing federal and state frameworks for Medicaid. In 1997, major national policy decisions were made regarding children's health, when the SCHIP program was established. The following observations reflect lessons learned from the perspective of Debbie I. Chang, who has worked on child health policy at the federal and state levels for the past 15 years. She led the implementation of SCHIP in 1997 at the Centers for Medicare and Medicaid Services and is now the Medicaid and SCHIP director for the state of Maryland.

- ▶ **Program eligibility rules should be simple to maximize coverage and ease administration.**

Under SCHIP, states have worked to make eligibility more uniform, and usually based on income, rather than welfare rules. Together with reforms to simplify Medicaid, SCHIP has almost eliminated Medicaid's complex system of providing eligibility for categories of children and women.

- ▶ **Simplifying the enrollment process and undertaking proactive outreach increases enrollment.**

SCHIP demonstrated that simple, short application forms that could be mailed in, coupled with local outreach efforts that target locations with many children, such as children's day care centers and schools, were effective at increasing the enrollment of eligible children.

- ▶ **New and established programs benefit from and influence each other—yet their structures differ according to the populations they serve.**

The simplification of enrollment under SCHIP has influenced Medicaid's enrollment processes. States have dropped Medicaid asset tests and face-to-face interviews and simplified Medicaid documentation requirements under Medicaid. Yet, Medicaid's administrative infrastructure (including its management information systems, quality-of-care mechanisms, and provider base) created a strong platform for launching SCHIP programs.

Program design also differs according to the income levels of the populations served. Programs that cover children in very poor families must respond to greater health care needs and limited family resources with comprehensive benefits (such as the current Medicaid benefits). But, as families with higher levels of income

are covered, states need the flexibility to design coverage that is similar to that found in the private sector. The mechanisms to subsidize private insurance coverage also need to be simplified.

- ▶ **Despite some inherent tension, the federal–state partnership works effectively to improve health for children.**

The arrangement of providing federal funds to match state investments provided opportunities and incentives for states to expand coverage. The federal government's broad parameters also gave states the flexibility to develop programs that addressed their unique needs. At the same time, enhanced federal matching resulted in more focused attention where virtually all states created new programs. Federal standards also set the framework for state choices on designing programs, while enhanced federal matching compensated for additional federal requirements.

- ▶ **Incrementally building on current programs is cost-effective, but results in equity issues.**

States provided different levels of health coverage to low-income children under their Medicaid programs. When new funding came available under SCHIP, states that already covered children at higher levels of poverty did not benefit as much from higher levels of federal funding. In addition, because of the focus on the currently uninsured, families who had already purchased coverage for their children or were underinsured did not benefit.

- ▶ **Accurate baseline data is needed to monitor success and improve accountability.**

Limitations of the data available on the number of uninsured children mean that states do not have good baseline data. This makes it difficult to determine how effectively the program has reduced the numbers of uninsured children because states do not have accurate baselines.

- ▶ **Implementing new programs takes time, and expectations should be realistic.**

SCHIP was enacted in August 1997, and the money became available to states with approved plans less than two months later. Soon after SCHIP was implemented, issues of how many children were enrolled were raised. Now, after four years, the number of children ever enrolled increased to 4.6 million in Fiscal Year 2001. Federal and state governments need time to systematically develop policies and design effective programs.

have spent. In part because federal financing is capped, SCHIP does not provide children with an entitlement to coverage, and while the capped funding is less advantageous to states, some states were attracted to SCHIP precisely because it did not involve an entitlement. Given the relatively short life of SCHIP, it is too soon to know how these features will affect states' willingness and ability to sustain coverage, maintain provider participation, and assure children's access to care.

The evolution of children's coverage through Medicaid and SCHIP also underscores the importance of designing programs for low-income children that recognize their health needs (which are often greater than those of their higher-income peers) and their families' limited resources. For poor and near-poor children covered under Medicaid, EPSDT provides services beyond the coverage available in typical employer-based health plans at no cost to the family. Most children do not use a high level of services, but some children need these services. Through SCHIP's extension of coverage to children in low-income families with incomes above Medicaid levels, the scope of benefits and appropriateness of cost sharing and premiums were reassessed. As different states try different approaches, they will undoubtedly learn more about how to design and implement health insurance programs that meet the needs of a broader group of low-income children.

The path to improving coverage for children has not been smooth, however, and many challenges are still

ahead. Medicaid has struggled with developing its own rules and procedures, separating from welfare, and bringing the public's perception of the program in line with its new role. SCHIP has had to survive unrealistic expectations that millions of children would be enrolled during the first year or two in operation, and states must contend with SCHIP block grant financing that may not fully respond to enrollment trends and coverage demands among children. Both programs have contended with a changing marketplace, rising health care costs, and, more recently, an economic downturn.

Publicly funded coverage for children through Medicaid and SCHIP fills a critical void in the patchwork health care system in the United States. With one out of five children enrolled in these programs, and more children eligible, public coverage has made and will undoubtedly continue to make a large contribution toward the goal of providing all children with health coverage and access to health care. Reaching children who are eligible for assistance, but remain uninsured, extending coverage to their families, and maintaining meaningful coverage for children and families who are enrolled are the most significant future coverage challenges.

The author Cindy Mann was a senior fellow at the Kaiser Commission on Medicaid and the Uninsured while writing this article.

ENDNOTES

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6. Health Resources and Services Administration, Maternal and Child Health Bureau. *Understanding Title V of the Social Security Act*. Available online at <ftp://ftp.hrsa.gov/mchb/titlevtoday/UnderstandingTitleV.pdf>.
7. Modeled on and replacing the Kerr-Mills assistance program for the aged.
8. Schneider, A., Elias, R., Garfield, R., et al. *The Medicaid resource book*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2002.
9. See the earlier journal issue on welfare to work, *The Future of Children* (Spring 1997) 7(1).
10. The other key provision related to expanding access to services was the “freedom of choice” provision, which allowed beneficiaries to obtain covered services from any qualified provider who accepted Medicaid payment. This provision was intended to broaden access to providers by prohibiting states from requiring beneficiaries to see only certain providers and by assuring that beneficiaries could see different providers if theirs did not provide the services they needed (for example, family planning).
11. In 1989, the EPSDT provision was further amended to require states to provide treatment services for problems discovered during EPSDT screenings, as long as the treatment involved services that could be covered under federal Medicaid rules.
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14. Kaiser Commission on Medicaid and the Uninsured calculations based on data reported in Committee on Ways and Means, U.S. House of Representatives. *1998 green book*. Washington, DC: U.S. Government Printing Office. May 19, 1998.
15. See the earlier journal issue on U.S. health care for children, *The Future of Children* (Winter 1992) 2(2).
16. See note 8, Schneider, et al.
17. Prior to 1981, the use of prepaid health plans under Medicaid was restricted to entities that could satisfy stringent federal requirements, the most significant of which was that at least 50% of a plan's members had to be from non-Medicaid or non-Medicare populations. In 1981, Congress changed this rule to require that prepaid plans in Medicaid draw only 25% of their membership from non-Medicaid or non-Medicare populations. The 1981 amendments also reduced federal standards for health plans and permitted states to seek waivers to the “freedom of choice” provision enacted in 1967.
18. Kaiser Commission on Medicaid and the Uninsured. *Medicaid and managed care*. Washington, DC: KCMU, December 2001.
19. Medicaid eligibility for elderly and disabled people is still tied to eligibility for federal Supplemental Security Income (SSI) benefits in most states.
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21. Estimate of number of children on Medicaid from Centers for Medicare and Medicaid Services. Unpublished Health Care Financing Administration 2082 data; estimate of percentage of child Medicaid beneficiaries receiving cash assistance based on Urban Institute. Unpublished analysis of Health Care Financing Administration data.
22. See note 21, Centers for Medicare and Medicaid Services; Urban Institute.
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 27. See note 1, Hoffman and Pohl.
 28. See the article on outreach and enrollment by Cohen Ross and Hill in this journal issue.
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