

SCHIP and Children's Health Coverage: Leveling the Playing Field for Minority Children

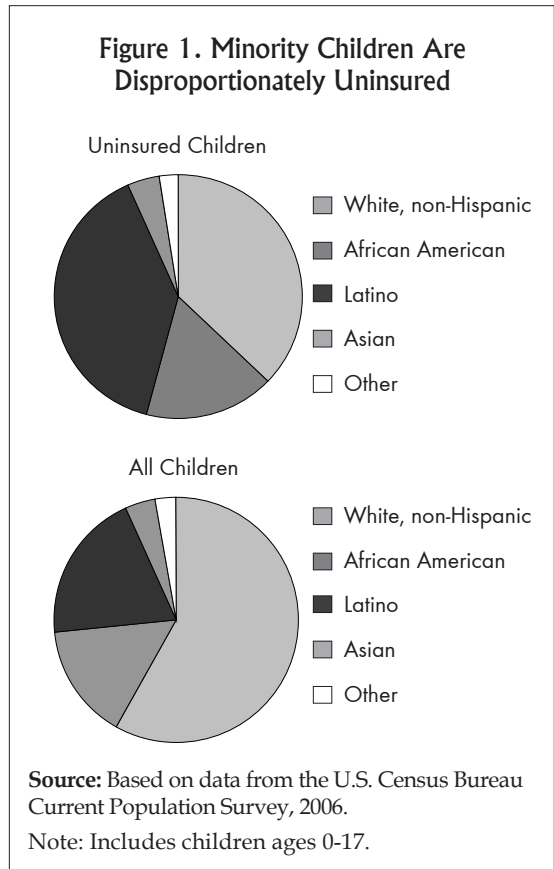
The SCHIP program will expire in 2007 unless it is reauthorized by Congress. Reauthorization provides an opportunity to review how

SCHIP works, examine what has been learned about children's health coverage in the last 10 years, and discuss what Congress must do to continue the progress made in reducing the number of uninsured children. More information on children's health coverage through SCHIP and Medicaid is available on the Families USA Web site at <http://www.familiesusa.org/issues/medicaid/medicaid-action/>.

Most Uninsured Children Are Racial and Ethnic Minorities

In 2005, more than 8 million children went without health insurance, and 60 percent of them belonged to a racial or ethnic minority group (Figure 1).¹ Health insurance is essential for children so that they have timely access to preventive health care services and treatment for conditions that could affect their health later in life. The gaps that persist in children's health coverage remain a major obstacle to eliminating the more pervasive health disparities that confront racial and ethnic minorities of all ages in the United States.

Reducing disparities in children's access to health care is an important and achievable goal. Health insurance is especially important for minority children because when they lack coverage, they are less likely to see a doctor. For example, uninsured African American and Latino children are less likely to have a personal doctor and more likely to forgo needed medical care than other uninsured children.² Fortunately, most uninsured children (74.1 percent) are eligible for health coverage through either Medicaid or the State Children's Health Insurance Program (SCHIP).³ This means that increasing support for these programs will be crucial to reducing health disparities.



Medicaid and SCHIP Play a Crucial Role in Covering Children of Color

Although children receive health coverage through a variety of sources, Medicaid and SCHIP play an especially important role in covering children from communities of color. Today, more than half of all children who receive health insurance through public programs belong to a racial or ethnic minority group. While most insured children (68.1 percent) have coverage through a parent's employer, slightly more than half of insured African American children (51.3 percent) and insured Latino children (50.3 percent) are covered by Medicaid or SCHIP.⁴

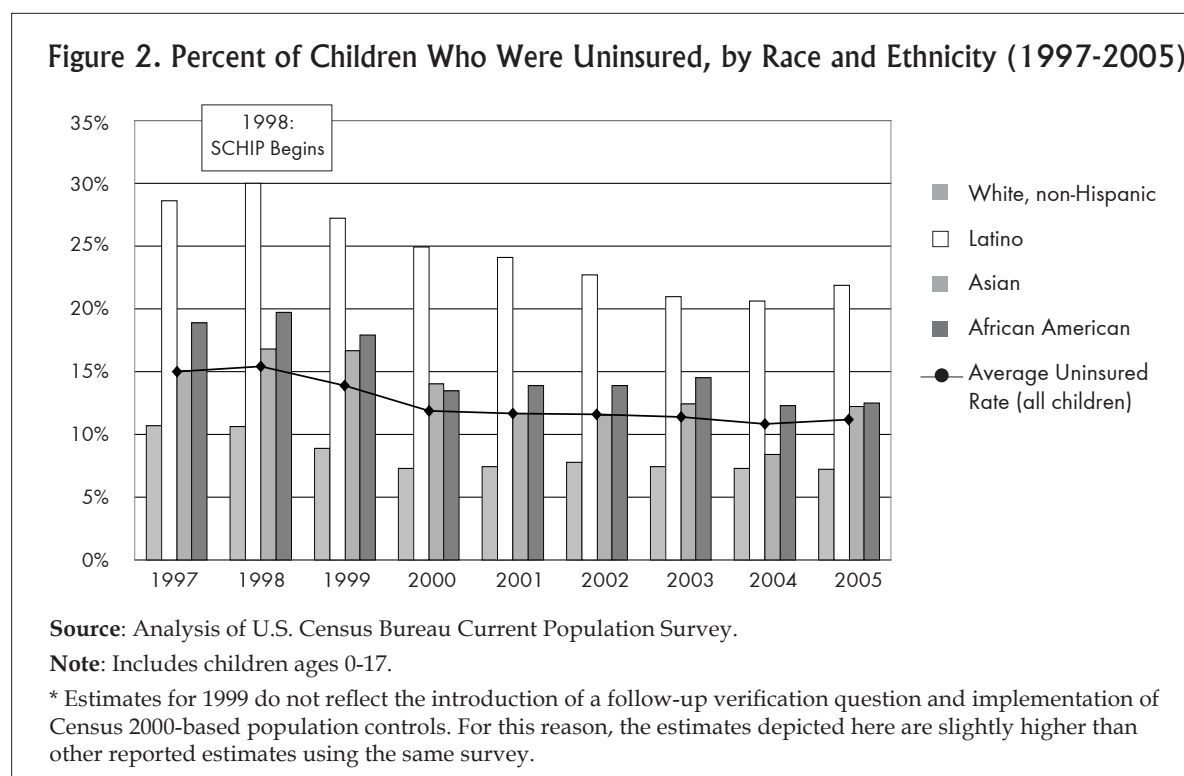
Minority children are more likely to have public coverage for a variety of reasons. For example, even though most children in Medicaid and SCHIP live in working families, children from communities of color are less likely to have employer-based coverage. This is because their parents are disproportionately more likely to work either in positions where health care benefits are not offered or for small companies that cannot afford to pay for employee health insurance.⁵ Even when parents are offered coverage through an employer, many cannot afford the premiums.

Together, Medicaid and SCHIP provide a vital safety net for America's low-income children. These children live in households with annual incomes below 200 percent of the federal poverty level (\$33,200 for a family of three in 2006).⁶ And because minority children are much more likely to live in low-income families, they are more likely to rely on programs like Medicaid and SCHIP for health care coverage.

Disparities in Coverage Have Decreased Since SCHIP Started

After SCHIP was created in 1997, the percent of children who were uninsured steadily declined, from a high of 15.4 percent in 1998 to a low of 10.8 percent in 2004.⁷ The decline was even more striking for racial and ethnic minorities. In 1998, roughly 30 percent of Latino children and 20 percent of African American children were uninsured. In 2004, those numbers had dropped to about 21 percent and 12 percent, respectively (Figure 2).⁸ While disparities in insurance coverage still exist, SCHIP and Medicaid played an important role in narrowing the coverage gap for minority children.

SCHIP was created at a time when more and more Americans were losing employer-based health insurance. The program expanded health coverage to many low-income children and was crucial to reducing both the number and proportion of children who were uninsured. Together, Medicaid and SCHIP were directly responsible for expanding children's health coverage, even as a growing number of parents lost employer-based coverage and became uninsured. And while many low-income children benefited from the expanded eligibility provided by SCHIP, minority children experienced the greatest gains from increased coverage through public programs.



SCHIP Plays an Important Role in Reducing Disparities in Access to Care

In addition to reducing the coverage gap for minority children, enrollment in SCHIP has also been shown to reduce disparities in access to health care services—an important measure of the program's success. For example, uninsured minority children are more likely than other uninsured children to have unmet health care needs and to lack a usual source of care, but a study of children enrolled in New York's SCHIP program for one year found an almost complete elimination of these disparities.⁹ A study of California's SCHIP population confirmed these results: Across racial and ethnic groups (including different language groups), enrollment in SCHIP was associated with a stark reduction in disparities in access to needed care.¹⁰

SCHIP Reauthorization: A Chance to Level the Playing Field

Together, SCHIP and Medicaid have made tremendous strides toward narrowing the coverage gap that exists for minority children. However, millions of children from communities of color remain uninsured, and more work must be done to ensure that these children receive the health care coverage they need. The good news is that the majority of uninsured children are already eligible for either Medicaid or SCHIP. In fact, more than 80 percent of uninsured African American children, and 70 percent of uninsured Latino children, appear to be eligible for public coverage.¹¹

But without additional funding for SCHIP, these children will remain uninsured, and the progress made over the past 10 years will be reversed as states scale back their SCHIP and Medicaid programs. At this point, there is insufficient federal funding for SCHIP to cover

the children currently enrolled, let alone to expand coverage to uninsured children who are eligible. To finish the job it started in 1997, Congress should add sufficient money to the federal budget to cover all uninsured, low-income children who are already eligible for Medicaid or SCHIP. This is a critical step for expanding coverage for minority children.

The reauthorization process also provides an opportunity to address the underlying barriers to enrollment in Medicaid and SCHIP that minorities are more likely to face. For example, distrust of the health care system, language and cultural barriers in the application process, and misinformation about eligibility rules are a few of the obstacles that can prevent eligible children from enrolling in public programs. Enrollment strategies targeted to minority communities, including the use of community health workers and promotoras to help guide families through the enrollment process, have been shown to increase enrollment and reduce disparities.¹² Congress should take advantage of SCHIP reauthorization to improve outreach efforts and simplify enrollment in order to reach the millions of uninsured children from communities of color who are eligible for Medicaid and SCHIP.

SCHIP reauthorization provides policymakers with a unique opportunity to address racial and ethnic disparities in children's access to health care. By prioritizing children's health care and increasing funding for this important program, Congress can level the playing field for children's health coverage and pave the way for reducing health disparities later in life.

¹ U.S. Census Bureau, "Table HI08. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children under 18 (All Children): 2005," *Current Population Survey 2005*, available online at http://pubdb3.census.gov/macro/032006/health/h08_000.htm, accessed on December 11, 2006.

² Children's Defense Fund, *Improving Children's Health: Understanding Children's Health Disparities and Promising Approaches to Address Them* (Washington: Children's Defense Fund, 2006).

³ Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* 26 (November 30, 2006): w22-w30.

⁴ U.S. Census Bureau, op cit.

⁵ E. Richard Brown, Victoria D. Ojeda, Roberta Wyn, et al., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (Los Angeles: UCLA Center for Health Policy Research and Kaiser Family Foundation, April 2000).

⁶ U.S. Department of Health and Human Services, "2006 Federal Poverty Guidelines," *Federal Register* 71, no. 15 (January 24, 2006): 3,848-3,849.

⁷ Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington: U.S. Census Bureau, August 2006).

⁸ Based on analysis of data from the U.S. Census Bureau's Current Population Survey, 1997-2005 (ages 0-17 years). In the estimates reported here, "African American" includes individuals who identify as "black alone" or "black, Hispanic" according to the terminology used by the U.S. Census Bureau, and "Latino" includes all individuals who identify their ethnicity as "Hispanic."

⁹ Laura Shone, Andrew Dick, Jonathan Klein, et al., "Reduction in Racial and Ethnic Disparities after Enrollment in the State Children's Health Insurance Program," *Pediatrics* 115 (June 2005): 697-705.

¹⁰ Michael Seid, James W. Varni, Leslie Cummings, and Matthias Schonlau, *Improving Access to Needed Health Care Improves Low-Income Children's Quality of Life* (Santa Monica, CA: RAND Corporation, 2006), available online at http://www.rand.org/pubs/research_briefs/RB9210/.

¹¹ Urban Institute analysis of data from the U.S. Census Bureau's Current Population Survey, 2004, as reported in *Going Without: America's Uninsured Children* (Washington: Robert Wood Johnson Foundation, August 2005).

¹² Glenn Flores, Milagros Abreu, Christine Chaisson, et al., "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children," *Pediatrics* 116 (December 2005): 1,433-1,441.