

Chapter 3: Children's Health Coverage

Years of national opinion surveys show there is broad, consistent public support for the goal of ensuring that America's children have the health care they need to thrive and succeed.¹

Health insurance is a key factor in determining whether children receive the medical care they need. Children without insurance are considerably less likely than insured children to see a doctor, have a usual place of care and receive preventive care.² Uninsured children are much more likely than insured children to have unmet medical needs;³ nearly a third of uninsured children (32.9 percent) went without any medical care for the entire year in 2003.⁴ Timely and appropriate care can avoid unnecessary costs (such as preventable hospitalizations), and make a substantial contribution to children's current and future well being.

Most children have coverage through their parent's job-based insurance.⁵ But for millions of families, private plans are not available or affordable. Over the past 40 years, Medicaid has been repeatedly expanded to try to fill the resulting coverage gaps for kids. In 1997, with the enactment of the State Children's Health Insurance Program (SCHIP), the nation committed itself to the goal of covering all low-income children.⁶

Remarkable progress has been made since then. A study published by the Robert Wood Johnson Foundation concluded that between the 1997 enactment of SCHIP and 2004, the number of uninsured children fell by two million.⁷ Nevertheless, more than eight million children (11.2 percent) lacked coverage in 2005, according to the Census Bureau.⁸ In 2006, a new state-based wave of interest in expanding coverage for children (sometimes including their families) emerged, with governors and legislators in Illinois⁹ and Massachusetts¹⁰ enacting new initiatives. And state executives in Wisconsin, Kansas, New Mexico, Pennsylvania, West Virginia and Washington, among others, have been pressing hard for expanded children's coverage.¹¹

HOW DO CHILDREN GET COVERAGE?

As noted, more children are covered through a parent's employer than through any other source. Almost 45 million children (more than six in 10) had employer-based coverage in 2005, the Census Bureau reports.¹² (See chart, "Some Sources of Health Coverage for Children, 2005.")

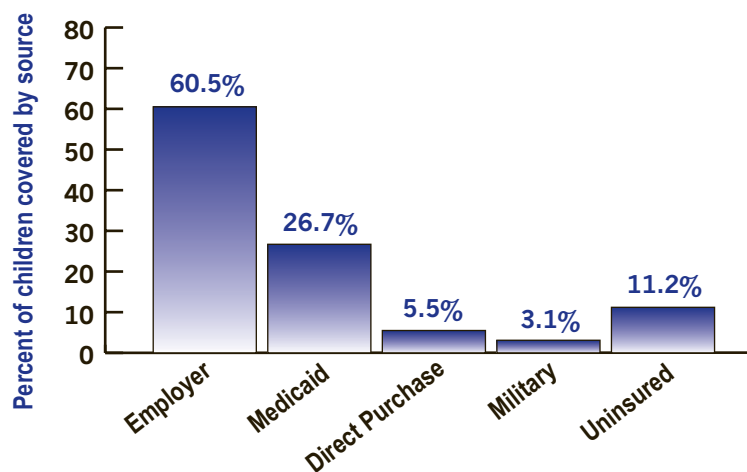
The availability of employer-based insurance for children is influenced by many factors. Small firms and firms in certain sectors (e.g., service firms) are less likely to

KEY FACTS

- Uninsured children are much more likely than insured children to have unmet medical needs.^a
- More than eight million children lacked coverage in 2005, according to the Census Bureau.^b
- Uninsured rates for children vary dramatically by state, from a 2005 low of 4.5 percent in Massachusetts to a high of 20.2 percent in New Mexico; 15 states had a percentage of uninsured children greater than the national average.^c
- Largely thanks to public coverage, the uninsured rate is significantly lower among children than adults. In 2005, 11.2 percent of children were uninsured, compared to 20.5 percent of non-elderly adults.^d
- About 22 million children were covered through Medicaid in 2005 and 4 million children through the State Children's Health Insurance Program (SCHIP).^e
- Most children on Medicaid qualify based on family income, but children may also qualify for Medicaid through other, largely disability-based, eligibility categories.

For story ideas on children's coverage, see page 39. A list of experts and websites also begins on page 39.

SOME SOURCES OF HEALTH COVERAGE FOR CHILDREN, 2005 (AGE < 18)



Note: Percentages total more than 100 since some children are covered by more than one source.

Source: U.S. Census Bureau (2006). "Table HI-5. Health Insurance Coverage Status and Type of Coverage by State -- Children Under 18: 1987 to 2005." (www.census.gov/hhes/www/hlthins/historic/hihist5.html)

offer coverage.¹³ Even if a firm offers coverage, some employees might not be eligible (for example, due to part-time status or being new on the job), or the cost might be beyond reach. In addition, some firms don't offer family coverage – or workers choose not to take up this option, which may be significantly more costly than self-only coverage.

In 2006, the average yearly premium for family-based coverage was \$11,480 and the average worker contribution was \$2,973.¹⁴ This represents more than two months of wages for a full-time worker earning \$7.75 an hour, or 18 percent of yearly earnings. Copayments, co-insurance and deductibles add to these costs.

Family income influences to a considerable degree whether a child has employer-based coverage. Only a quarter of all children with family incomes up to 200 percent of the federal poverty level (FPL) have employer-based coverage—even though two-thirds live in families with one or more full-time worker.¹⁵

In general, the lower a family's income, the higher the risk that the children will be uninsured. Nearly a quarter of low-income children with incomes at or below the federal poverty level were uninsured in 2004, compared to 16 percent of children in families

with incomes between 100 and 200 percent of the poverty level, and 7.6 percent of children in families with incomes between 200-400 percent of the poverty level.¹⁶ (In 2006, the poverty level for a family of four is about \$20,000.)

Between 2000 and 2005, through the economic downturn and even through the subsequent recovery, employer-based coverage trended downward for both adults and children.¹⁷ Among families with working parents, in 2004, 70 percent of uninsured children had someone in the family who worked at least part time during the year; 58 percent had a full-time worker.¹⁸ The number of children getting coverage through public programs, however, trended upward.¹⁹ As a result, the uninsured rate for children dropped even during tough fiscal times, growing slightly in 2005.²⁰ (See chart, "Trends in Uninsured Children, 2000 - 2005.")

According to the Centers for Disease Control and Prevention (CDC), between 1997 and 2005 the uninsured rate among "near poor" children (those with family incomes between 100 and 200 percent of FPL) dropped by more than a third from 22.6 percent to 14.6 percent. For children below the FPL, the uninsured rate was cut almost in half, falling from 22.4 percent to 12.1 percent.²¹

This success in reducing the number of children without coverage is attributable not just to SCHIP, but to the combined effects of Medicaid and SCHIP. Publicly funded insurance boosted coverage rates in good economic times and protected children from losing ground during the downturn.

The national uninsured picture masks large variations across states. In 2005, uninsured rates for children ranged from a low of 4.5 percent in Massachusetts to a high of 20.2 percent in New Mexico. The national average was 11.2 percent.²²

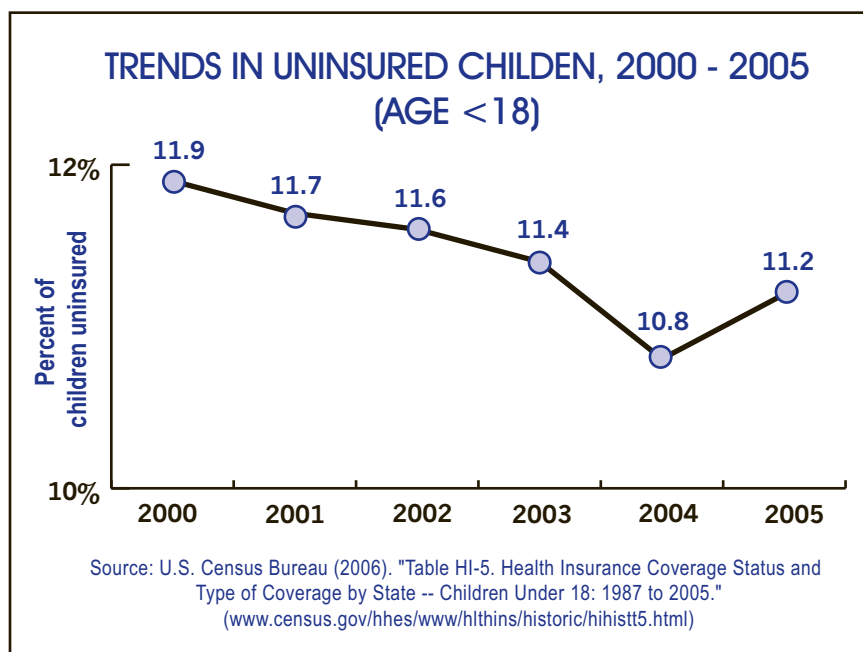
MEDICAID'S ROLE FOR CHILDREN

As noted, publicly funded insurance is a vital source of coverage for children, and its importance has been growing. About 22 million children were covered through Medicaid in 2005 and 4 million children through SCHIP.²³

Children make up a little more than half of all Medicaid enrollees nationwide.²⁴ However, because most children are inexpensive to insure, they accounted for only 17 percent of total Medicaid spending in 2003.²⁵ (See chart, "Average Medicaid Spending Per Beneficiary, 2003.") The average cost of covering a child that year was \$1,410, compared to average spending of \$10,147 for each elderly beneficiary, and \$11,659 per disabled beneficiary.²⁶ (Spending for the elderly and disabled includes long-term care and acute care; spending for children includes acute care only.)

Eligibility Rules - Medicaid income eligibility levels for children are set through a combination of federal minimum standards and state options. The federal minimum eligibility standards determine who must be covered if a state chooses to participate in Medicaid (and all do). These standards are much more inclusive for children (and pregnant women) than for other groups.

- Young children (under age six) must be covered if their family income is below 133 percent of the FPL, or \$22,078 a year in 2006 for a family of three.
- Older children (age six to 18) must be covered if their income is below 100 percent of the FPL, or \$16,600 a year for a family of three.
- By comparison, there is no federally required minimum for parents. The minimum eligibility level for parents in the median state is only 42 percent of the FPL, or \$6,972 a year for a family of three.²⁷



States may cover children at higher income levels. Almost all states cover very young children (under age one) at higher levels, and about half the states have substantially expanded Medicaid coverage for children of all ages:

- Twenty-five states cover children of all ages with incomes up to or above 150 percent of the FPL. Twelve of these states cover children of all ages up to 200 percent of the poverty line or higher.
- Twenty states cover children age one and older only at the federal minimum standards. (All of these states cover children at higher income levels under SCHIP.)²⁸

Clearly, for children in particular, Medicaid is no longer a program just for the "welfare poor." Even at the minimum standards, Medicaid eligibility is considerably above state welfare eligibility levels.²⁹

Children who qualify based on family income make up the largest group of children enrolled in Medicaid, but children may also qualify for Medicaid through other eligibility categories, largely based on disabilities.

Citizenship Requirements - Under federal rules enacted in 1996, a child must be either a U.S. citizen or a lawfully present non-citizen who has been in the

country for at least five years in order to qualify for Medicaid or SCHIP (some narrow exceptions apply). Those who do not meet these criteria can qualify for coverage only for emergency care.³⁰ States can, however, cover non-citizen children with separate state funds.³¹

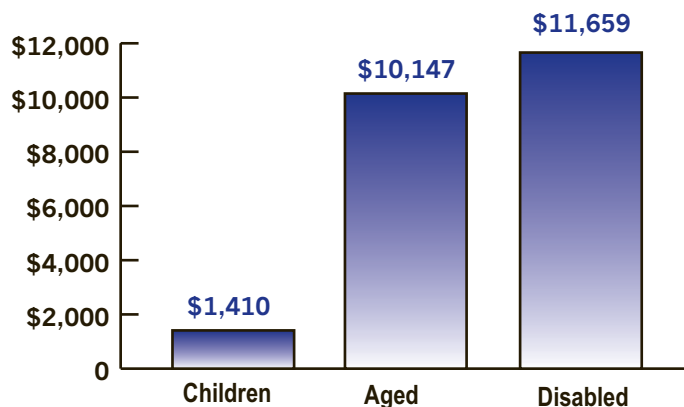
The Deficit Reduction Act of 2005 (DRA) changed many of the rules under Medicaid, including citizenship documentation requirements. Effective July 1, 2006, all applicants for Medicaid coverage, including children, must supply proof of citizenship.³² Children can demonstrate citizenship using school or daycare records or affidavits signed by a parent or guardian.³³

Benefits – Under federal law, standard Medicaid benefits for acute care include physician services, lab services, inpatient and outpatient hospital services, family planning services and supplies, nurse midwife services, certified nurse practitioner services, and services provided in certain clinic settings, including rural health clinics. Preventive services include immunizations and prenatal care, and the program also offers long-term care and care in certain institutional and non-institutional settings. But there is no single Medicaid benefits package, since states have broad discretion to determine the scope and content of Medicaid benefits.³⁴

For children, particularly those requiring intensive services, the Early Screening Periodic Diagnostic and Treatment Service (EPSDT) benefit is key. Congress first established EPSDT in 1967 (two years after Medicaid began) to assure that all children receive regular health, dental, hearing, and vision checkups.³⁵ Congress strengthened the law in 1989. Since then, states have been required to provide all necessary care for children, even if the medical service they need is not covered by that state for adults.³⁶

For example, if a child needs three speech therapy sessions a week for an extended period to address hearing and speech problems, Medicaid must cover those sessions even though the state might not cover speech therapy, or limits the number of sessions covered for adults. Although the DRA did change

AVERAGE MEDICAID SPENDING PER BENEFICIARY, 2003 (BY ENROLLEE GROUP)



Note: Spending for the aged and disabled includes long-term care and acute care. Spending for children includes acute care only.

Source: Kaiser Commission on Medicaid and the Uninsured (2006).
"The Medicaid Program at a Glance."
(www.kff.org/medicaid/upload/7235.pdf)

many Medicaid benefit rules, Congress maintained the EPSDT guarantees for children.³⁷

Out-of-Pocket Costs - Until DRA, Medicaid rules generally prohibited states from charging families to enroll their children in Medicaid or imposing costs when children used services. Beginning in April 2006 the DRA allows — but does not require — states to charge copayments, within federal limits, when children go to a doctor, hospital or clinic, fill a prescription, or use certain emergency room services, and to deny services if their families cannot pay. They may also require premiums for children above 150 percent of the FPL.³⁸ It is not clear how many states will pick up the new options and, if they do, what they will charge and at what income levels.

SCHIP'S ROLE FOR CHILDREN

Congress enacted SCHIP in 1997 with strong bipartisan support, offering states federal funds to expand coverage for children whose family income puts them over Medicaid limits but who still cannot afford private insurance. States can use SCHIP funds to expand coverage through a separate child health program, a Medicaid expansion, or a combination of the two approaches.³⁹ SCHIP was authorized and funded for ten years; it comes up for reauthorization in 2007.⁴⁰

Medicaid and SCHIP Federal Financing Rules

Medicaid	SCHIP
Federal funds are available to states on a matching basis	Same rules apply
Matching rates vary between 50-78%; states with lower per capita incomes have higher federal matching rates	Matching rates are “enhanced” relative to Medicaid (i.e., more favorable to states); they range between 65 and 85%
Federal funding is on an “as-needed” basis; no cap	Federal funds are capped nationwide and for each state based on an annual allocation formula
Federal funding automatically adjusts if enrollment rises or if per person health care costs increase	Federal funding is capped; states that reach their caps may receive some additional funds not spent by other states but these “reallocations” are not assured and level is not predicted

Source: Cindy Mann (2006), Executive Director, Center for Children and Families, Georgetown University

Every state has picked up the SCHIP option in one form or another. As of October, 2005:

- Nineteen states use their SCHIP funds to cover children in separate programs;
- Twelve states (including Washington DC) expanded Medicaid, and
- Twenty states did both.⁴¹

SCHIP is much smaller than Medicaid (covering about a fifth as many children), but it is Medicaid’s important companion. Both programs are jointly funded by states and the federal government and administered by the states subject to some federal oversight.⁴² In addition, while the children covered by the two programs can be very different (for example, children with disabilities are more likely to be enrolled in Medicaid than in SCHIP), there is also considerable overlap.

Children often move from one program to the other as their family income fluctuates or even as they age out of Medicaid eligibility.⁴³ In addition, a child who would be eligible for SCHIP in one state could be eligible for Medicaid in another state. For example, children living in a four-person family where both parents work full time at \$9.50 an hour would be eligible for SCHIP in Georgia but eligible for Medicaid in Louisiana.⁴⁴

There are, however, important differences between SCHIP and Medicaid, most notably relating to financing, children’s “entitlement” to coverage and the federal benefit standards.

Financing - Medicaid and SCHIP both rely on a combination of state and federal funding, but federal SCHIP funds are capped while Medicaid funds are open-ended. If more eligible children enroll in Medicaid due to a plant closing, a hurricane or an economic downturn, federal funding automatically adjusts, but in SCHIP each state receives a finite amount of funds (their “allotment”). (Some states also have received additional capped funds reallocated from states with unspent allotments.)⁴⁵ (The box “Medicaid and SCHIP Federal Financing Rules” shows some of the key differences between Medicaid and SCHIP financing arrangements.)

In the early years of SCHIP, states had enough federal SCHIP funds to meet their costs, but as the program ramped up and enrollment grew, state spending rose relative to available funds. Eighteen states are projected to face a shortfall in federal fiscal year 2007.⁴⁶ SCHIP has been found to have been a successful and effective program,⁴⁷ but funding shortfalls and the lack of predictability in the level of federal funds available to states to cover children has been a major, ongoing issue.⁴⁸

Entitlement v. Enrollment Freezes - Another major difference between Medicaid and SCHIP is that children who meet all of the state's eligibility rules are not guaranteed enrollment under SCHIP – there is no “entitlement” to coverage for children under federal SCHIP rules. By contrast, children eligible for Medicaid must be enrolled if they apply; states cannot cap enrollment and create waiting lists.

During the height of the economic downturn in 2001-2003, seven states stopped enrolling children in their separate SCHIP programs, and, as a result, enrollment levels in those states dropped, sometimes quite sharply.⁴⁹ In Florida, for example, SCHIP enrollment declined by 48,000 children, a 15 percent decline, between December 2003 and December 2004.⁵⁰ All but one of the states that froze SCHIP enrollment have since reopened (enrollment was still frozen in mid-2006 for a Medicaid waiver program in Tennessee).⁵¹ SCHIP enrollment increased in 2005, just as it increased in previous years.⁵² However, the connection between the most recent enrollment increases and the reopening of coverage freezes is unclear.

Benefits - Federal benefit standards in SCHIP leave most of the decisions about what benefits will be covered and the scope of those benefits to states. States can provide a very comprehensive benefit package, similar to Medicaid, or they can cover a much more limited scope of care. In most states, the benefit packages are somewhat less comprehensive than Medicaid but they are not “bare bones.” Coverage for services such as mental health services, vision and dental care, and certain types of rehabilitative services (like speech or physical therapy) are often limited.⁵³

A more subtle but important distinction between SCHIP and Medicaid is that SCHIP plans – like many commercial insurance plans – can limit coverage to services that will cure or treat an illness or injury within a short period of time. Medicaid is called upon “to correct or ameliorate defects and physical and mental health conditions,”⁵⁴ including longer-term rehabilitation services.⁵⁵

Out-of-Pocket Costs - In general, SCHIP rules allow limited cost sharing and premiums for children with incomes under 150 percent of the FPL, and premiums and cost sharing up to five percent of family income for children with family incomes

above that level. Many states have had experience charging premiums and imposing copayments in SCHIP, with mixed results.⁵⁶

GETTING TO THE FINISH LINE— COVERING ALL UNINSURED CHILDREN

Virtually all uninsured children fall into three groups with respect to public programs: (1) children who are eligible for Medicaid or SCHIP but who are not enrolled; (2) those whose family incomes qualify them for Medicaid or SCHIP but who cannot enroll because of federal immigrant restrictions; and (3) children whose family incomes are too high for public coverage.

According to an analysis of 2002 data, nearly three out of four uninsured children were eligible for public coverage, with about half of all uninsured children eligible for Medicaid and about 23 percent eligible for SCHIP. The remaining uninsured children were ineligible for public coverage either because their family income was above the eligibility levels operating in their state or due to immigration status.⁵⁷

Eligible but Uninsured - The expansions in public coverage over the past several years, along with outreach and simplified enrollment and renewal procedures, have not only led to millions more children successfully enrolling, but also meant that many of the children who remain uninsured are now eligible for coverage. Compared to a decade ago fewer children are uninsured, and among those who are uninsured a higher portion are eligible for Medicaid or SCHIP.⁵⁸

What can be done to cover these children? States, localities and community-based organizations have generally found that solutions are at hand – if a state is prepared to bear the costs of higher enrollment rates. A number of studies and initiatives have identified successful practices, and state experience over the past several years has demonstrated that if you build it right, they will enroll.⁵⁹ For example, in Washington state, enrollment declined in 2003 after 12-month renewal cycles were replaced with 6-month cycles, and began to increase again shortly after the 12-month renewal cycle was reinstated in January 2005.⁶⁰

Racial and Ethnic Coverage Gaps - One of the most sobering statistics on children's insurance rates are the differences across racial and ethnic groups that show, in particular, the high rates of uninsurance among Hispanic children.⁶¹ Hispanic and black (non-Hispanic) children both have much lower rates of employer-based coverage than white children⁶² and, in large part because their families tend to have lower incomes than white children,⁶³ they are more likely to be covered by public insurance than white children.⁶⁴

Coverage disparities are particularly acute for Hispanic children, even controlling for income. Black and non-Hispanic white children with family incomes below 200 percent of the FPL are uninsured at roughly the same rate – 14 to 15 percent. The uninsured rate for Hispanic children with family incomes below 200 percent of the FPL, however, is much higher – 24.9 percent.⁶⁵ This is likely due to language barriers and immigration-related barriers (including where a child is a citizen and eligible for Medicaid or SCHIP, but his or her parents are reluctant to apply due to their immigration status).⁶⁶

To a large extent, the future of children's health rests with families, communities and policymakers at the state and federal level. Some of the solutions are at hand – such as expanding coverage through the public sector, and financing and pooling mechanisms that can make it possible for even very small employers to offer working families affordable coverage. Solutions are also available for enhancing children's health and well-being through programs that focus on nutrition education and opportunities for physical exercise. (Such programs are especially valuable for overweight children.) With the reauthorization of SCHIP scheduled to take place in 2007, these issues are likely to again be at the forefront of health policy debates and discussions.

STORY IDEAS

- Some 18 states face SCHIP funding shortfalls in 2006-2007. The Administration proposed level funding for SCHIP in the FY 2007 budget. If SCHIP is level-funded over the next several years, what will be the impact on children's coverage in your state?
- Coming out of tight fiscal times, some states are again looking to expand and improve children's

coverage. If your state is expanding coverage, are policymakers and the public pleased with the results?

- The Deficit Reduction Act allows states, for the first time, to charge children in Medicaid copayments and in some cases premiums. Is your state imposing new copays? Is there a discernible impact on children's enrollment and access to care? If there are copays that families cannot pay, are they being turned away by providers?
- The DRA requires states to collect documents from families to prove citizenship before their children can be enrolled in Medicaid (this new requirement applies just to citizen children; immigrant children are already subject to verification requirements). How is this new rule working, or has your state decided to delay this requirement? What is the impact on enrollment numbers?
- "Waivers" allow states to operate their Medicaid programs in ways that do not conform to regular federal rules. Does your state have a waiver in progress or in the planning stage for children's coverage under SCHIP or Medicaid? If so, are the benefits offered under the waiver richer or leaner? What is the impact on costs for families and the state?
- Do uninsured children in your area have any access to health care services outside of the emergency room? How reliable are such services, what is the quality, and what do they cost?

EXPERTS AND WEBSITES

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Alliance for Health Reform
www.allhealth.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Enterprise Institute
www.aei.org

American Hospital Association
www.aha.org

American Psychiatric Association
www.psych.org/

American Psychological Association
www.apa.org

America's Health Insurance Plans
www.ahip.org

America's Promise
www.americaspromise.org

AMERIGROUP District of Columbia
www.amerigroupcorp.com

Annie E. Casey Foundation
www.aecf.org

Association of Maternal Child Health Programs
www.amchp.org

Center on Budget and Policy Priorities
www.cbpp.org

Centers for Medicare and Medicaid Services
www.cms.hhs.gov

Child Welfare League of America
www.cwla.org

Children's Defense Fund
www.childrensdefense.org

The Children's Partnership
www.childrenpartnership.org

The Commonwealth Fund
www.cmwf.org

Covering Kids and Families
www.coveringkidsandfamilies.org

Economic & Social Research Institute
www.esresearch.org

Families USA
www.families.org

George Washington University Department of
Health Policy
www.gwhealthpolicy.org

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http://ihcrp.georgetown.edu/

Government Accountability Office
www.gao.gov

Health Management Associates
www.hma-corp.com

Healthcare Leadership Council
www.hlc.org

The Heritage Foundation
www.heritage.org

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www.insurekidsnow.gov

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www.kff.org/about/kcmu.cfm

Kaiser Family Foundation
www.kff.org

Mathematica Policy Research
www.mathematica-mpr.com

MCH Policy Research Center
www.mchpolicy.org

National Academy for State Health Policy
www.nashp.org

National Association of Child Advocates
www.childadvocacy.org

National Association of Children's Hospitals
www.childrenshospitals.net

National Association of Community Health
Centers
www.nachc.com

National Association of Public Hospitals
www.naph.org

National Conference of State Legislatures
www.ncsl.org

National Governors Association
www.nga.org

National Health Law Program
www.healthlaw.org

National Partnership for Women and Families
www.nationalpartnership.org

National Women's Law Center
www.nwlc.org

Nemours Health and Prevention Services
www.nemours.org

The Packard Foundation
www.packard.org

Robert Wood Johnson Foundation
www.rwjf.org

Save The Safety Net Campaign
www.savethesafetynet.org

United Hospital Fund
www.uhfny.org

Urban Institute
www.urban.org

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