Ten years ago, health insurance coverage for children in the United States appeared to be on the decline. At that time, in the first issue of *The Future of Children* that focused on health care, we observed that high and rising health care costs, an economic downturn, and concern that the “dynamics in the private health insurance market make continued coverage unpredictable” were all contributing to the public’s dissatisfaction with the health care system.1 The evidence presented in that journal issue suggested that children’s health care was being adversely affected by the same forces buffeting the rest of the health care system. For example, one article reported that children were much more likely to lack health insurance in 1987 than in 1977 and that, over that same period, health care used by uninsured children declined relative to use by children with coverage.2 As this issue goes to press, the economy is once again in a recession after years of strong growth, health care costs are rising rapidly again after several years of moderate growth, and the number of uninsured is growing. Unlike the situation a decade ago, however, the rate of uninsurance among children, which peaked in 1998 at 15.4%, has been declining recently, thanks to the expansion of public health insurance programs for children.

The national commitment to public health insurance programs for children has evolved over several decades, beginning in 1965 with Medicaid for poor children and culminating in 1997 with the enactment of the State Children’s Health Insurance Program (SCHIP) for the uninsured children of working, low-income families. Nationally, almost two-thirds of all children are covered by employer-sponsored health plans offered to their parents in the workplace. Although many low-income children—children in families with incomes below 200% of the federal poverty level (FPL)—have access to employer-sponsored insurance through their parents, many parents cannot afford the premiums to cover the entire family. Other low-income parents work in low-paying jobs that do not offer health coverage, and these parents cannot afford to purchase insurance on their own. For the children of such parents, public coverage plays a critical role. In 2001, Medicaid and SCHIP provided coverage to approximately 24 million children (30% of all children and more than 40% of low-income children), and in 2002, federal and state funds of more than $40 billion were spent on health coverage for low-income children.3

The public investment in children’s health insurance reflects both a national commitment to protect children’s health and the social value that Americans place on children’s well-being. Public-opinion surveys demonstrate broad public support for children’s health insurance; and although many factors in children’s physical and social environments influence their health and well-being, health insurance is an important tool that gives children access to crucial health services.
Despite the progress of recent years, high uninsurance rates among low-income children and families continue to be a difficult and complex policy problem, while state and federal budget deficits coupled with problems with the federal funding formula for SCHIP threaten to undo recent gains. Yet, the findings presented in this journal issue suggest that Medicaid and SCHIP have demonstrated their potential for improving the lives of America’s most vulnerable children. If states and policymakers build on the success of existing programs, these programs could eradicate uninsurance among low-income children in the United States.

This journal issue addresses some of the most persistent questions related to publicly funded health insurance for children and synthesizes lessons learned about how to make these programs more responsive to the needs of low-income children. Among the questions addressed are: Which children are still uninsured and why? What are effective ways to enroll eligible children in public health insurance programs and keep them enrolled? How can public insurance programs better serve the needs of especially vulnerable children, including children with special health care needs, adolescents, and children in immigrant families? We also highlight some creative ways to insure more children.

This article frames some of these issues and draws on the most current research to point to solutions to persistent problems. The article begins by discussing the importance of health insurance for children’s access to health care and describes the progress that has been made in providing coverage for children. The challenges in fulfilling the promise of public health insurance programs are discussed, as well as the steps to extend these programs and implement strategies to cover virtually all low-income children.

**Health Insurance Matters**

At the most basic level, both private and public health insurance coverage reduce the out-of-pocket costs of health care. As a result, children have greater access to health care services and reap the benefits of such services, and families are cushioned from the economic hardship that can accompany an illness or injury requiring medical care. In addition to the tangible benefits for children’s health and families’ economic well-being, health insurance coverage can reduce stress for parents who might otherwise be anxious or frightened about the prospect of rearing children without such insurance. Depending on the scope and depth of benefits offered, health insurance can facilitate access to care for acute and chronic illness, as well as access to preventive care. Improved access to effective health care can improve children’s health status over time, which in turn may positively affect many other aspects of children’s lives. In addition, by helping to underwrite the health care costs of serious illness, insurance reduces the risk that illness or injury will result in economic hardship, which may be especially catastrophic for families with limited means. Hughes and Ng relate in this issue that about 36% of families of children newly enrolled in public coverage reported that the lack of coverage had created financial difficulties for them prior to enrollment, and 74% of these parents reported being worried, scared, and stressed before their children had coverage. By reducing the financial risks uninsured families face, insurance coverage for children can help reduce stress and improve a family’s quality of life.

**Benefits of Access to Health Care**

Research demonstrates that health insurance—whether privately or publicly sponsored—is positively associated with key indicators of children’s use of health services. In comparison to their uninsured peers, children who are insured are more likely to have a regular source of medical care and to receive health care when they need it, and they visit health care practitioners more often.

For instance, a recent study that looked at patterns of health care use among children who were enrolled in SCHIP and those who were uninsured found that children covered under SCHIP were more likely than their uninsured peers to have well-child care, dental and specialty visits, and recommended immunizations. The same study also looked at use patterns among children before and during enrollment in SCHIP and found that children had more outpatient visits and were more likely to have a well-child care visit after they enrolled.

Increased access to health care services also helps ensure that children get the health services they need. For example, insured children consistently have fewer unmet health care needs than their uninsured peers. In a study that examined levels of unmet need for medical care, dental care, and prescription drugs among the same group of
Health Insurance for Children

children before and after they enrolled in SCHIP, levels of unmet need decreased in all categories after enrollment in the public insurance program. A study that compared low-income children with Medicaid coverage and those without insurance found that children with Medicaid coverage were less likely to have unmet or delayed needs for prescription drugs and for medical, surgical, and dental care. In contrast, uninsured children are more likely to have health problems that routine health care could either prevent or help to manage, and they often fail to receive prescribed medications because of cost.

Insurance is also a powerful predictor of whether a child has a regular source of health care. Overall, having a regular source of care, particularly primary care, encourages the use of health services and increases the benefits of services received. As Hughes and Ng note in their article, children who have a regular source of care are more likely to receive needed immunizations and have annual preventive care visits. Their families also report higher levels of satisfaction with their health care. Furthermore, there is evidence that when children develop long-term relationships with a particular health care provider, they may receive more accurate diagnoses, require fewer hospitalizations, and incur lower health care costs.

Of course, health insurance alone cannot be expected to always improve health status; too many other factors are important. Nonetheless, some studies suggest that health insurance can play a very important role. For example, several studies suggest that on select measures, the health of children improves with insurance. A recent evaluation of California’s SCHIP program, Healthy Families, indicated that children who started the program with the poorest parent-reported health status enjoyed dramatic improvements in health after one year in the program, whereas children who started the program in relatively good health maintained their health status. In another study, parents of children with asthma reported improvements in their children’s health after enrollment in New York’s Child Health Plus program.

Other Factors Affecting Health Status and Access to Care

As mentioned above, children’s health status is shaped by a number of factors, many of which—culture, environment, socioeconomic status, geographic location—are not influenced by access to health care. Furthermore, the benefits of health care are bounded at any point in time by limits on scientific knowledge and technical capacity. Thus, although increasing health insurance coverage may improve children’s health, Hughes and Ng caution that it is only one of many issues that must be considered to promote children’s health. The larger social and environmental context that shapes children’s health also needs to be addressed to improve health outcomes for disadvantaged children.

Even families with health coverage may face barriers to receiving care, such as the difficulty of finding a health care provider who is conveniently located, with hours that can accommodate a family’s work and child care schedules. Families may also find it difficult to find providers with the linguistic skills and cultural sensitivity necessary to provide quality care. The low reimbursement rates and the administrative burdens placed on providers by some public insurance programs make many providers reluctant to participate, resulting in additional access problems for families and children. These issues will need to be addressed if public health insurance programs are to reach their full potential to meet children’s needs.

Current Progress in Expanding Public Coverage for Children

Although the creation of SCHIP may have motivated the most recent growth in coverage for children, Mann and colleagues note in this journal issue that public health insurance for children has a long history. The authors trace current programs back to the maternal and child health programs of the Depression Era, including grants to the states for maternal and child welfare through the Social Security Act of 1935 and cash assistance through the Aid to Families with Dependent Children (AFDC) welfare program. The next significant milestone was the 1965 enactment of Medicaid, which provided medical assistance to families who were receiving welfare—primarily unemployed single mothers and their children under age 18. Medicaid also provides coverage for low-income seniors and people with disabilities. The program is structured as a joint federal–state program. States administer the program, making specific decisions about eligibility and benefits within broad
guidelines set by the federal government. The federal government in turn provides matching funds, or payments to the states for some (about 57% on average) of the costs involved with providing health services to Medicaid beneficiaries. A series of expansions (known as the poverty-related expansions) to the Medicaid program began in the mid-1980s and provided the building blocks for SCHIP. For example, the link between welfare receipt and participation in Medicaid was weakened to allow states to cover children in low-income families who were not receiving cash assistance. This change substantially increased Medicaid enrollment of children in the late 1980s and early 1990s.

When Congress reformed welfare in 1996, the Personal Responsibility Work and Opportunity Reconciliation Act (PRWORA) completed the delinking of Medicaid eligibility and the receipt of cash assistance that had begun years earlier. As a result, eligibility for Medicaid is now determined by a family’s income and other resources, not by its status as a welfare recipient. Severing the link between Medicaid and welfare has had its advantages as well as disadvantages. On the one hand, the stigma associated with public benefit programs may have deterred some eligible families from taking advantage of Medicaid. On the other hand, the welfare system did provide a comprehensive intake process that helped some needy, low-income, female-headed families receive a variety of public supports, including Medicaid. Following enactment of PRWORA, children’s enrollment in Medicaid declined, but it has recovered in recent years.

Following a failed attempt by the Clinton administration to institute comprehensive health reform in the mid-1990s, the political momentum around health care focused toward incrementally broadening coverage for children. The result was SCHIP, which was enacted in 1997 through Title XXI of the Social Security Act. Building on the framework provided by Medicaid, SCHIP was intended to provide insurance for low-income, working families who earned too much to qualify for Medicaid, but did not have private coverage. Funded through a federal block grant, the program gave states more flexibility than Medicaid offered to experiment with a variety of approaches to expanding coverage for low-income, uninsured children. For example, states have the option to simply expand eligibility for health coverage under an existing Medicaid plan (Medicaid expansion SCHIP), create a separate SCHIP program, or use a combination of both approaches.

Although Medicaid is targeted to children in families with very low incomes, while SCHIP targets children in higher-income (yet still low-income) families, the two programs have evolved to be interdependent and complementary in a number of areas. (The interdependence between the programs may be beneficial for children, as recent research indicates that many children move back and forth between the two programs as family income changes.) Federal law links the two programs by requiring that children who apply for health coverage under separate SCHIP programs be screened for Medicaid eligibility as well and enrolled in the program for which they qualify. In addition, Wysen and colleagues note that during SCHIP’s initial implementation phase (from 1998 to 2000), the program benefitted from the extensive infrastructure for providing access to health services that state Medicaid programs had developed. Several separate SCHIP programs contracted with health plans their states’ Medicaid programs used, and they used similar quality-assurance techniques. In turn, SCHIP influenced Medicaid enrollment procedures and systems, making it easier for eligible children to enroll in both programs. Nonetheless, the potential still exists to further align and coordinate the two programs in order to serve children more effectively.

The past decade has brought progress in improving children’s access to health care on several important fronts, including reductions in the numbers of children without health coverage, systems that streamline and align enrollment and renewal in public health insurance programs, and the provision of comprehensive health benefits to needy children. In addition, for the first time, public health insurance programs actively worked to enroll eligible children and designed promotional campaigns to encourage families to participate.

### Reducing Uninsurance Rates among Children

Between 1998 and 2002, the number of children in the United States who lacked health coverage declined by approximately 2.6% (1.7 million children). After SCHIP was launched in 1997, health coverage for chil-
dren in families between 100% and 200% of the FPL, SCHIP’s primary target group, increased markedly. Holahan and colleagues note in this issue that in addition to the expansions in public coverage for children that occurred from 1994 to 2000, a robust economy helped drive down uninsurance rates for children by increasing their families’ access to employment-sponsored coverage.

By 2001, Medicaid was providing health coverage to 21 million low-income children, and SCHIP to nearly 3.5 million low-income children. These programs now serve as the primary source of coverage for children from low-income families (those with incomes below 200% of the FPL, or $36,200 for a family of four in 2002).

Simplifying Enrollment
The attention paid to outreach and simplifying enrollment in the SCHIP program has been unusual for public benefit programs, which frequently strive to limit access and restrain usage. SCHIP is designed to reach children in low-income, working families, some of whom may have little experience with public benefits. The program’s success, which has been measured by how effectively it reaches its enrollment targets, rests on its ability to find and appeal to such families, and program administrators have invested funds and energy in marketing and in streamlining procedures and systems to make programs more attractive.

These SCHIP innovations have subsequently influenced Medicaid. Because of its historical link to welfare, Medicaid’s application and enrollment procedures once reflected welfare application procedures: long, complicated forms that needed to be completed in a welfare office; face-to-face interviews that included intrusive questions; and onerous documentation and filing requirements. In the mid-1990s, before SCHIP was created, states started simplifying Medicaid enrollment procedures for children, eliminating asset tests and face-to-face interview requirements and allowing families to apply at some hospitals and clinics rather than welfare offices. SCHIP greatly accelerated this simplification process, and by January 2002, most states had adopted key simplification strategies, which are described in the articles by Cohen Ross and Hill and by Wysen and colleagues.

Providing Comprehensive Health Benefits
The benefit packages under SCHIP and Medicaid in most instances are more generous than those typically offered under private plans. The benefits children receive under Medicaid, for example, are considered particularly comprehensive. Most significant for children was the 1967 creation of the Early Periodic Screening, Diagnosis, and Treatment program (EPSDT) as a component of Medicaid. EPSDT provides comprehensive screenings—such as vision, dental, and hearing screenings—as well as diagnostic and treatment services. As Mann and colleagues explain, the EPSDT program extended Medicaid’s role from simply paying for health services to actively trying to ensure that children receive comprehensive preventive care and treatment with regular health screenings, physician and hospital visits, well-child care, and vision and dental care. Although Medicaid benefits vary by state, they tend to cover more services than are typical under private health insurance or SCHIP. In addition, unlike families with private health coverage, and to a lesser extent SCHIP, families usually do not have to contribute financially toward the care of children covered under Medicaid (cost sharing).

SCHIP’s benefits are designed to be more comprehensive than private coverage, but they tend to be less comprehensive than Medicaid’s. For example, SCHIP benefits include physician, hospital, well-baby and well-child care, prescription drugs, and limited behavioral and personal care services, but not the comprehensive screenings provided under EPSDT. In addition, separate SCHIP programs usually require families to pay premiums and contribute toward the cost of health care that their children receive under the programs, although federal law prohibits these costs from exceeding 5% of a family’s annual income.

Fulfilling the Promise
Medicaid and SCHIP, aided by a strong economy, have made substantial progress in expanding health coverage to low-income children. However, as many as 9 million American children still lack health insurance. If the problem of uninsured children in the United States is to be solved—and public-opinion surveys document that 85% to 90% of Americans think it should be—public health insurance programs have
been demonstrated to be an effective vehicle for providing health coverage to children. Indeed, data presented in the article by Holahan and colleagues in this journal issue demonstrate the potential of these programs, when implemented effectively, to provide health coverage to almost all uninsured children nationwide (see Table 1). Most important to reducing the uninsurance problem facing children is raising participation in Medicaid and SCHIP, as 76% of uninsured children are already eligible for coverage under SCHIP and Medicaid, but are not enrolled. A continued focus on simple and convenient enrollment and renewal systems, as well as proactive outreach and educational efforts, will be key to reaching these children. Special efforts will be needed to enroll Latino and other minority children, children in immigrant families (families in which at least one member is an immigrant), and adolescents. Children in these groups are all over-represented in the ranks of the eligible, but uninsured.

In addition, 6% of uninsured children are undocumented immigrants who would meet the income-eligibility levels for Medicaid and SCHIP. Expanding these programs to cover this population of children and restoring legal immigrant children’s eligibility for federal Medicaid and SCHIP funds (repealed in 1996) would not only reduce the number of uninsured children directly, but could have an important positive impact on the large population of currently eligible but unenrolled children in immigrant families. Lastly, expanding SCHIP eligibility to uninsured children in families with incomes below 300% of the FPL, as several states have done, with adequate provisions to minimize the substitution of public coverage for privately financed coverage (crowd-out) could provide coverage for another 5% of uninsured children. Building on the current

Table 1

The Potential of Medicaid and SCHIP to Reduce the Number of Uninsured Children in the United States

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent of Uninsured Children</th>
<th>Number of Children (in millions)</th>
<th>Annual Cost of Coveragea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Eligible for Medicaid</td>
<td>51%</td>
<td>4.69</td>
<td>$2.9</td>
</tr>
<tr>
<td>Currently Eligible for SCHIP</td>
<td>25%</td>
<td>2.30</td>
<td>$0.8</td>
</tr>
<tr>
<td>Undocumented Low-Income Immigrant Children</td>
<td>6%</td>
<td>0.55</td>
<td>$0.5</td>
</tr>
<tr>
<td>Uninsured Children Made Eligible by Expanding SCHIP Coverage to 300% of the FPL</td>
<td>5%</td>
<td>0.46</td>
<td>$0.2</td>
</tr>
<tr>
<td>Total Children and Costs Associated with Use of Existing Programs to Cover Uninsured Children Up to 300% of the FPLb</td>
<td>87%</td>
<td>8.00</td>
<td>$4.3</td>
</tr>
<tr>
<td>Uninsured Children in Families with Incomes above 300% of the FPLc</td>
<td>13%</td>
<td>1.2</td>
<td>–</td>
</tr>
</tbody>
</table>

aAssumptions in calculations: average annual cost per enrollee—$1,431 in Medicaid and $1,273 in SCHIP; federal matching rates—Medicaid 57% and SCHIP 74%; undocumented children eligible for Medicaid and SCHIP in the same ratio as eligible unenrolled children.

bTotals may not equal 100%, due to rounding.

cThese children constitute less than 2% of all children in the United States.

Sources: Cost data from Holahan, J., and Kenney, G. Urban Institute, based on March 2002 Congressional Budget Office estimates. See also the article by Holahan and colleagues in this journal issue.
system of public and private coverage for children, these additional strategies could leave only about 3% of all children without health insurance.

Currently, however, the progress of recent years, let alone the promise of these additional steps, is threatened by massive budget shortfalls in most states, a growing federal deficit, and an economic slowdown and rising health care costs, which are eroding private health care coverage. In such a fiscal environment, suggesting even modest expansions of coverage may appear audacious, yet as indicated in Table 1, the marginal cost of covering immigrant children and uninsured children up to 300% of the FPL is small relative to the amount that is already being spent to cover currently eligible children ($44 billion) and the amount that will be needed to provide coverage for currently eligible children who are not enrolled in public insurance programs. In any case, to fulfill the promise of the current Medicaid and SCHIP programs, the current federal–state funding systems for these programs will need to be stabilized, enhanced, and better coordinated with the private insurance system.

Because fiscal conditions appear to be so critical to fulfilling the promise of children’s public health insurance programs, reforming program financing is the focus of the next section. We then turn our attention to program operations in the areas of outreach, enrollment, and retention; the needs of especially vulnerable populations; and lastly, program expansions.

**Financing Public Health Insurance Programs**

The rapid growth in public health insurance programs combined with the economic slowdown has surfaced several problems with the federal–state financing systems for Medicaid and SCHIP. Several of these issues, including the need for more money for public health insurance programs during recessions, when tax revenues are down, idiosyncrasies in the financing system for SCHIP, and unequal federal cost-sharing rates for SCHIP and Medicaid, are discussed in this section. In addition, the potentially cost-saving strategy of extending public coverage by using public funds to subsidize employment-based coverage is explored.

**Counter-Cyclical Financing**

For the first time since SCHIP was created, public health insurance programs are struggling to maintain the status quo in the face of rising health care costs, state and federal budget deficits, a weak economy, and a rising number of unemployed and uninsured families.

The demand for public health insurance increases during hard economic times because as unemployment rises, families lose access to employer-sponsored coverage. Approximately 1.4 million Americans lost their health insurance in 2001, and a recent study found that an increase in the unemployment rate of 1% would increase Medicaid enrollment by more than 1.5 million persons, including 1 million children. The overall cost to the Medicaid program of this increase in enrollment was estimated at almost $3 billion, including $1.2 billion to be borne by states. In addition, health care costs have begun to increase rapidly after several years of relative stability. This acceleration in the costs of health care has increased the cost of employer-sponsored coverage, reducing the number of companies that offer employment-based health coverage. Many employers that do offer coverage are asking employees to pay a higher portion of the cost of coverage, leading some employees to drop coverage (particularly dependent coverage, which is less heavily subsidized by employers than coverage for the employee alone).

A slowdown in the economy and an increase in unemployment also impact state and federal revenues. As a result, states and the federal government are struggling with growing budget deficits. States are also feeling the pressure from increased health care costs. Medicaid spending, which makes up more than 20% of all state budgets, is outpacing total state revenue growth. Second only to education in most state budgets, spending on Medicaid, fueled primarily by increases in costs for the elderly and disabled, has grown by 25% over the last two years. States have a limited number of strategies to control program costs. They can reduce program enrollment, reduce benefits, increase cost sharing (premiums, co-payments, and so forth), or reduce payments to providers. All will reduce access to health care. To date, states have applied these options primarily to Medicaid programs for adults, but as states’ fiscal crises deepen, there are increasing reports of plans to apply these cost-cutting measures to programs for children as well.

Governors are projecting revenue shortfalls of $30 billion in 2003, and as much as $80 billion in 2004.
thermore, all states but one (Vermont) are required to balance their budgets each year, which means they must either raise taxes or cut spending on social programs. The federal government also operated with a deficit in 2002 and has a projected deficit close to $200 billion in 2003. Unlike states, however, the federal government can operate with a budget deficit, which gives it more flexibility to contribute to safety net programs during hard economic times.

To cope with the increased need for public health insurance programs during economic downturns and budget crises, state and federal governments would be wise to develop a counter-cyclical financing system that ensures funding for public programs during recessions, when demand for the programs increases. (Although many states have so-called rainy day funds to help cope with revenue shortfalls, these funds do not appear to be adequate to also accommodate the increase in demand for public health insurance coverage that accompanies economic slowdowns.) A possible model for public health insurance programs to follow is the funding system for unemployment insurance. The state and federal governments have established unemployment insurance trust fund accounts for each state that is funded by a payroll tax. When employment is high, the trust fund is built up. When employment is low, the trust fund is drawn down to pay unemployment claims. The federal government can also contribute additional money into the trust fund during difficult times to extend unemployment benefits, as the Bush administration has proposed to do in 2003. A similar counter-cyclical funding system would help ensure adequate funding for SCHIP and Medicaid when demand for the programs increases during difficult economic times.

Another strategy would be to temporarily increase the federal government’s contribution (the federal matching rate) for SCHIP and Medicaid to help states during economic downturns. Legislation to temporarily increase the federal matching rate for Medicaid and also to provide additional fiscal relief for states via federal block grants was introduced in Congress in 2002, but it did not pass. This suggests the need for a more reliable mechanism, such as a specific set of criteria (state revenues dropping below a certain level or an increase in unemployment by a specified amount) to trigger increases in the matching rate and to help states avoid program cuts during recessions.

**RECOMMENDATION: Counter-Cyclical Financing**

State and federal governments should create a financing system that increases funds for Medicaid and SCHIP to meet the increased demand for public health insurance during economic downturns.

**Problems with SCHIP Funding**

SCHIP also faces several major federal funding problems unrelated to states’ current budget problems. These problems are by-products of the way that Congress scheduled the distribution of federal funds to the states for SCHIP. SCHIP was funded as a block grant to states, providing them with $40 billion over 10 years. Yet, the money was not distributed evenly over the 10 years. Instead, Congress allocated more money for the first 4 and last 3 years of the program than for the middle years in order to meet balanced-budget targets. As a result, federal funding for SCHIP decreases by more than $1 billion in each fiscal year from 2002 to 2004. This decrease (the “SCHIP dip”) unfortunately coincides with an increased need for SCHIP funds because of steadily increasing enrollment.

In addition, almost $3 billion of unspent federal SCHIP funds are scheduled to “expire” and return to the U.S. Treasury at the end of 2002 and 2003. These funds will expire because they were not used within the time period established by the SCHIP statute. Although SCHIP (like all new public programs) needed time to establish itself and to meet federal budgeting requirements, Congress allocated more funding to the states in each of the first four years of the program than for any of the next five years. States were allowed to carry forward their unspent federal SCHIP allotments for three years, however, to smooth out the federal funding stream and to fund program growth. Many states have not yet used up all their allotment carry forwards, and although Congress enacted a temporary fix in 2000—reallocating and extending the timeline for use of unspent funds—these funds will revert to the Treasury unless their availability is extended again.
Finally, the allocation formula specified in the statute has resulted in many states receiving more federal funding than they need, while other states may soon use up their initial federal SCHIP allotments. The SCHIP statute provides for unspent funds to be reallocated after three years from the states with unspent allotments to those that have fully spent their federal funds. This reallocation process has been only a limited success, however, with some states having to return their unspent allotment to the Treasury, while others are considering capping their program enrollments when their federal funds are used up.

The net result of these funding quirks is that SCHIP enrollment may slow or even fall (about one-quarter, 900,000, of the children now served by SCHIP may lose their coverage) because 17 states may not have sufficient federal funding to sustain their SCHIP programs between 2003 and 2007. (Because of the SCHIP dip and the expiration of funds, states will have about $6 billion less in federal funding for SCHIP over this four-year period.) Without adequate funding, the program will not be able to provide coverage for children as was intended; and without changing the way funding is allocated among states, states that have fully used their SCHIP funds will not receive additional money to continue to build their programs and may even be unable to avoid having to reduce the number of children they insure.

Legislation to address some of these SCHIP funding problems was introduced in the Senate in 2002 and again this year, and the National Governors’ Association and others have proposed remedies for SCHIP’s funding problems. But to date, nothing has passed, and $1.2 billion in unspent federal SCHIP funding reverted to the Treasury at the end of Fiscal Year 2002.

**RECOMMENDATION: SCHIP Funding**

The federal government and states should work together to resolve the funding problems in SCHIP to ensure stable and adequate federal funding for SCHIP in all states.

**Discrepancies in the Federal Matching Rate**

The federal matching rate refers to the percentage of program costs that the federal government provides to states for their Medicaid and SCHIP programs. This rate, which depends on a number of factors, varies among states and over time. In general, the federal matching rate is higher in states that have fewer resources per person than in wealthier states.

Yet, while Medicaid serves many more children than SCHIP and targets children in families with lower incomes than those covered under SCHIP, the federal matching rate for SCHIP is on average 30% higher than the rate for Medicaid. As a result, the federal government currently pays about 57% of Medicaid program costs and 74% of SCHIP costs, which means that states have to use more of their own money to cover children who are eligible for Medicaid than to cover children in SCHIP. This provides states with a financial incentive to enroll children in SCHIP rather than Medicaid because states can use fewer state dollars per SCHIP enrollee.

Raising the federal matching rate for children enrolled in Medicaid to the same level as the SCHIP rate would help states deal with their current financial crises and would be good policy for children for several reasons. First, Medicaid serves the bulk of low-income, uninsured children and is designed for the very disadvantaged, those who need public coverage the most. One out of every five children nationwide receives health coverage under Medicaid. Medicaid pays for 30% of all pediatrician visits, 38% of child hospitalizations, and 40% of all U.S. births. Raising the federal Medicaid matching rate would make it easier for states to maintain and improve the quality and integrity of their children’s Medicaid programs. In addition, because more than one-half of uninsured children are in fact eligible for Medicaid, raising the matching rate would reduce the cost to states of enrolling these uninsured children, increasing the likelihood that states will move more aggressively to reach and enroll these children. Also, because the federal government can run a budget deficit while states cannot, Congress might consider raising the matching rate to help states serve vulnerable children during difficult economic times, when demand for public health coverage increases. Finally, many children currently move back and forth between SCHIP and Medicaid as their families’ economic circumstances change or they age. Using the SCHIP matching
rate for both programs would simplify administration and reduce the need for certain program eligibility rules and procedures that can act as barriers to enrolling children in either program.54

The risk, however, particularly in challenging fiscal environments, is that states will use the additional funds provided by an increased federal Medicaid match for other programs. Therefore, it may be appropriate to tie any increase in the Medicaid matching rate to a requirement that states maintain most or all of their funding commitments to their children’s Medicaid programs. This would create an incentive for states to expand program enrollment or improve their programs in other ways, such as by enriching benefit packages or increasing reimbursement for providers.

**RECOMMENDATION: Federal Matching Rates**

The federal government should raise the federal Medicaid matching rate for children to the same level as the SCHIP matching rate to encourage states to enroll more children in Medicaid, to provide states with fiscal relief, and to simplify administration.

**Coordinating with Employer-Sponsored Coverage**

Cost remains a barrier to expanding public health coverage for children, especially in difficult economic times. One potentially cost-effective avenue for expanding health coverage to children and families is to use public funds to subsidize private group health insurance offered through employers. This approach is practical because, although many uninsured poor children have parents who work at jobs that do not offer health coverage, 40% to 50% of uninsured children in families with incomes between 133% and 250% of the FPL have access to employer-sponsored coverage. In addition, the business community supports health coverage for children: 9 out of 10 employers nationwide reported concerns about uninsured children and their belief that every child should have some basic level of health care.55

Both SCHIP and Medicaid already authorize the use of public funds to help eligible low-income families pay the premiums for employer-based coverage. Curtis and Neuschler in this journal issue describe a strategy called premium assistance that uses public funds to enroll eligible children in their parents’ employer-sponsored coverage. Premium assistance offers the potential for cost savings because employers usually cover most (70% to 75%) of the costs involved with providing family coverage.56 For example, Rhode Island saves an average of $178 per month for each family enrolled in its premium-assistance Medicaid program rather than its straight Medicaid program.57 Moreover, through premium-assistance programs, states can frequently insure entire families for less than the cost of enrolling eligible children in Medicaid or SCHIP. Children benefit when their parents have health coverage, and many parents prefer to have all family members in the same health plan.

As Curtis and Neuschler note, although a number of states have attempted to launch premium-assistance programs, progress has been slow, in part because of administrative rules under SCHIP intended to protect children from the limited benefit packages and families from the potentially burdensome cost sharing found in some private insurance plans. Recently, waivers have been granted to several states to relax some of these restrictions on the condition that families can choose to enroll their children in either the “regular” SCHIP program or an employer-sponsored plan and can switch to the purely public plan if they find that the employer-sponsored plan does not meet their needs.58

**RECOMMENDATION: Coordination with Private Coverage**

States and the federal government should cooperate in developing cost-effective health coverage for low-income children and their families by coordinating public health insurance programs with private, employer-sponsored coverage.

**Addressing Barriers to Outreach, Enrollment, and Retention**

Because the Medicaid and SCHIP programs have tremendous potential to address the problem of uninsured children, understanding and addressing the factors
associated with children’s participation or lack of participation in these programs is key to solving the problem. Program policies and administrative practices, lack of knowledge about program availability, and not wanting or needing coverage have been identified as the main impediments to participation (see the article by Holahan and colleagues in this journal issue). Accordingly, simplifying program rules and administrative practices associated with both enrollment and retention, and educating parents about the availability and value of coverage (outreach activities), can lead to significant reductions in the ranks of uninsured children. (See the article by Wong in this journal issue for a discussion of innovative approaches to reducing uninsurance among children.)

Understanding the Causes and Consequences
Before modifying program practices and procedures, it is important to consider why these practices exist. Many program requirements and administrative procedures were established to ensure program integrity—that is, to make sure that the programs serve only the children they were intended to serve. For instance, documentation of income requirements helps to assure that only children in families with incomes that qualify them for public health coverage receive it. (In this issue, Blumberg discusses the challenges of targeting coverage to specific populations while ensuring that a wide range of children are served.) The downside of using daunting administrative procedures (extensive documentation requirements, long detailed application forms, in-person interview requirements, frequent reporting, or reenrollment requirements) to ensure program integrity is that they can discourage even eligible families from participating in important programs.

A solution, however, lies in the definition of “program integrity.” If a more comprehensive definition were used, one that includes how well a program serves its eligible population as well as how effectively it screens out the ineligible, the states could focus on balancing the impacts of exclusionary requirements against the imperative to serve targeted populations. Ultimately, decisions as to which administrative practices should be retained can be based on empirical research on the impact on program integrity of different policies and procedures, and agreement among stakeholders on what are acceptable trade-offs between enrolling eligible and excluding ineligible children and families.

Unfortunately, there has been little research on the impact of different administrative procedures on program integrity. There is, however, much anecdotal evidence (as documented by Cohen Ross and Hill in this issue) of the positive effect on program participation of administrative simplification and of a change in the relative values assigned to enrolling versus excluding children from public health insurance programs that accompanied the rollout of the SCHIP program beginning in 1998.

Specifically, when Medicaid was viewed as a welfare program tied to cash assistance, it included many administrative rules, practices, and procedures to discourage participation. With the advent of SCHIP and federal welfare reform, however, the reframing of the children’s Medicaid program as a health insurance program, and a shift in policy focus to reducing the number of uninsured children, many of the administrative barriers to children’s participation in Medicaid were reduced or eliminated.

At the same time, in some states vestiges of the old restrictive Medicaid system remain, which means that the system that serves the poorest children still has more enrollment barriers than does SCHIP. For example, as of January 2002, four states required face-to-face interviews for enrollment into their children’s Medicaid programs; only one state required these interviews for its SCHIP program as well. Four states also maintained an asset test (families need to document their assets on the application for benefits and are not eligible if their assets exceed a certain level) in their Medicaid programs, whereas only one SCHIP program had an asset test. In addition, many states that cover low-income parents as well as children in their Medicaid programs impose more enrollment requirements on adult family members than on children, with the result that it is more difficult for children to enroll as part of a family than as individuals. This complicates matters for parents and runs counter to parents’ preference to enroll the entire family in a single insurance program.

The good news, however, is that most states have greatly improved their enrollment procedures in recent years (38 states required face-to-face interviews in 1997), and states are gradually adopting other procedures to simplify enrollment and retention processes. For example, 13 states do not require families to provide verification of the income they report on their applications. This system greatly reduces the paperwork burden on families. These
states now verify income and other information by matching identifying information provided by the family with existing state databases. Some states that have adopted self-declaration report a substantial reduction in application-processing time and costs while maintaining high levels of accuracy.59 Other studies have documented administrative cost savings from other administrative simplifications. Because effective simplification strategies increase enrollment in health insurance programs, however, they are not likely to reduce overall program costs. Nonetheless, reducing administrative costs can free up resources for delivery of health care services to enrollees.

There is a danger that in the current fiscal environment, states will undo some of the administrative simplifications adopted in recent years in order to reduce program participation and program costs. For example, in 2001 Kentucky rescinded its policy that allowed self-declaration of income on children’s health insurance applications, and it is considering reinstatement of face-to-face interview requirements at initial enrollment.60 Using administrative procedures to reduce enrollments and public expenditures on coverage for children runs counter to the purpose of the programs.

Improving the Alignment of SCHIP and Medicaid
Further efforts can be made to streamline and simplify enrollment. One key area requiring further work, for example, is the need to improve the alignment of rules and procedures between Medicaid and SCHIP. Thirty-five states offer both Medicaid and separate SCHIP programs for low-income children. Yet, the interdependent and complementary relationship of Medicaid and SCHIP means that children move from one program to another as their family circumstances change or as they age. Aligning the programs and simplifying procedures that allow children to move between the programs would make the programs easier for families to navigate and would enable children to receive care more efficiently.

Thirty-three of the states that have separate SCHIP programs allow families to use a single form to apply for both Medicaid and SCHIP for their children, but many programs maintain program and procedural characteristics that create hurdles for families. Families may even have some children eligible for Medicaid and others eligible for SCHIP, so the families must comply with different sets of reporting requirements, deadlines, and procedures to provide health coverage for all their children.61 Twenty states, however, have enacted uniform eligibility criteria for all children in a single family.

Programs can also be more responsive to changes in family circumstances by making it easier for children in families experiencing financial hardship to transfer from a separate SCHIP program into a Medicaid program (as most Medicaid programs do not require a financial contribution, whereas some SCHIP programs do). States can facilitate transfers by using a joint renewal application and establishing systems for sharing relevant information about children participating in both programs.62 For example, Florida and Texas transfer applications electronically, whereas Kansas and New Jersey coordinate among eligibility workers to determine children’s eligibility for either program. Other states with separate programs have facilitated enrollment and maximized administrative efficiency by using similar methods to determine eligibility and similar enrollment procedures, and by allowing one worker to determine eligibility for both programs.

Making Renewal as Easy as Possible
Enrolling eligible children in public coverage programs is only the first step toward ensuring their access to health care; keeping children enrolled presents an ongoing challenge. Many studies have demonstrated that eligible children are at risk for losing coverage at any time, but that the probability of disenrollment is highest when children must renew their coverage. Both SCHIP and Medicaid have encountered the problem of “churning,” in which children lose coverage but reenroll within a few months. Other children bounce between Medicaid, SCHIP, and private coverage. An unknown number may experience protracted periods of uninsurance after disenrollment. In response, states have adopted a variety of approaches for simplifying renewal policies and procedures, as outlined below and discussed in the article by Cohen Ross and Hill.

For example, a growing number of states allow families to renew coverage for their children at longer intervals (such as every 12 months rather than every 6) or allow children to retain their public coverage for a full year even if their family income changes.63 Twenty-one states are using joint renewal forms for Medicaid and SCHIP, which are helpful to families who have children in different programs or whose changed circumstances have
shifted their eligibility from one program to the other. Some states provide families with preprinted renewal forms and ask them to provide updates at renewal only on information that has changed. States are also experimenting with different methods for following up with families, such as phone calls, to remind them to reenroll their children. Florida uses a method called automatic or passive reenrollment in its SCHIP program. This procedure allows children to remain enrolled as long as families do not notify the program that their circumstances have changed, but continue to pay the program premiums. A recently published study found that although other states experienced 30% to 50% drops in enrollment at renewal in the absence of premiums, Florida’s disenrollment at renewal was only 5%.64

RECOMMENDATION: Streamlined Procedures

States should make application, enrollment, and renewal procedures for Medicaid and SCHIP as easy as possible and should ensure that rules designed to maintain program integrity do not deter participation by eligible children.

Innovative Measures to Facilitate Enrollment

Two promising measures for streamlining enrollment, highlighted in this journal issue in articles by Klein and by Horner and colleagues, respectively, are presumptive eligibility and coordination with other public programs for children. A small number of states have used these strategies to ensure that eligible children receive coverage as quickly as possible and to create partnerships with other public programs that target children in low-income families.

Presumptive Eligibility

Presumptive eligibility allows entities such as health care providers and schools to immediately, but temporarily, enroll children who appear eligible into public health insurance programs. While their families complete the application process, the children will receive health care services for which providers are reimbursed, even if a child is ultimately found to be ineligible.65 As of August 2002, 10 states had adopted presumptive eligibility under Medicaid, and 5 states had adopted it under SCHIP.66 Klein explains that in addition to ensuring quick access to care, presumptive eligibility allows states to involve community-based organizations in enrollment as well as outreach. In turn, families can learn about children’s health insurance and receive application assistance from familiar and trusted sources. A national survey of low-income families with uninsured children showed that parents were more likely to enroll their children in Medicaid if they could enroll immediately upon receiving services and provide forms later.67 A downside of presumptive eligibility is that it will increase the number of ineligible children who are enrolled and receive services and will also increase disenrollment rates when these children are disenrolled. There is also some risk that presumptive eligibility, because it provides coverage at the point of service, could encourage families to use the programs for episodic and sporadic acute care rather than for preventive care. It may be appropriate, therefore, for states to monitor the effect of presumptive eligibility on care-seeking behavior and to provide education or other supports to encourage sound program utilization by children enrolled through the process.

Coordinate with Other Public Programs

Another potentially effective approach is to coordinate enrollment for health insurance with enrollment in other public benefit programs. Many uninsured children are enrolled in other public programs that have eligibility requirements similar to Medicaid and SCHIP.68 For example, 63% of low-income, uninsured children are in families that receive food stamps or participate in nutrition programs such as the National School Lunch Program or the Special Supplemental Food Program for Women, Infants, and Children (WIC). Through a strategy known as express lane eligibility, Medicaid and SCHIP are linked with other public programs that target children in low-income families. An uninsured child’s enrollment in those programs can then serve as a basis for qualifying that child for public health insurance.69 Using this approach, states and other organizations can take affirmative steps to ensure that children who are enrolled in other public benefit programs are enrolled in health insurance as well.

Approaches of varying intensity are possible. For example, application for or enrollment in other public
benefit programs could be used as the basis for outreach to families for Medicaid or SCHIP. Joint applications could be developed for these programs, and enrollment in the health insurance programs could be facilitated by the staff and systems that handle enrollment into the other programs. A potential limitation of this approach is that several of the public benefit programs (specifically the nutrition programs) have less stringent enrollment criteria than do Medicaid or SCHIP—they typically do not require verification of income or citizenship. Accordingly, linking these programs to Medicaid and SCHIP may subject participants in the other programs to a more rigorous level of scrutiny and may theoretically lead to a reduction in participation in the other programs. It may be prudent, therefore, to approach program coordination efforts cautiously and to monitor the impact of these efforts not only on enrollment in public health insurance programs, but on enrollment in the other public benefit programs as well.

Linking outreach for Medicaid and SCHIP to application for employment insurance or to job termination procedures may be another effective but underutilized way of boosting program participation and cushioning the impact of job loss on families with children. Because the majority of children obtain health insurance through their parents’ employment, a parent’s job loss can trigger an episode of uninsurance. Although families have the option under COBRA of continuing coverage for up to 18 months after a job termination, this unsubsidized coverage is unaffordable for many low- to moderate-income families. Job loss may also trigger a reduction in family income, which may make a child eligible for Medicaid or SCHIP. Accordingly, it appears likely that the time of application for unemployment insurance, or the formal exit interview at which employees are informed of their COBRA options, presents an opportunity to enroll children in public health insurance programs. This opportunity was explored in Congress in late 2001 and early 2002 in response to the rapid rise in unemployment that followed the terrorist acts on September 11, 2001, but interest in such linkages waned because of difficulties in working out the details of how to target coverage to those affected indirectly by the attack.

RECOMMENDATION: Coordination with Other Programs

States should coordinate enrollment in public health insurance programs with enrollment in other public benefit programs that target low-income children (such as school lunch and food stamp programs) to increase children’s coverage.

Sustain Outreach Efforts

The launch of SCHIP in 1998 spurred intensive efforts to make the public aware of the new program and to actively encourage enrollment. SCHIP’s objective of reducing the number of uninsured children in the United States dramatically influenced Medicaid’s outreach and enrollment procedures. For the first time, a public health program emphasized the importance of program promotion and active efforts to enroll eligible children. As described by Perry in this journal issue, states developed a range of marketing strategies to promote their public programs, including choosing appealing names and engaging the media, churches, and schools in enrollment campaigns. Most states (73%) promoted their SCHIP and Medicaid programs jointly, which likely increased enrollment in both. Some states report that they enrolled several eligible but previously uninsured children in Medicaid for every child enrolled in SCHIP.

Yet budget constraints and an economic downturn have severely constrained states’ ability to continue with their public education and media campaigns. State budget shortfalls not only put pressure on outreach budgets directly, but also create strong incentives to reduce outreach efforts in order to slow or reverse the growth in program enrollments and program expenditures. Nonetheless, sustaining intensive outreach and public education efforts is necessary to reduce the high numbers of uninsured children who are eligible for public coverage but not enrolled—especially since lack of knowledge about program availability and not valuing coverage remain important impediments to participation.

At this point in the evolution of the SCHIP and Medicaid programs, targeting outreach and public education...
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campaigns to specific groups with elevated rates of uninsurance, such as children in immigrant families, other minorities, and adolescents, may make good use of limited funds. Outreach to immigrant families should be in their own languages, should employ culturally appropriate messages to educate parents about the value of coverage and how to access the system, and should seek to allay inappropriate fears that program participation will jeopardize a family’s stay in the United States. Similarly, adolescents need outreach programs that speak to their needs and concerns. Lastly, outreach to families made eligible for SCHIP or Medicaid as a result of the economic downturn may be particularly valuable if these families have not interacted with public assistance programs in the past. For all these groups, outreach from community-based organizations and institutions—and from other public benefit programs such as unemployment insurance—can be cost-effective.

Working with Community-Based Organizations

Increasingly in recent years, states have partnered with community-based organizations and institutions as part of their outreach efforts, opening new opportunities for reaching vulnerable populations such as adolescents and immigrants. SCHIP administrators have developed partnerships with community-based organizations to assist with enrollment in public health coverage and to complement broad outreach and marketing campaigns. Unlike Medicaid regulations, federal SCHIP regulations allowed states to use a variety of organizations to determine a child’s eligibility for coverage. SCHIP used this flexibility to leverage the trusting relationships that families develop with familiar organizations they deal with frequently, such as schools and community health clinics. One study showed that California families who received assistance from community organizations during the application process were approved for coverage at a higher rate than those who did not receive assistance. In particular, Cohen Ross and Hill note in this journal issue that community organizations may provide invaluable assistance for families that do not speak English, have concerns about how program participation might impact their immigration status, or simply need a convenient place to apply during off hours. Culturally competent, community-based organizations can be an effective way to reach uninsured immigrant children. In addition, some communities have existing traditions of health-related outreach that programs can incorporate into their efforts to reach eligible children. For example, in the article by Lessard and Ku in this journal issue, the promotoras in many Latino communities are highlighted as a useful resource for helping families navigate public programs.

In addition, community organizations have provided important feedback to program administrators that has resulted in improved applications. For instance, in response to input from schools and community groups that staffed an enrollment event in the public schools, Chicago shortened its application and clarified that parents did not have to provide their own Social Security numbers when applying for coverage for their children.

RECOMMENDATION: Outreach and Education

States and the federal government should maintain outreach and public education as a priority and should work with community-based organizations to target children who are disproportionately uninsured, such as adolescents, minority children, and children in immigrant and newly unemployed families.

Focusing on Vulnerable Populations

Rates of uninsurance and access to appropriate care among children vary along dimensions such as family income; parental work status; age, race, and ethnicity; citizenship status; geographic location; and need for care. Some groups of children, such as adolescents and children in immigrant families, particularly Latinos, have a higher risk for being uninsured. These two groups of children, as well as children with special health care needs, would all benefit from health insurance programs that are responsive to their high-priority needs and concerns. Three articles in this journal issue discuss the challenges of reaching difficult-to-serve populations and describe strategies for serving these vulnerable children more effectively.

Tailoring Programs to Accommodate Children with Special Health Care Needs

Preliminary data from the first nationwide survey of children with special health care needs (SHCNs) indicates that children with special needs represent 15% to 18% of the total population of American children. Although the
term “special health care needs” has been defined in a number of ways, these children tend to have chronic conditions and a high need for services, especially specialty and ancillary care. Accordingly, care for these children accounts for almost 50% of all health care expenditures for children.\(^7\) Children with SHCNs are also especially vulnerable to adverse health outcomes and are therefore an important group to consider when designing public health insurance programs.

In an article in this journal issue, Szilagyi reviews the publicly funded programs that serve children with SHCNs and describes the challenges and opportunities involved in their care. In addition to Medicaid and SCHIP, children with SHCNs are also served by Title V of the Social Security Act, which provides money to states for community-based programs; Supplemental Security Income (SSI), also a Social Security program, which provides cash assistance to families to help with expenses related to disabilities; and Katie Beckett waivers, which allow states to use Medicaid funds to cover health care for children with SHCNs who otherwise would be ineligible and would have to forgo needed care. As Szilagyi notes, Medicaid is particularly well suited for children with SHCNs because it offers a very comprehensive benefit package and is an entitlement with little or no cost sharing. In fact, families of children with SHCNs are generally more satisfied with the care provided through Medicaid than they are with private insurance coverage.\(^6\) A consistent finding, however, is that Medicaid’s low reimbursement rates for providers make many providers reluctant to care for children with SHCNs, which can limit children’s access to appropriate care.

Although most separate SCHIP programs offer children with SHCNs a richer, more appropriate benefit package than the typical commercial plan, many basic SCHIP plans fall short of Medicaid in providing for children with SHCNs. Some states try to supplement basic SCHIP benefits with wraparound coverage (additional coverage, such as for dental or rehabilitation services) or carve-out programs (special service delivery programs, such as for mental health services), but these arrangements may complicate access to and coordination of services, and there is yet little systematic evidence as to how well these arrangements are working.

In addition, some states require that children be uninsured for anywhere from one to six months before enrolling in SCHIP.\(^7\) The purpose of this provision is to discourage families with employer-sponsored insurance from switching to SCHIP. Yet, as Szilagyi notes, such waiting periods present a particular risk for children with chronic or urgent medical conditions who need health coverage without delay. Some states have attempted to remedy this problem by exempting children with special needs from waiting periods.\(^8\) Other states have exempted children from waiting periods if their families have spent more than a certain proportion of their income (for example, 5% in Connecticut) on health care.\(^9\)

Szilagyi also identifies a number of ways in which health insurance programs for children, private as well as public, could be improved, including enhanced outreach, improved wraparound (supplemental) services, strengthened provider networks, financial incentives appropriate for the additional costs of caring for children with SHCNs, improved care management and cross-program collaboration, and enhanced quality-monitoring and quality-improvement programs.

**RECOMMENDATION: Children with Special Health Care Needs**

States should monitor how well their Medicaid and SCHIP programs are serving children with special health care needs in the areas of enrollment, scope of benefits, access to providers, and coordination of care, and take appropriate action to improve performance.

**Adolescents**

Adolescence is a unique developmental stage of accelerated growth, when a number of physiological, cognitive, social, and emotional changes occur simultaneously. As a result, according to Brindis and colleagues in this journal issue, prevention, early intervention, and health education are especially important for adolescent children. Yet, adolescents are significantly less likely than their younger peers to have health coverage, and participation rates in public programs are lower for eligible teens than for eligible children under age six.\(^8\) Low insurance rates among adolescents are troubling because the transition from childhood to adulthood represents a critical oppor-
tunity to prevent the onset of health-damaging, risky behaviors such as smoking, substance abuse, or unsafe sex, which can lead to lifelong health problems and unwanted pregnancies.

Although historically the Medicaid eligibility standards for adolescents were more restrictive than for younger children, program expansions in the late 1980s through the early 1990s and the creation of SCHIP in 1997 greatly increased adolescents’ eligibility for public health insurance. These expansions of coverage equalized eligibility thresholds for children of different ages, but studies show that low-income parents of adolescents are still less likely to think their children are eligible for public coverage than parents with younger children. As a result, the uninsurance rate among adolescents (children ages 10 to 18) is about 14%, with even higher rates among low-income and minority adolescents.

To increase participation by adolescents in public health insurance programs, more attention needs to be paid to developing effective outreach and enrollment strategies and to providing a health care delivery system that is responsive to adolescents’ needs and concerns. Little is known about which outreach strategies are effective in reaching adolescents generally or what works with specific subpopulations of youth who are at high risk for health problems. Brindis and colleagues recommend that states work with service organizations, schools, and health care providers to develop, implement, and evaluate outreach strategies targeted to adolescents. Once enrolled, adolescents will also need education on how to access services, because many adolescents may want to access services independently of their parents.

Adolescents need a broader set of health care services than do younger children (for example, family-planning, reproductive health, mental health, and substance-abuse services) and may access services in different venues (school-based and family-planning clinics, for example) than younger children. In addition, studies show that assurances of confidentiality increase adolescents’ effective use of care and that without confidentiality protection some adolescents will forgo care. However, not all states have modified their Medicaid and SCHIP programs to address adolescents’ needs. In addition, studies show that assurance of confidentiality increase adolescents’ effective use of care and that without confidentiality protection some adolescents will forgo care. However, not all states have modified their Medicaid and SCHIP programs to address adolescents’ needs. For example, some programs do not cover appropriate preventive services for adolescents in accordance with the most current guidelines. Restrictions on mental health and substance-abuse treatment benefits, which may apply as well to younger children and adults, may have greater significance for adolescents than they do for other age groups. Lastly, although all states offer some confidentiality protections to adolescents under age 18, Brindis and colleagues report that more could be done to improve the policies and practices of health plans and health care providers to assure confidentiality protections for adolescents.

Brindis and colleagues identify two groups of adolescents needing special attention: those leaving foster care and those leaving the juvenile justice system. Many adolescents who leave the foster care system at age 16 or older have serious unmet physical and mental health needs, but lack familial and financial supports. These highly vulnerable adolescents are covered by Medicaid while in foster care, but become uninsured after leaving foster care because few states have taken advantage of a federal option to expand Medicaid coverage to age 21 for members of this population. Similarly, many youth in the juvenile justice system experience significant behavioral problems and acute and chronic medical conditions. While in custody, these youth receive care through the juvenile justice system, but many of their problems persist when they leave custody. Because many of these youth are eligible for Medicaid or SCHIP upon their release from custody, Brindis and colleagues recommend screening these young people for eligibility for these programs upon their release.

**RECOMMENDATION: Adolescents**

States should experiment with special outreach efforts to increase adolescent participation in Medicaid and SCHIP and should closely monitor how well these programs are meeting adolescents’ needs.

**Immigrants**

The United States is a nation of immigrants, yet many children in immigrant families are not covered by health insurance. One in five children under age 18 is either an immigrant or a member of an immigrant family (see the article by Lessard and Ku in this journal issue for a
detailed description of different categories of immigrant families).\textsuperscript{83} The majority (75\%) of these children are native-born citizens, while 25\% are noncitizens. Since 1990, the number of children in immigrant families has increased seven times faster than the number of children in nonimmigrant families. As Lessard and Ku put it, one of the most important risk factors for lack of health insurance among children in the United States is family immigration status. One in four uninsured children lives in an immigrant family.\textsuperscript{84}

A subset of immigrant children is barred from participating in Medicaid and SCHIP by eligibility restrictions, but many low-income children in immigrant families are in fact eligible for coverage, but not enrolled. Eligible children remain without coverage because their families encounter too many obstacles (for example, language barriers and documentation requirements) while trying to enroll them, are confused about program availability and eligibility, or fear the possible repercussions of accessing public benefits. In their article, Lessard and Ku outline a number of suggestions for addressing these barriers.

Several studies have documented the negative impact of welfare reform on immigrant children’s use of public health insurance programs and other benefits.\textsuperscript{85} Some of the confusion about eligibility stems from the new categories of eligibility for all public benefits, including health insurance, created when Congress reformed federal welfare policies in 1996. These new categories distinguish between immigrants who entered the United States before and after August 22, 1996, the date the law was passed.\textsuperscript{86} Overall, as Lessard and Ku note, the proportion of eligible immigrant children covered by Medicaid and SCHIP dropped by nearly 8\% after the 1996 welfare law was enacted.\textsuperscript{87}

In addition, the anti-immigrant policy climate of the 1990s appears to have eroded immigrants’ confidence in their ability to access public benefits without repercussions even if they are eligible.\textsuperscript{88} For instance, in a recent three-city (San Francisco, Miami, and New York) survey of Latina mothers who had just given birth, those who lived in California were six times more likely to report facing obstacles and a sense of fear when they attempted to access publicly provided health care services than similar women in New York and Florida.\textsuperscript{89} Common concerns were that applying for public health insurance would jeopardize their immigration status or make it more difficult to become citizens and that they would someday have to reimburse the government for health care costs. Such concerns acted as barriers to participation for many women who were eligible for coverage. A series of California policies, such as Proposition 187, a 1994 ballot measure that would have restricted the access of undocumented immigrants to most public services, appear to have contributed to an environment of anxiety among immigrants.

Overall, the restrictions on providing coverage to legal immigrant children in the 1996 federal welfare law appear to have adversely affected the participation of eligible children in immigrant families as well. The situation is made more confusing by a provision of the legislation that allows children to enroll in federally funded Medicaid and SCHIP programs after five years of residence in the United States. Coupled with the fact that children born in the United States are citizens and so are eligible for coverage, this provision means that immigrant families can have children in multiple eligibility classifications that will change over time. Fortunately, several states have offered Medicaid and SCHIP coverage to legal immigrant children with state funds; however, these programs may be in jeopardy when state budgets are constrained.

**Restore Eligibility for Legal Immigrant Children**

Restoring federal eligibility for public health coverage for those who lost coverage as a result of welfare reform in 1996 would have several major benefits. It would provide coverage to a number of low-income immigrant children currently barred from participating in public programs they would have been eligible for prior to August 22, 1996; simplify the application processes for these programs for all children; reduce the anxiety and concern that immigrant families feel about accessing public health coverage for their children; and perhaps, therefore, increase participation in these programs by currently eligible children. Federal support would be especially important now, when states that are providing this coverage without federal funds are facing revenue shortfalls. Moreover, restoring these benefits would make federal policy toward legal immigrant children more consistent. Last year, the food stamp eligibility that had been revoked for these children in 1996 was restored, and they remain eligible for federal nutrition programs such as school lunch and WIC.
RECOMMENDATION: Legal Immigrant Children

The federal government should restore its funding for public health insurance programs for legal immigrant children who lost coverage following the enactment of welfare reform in 1996.

Cover Low-Income Children Regardless of Immigration Status

Restoring federal eligibility for all legal immigrant children would not help the undocumented immigrant children who comprise 6% of uninsured children. All states are required to cover eligible immigrants’ emergency medical care under Medicaid, and some states allow children to enroll in advance for the emergency care benefit. Even though enrolling children in strictly limited programs is not ideal, enhancing access to emergency care could lead to earlier and less costly interventions.90

Although extending health coverage to undocumented immigrant children may seem to be a daunting political challenge, ample precedent to do so exists. Lessard and Ku describe initiatives in several states and localities to insure immigrant children, regardless of immigration status.91 They also note that undocumented children are currently eligible for nutrition programs such as school lunch and breakfast. There is also strong reason to believe that eliminating immigration status as a factor in program eligibility could substantially increase participation by children in immigrant families who are eligible under current law, but who do not enroll because of confusion or concerns that the immigration status of other family members could be threatened by their participation.

Expanding federal coverage to include undocumented children will also provide fiscal relief to states and safety net providers. Three states and the District of Columbia use their own funds to provide at least some coverage for undocumented children. In addition, to the extent that state and locally funded safety net providers end up serving the health care needs of low-income immigrant children with little remuneration, federal participation in the funding of health insurance for these children can help reduce state and local outlays and shore up safety net providers.

Provide Linguistic and Culturally Competent Assistance

For children in immigrant families, restoring or expanding eligibility for Medicaid and SCHIP will not alone guarantee enrollment or access to health care services. Immigrant parents and their children will need linguistically and culturally competent assistance in applying for benefits and using the health care system. As previously discussed, trusted community groups can play that role as well as help allay concerns that getting medical assistance might endanger a family’s immigration status. In addition, because linguistic and cultural competence are integral to quality health care, efforts (resources, administrative procedures, and monitoring) to assure the greater availability of such care should be part of any attempts to service this population.

Lastly, although there are many ongoing evaluations of the impact of coverage expansions on children, little is known about how coverage expansions impact children in immigrant families. This issue requires more research to help us understand how to effectively reach, enroll, and serve these children, as well as to measure the benefits they may derive from coverage. In addition, because of concerns about the possible adverse effects of expanding coverage for immigrant children on state budgets and immigration patterns, these two issues should be studied as well.

RECOMMENDATION: Undocumented Children

States and the federal government should expand Medicaid and SCHIP coverage to all low-income children regardless of immigration status and should provide linguistically and culturally appropriate services to ensure that all children can benefit from the expanded coverage.

Next Steps: Expanding Coverage to More Children and to Parents

Though SCHIP and Medicaid have made substantial progress in filling the gaps in health coverage for children in families that cannot afford private insurance, many children still fall through the cracks between public and private health insurance programs. Two ways to improve coverage for children are raising the
income eligibility level for SCHIP and expanding SCHIP coverage to parents.

**Raising SCHIP Income Eligibility**

In addition to children in immigrant families, many other low-income children lack coverage, because not all states have increased coverage under SCHIP to 200% of the FPL. Even at that level, some uninsured children in families with somewhat higher incomes do not qualify for public coverage, but nonetheless have difficulty affording private coverage. As was pointed out earlier, further expanding SCHIP eligibility to uninsured children in families with income below 300% of the FPL could provide coverage for 5% of all currently uninsured children.

Ten states have taken advantage of available SCHIP funds and the generous SCHIP federal matching rate to expand coverage to children in families with incomes above 200% of the FPL. (New Jersey has the highest eligibility level at 350%.) Many of these programs impose modest cost sharing on families in the form of premiums and co-payments for services. Cost-sharing requirements typically increase as family income rises. New York charges the full cost of its SCHIP program for families with incomes above 208% of the FPL, but most states continue to substantially subsidize their programs for families with incomes above 200% of the FPL.

One reason for expanding eligibility for public programs above 200% of the FPL is variation in the cost of living. For example, several counties in the San Francisco Bay Area have recently launched locally financed programs to cover children in families with incomes up to 300% or 400% of the FPL. (California covers children to 250% of the FPL in its SCHIP program). These programs attempt to address the very high cost of living in the Bay Area. Another reason to consider expanding eligibility for public health insurance to uninsured children in families with incomes between 200% and 300% of the FPL is that about one-half of these children reside in families that do not have access to employer-sponsored coverage.

Expansion of public coverage to children in families with incomes up to 300% of the FPL will require some special considerations, however. First, because approximately 50% of uninsured children in families with incomes between 200% and 300% of the FPL have access to employer-sponsored coverage, coverage expansions to this group might be accomplished at lower cost through employer buy-in programs. Coordination with employer-sponsored insurance may be easier to administer in this income range because there may be less need to compensate for the higher cost sharing and more limited scope of benefits frequently associated with private insurance for this group of children than for children in families with lower incomes.

Second, because within this income band there are almost 10 times as many children with employer-sponsored coverage as there are uninsured children, public programs for this population should be designed to minimize crowd-out. Cost-sharing arrangements (premiums and co-payments) of a magnitude more like generous employer-sponsored programs than public programs may be appropriate for this income group. However, very little is known about why children in this income band are uninsured or how these program features might affect their participation in public programs, use of services, or propensity to switch from private to public programs. So it may be valuable to include a research and evaluation component in further public program expansions to children in higher-income families to get the answers to these key program design questions.

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**Recommendation: Income Eligibility Levels**

All states should increase eligibility under SCHIP to include all children in families with incomes up to 200% of the federal poverty level, as intended in the SCHIP statute, and, as funds become available, experiment with expanding coverage to children in families with incomes up to 300% of the federal poverty level.

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**Cover Entire Families**

Some states and researchers have begun to test the relationship between reaching and enrolling uninsured children and expanding health insurance to parents. Nearly 75% of uninsured children who are eligible for Medicaid or SCHIP have at least one parent who is uninsured. Of these 9 million uninsured parents, nearly three out of four work, earning below 200% of the FPL at jobs that often offer limited or no health insurance coverage.
In studies that compared children’s Medicaid enrollment in states that expanded Medicaid to include parents versus states that did not cover parents, children were found to have higher rates of Medicaid participation in states that had instituted broader expansions.94 One study found that an expansion of the Medicaid program to cover parents in Massachusetts led to a 14 percentage point increase in Medicaid coverage among children, most of whom had already been eligible for Medicaid.95 When Rhode Island expanded its SCHIP program to cover parents, the number of children who enrolled increased by 47% over three years, compared to an increase of 10% over three years before the expansion to parents.96

Evidence also suggests that parental insurance coverage affects the quantity and quality of the care children receive—even if the children themselves have no coverage. Children are two to three times more likely to see a doctor if their parents have seen a doctor, and parents with insurance are more likely to seek care.97 In addition, a recent Institute of Medicine report observed, “[I]f just one member of a family does not have health insurance, it adversely affects the health, emotional well-being and financial stability of the entire household.”98 The report cites evidence that parents’ poor physical or emotional health can undermine their children’s emotional health and development and can lead to poorer school performance, difficulty with socialization, and higher rates of emotional disorders.

Private employer-sponsored health insurance is the primary source of coverage for adults in the United States; however, the availability of employer-sponsored coverage is highly correlated with earnings, with the result that many low-income parents do not have access to employer-sponsored coverage. Recent public policy changes, however, have increased states’ options for covering low-income parents under Medicaid or SCHIP. The provisions of PRWORA (the federal welfare reform law) decoupled Medicaid from cash welfare benefits and made it easier for states to cover more low-income parents under Medicaid. Five states had adopted this approach by July 2000. In addition, 10 states have used Medicaid 1115 waivers, and 4 states have used SCHIP 1115 waivers to cover parents. (These demonstration waivers allow the Secretary of Health and Human Services to waive provisions of the Medicaid and SCHIP laws for research and demonstration purposes that further the interests of the programs.) States that most recently implemented SCHIP parental expansions report that they quickly met or exceeded their enrollment targets for parents.99

The recent economic downturn and ensuing state budget shortfalls have dampened interest in large-scale expansions of public coverage for parents. For example, California has twice delayed a major expansion of its SCHIP program to cover parents in families with incomes between 100% and 200% of the FPL, and the governor has proposed a rollback of the Medicaid family-income-eligibility level for parents from 100% to 63% of the FPL. Most parental coverage is optional under Medicaid and SCHIP, and parents are more expensive to cover on a per-capita basis than are children. States are showing more interest in using Medicaid and SCHIP funds to provide family coverage by buying into employer-sponsored coverage (as described above), however, and the federal government has signaled its willingness to help facilitate these buy-in plans by reducing some of the regulatory complexities that made these plans difficult to administer in the past.

**Conclusion**

Medicaid and SCHIP have provided a blueprint for successfully insuring low-income children. Although these programs have yet to completely fulfill their promise, the encouraging news is that the programs need only be improved and expanded to continue to make major inroads in reducing the numbers of uninsured children in the United States.

The articles in this journal help provide a picture of what these programs might look like if they fulfilled their promise. All eligible children would be enrolled and would continue to receive health coverage as long as they needed it. The programs would be financed in a manner that reflects the reality that demand for public coverage increases during economic downturns. Federal funding would be stable, secure, and adequate to meet the needs of programs and would provide incentives for states to cover as many eligible children as possible. In addition, federal matching rates for Medicaid and SCHIP would be equalized to make states indifferent to covering children under Medicaid or SCHIP. Federal funding would also acknowledge the extent of Medicaid’s responsibility for providing health coverage to the nation’s...
neediest children. Finally, the financing problems that threaten SCHIP would be resolved. States, for their part, would behave responsively to make sure that programs were adequately funded over the long run, regardless of the state of the economy, and that benefit packages and the level of provider reimbursement were adequate to assure children access to appropriate care.

In light of the interdependent and complementary relationship of Medicaid and SCHIP, systems for the two programs would be streamlined and aligned. Relevant application information would be shared efficiently using up-to-date technologies, and administration for both programs would be seamlessly coordinated. The programs would also coordinate with private coverage and other public programs to make sure children maintain coverage as their family circumstances change.

As this journal issue goes to press, the U.S. health care system continues to be buffeted by the same forces—rising costs, high and rising rates of uninsurance for some groups, gaps in coverage for others (including the elderly), concerns about quality, and disgruntled providers—that have plagued the system for many years. It is possible that the current “crisis” will spawn a revolutionary set of reforms and restructuring that will successfully address these problems. If not, it would appear that the next best achievable outcome for children would come from continuing to build on the insurance systems in place to expand and assure children’s access to appropriate medical care. As U.S. Representative Henry Waxman, a driving force behind expansions of Medicaid coverage for children, once observed, “Incrementalism may not get much press, but it does work.”100

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8. See note 5, Dubay and Kenney.


12. See note 9, Starfield.


17. See the article by Hughes and Ng in this journal issue.

18. As noted in the article by Mann and colleagues in this journal issue, this structure was modeled on an earlier public health program for older Americans known as Kerr-Mills.

19. See the article by Wysen and colleagues in this journal issue.


23. However, states could use federal waivers to modify their Medicaid programs.

24. This rule is known as the “screen and enroll requirement.”

25. See also the article by Mann and colleagues in this journal issue, Box 2, “Views from Debbie Chang: A Federal and State Perspective.”

26. National Center for Health Statistics. Early release of selected estimates based on data from the January–September 2002 National Health Interview Survey. Available online at http://www.cdc.gov/nchs/about/major/nihs/released200303.htm. See also the article by Holahan and colleagues in this journal issue. It is important to note that differences in the way data were calculated during this period may bias results.


29. See the article by Mann and colleagues in this journal issue.

30. See the article by Wysen and colleagues in this journal issue, Figure 3.


33. See note 31, Schneider.

34. See note 31, Mitchell and Riley, and *Social Security Act*.

35. See the article by Wysen and colleagues in this journal issue, Table 2, for a list of cost-sharing requirements by state.

36. See the article by Holahan and colleagues in this journal issue.


44. Park, E., Ku, L., and Broadus, M. OMB estimates 900,000 children will lose health insurance due to reductions in federal SCHIP funding. Washington, DC: Center on Budget and Policy Priorities, 2002.
45. See note 44, Park, et al.
46. See note 43, Families USA.
48. The federal government matches state funds for SCHIP at a rate 30% higher than it matches state funds for Medicaid, according to the Federal Medical Assistance Percentage (FMAP), which determines the portion of Medicaid expenses the federal government contributes. For example, if a state’s FMAP is 50% (the federal government contributes 50% of its Medicaid expenses), the federal government will match funds under the SCHIP program at 65% (.30 x 50% = 15%, and 50% + 15% = 65%), with a maximum federal match under SCHIP of 85%. See http://www.aap.org/advocacy/schipsum.htm#stat.
49. See the article by Wysen and colleagues in this journal issue.


80. See the article by Holahan and colleagues in this journal issue.


84. See note 83, Morse.


86. See note 83, Morse.

87. See the article by Lessard and Ku in this journal issue, Figure 3, for an illustration of this decline.

88. See note 85, Zimmermann and Fix.


91. As of September 2002, 3 states and the District of Columbia provided coverage to undocumented children. See the article by Lessard and Ku in this journal issue, Figure 5, for further information about state funding for immigrant children.


97. See note 93, Lambrew, p. 1.

