

SCHIP at a Crossroads: Experiences to Date and Challenges Ahead

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Recent Policy Changes in Medicaid
and SCHIP Coverage for Children

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Background on the State Children's Health Insurance Program

- SCHIP was created in August 1997
- SCHIP allows states to extend public health insurance coverage to uninsured children not eligible for Medicaid
- SCHIP is a block grant not an entitlement program, funded with \$40 billion over the first 10 years
- States receive a higher federal match for SCHIP
- States can expand Medicaid, create a separate program, or use a combination approach
- States with separate programs have more flexibility than under Medicaid in the areas of benefits, cost sharing, crowd-out prevention, and enrollment limits

Road Map

Experiences to Date:

- State Policy Responses
- Enrollment and Coverage
- Program Participation and Familiarity
- Access to Care Under SCHIP

Challenges Ahead:

- Reauthorization
- Broader Issues

State Policy Responses to SCHIP

- Enhanced federal match, strong economies, and bipartisan support fueled rapid state response (all states adopted SCHIP w/in two years)
- Over two-thirds of states adopted separate programs, either alone or in combination with smaller Medicaid expansions
- Over two-thirds set income limits at 200 percent of poverty or above
- Over a quarter of states are covering pregnant women or other adults under SCHIP

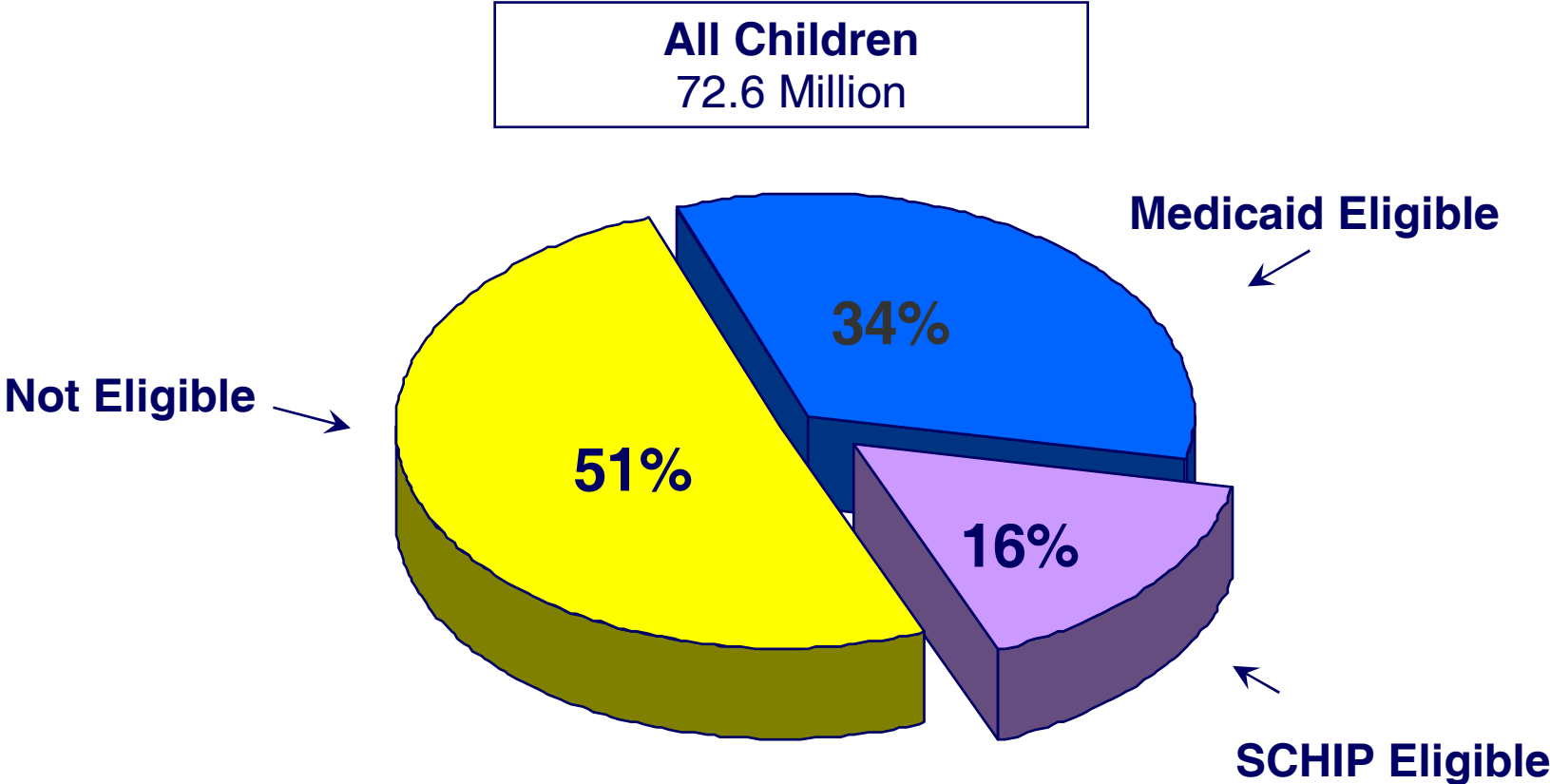
State Policy Responses to SCHIP – Outreach, Enrollment, and Retention

- Unprecedented investment in outreach
 - Mass media campaigns (to raise awareness)
 - Community-based efforts (to reach hard-to-reach)
 - Application assistance models (to link outreach and enrollment)
- Significant enrollment simplification
 - Short forms, mail-in options, reduced verification, dropped assets tests, 12-month continuous coverage are now the norm
- Efforts to streamline eligibility renewal slower to emerge and less widespread
- Critical “spill over” as most reforms also adopted by Medicaid

State Policy Responses to SCHIP – Benefits and Service Delivery

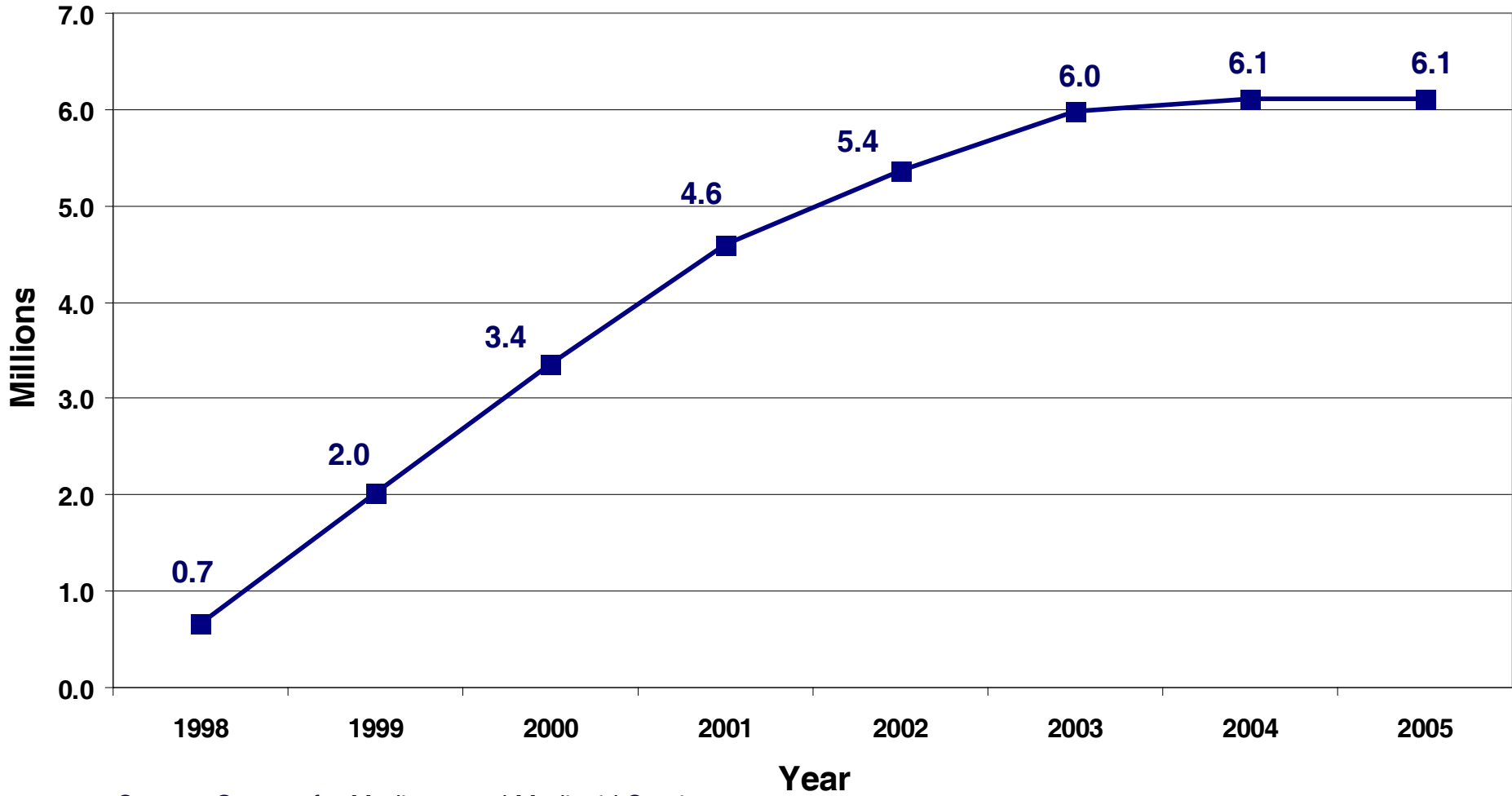
- Medicaid expansions required to cover full Medicaid package
- Separate programs' benefits approach breadth of Medicaid and are broader than most private insurance, covering:
 - Preventive services in accordance w/ AAP guidelines
 - Dental, hearing, and vision screening
- Use of managed care almost universal under SCHIP, and more widespread than Medicaid
- Nearly all separate programs adopted sliding scale monthly premiums or annual enrollment fees, and copayments on selected services and majority use “waiting periods” to deter crowd out

States Greatly Expanded Eligibility for Public Programs with SCHIP



Source: 2002 National Survey of America's Families using July 2002 eligibility rules.

SCHIP Enrollment by Fiscal Year



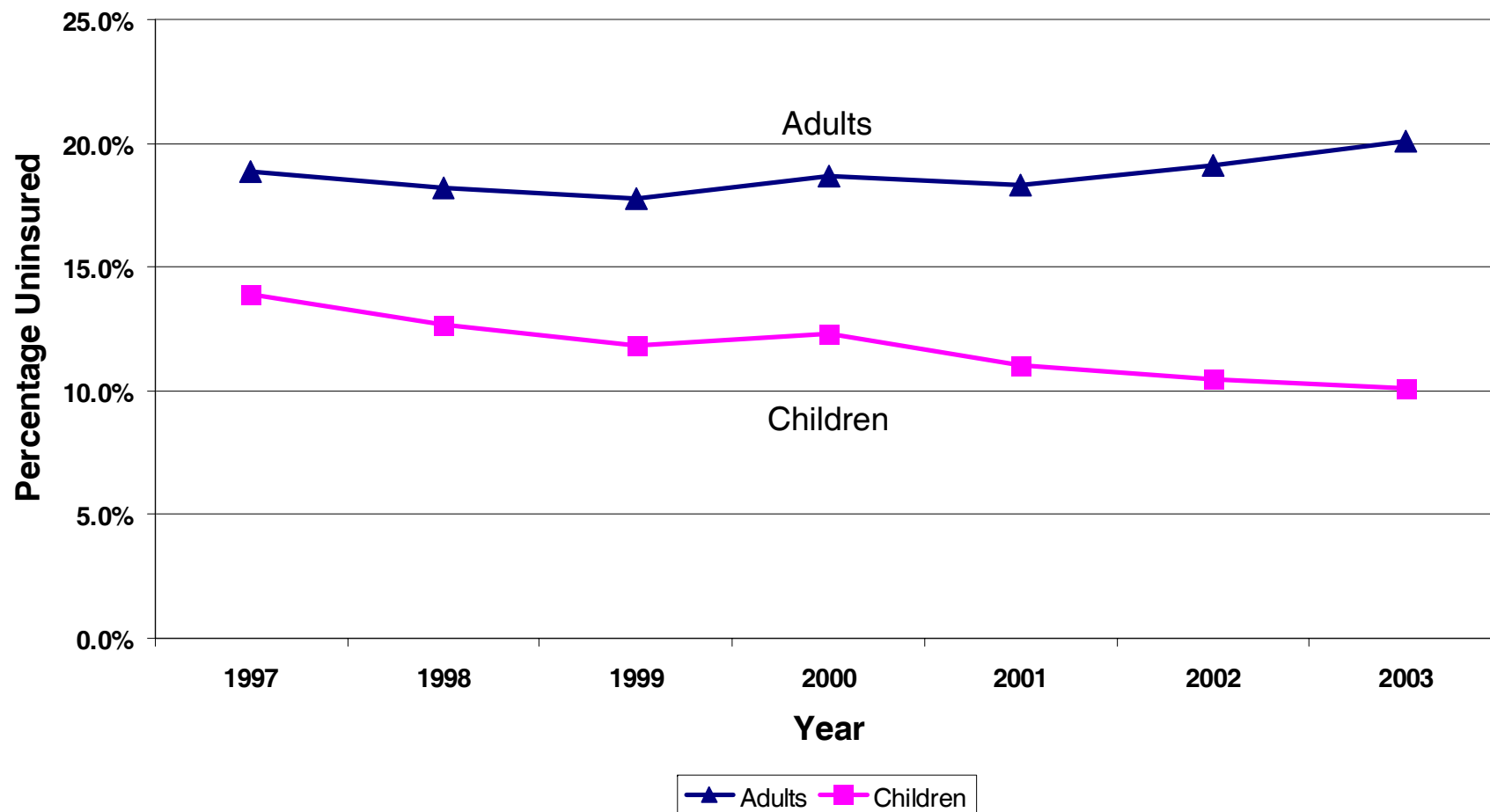
Source: Centers for Medicare and Medicaid Services

Note: These figures reflect the number of children enrolled in SCHIP at any point during the year.

National Findings on Insurance Impacts

- Every available household survey documents declines in uninsured rates for children, with gains concentrated among low-income and minority children after 1997
- Multiple econometric studies show that the State Children's Health Insurance Program reduced uninsurance among children and substituted for employer-sponsored coverage to an extent
- Magnitude of impacts varies across studies
- Studies of SCHIP enrollees indicate that most do not have access to employer-sponsored coverage and that few transfer directly from employer-sponsored coverage
- Studies also show positive spillover coverage effects for Medicaid

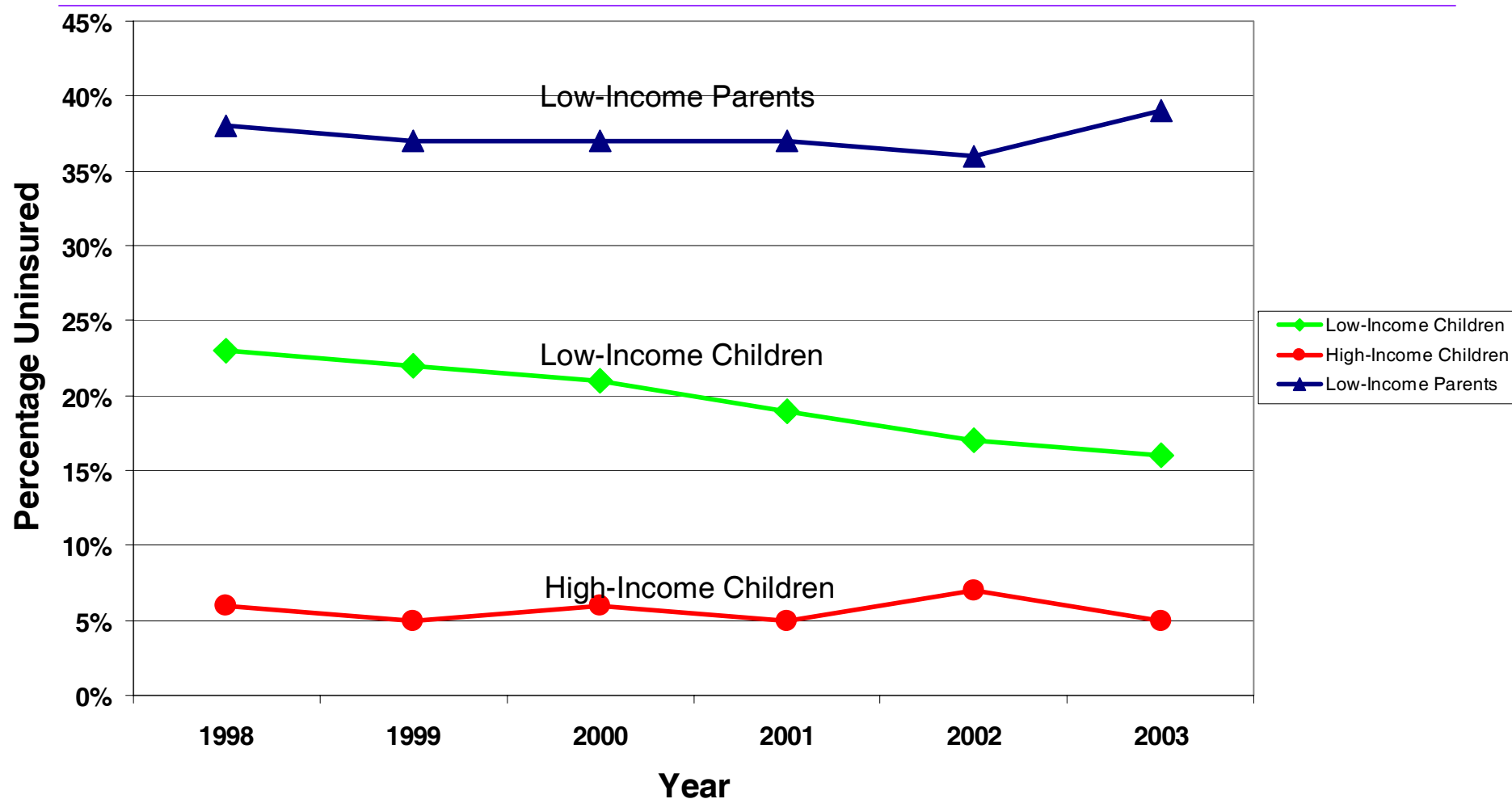
Share without Health Insurance Coverage at the Time of Interview, by Age Group: 1997-2003



Source: Schiller JS, Martinez M, Barnes P. Early release of selected estimates based on data from the 2005 National Health Interview Survey. National Center for Health Statistics. <http://www.cdc.gov/nchs/nhis.htm>. June 2006.

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Trends in Uninsurance Among Children by Income Group and Low-Income Parents, 1998-2003

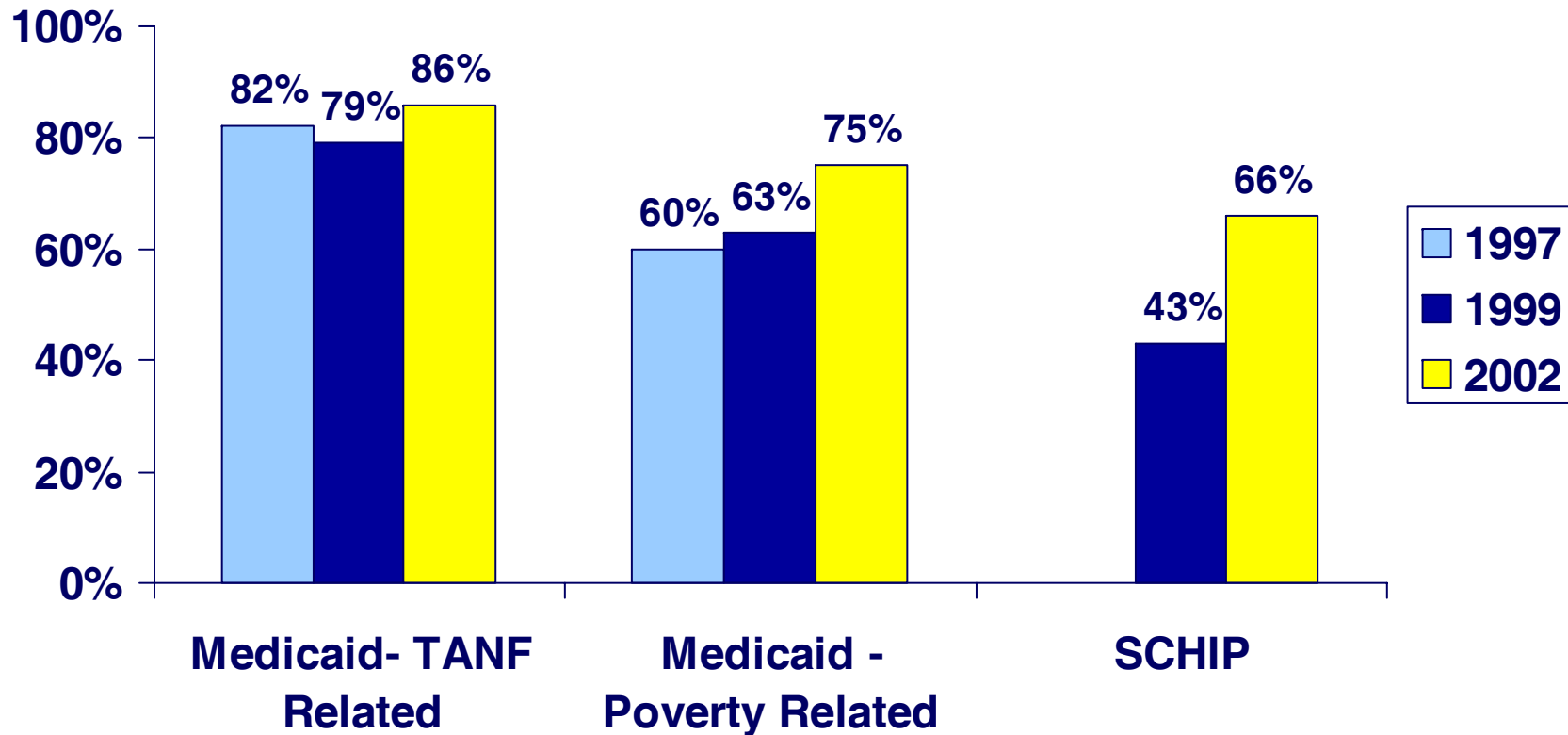


Source: Urban Institute tabulations of the 1998 to 2003 National Health Interview Survey

Note: Low-income families are defined as those with incomes at or below 200% of the Federal Poverty Level.

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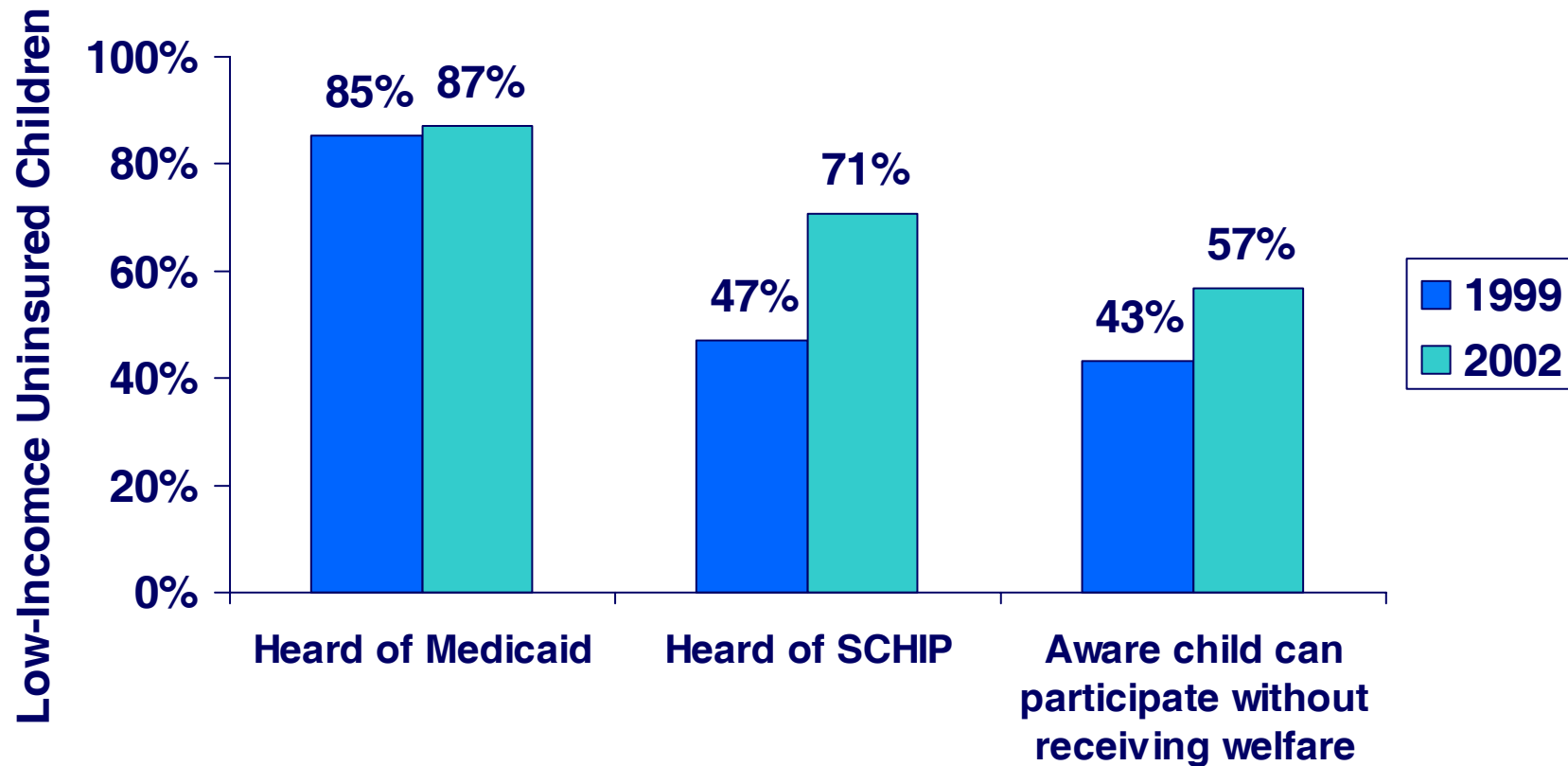
Participation in Both Medicaid and SCHIP Increased Over Time



Source: 1997,1999,2002 National Survey of America's Families

Note: Excludes children with private coverage and defined for citizen children ages 0 to 17.

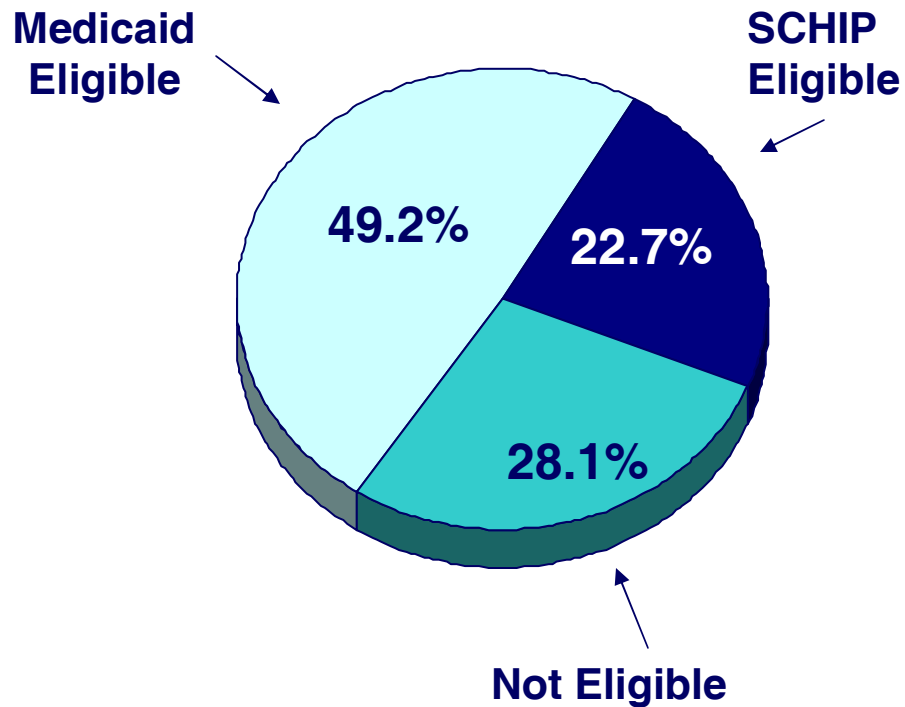
Familiarity with Public Health Insurance Programs Increased between 1999 and 2002



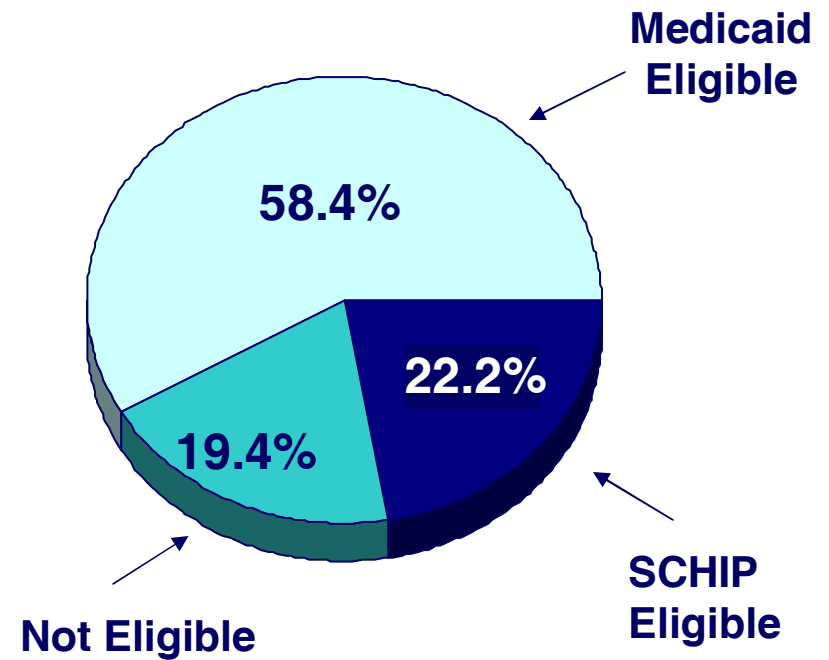
Source: Kenney, Haley and Tebay (2003)

Most Uninsured Children are Eligible for Public Insurance Coverage

Uninsured Children

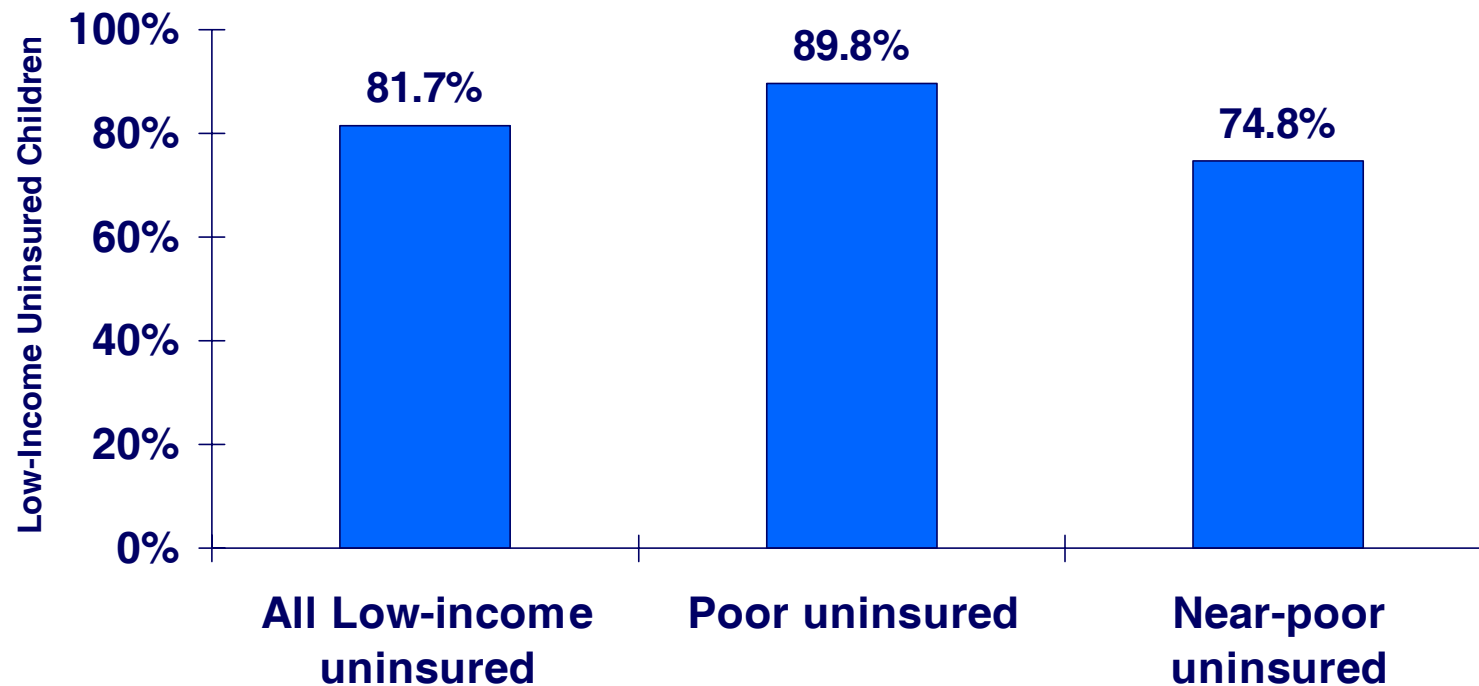


Low-Income Uninsured Children



Source: 2002 National Survey of America's Families using July 2002 eligibility rules.

Interest in Enrolling in Medicaid and SCHIP is High



Source: Kenney, Haley and Tebay (2003)

SCHIP is Meeting The Primary Health Care Needs of Most Enrollees

- Nearly half had received a well-child visit in the 6 months prior to the survey.
- More than 90% had a usual source of medical care and more than 80% had a usual source of dental care.
- More than 80% of parents were very confident they could meet their child's health care needs.

Source: 2002 Congressionally Mandated Survey of SCHIP Enrollees in Ten States.

Some Subgroups of Children Have Better Access in SCHIP than Others

- Parents with more education and parents who speak English were more confident they could meet their child's health care needs.
- Children with greater healthcare needs were more likely to have unmet health care needs and their parents were less likely to be confident they could meet their child's health care needs.

Source: 2002 Congressionally Mandated Survey of SCHIP Enrollees in Ten States.

SCHIP Improves Access to Care Compared with the Care Children Get Before Enrolling

- SCHIP enrollees were more likely to receive preventive dental care, to have a usual source of medical care and to have parents who were confident they could meet their child's health care needs and less likely to have unmet needs for physician services, prescription drugs, dental care, or specialty care.
- Similar patterns found for children in different subgroups defined by their race/ethnicity, age, health status, and parent's educational attainment, and for ten different states and different program types.

Source: 2002 Congressionally Mandated Survey of SCHIP Enrollees in Ten States.

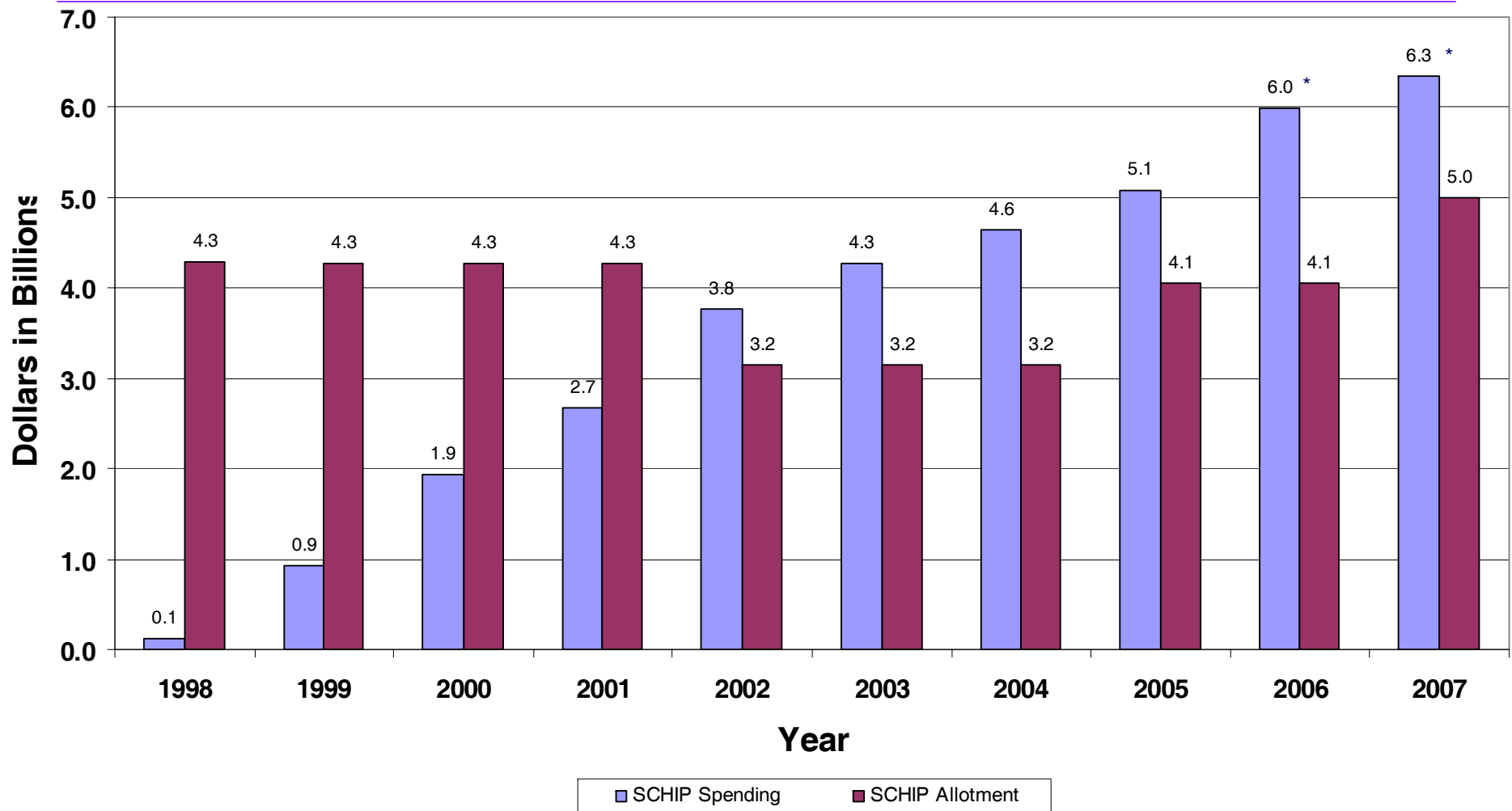
Summary of SCHIP's Accomplishments

- Though optional, SCHIP led to coverage expansions in all states and raised eligibility thresholds to 200% FPL or higher in most states.
- Prompted new outreach efforts and enrollment simplification which spilled over into Medicaid.
- Has become an important source of coverage, now providing coverage to 4 million children at a point in time and 6 million children over the course of a year.
- Contributed to declines in uninsurance among poor and near-poor children.
- Did not promote large-scale crowd-out: most SCHIP enrollees lack access to employer coverage.
- Improved access to care among low-income children.

SCHIP Reauthorization: Key Issues

- Adequacy of federal funding level and current funding allocation across states
- Persistent uninsured problem among SCHIP (and Medicaid) eligible children
- Absence of ongoing information from states and plans on quality of and access to care

Gap Between Available Federal Funds and Spending is Growing



Source: Congressional Research Service (CRS) analysis and CRS SCHIP Projection Model

* Projected Spending Level

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Broader Issues to Consider

- Relative SCHIP and Medicaid matching rates
- Pros and cons of having multiple health care programs for low-income children in a state
- Underinsurance problems among low-income kids with private coverage
- Coverage gaps among poor and near-poor parents
- Critical role of Medicaid

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