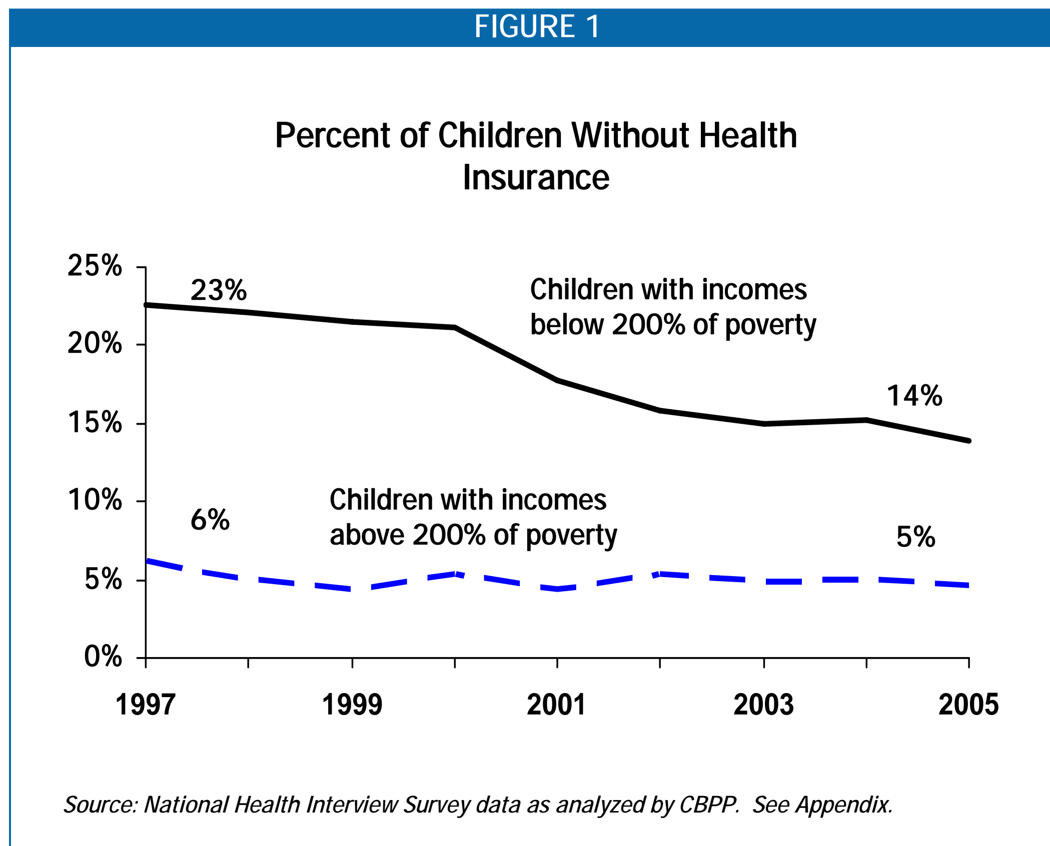
MEDICAID AND SCHIP HAVE REDUCED THE SHARE OF LOW-INCOME CHILDREN WHO ARE UNINSURED BY OVER ONE-THIRD

- The proportion of low-income children who are uninsured dropped by more than one-third between 1997 (the year before SCHIP was implemented) and 2005, according to data from the Centers for Disease Control and Prevention's National Health Interview Survey (NHIS). (See the Appendix for more information about this survey.)

- As states implemented their SCHIP programs, they developed streamlined methods to enroll low-income children; states usually adopted similar changes to streamline enrollment for children in Medicaid and to coordinate enrollment between the two programs. These policies increased the number of low-income children covered by public programs and reduced the percentage of low-income children who are uninsured, despite a serious decline in the availability of employer-sponsored coverage for these children.

- In comparison, the percentage of children with incomes *greater* than twice the poverty line — which is above the SCHIP income limit in most states — who lack coverage declined relatively little, from 6 percent in 1997 to 5 percent to 2005. Still, low-income children are much more likely to be uninsured than those with higher incomes.

FIGURE 1



Source: National Health Interview Survey data as analyzed by CBPP. See Appendix.

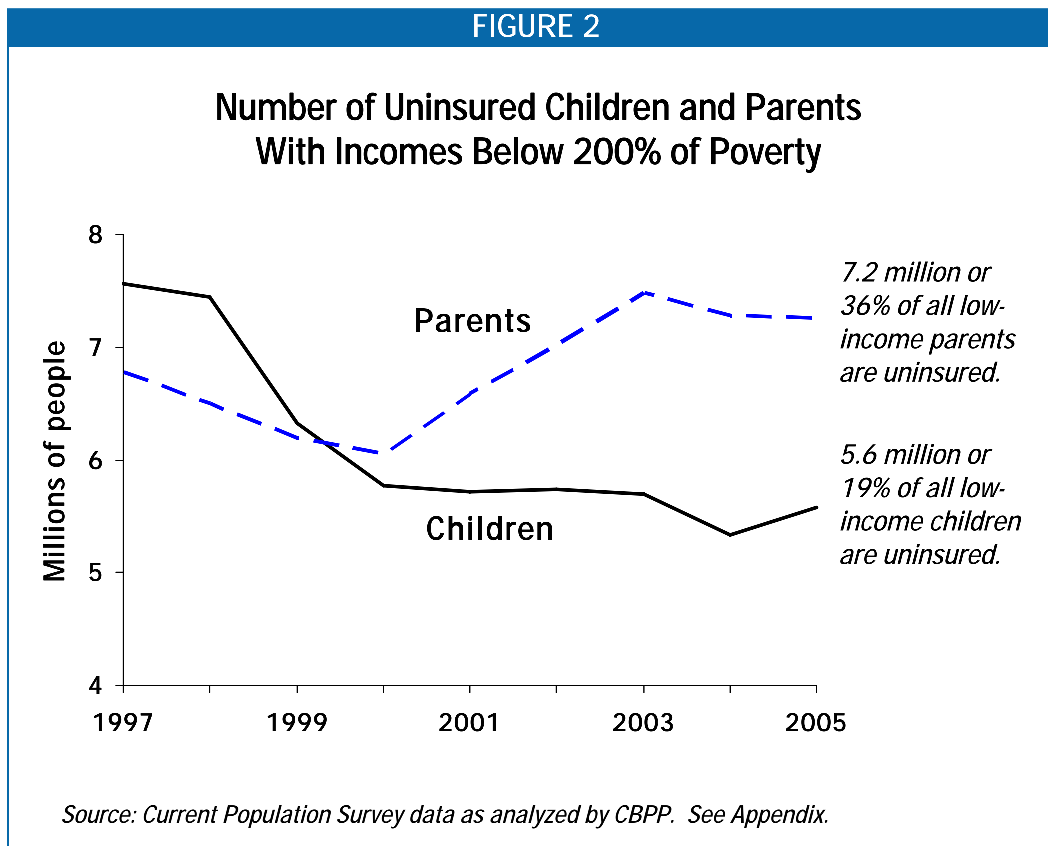
LOW-INCOME CHILDREN'S COVERAGE HAS IMPROVED, BUT PARENTS' COVERAGE HAS WEAKENED

- The number of low-income children without health insurance fell from 7.6 million in 1997 to 5.6 million in 2005, according to data from the Census Bureau's Current Population Survey (CPS). This improvement occurred even though the percent of low-income children with employer-sponsored health insurance fell from 29 percent in 1997 to 26 percent in 2005.

- Both the CPS data and the NHIS data (see Figure 1) reveal large improvements in health coverage among low-income children between 1997 and 2005. Not surprisingly, the two surveys sometimes differ slightly due to methodological differences, described in the Appendix. For example, the CPS data, unlike the NHIS data, indicate a small rise in the number of uninsured children between 2004 and 2005.

- Even as the number of uninsured low-income children fell substantially, the number of uninsured low-income *parents* increased, from 6.8 million in 1997 to 7.3 million in 2005. While Medicaid and SCHIP expansions aided children's coverage, there was less support for expanded public coverage of low-income parents to offset the erosion of private insurance. (The effects of parent coverage are discussed more in Figures 10 and 11.)

FIGURE 2



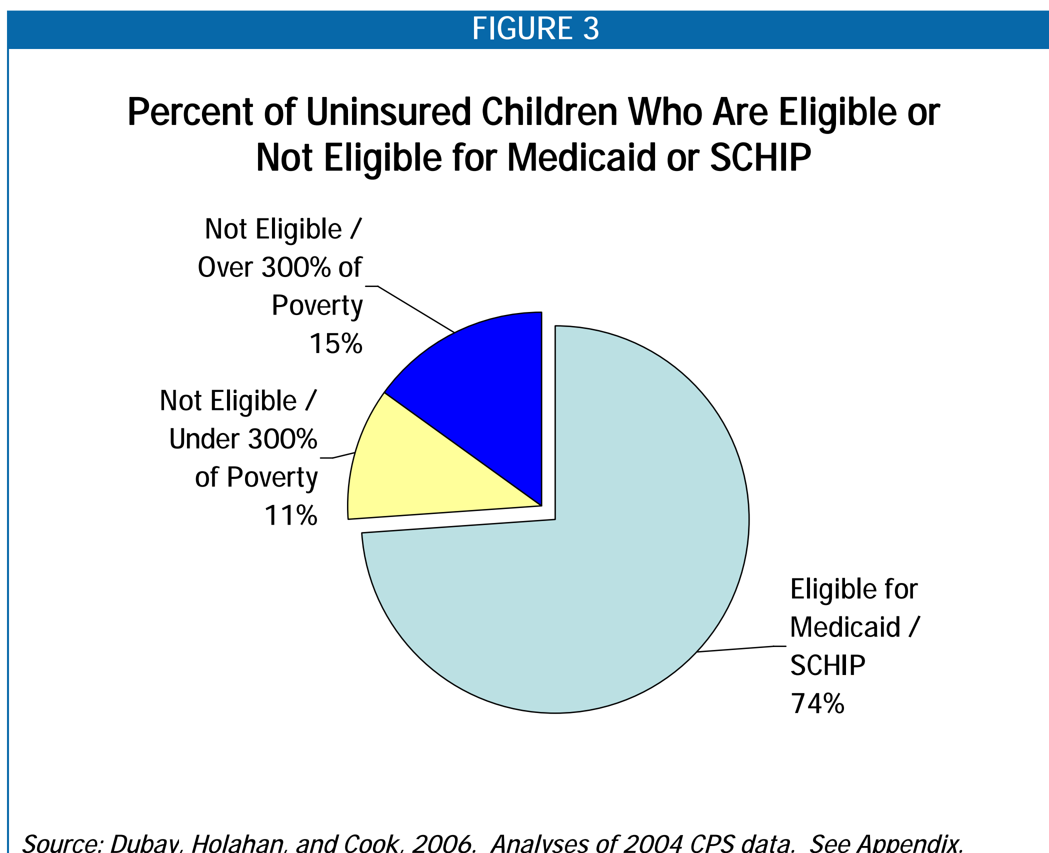
Source: Current Population Survey data as analyzed by CBPP. See Appendix.

MOST UNINSURED CHILDREN ARE ELIGIBLE FOR MEDICAID OR SCHIP

- Roughly 7 out of every 10 of the children who were uninsured in 2004 were eligible for Medicaid or SCHIP (based on each state's eligibility rules at the time), according to Urban Institute analyses (Dubay, Holahan and Cook, 2006, see the appendix for more information). In most states, children with incomes below 200 percent of the poverty line are eligible for SCHIP, although some states have higher income limits for children and some set them lower (Cohen Ross *et al.,* 2007).

- Major gains in coverage of uninsured children will thus require increasing Medicaid and SCHIP participation by eligible children and ensuring that federal and state funds are available to pay for their coverage.

FIGURE 3

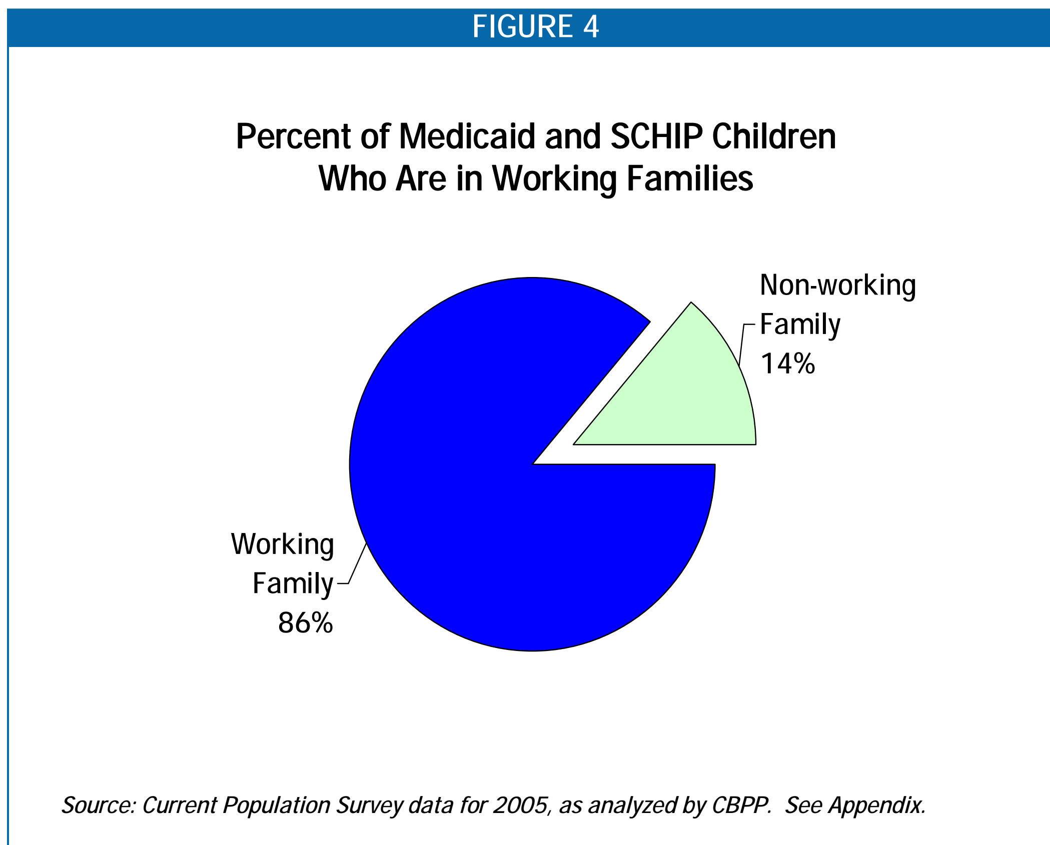


Source: Dubay, Holahan, and Cook, 2006. Analyses of 2004 CPS data. See Appendix.

MOST CHILDREN COVERED BY MEDICAID OR SCHIP ARE IN WORKING FAMILIES

- About six out of every seven children on Medicaid or SCHIP have one or more working parents.
- A major reason why low-income children rely on Medicaid or SCHIP is that their parents are unable to attain affordable private health coverage for their children through the workplace. Many low-wage jobs do not offer health insurance or do not offer coverage that is affordable to low-income families.
- Thus, extending health insurance to children in low-income families provides incentives that help their parents continue to work, even if they have low-wage jobs that do not offer health insurance for dependents.

FIGURE 4



Source: Current Population Survey data for 2005, as analyzed by CBPP. See Appendix.

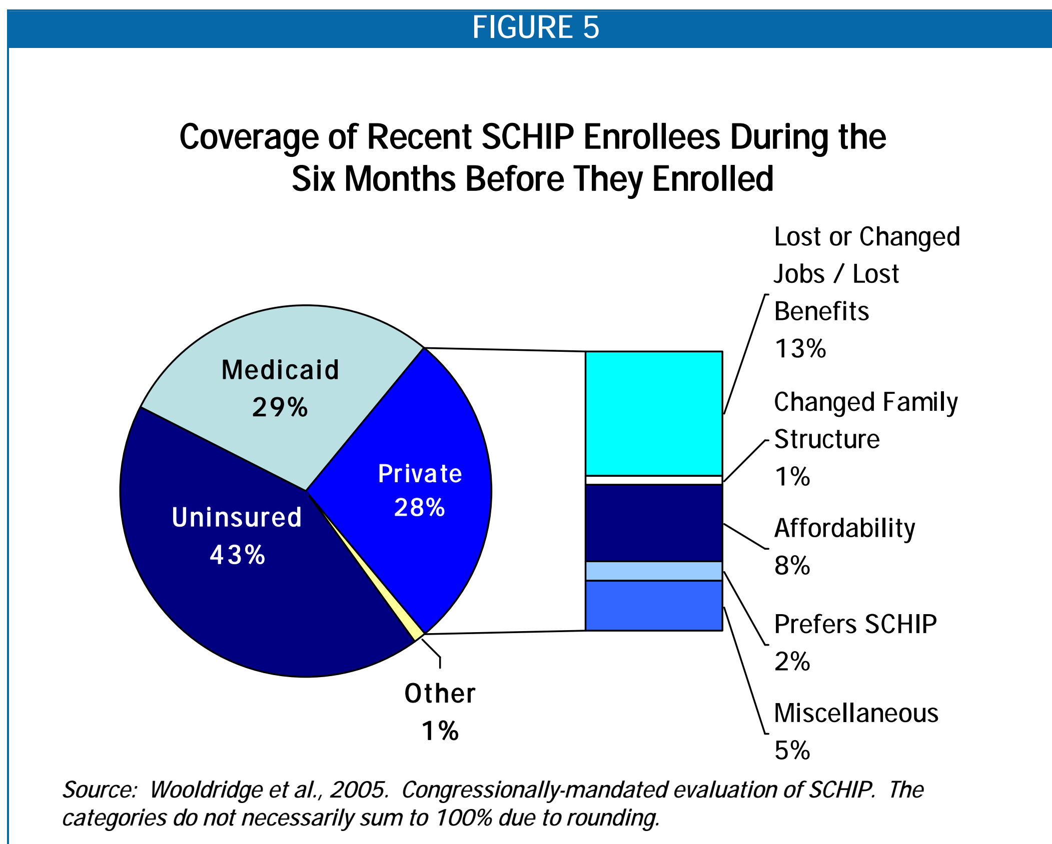
SCHIP COVERS LOW-INCOME CHILDREN WHO WOULD OTHERWISE BE UNINSURED

- A congressionally mandated evaluation of SCHIP found that most enrollees would have been uninsured if they were not covered by SCHIP (Wooldridge *et al.,* 2005).

- In ten states, researchers surveyed the insurance held by SCHIP children in the six months before enrollment. Almost half (43 percent) of the children were uninsured for all six months before joining SCHIP. More than one-quarter (29 percent) were previously on Medicaid, but had to shift into SCHIP because they were no longer Medicaid-eligible. Another 13 percent had lost private coverage involuntarily before joining SCHIP. Reasons for the loss include: job loss or employment change, loss of health insurance benefits with the same job, or change in family structure (e.g., divorce).

- For 8 percent of the children, private insurance was available but the parents believed it was unaffordable and decided to enroll in SCHIP for affordable coverage. Only 2 percent of children were enrolled in SCHIP simply due to preference.

- In comparison, a survey of adults with consumer-driven health plans (e.g., Health Savings Accounts) found that only 10 percent were previously uninsured; the rest were already insured (Fronstin and Collins 2006).

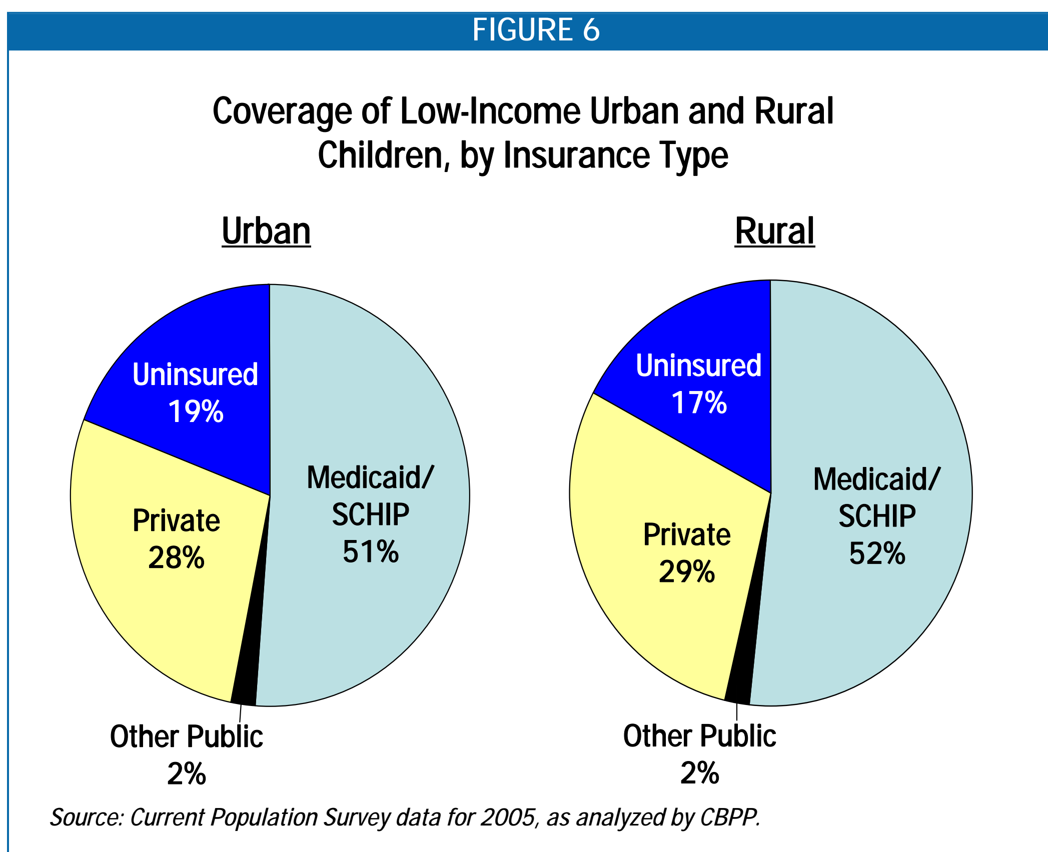


IN URBAN AND RURAL AREAS ALIKE, ABOUT HALF OF LOW-INCOME CHILDREN ARE COVERED BY MEDICAID OR SCHIP

- Many people think of Medicaid and SCHIP as serving urban children and are not aware of the substantial number of rural families who also benefit. In both urban (metropolitan) and rural (non-metropolitan) areas, slightly more than half of low-income children are covered by Medicaid or SCHIP, according to CPS data.

- Also, in both urban and rural areas, slightly less than one-fifth of low-income children are uninsured.

FIGURE 6



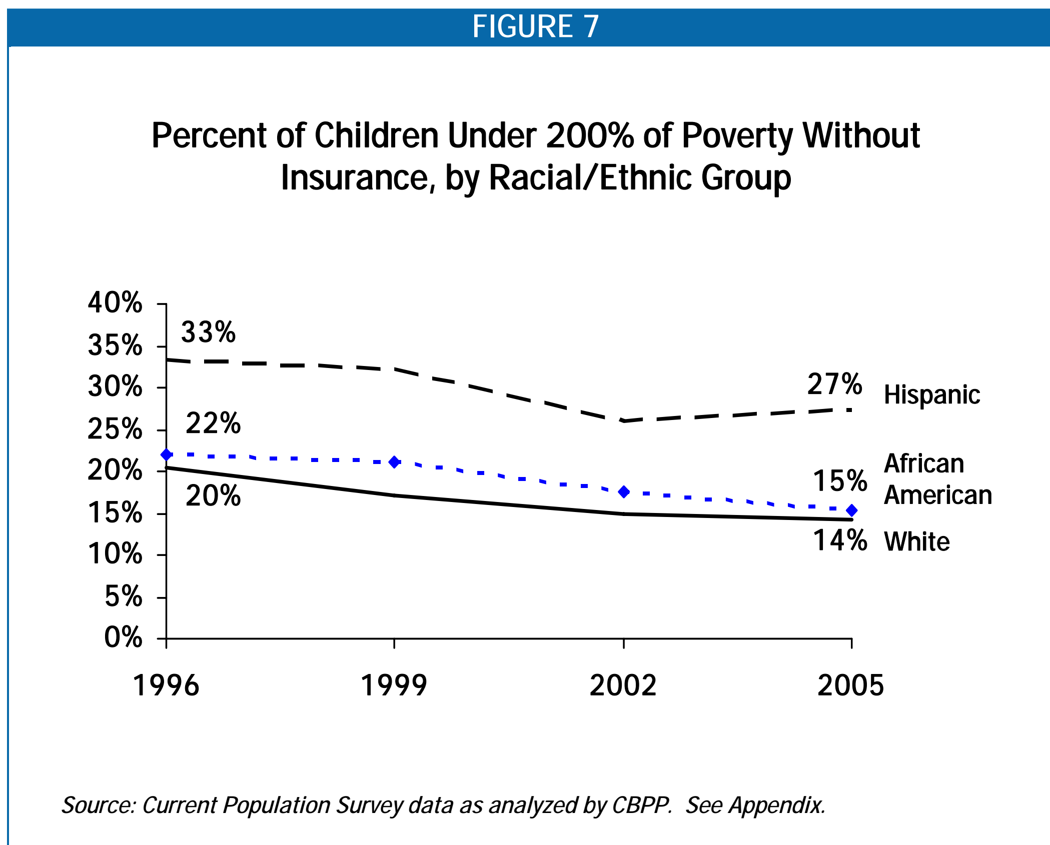
Source: Current Population Survey data for 2005, as analyzed by CBPP.

IMPROVEMENTS IN LOW-INCOME CHILDREN'S HEALTH COVERAGE HAVE HELPED WHITE, AFRICAN AMERICAN, AND HISPANIC CHILDREN ALIKE

- Medicaid and SCHIP have played a critical role in improving the health insurance coverage of low-income white, African American, and Hispanic children. Between 1996 and 2005, the percentage of low-income children who lack health insurance has dropped substantially for all three racial/ethnic groups, according to CPS data. For each racial/ethnic group, the main reason for the improvement is greater enrollment in Medicaid and SCHIP.

- Disparities based on race and ethnicity continue to exist in children's health coverage. In particular, low-income Hispanic children are far more likely to be uninsured than white or African American children. Nonetheless, the expansions of public coverage that occurred over the past decade have improved health insurance coverage for low-income children on an across the board basis.

FIGURE 7

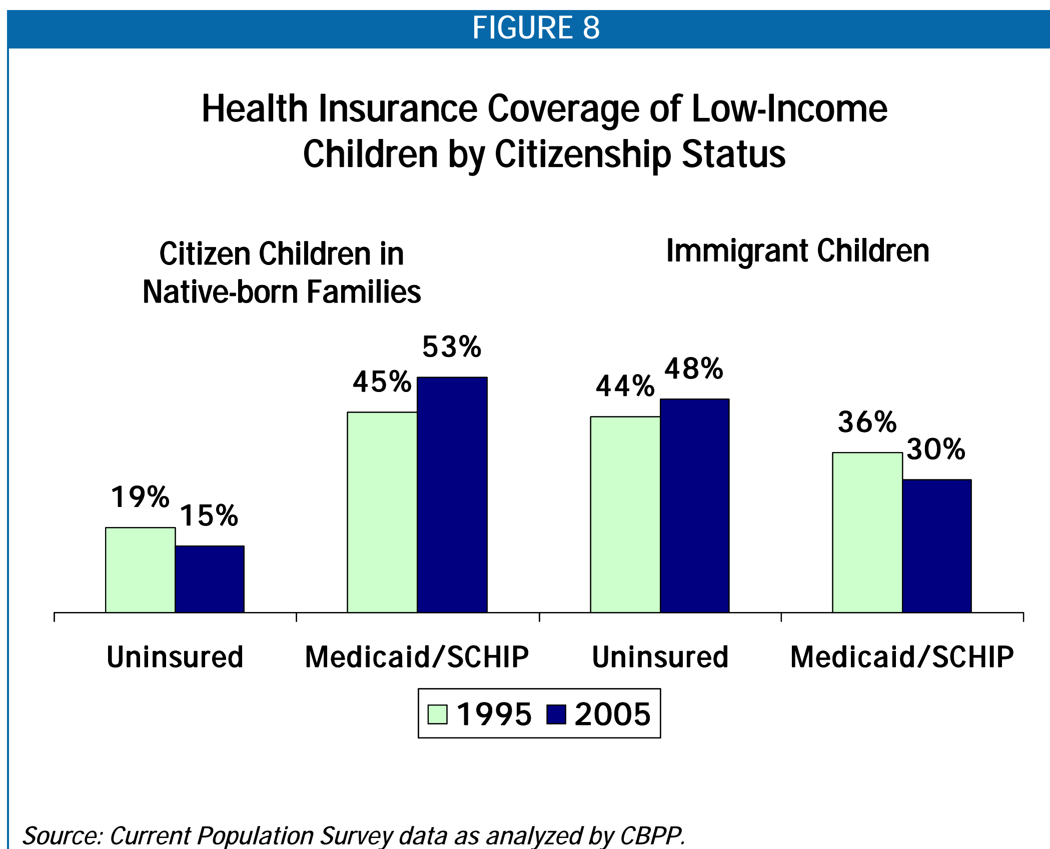


Source: Current Population Survey data as analyzed by CBPP. See Appendix.

THE GAP IN COVERAGE BETWEEN CITIZEN AND IMMIGRANT CHILDREN HAS WIDENED

- While health coverage has improved for most children over the past decade, coverage for immigrant children has eroded. (Immigrant children means foreign-born children who are not citizens. The Census data do not differentiate between lawful permanent resident immigrant children, undocumented children, and those with visas.)
- Under a 1996 law, many immigrants who legally entered the United States after August 1996 are ineligible for Medicaid or SCHIP during their first five years in the country. Thus, a large number of low-income legal immigrant children have been barred from the recent expansions of children's coverage. (Some states continue to offer coverage to low-income legal immigrant children using only state funds, so that they now bear costs once borne by the federal government.)
- Even in 1995, low-income immigrant children were much less likely to have health coverage than low-income citizen children whose parents are native-born. Over the past decade, this disparity has widened further and almost half of low-income immigrant children are uninsured.

FIGURE 8

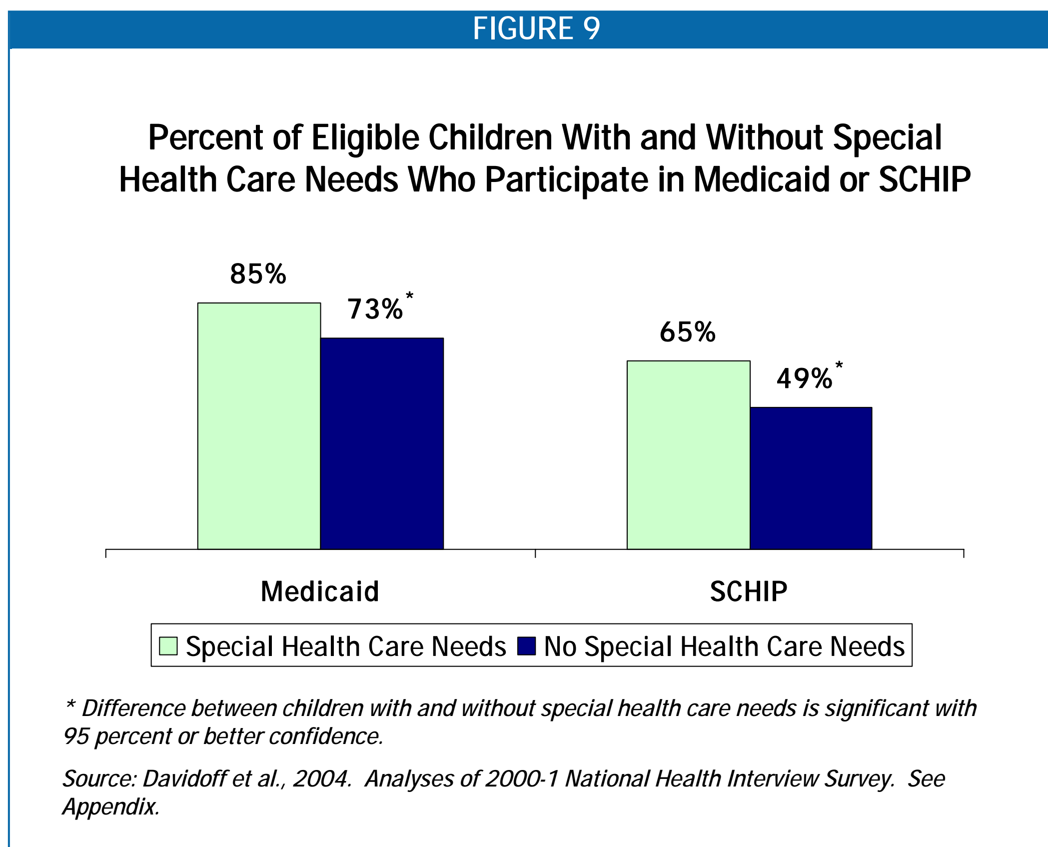


Source: Current Population Survey data as analyzed by CBPP.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS ARE PARTICULARLY RELIANT ON MEDICAID AND SCHIP

- Many children with developmental, medical, behavioral, or cognitive problems require specialized care to meet their health needs. Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services guarantee that screening services and all medically necessary treatment services are available to children. SCHIP does not include such a guarantee, and while state SCHIP programs typically offer a wide array of benefits, certain services — such as physical, occupational, and speech therapy — can be difficult to obtain in some states (CHIRI, 2006).

- Because of their health disorders, children with special health care needs are particularly reliant on Medicaid and SCHIP. Such children are more likely to be eligible for these programs than children without special health care needs, and when they are eligible, they are more likely to participate, according to Urban Institute analyses (Davidoff *et al.*, 2004).



** Difference between children with and without special health care needs is significant with 95 percent or better confidence.*

Source: Davidoff et al., 2004. Analyses of 2000-1 National Health Interview Survey. See Appendix.

COVERING LOW-INCOME PARENTS INCREASES ENROLLMENT OF ELIGIBLE CHILDREN

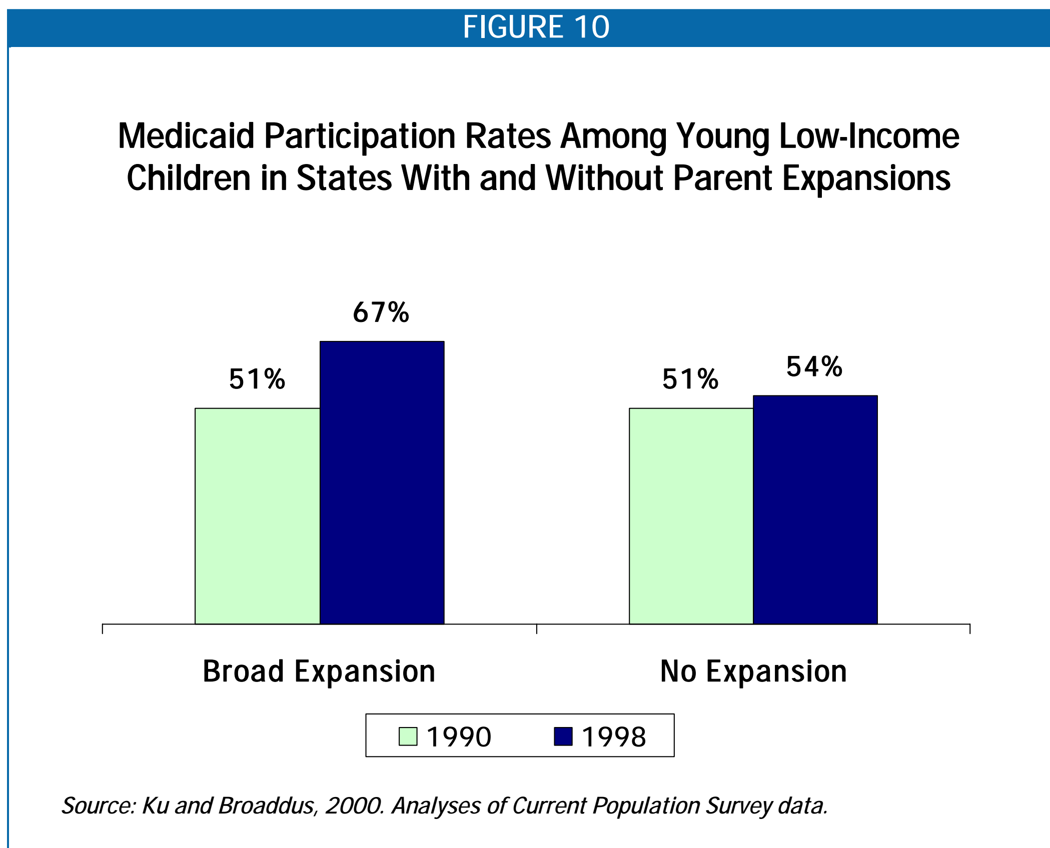
- A number of research studies have demonstrated that one of the most effective ways to improve participation in publicly funded health programs by eligible low-income children is to provide health coverage to their parents as well (Ku and Broaddus, 2006).

- Under SCHIP, most states have raised income eligibility limits for children to at least 200 percent of the poverty line. Yet the median income eligibility level for *parents* is just 65 percent of the poverty line (Cohen Ross *et al.,* 2007).

- Participation rates for eligible young low-income children (under the age of six) grew more in states that expanded parent eligibility than in states without such expansions, a CBPP study found. In all of the states the young children were eligible for public coverage; the key difference was whether the state also expanded coverage for low-income parents.

- Other studies indicate that children whose parents are insured make better use of health services and are more likely to get preventive health care than children whose parents are not insured (Davidoff *et al.,* 2003; Gifford *et al.,* 2005).

FIGURE 10



Source: Ku and Broaddus, 2000. Analyses of Current Population Survey data.

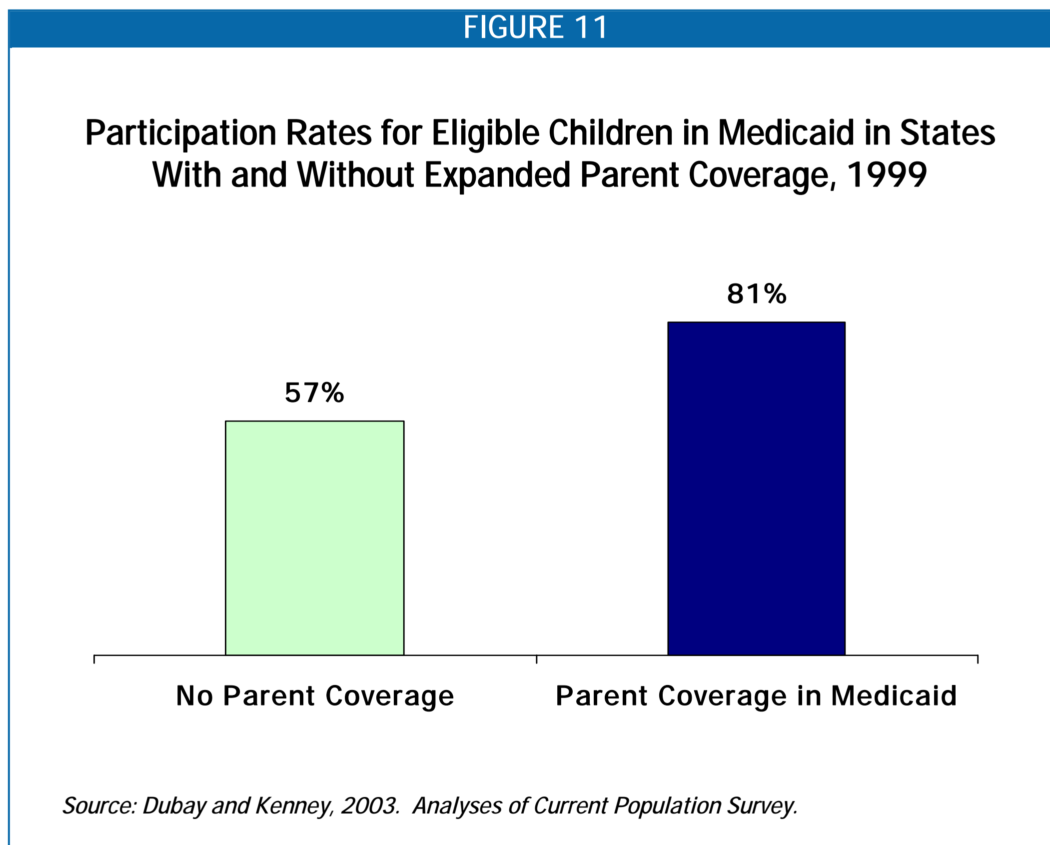
COVERING LOW-INCOME PARENTS INCREASES ENROLLMENT OF ELIGIBLE CHILDREN (CONTINUED)

- Analyses by Urban Institute researchers have also indicated that more eligible children participate in publicly funded coverage in states that expand coverage for parents (Dubay and Kenney, 2003).

- A new analysis from Harvard University indicates that covering parents may help children remain enrolled in Medicaid or SCHIP longer (Sommers, 2006). The study found that children were 38-76 percent more likely to remain insured when their parents were also covered.

- A review by the Institute of Medicine, an arm of the National Academy of Sciences, concluded, "Extension of publicly supported health insurance to low-income uninsured parents is associated with increased enrollment among children (Institute of Medicine, 2002).

FIGURE 11



Source: Dubay and Kenney, 2003. Analyses of Current Population Survey.