

# **Improving Children's Health**

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*A Chartbook About the Roles of Medicaid and SCHIP*

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## Summary

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This chartbook summarizes numerous recent research findings about children who receive health insurance coverage from either Medicaid or the State Children's Health Insurance Program (SCHIP), the two primary publicly-funded health insurance programs for low-income children. The findings are drawn from a variety of recent sources, including the Centers for Disease Control and Prevention's (CDC's) 2001 National Health Interview Survey.

### Key findings:

- Children's coverage under SCHIP and Medicaid grew between 1997 and early 2003. These gains led to a one-third reduction in the percentage of low-income children who are uninsured (Figure 1). Children's health insurance coverage improved despite the recent weak economy and the erosion of private health insurance coverage. This progress is now being threatened, however, by budget cuts in many states that reduce the eligibility or enrollment of low-income children in the public health insurance programs.
- The children served by Medicaid and SCHIP are quite needy, in terms of both low family incomes and the prevalence of health problems. Compared to both privately-insured children and uninsured children, children covered by the public programs are more likely to:
  - be members of low-income families (Figure 2),
  - be only in fair or poor health, as reported by their parents (Figure 3),
  - have asthma (Figure 4),
  - have learning disorders (Figure 5), and
  - have medical conditions that require regular treatment with prescription drugs (Figure 6).
- Publicly-insured children gain better access to health care services. Compared to *uninsured* children, publicly-insured children are:
  - more likely to have a "medical home" (i.e., a usual source of health care) (Figure 7),

- more likely to obtain preventive and primary medical care (Figures 9 and 10),
  - more likely to receive dental care (Figure 11), and
  - less likely to miss needed medical or dental care because their families cannot afford the care (Figure 12).
- The access to medical care received by Medicaid and SCHIP children is usually on par with that received by *privately-insured children*, who would be expected to have better access to care since privately-insured children are in families with much higher incomes (Figures 7, 9, 10 and 12).
- Publicly-insured children are slightly less likely to get dental care than privately-insured children. This may indicate a need to upgrade children's dental services in the public programs (Figures 11 and 12).
- A study by Urban Institute researchers found that, after more rigorously controlling for differences in the health, socioeconomic and demographic characteristics of children on Medicaid and those with private health insurance, publicly-insured children are *more* likely to obtain medical care, preventive care and dental care than similar low-income privately-insured children (Dubay and Kenney 2001). This suggests that the public programs may actually be more effective in delivering health care than the private health insurance that is available for low-income children. Private health insurance typically has higher cost-sharing and more limited benefits than Medicaid, which could hinder the use of health services by low-income privately-insured children.
- Over the past decade, access to a usual source of health care has improved for publicly-insured children, but has deteriorated for children who lack insurance (Figure 8).
- One recent federal analysis found that children are less likely to be hospitalized for preventable diseases when they live in areas that cover more people in their Medicaid programs (Billings and Weinick 2003). This suggests that the primary and preventive care received by children in the public programs helps reduce unnecessary and expensive hospitalizations.
- Medicaid and SCHIP can improve children's health. Children currently insured by the public programs are more likely to be in better health today than a year ago, compared with children covered by private insurance or uninsured children (Figure 13). Recent evaluations of three state SCHIP programs have found that children's health often improves after they join.

Taken together, these findings indicate that the federal and state policies that were initiated in the late 1990s to expand children's health insurance coverage have been successful in lowering the number of uninsured children, in providing access to good quality medical and dental care services, and in improving children's health. As states have developed their SCHIP

programs, they expanded eligibility and devised new approaches to simplify and streamline eligibility procedures and to provide outreach. These new methods led to similar efforts to improve procedures for children in Medicaid as well. More low-income children were thus able to gain coverage in the public programs, and fewer were uninsured.

The results on health care use and on improvements in health documented in this report are consistent with other reviews of the research, which also have identified the beneficial effects of Medicaid and SCHIP for children (Bennett, Kenney and Dubay 2003; O'Brien and Mann 2003).

Unfortunately, there are signs that the progress in children's health coverage is eroding. A number of states have adopted policies that will reduce children's enrollment in Medicaid or SCHIP because of state budget pressures. A recent report found that states have adopted policies that are cutting about 1.2 to 1.6 million people off Medicaid, SCHIP or similar state-funded health insurance programs, of whom almost half — 490,000 to 650,000 — are low-income children (Ku and Nimalendran 2003). Six states (Alabama, Colorado, Florida, Maryland, Montana, and Utah) have frozen or capped enrollment in their SCHIP programs, so that eligible, low-income children who apply are denied entry (Cohen Ross and Cox 2003). Governor Schwarzenegger has proposed freezing enrollment in SCHIP in California as well, which could preclude coverage of more than 100,000 children in that state alone.

As states begin to plan their budgets for the state fiscal years that (in most states) begin July 1, 2004, there is strong pressure for states to cut Medicaid and SCHIP programs further because of state budget shortfalls. The pressure is heightened in many states because the federal fiscal relief measures enacted in May 2003 are scheduled to expire on June 30, 2004. The fiscal relief legislation made health programs more affordable for states by temporarily increasing the federal matching rate for Medicaid.

In addition, in the next few years, an increasing number of states will begin to run out of federal funds for their SCHIP programs. Unlike Medicaid, which is an entitlement program, states receive fixed federal grants for SCHIP, and many states will be unable to sustain their current SCHIP enrollment levels under the current federal funding arrangements. A larger number of states have unspent federal funds in their SCHIP grants that could be used to help meet the needs of the states that are running short, but federal funding procedures for SCHIP would have to be modified for this to occur.

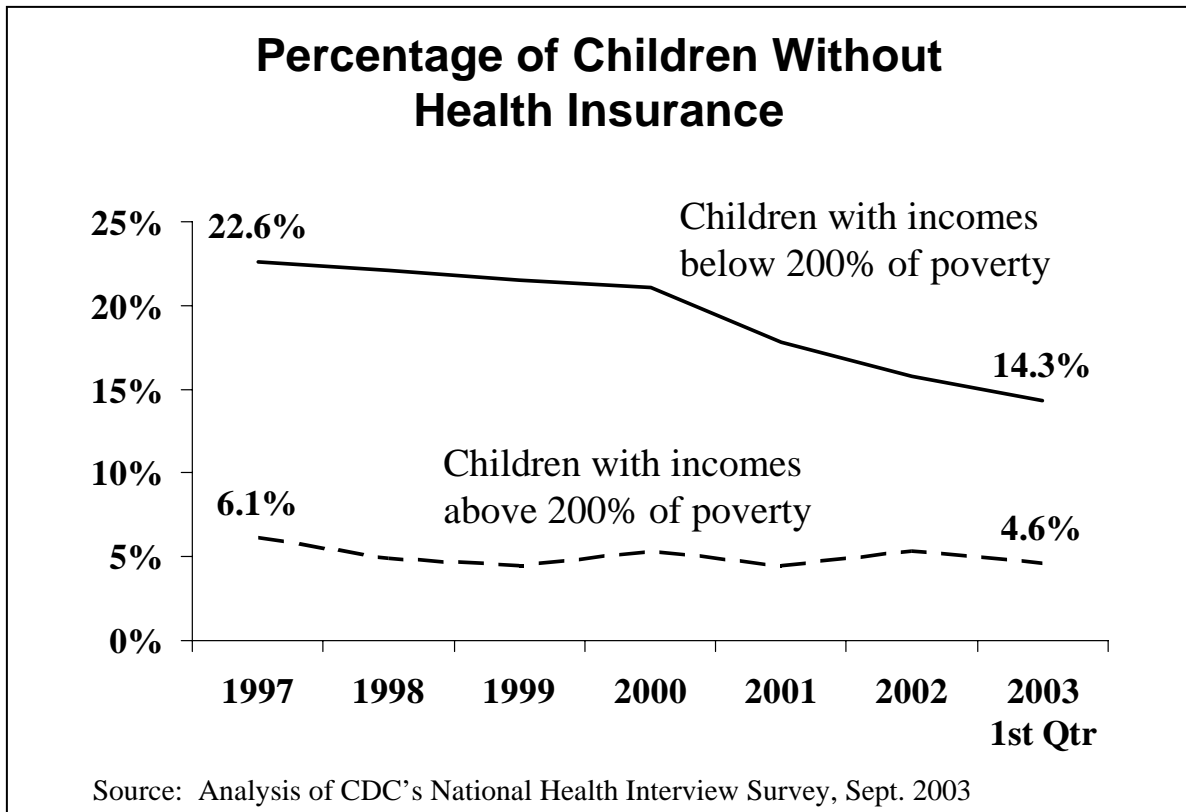
The expansions of children's health insurance coverage under Medicaid and SCHIP have been major public policy successes. They have helped lower the number of uninsured children, given these children better access to medical and dental care and helped improve their health.

Although evidence of the success of the children's health insurance programs is accumulating, there are signs that the programs are being weakened. Unless the federal government and the states take steps to shore up these vital programs, the progress that has been made in recent years could erode.

[Note: A brief discussion about the data, notes about specific figures and references are located at the end of the report.]

## Figure 1 Trends in Insurance Coverage of Low-income Children

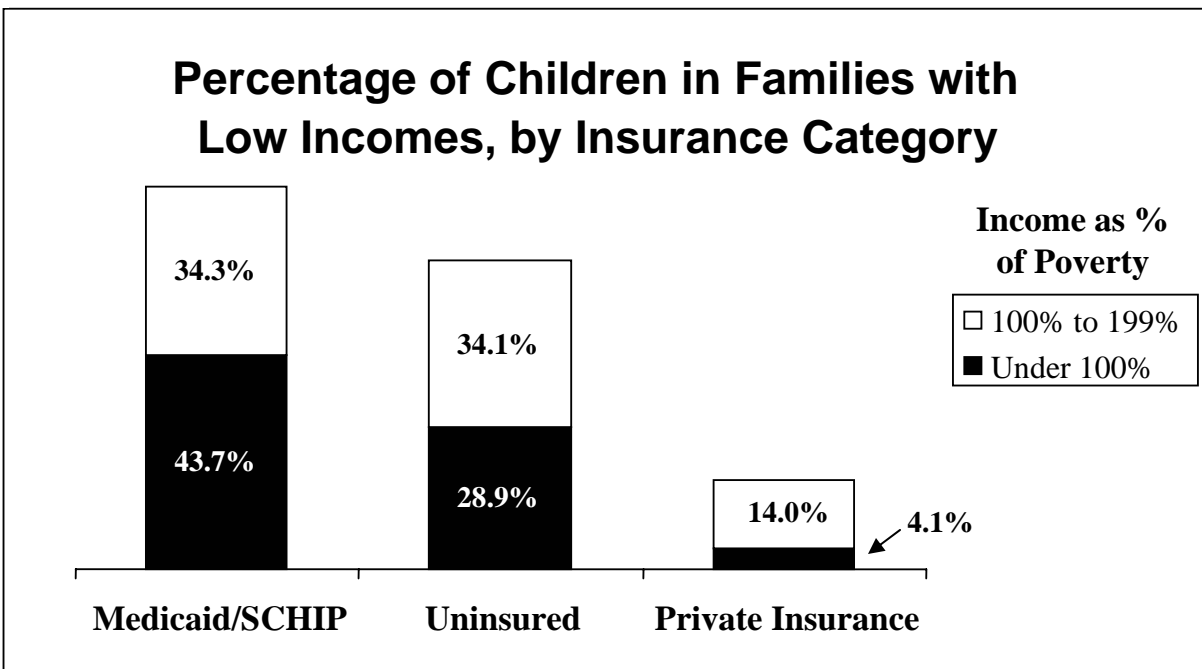
- Data from the CDC's National Health Interview Survey show that, because of the expansions of SCHIP and Medicaid, the proportion of low-income children (those with incomes below twice the poverty line) who are uninsured has fallen from 23 percent in 1997 (the year SCHIP legislation was enacted) to 14 percent in the first quarter of 2003, a reduction of more than one-third (Ku 2003).
- In contrast, the percentage of children with incomes greater than twice the poverty line who lack insurance coverage declined much less during this period. Such children are not eligible for the public programs in most states.
- Analyses of the Census Bureau's Current Population Survey and the Urban Institute's National Survey of America's Families (Bandari and Gifford 2003, Kenney, et al. 2003) also found that expansions of public coverage for children reduced the share of children who are uninsured.



Source: CDC 2003a, National Health Interview Survey, as analyzed by CBPP. See note at end.

## Figure 2 Low-Income Children

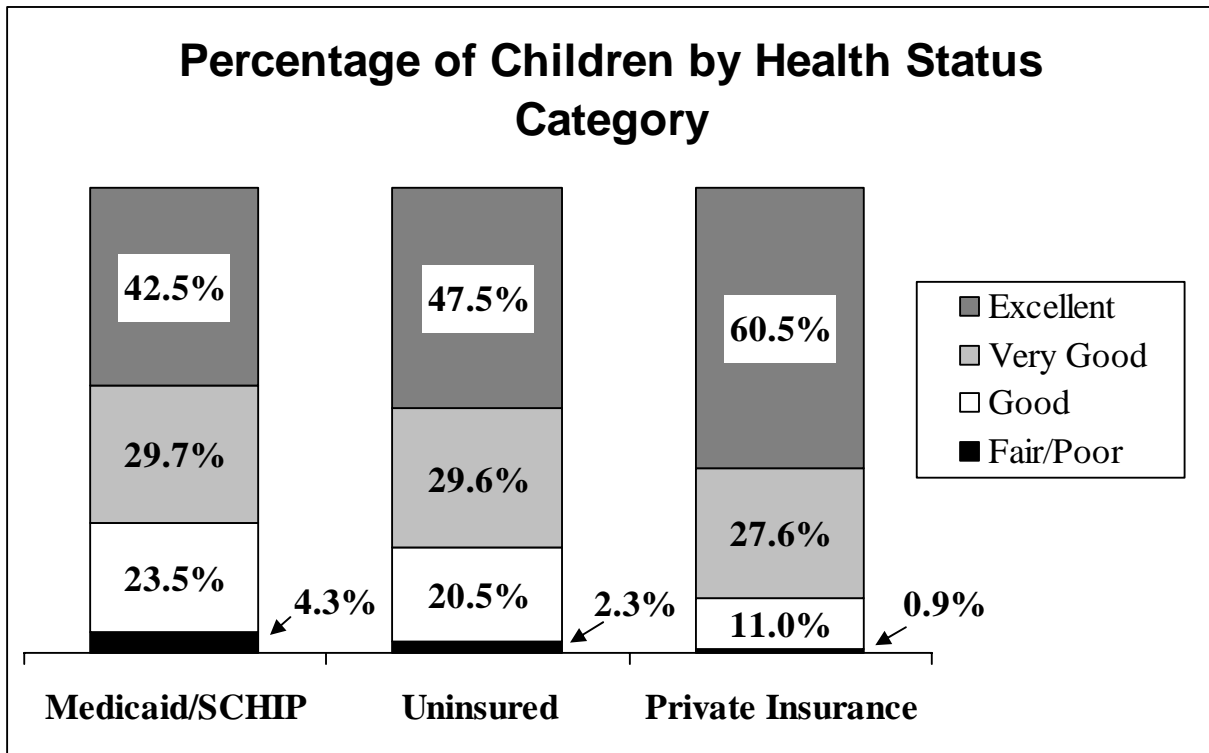
- Children covered by Medicaid or SCHIP usually have much lower incomes than children covered by private insurance and somewhat lower incomes than uninsured children.
- Children covered by the public programs are about ten times as likely to have family incomes below the poverty line as privately-insured children and about 50 percent more likely to be poor as uninsured children.
- Other data show that children covered by Medicaid and SCHIP, as well as uninsured children, are primarily members of families with working parents. Although the parents work, they may not be offered employer-sponsored health insurance for their children or they may not be able to afford the premiums for private insurance.



Source: March 2003 Current Population Survey, as analyzed by CBPP. See note at end.

### Figure 3 Health Status

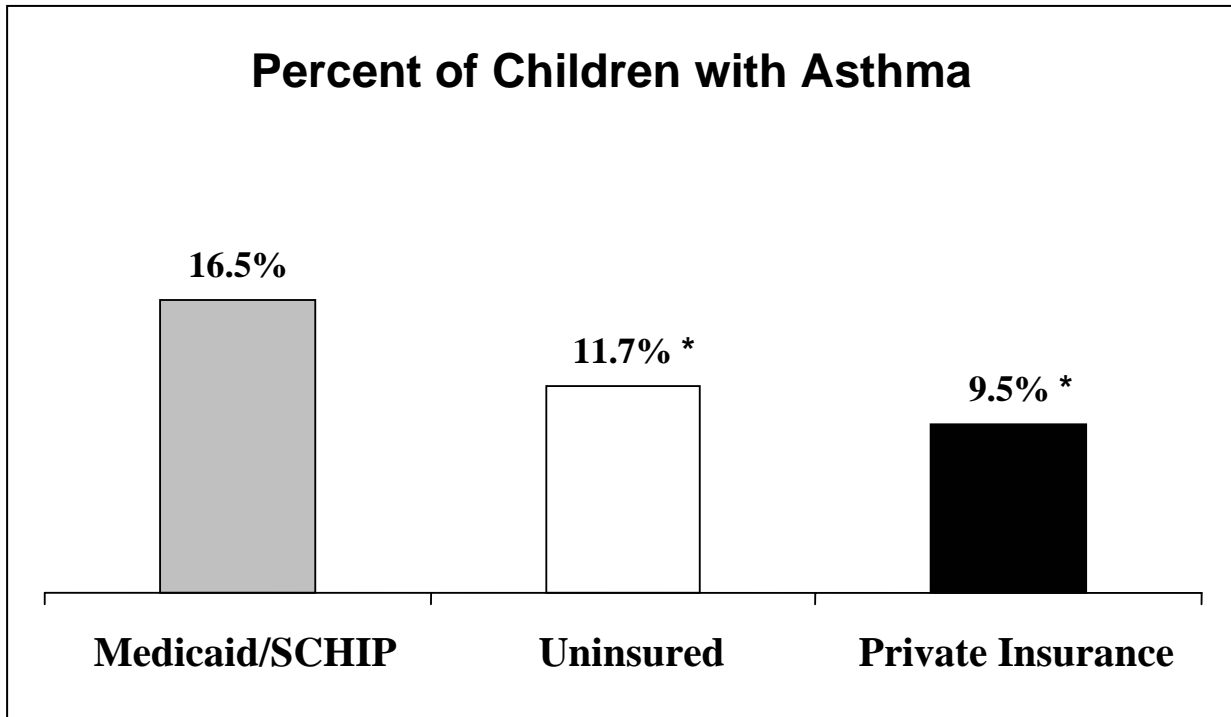
- Children in Medicaid or SCHIP are four times more likely to have “fair” or “poor” health — as assessed by their parents or caretakers — than privately-insured children and about twice as likely to be in fair or poor health as uninsured children. Publicly-insured children are also less likely to be in “excellent” health.
- While children covered under the public programs can be in poorer health than other children, their health often improves significantly after enrollment in Medicaid or SCHIP (see Figure 13).
- Medicaid and SCHIP play an important role in addressing the health needs of many of the nation’s sickest children, but many other children with fair or poor health remain uninsured. One reason that children enrolled in public programs may be in worse health than uninsured children is that parents are more likely to enroll their children in Medicaid or SCHIP when their children have health problems.



Source: CDC 2003b, analyses of 2001 National Health Interview Survey

## Figure 4 Asthma

- Asthma is one of the most common and serious childhood diseases. It is the leading cause of pediatric hospitalizations and the number one cause of school days missed (Center for Health Care Strategies 2001).
- About one-sixth of children served by Medicaid or SCHIP have been diagnosed as being asthmatic at some point in their life.
- Publicly-insured children are more likely to have asthma than uninsured children and children with private insurance.
- Medicaid and SCHIP can provide access to primary medical care and to medications (e.g., inhalers) that ease asthma and prevent asthma attacks, in order to avoid unnecessary and expensive treatments in emergency rooms or admissions to the hospital.

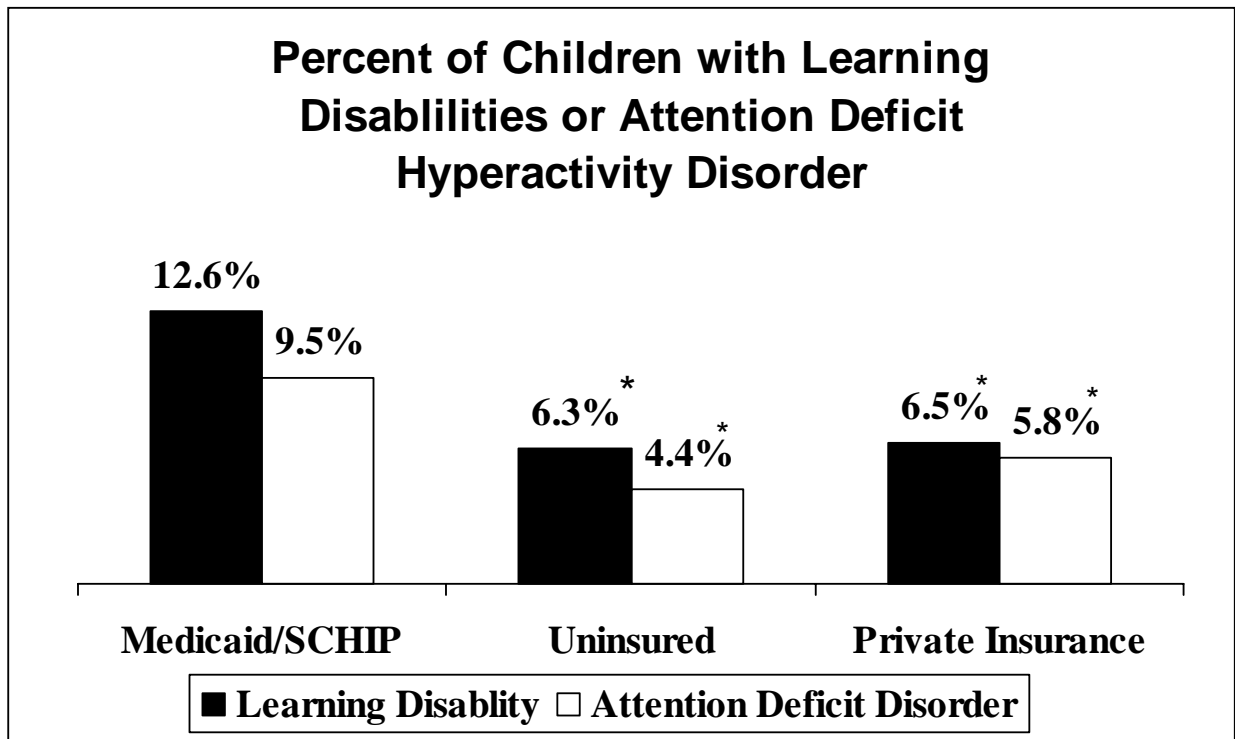


\*Difference from Medicaid/SCHIP is significant with 90% or better confidence.  
Source: CDC 2003b, analyses of 2001 National Health Interview Survey



## Figure 5 Learning Disorders

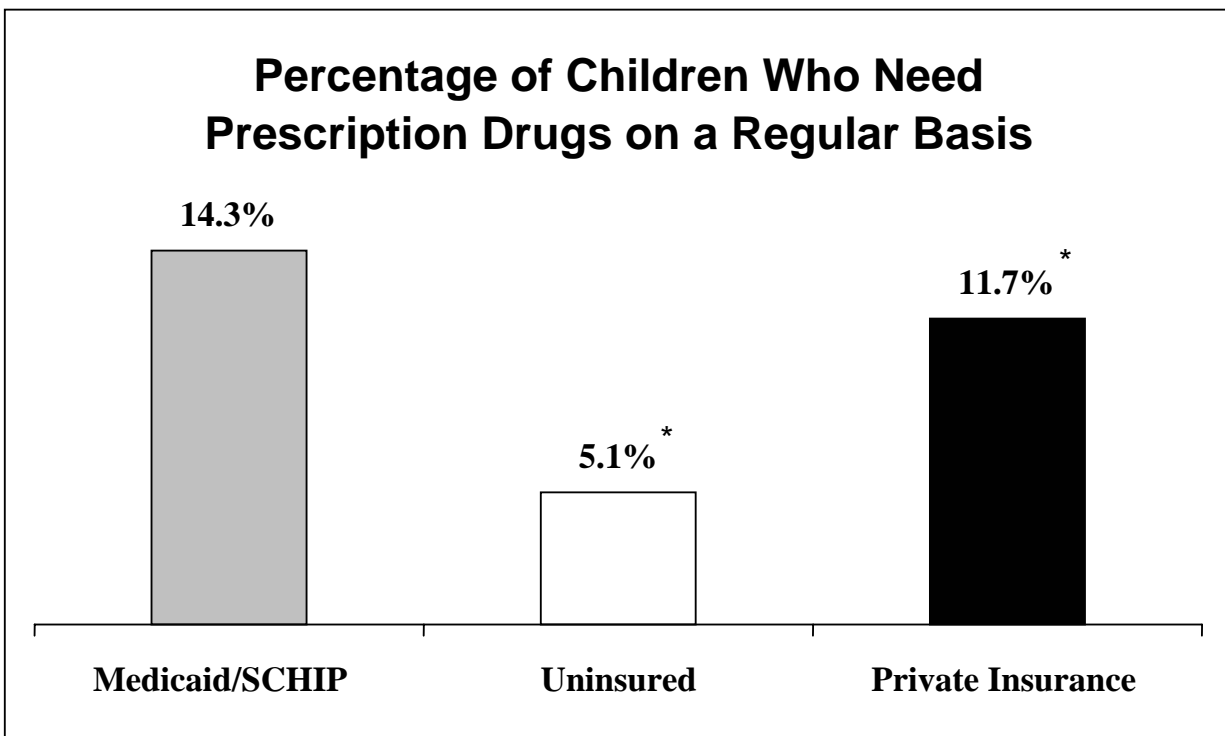
- Children covered by public insurance are more likely to have been diagnosed with learning disabilities or attention deficit hyperactivity disorder than privately-insured or uninsured children.
- Medicaid and SCHIP provide access to medical, behavioral and other therapeutic care services that help these children and improve their opportunities to learn at school.
- The public insurance programs can serve as a financial bridge between schools and health care for these children. In many cases, teachers, counselors or other school personnel initially identify problems among schoolchildren and Medicaid or SCHIP then covers the health care services these children need.



\*Difference from Medicaid/SCHIP is significant with 90% or better confidence.  
Source: CDC 2003b, analyses of 2001 National Health Interview Survey

## Figure 6 Need for Medications

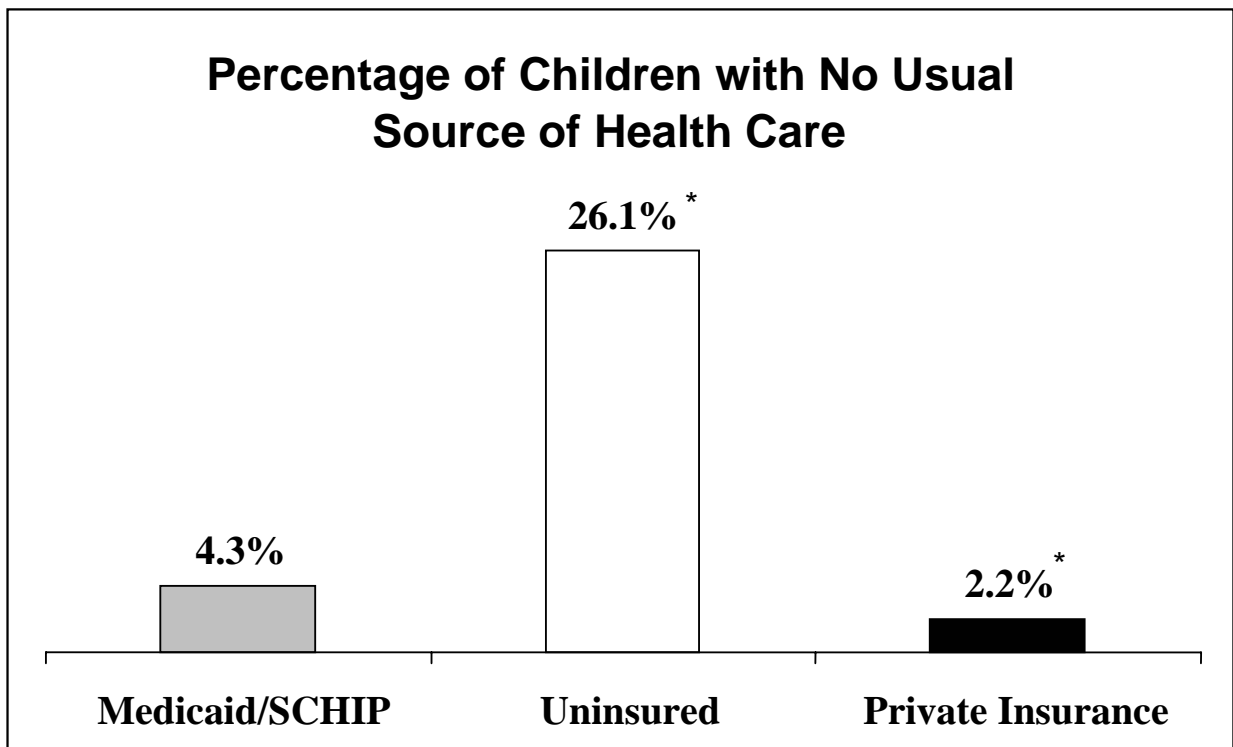
- A large share of the children served by Medicaid and SCHIP has chronic health conditions or other special health care needs that require regular treatment using prescription drugs.
- Children served by the public programs were about three times as likely to have a medical problem that has required regular treatment with medications (treatment for three or more months) than uninsured children. The publicly-insured children were also more likely to have such medical conditions than privately-insured children.
- Medicaid and SCHIP programs offer prescription drug coverage so that children can get the medications they need to treat their illnesses.



\*Difference from Medicaid/SCHIP is significant with 90% or better confidence.  
Source: CDC 2003b, analyses of 2001 National Health Interview Survey.

## Figure 7 Usual Source of Health Care

- Medicaid and SCHIP help guarantee that children have a “medical home” — a usual source of health care, such as a clinic, doctor’s office or health maintenance organization. Thus, their families know where their children can get primary and preventive health care. Doctors and nurses can provide better quality care because they are familiar with their patients’ medical histories and needs.
- Research has shown that having a medical home can increase the quality and continuity of health care services that patients receive.
- Children in Medicaid and SCHIP are far more likely to have a usual health care source than uninsured children. Publicly-insured children are almost as likely to have a usual source of care as privately-insured children.

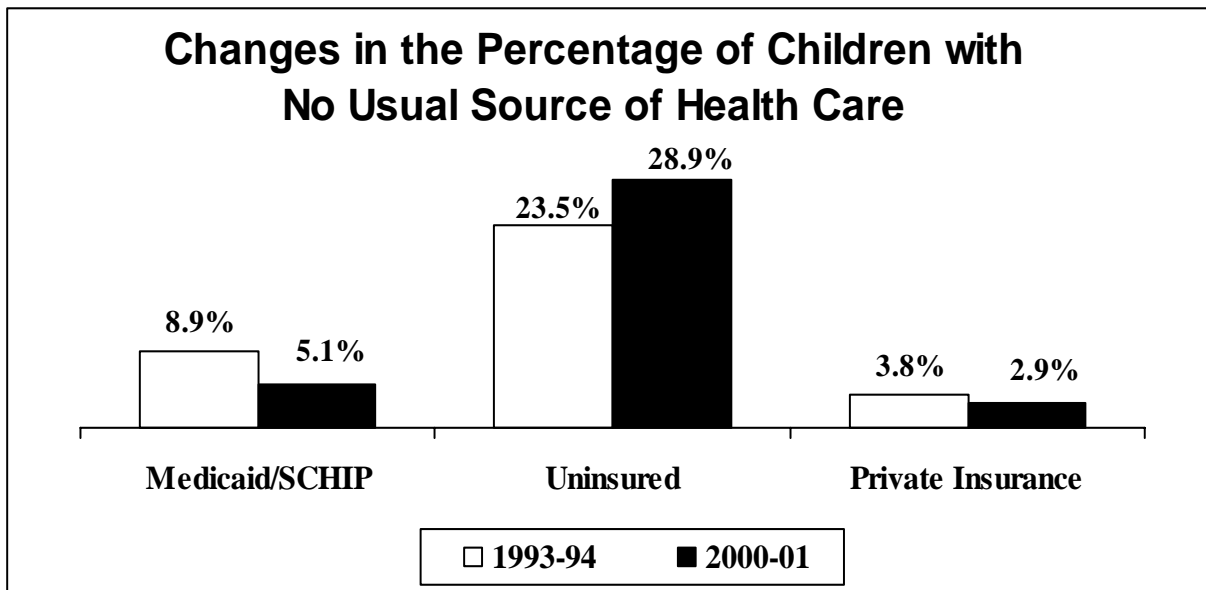


\*Difference from Medicaid/SCHIP is significant with 90% or better confidence.

Source: CDC 2003b, analyses of 2001 National Health Interview Survey. See note at end.

## Figure 8 Trends in Usual Source of Care

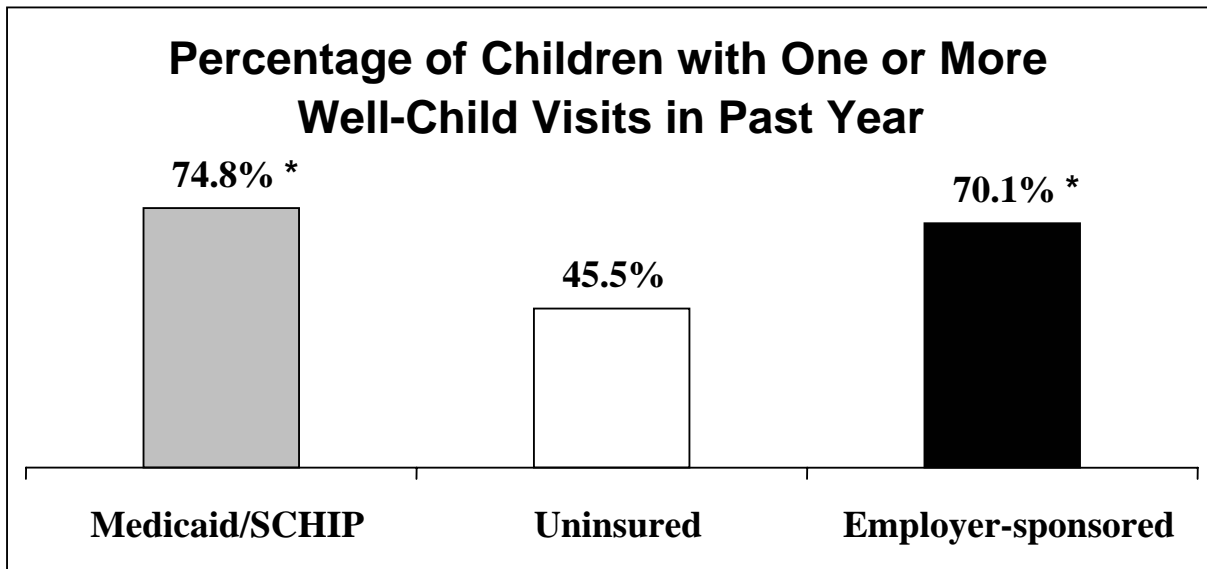
- Between 1993-4 and 2000-1, the percentage of children covered by Medicaid or SCHIP who had no usual source of health care declined. In contrast, uninsured children became less likely to have a usual source of health care.
- Because Medicaid or SCHIP reimbursement rates for physicians are often below levels paid by other insurers, some physicians limit the extent to which they see patients covered by the public programs. Despite these problems, the CDC data indicate that almost all children served by the public programs have a usual source of health care and that access to medical homes has improved in recent years.



Source: CDC 2003c, analysis of National Health Interview Survey data. See note at end.

## Figure 9 Preventive Care

- The American Academy of Pediatrics and other organizations recommend that children obtain regular preventive health care, or “well-child visits.” At such visits, children can receive routine preventive health services, such as immunizations, be screened for signs of developmental or medical problems that could pose a long-term risk to their health or well-being, have their vision and hearing checked, and receive health education and counseling about healthy behaviors. In Medicaid and SCHIP, well-child visits are core elements of health services offered to children.
- Children served by Medicaid and SCHIP are much more likely to obtain these important preventive health services than uninsured children. They receive well-child visits at rates similar to privately-insured children.
- A major federal study found that geographic areas with greater Medicaid coverage experienced lower rates of preventable hospitalizations for children (Billings and Weinick 2003). These findings suggest that when children gain better access to primary and preventive care through the public programs, they are less likely to be hospitalized for diseases like asthma or diabetes.

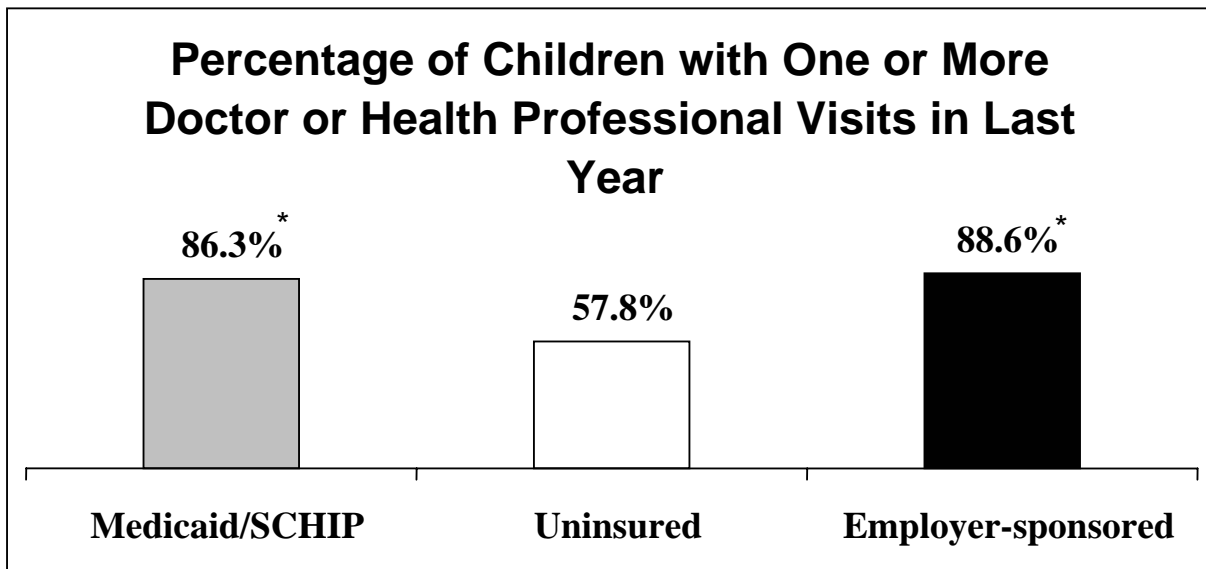


\*Difference from uninsured is significant with 90% or better confidence.

Source: Kenney, et al. 2003, analyses of National Survey of America's Families.

## Figure 10 Access to Physician Services

- Medicaid and SCHIP can improve access to primary medical care for children. Data from the National Survey of America's Families show that publicly-insured children are about 50 percent more likely to have seen a physician or other health care professional in the last year as children who are uninsured. Publicly-insured children see doctors at about the same rate as privately-insured children.
- While low Medicaid or SCHIP payment rates can reduce physicians' willingness to care for Medicaid or SCHIP patients, these data suggest that children covered by the public programs are nonetheless about as likely to see a doctor as privately-insured children.
- An earlier Urban Institute study found that, after controlling for differences in income, health status and other demographic characteristics, children on Medicaid typically saw physicians more often and received more primary and preventive medical care than similar low-income privately-insured children (Dubay and Kenney 2001). For low-income children, public programs may be more effective in providing care than private health insurance. This could be because private health insurance plans typically have higher cost-sharing and fewer benefits than Medicaid.

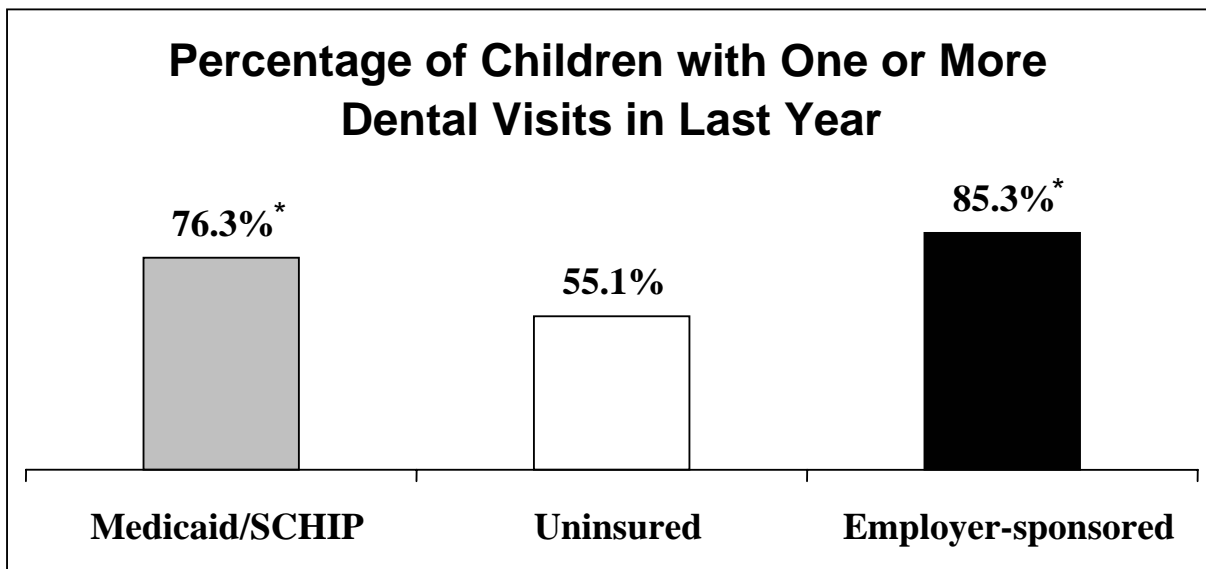


\*Difference from uninsured is significant with 90% or better confidence.

Source: Kenney, et al. 2003, analyses of National Survey of America's Families.

## Figure 11 Access to Dental Care

- Tooth decay and other oral health problems are among the most common untreated health problems affecting America's children. Children covered by Medicaid or SCHIP are much more likely to have received dental care in the past year than uninsured children. All Medicaid programs are required to offer dental care for children and almost all SCHIP programs offer dental benefits.
- Publicly-insured children are, however, somewhat less likely to receive dental care than privately-insured children, who are generally more affluent and who may thus have better access to dentist's offices.
- Recent reports have suggested ways that states could strengthen access to dental care in Medicaid and SCHIP (CHIRI 2003; Children's Dental Health Project 2003; National Conference of State Legislatures 2002).
- On the other hand, an earlier Urban Institute study found that children with Medicaid were *more* likely to receive dental care than similar low-income privately-insured children, after controlling for income, health and other differences (Dubay and Kenney 2001).

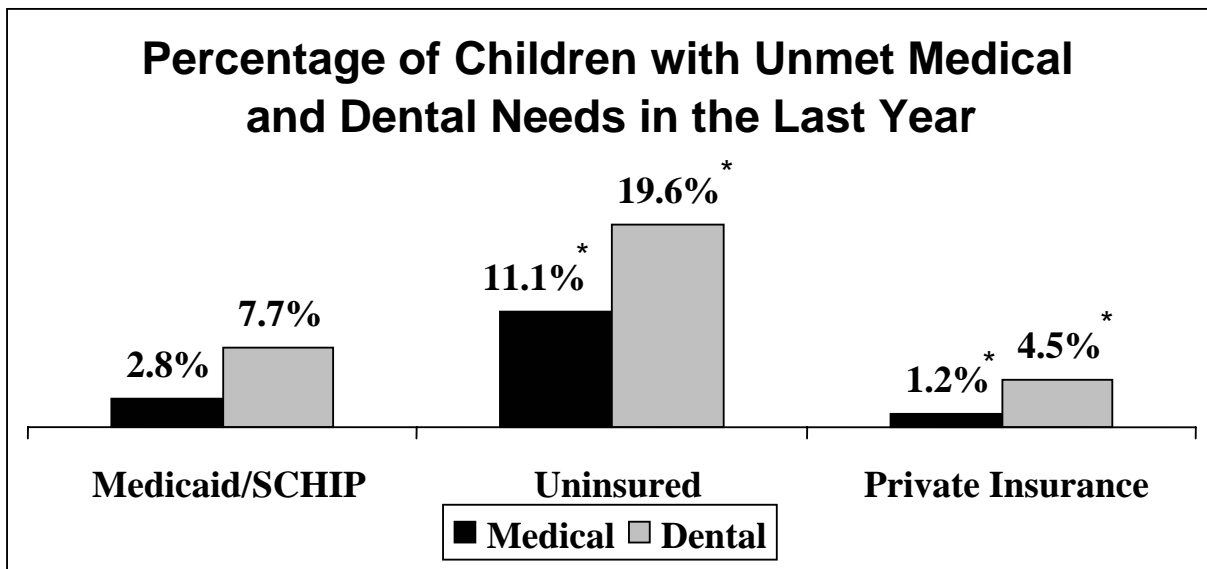


\*Difference from uninsured is significant with 90% or better confidence.

Source: Kenney, et al. 2003, analyses of National Survey of America's Families.

## Figure 12 Unmet Medical and Dental Needs

- Parents report their children have “unmet” medical or dental needs if the children needed care in the past 12 months but did not get such care because the families could not afford it.
- In some cases, unmet medical needs may lead to more serious medical conditions that require more expensive or intensive medical treatment. For example, untreated juvenile diabetes may result in a diabetic coma which could require hospitalization or may lead to permanent disabilities.
- Uninsured children are more than four times as likely to have unmet medical needs and about three times as likely to have unmet dental needs as children covered by Medicaid or SCHIP.
- The levels of unmet needs for publicly-insured children are almost twice those of privately-insured children. Given that privately-insured children have much average higher incomes than publicly-insured children, it is not surprising that privately-insured families are less likely to report they could not afford health care for their children. (Some low-income children currently enrolled in Medicaid or SCHIP were not covered for all of the prior year and may have been uninsured for part of the year.)



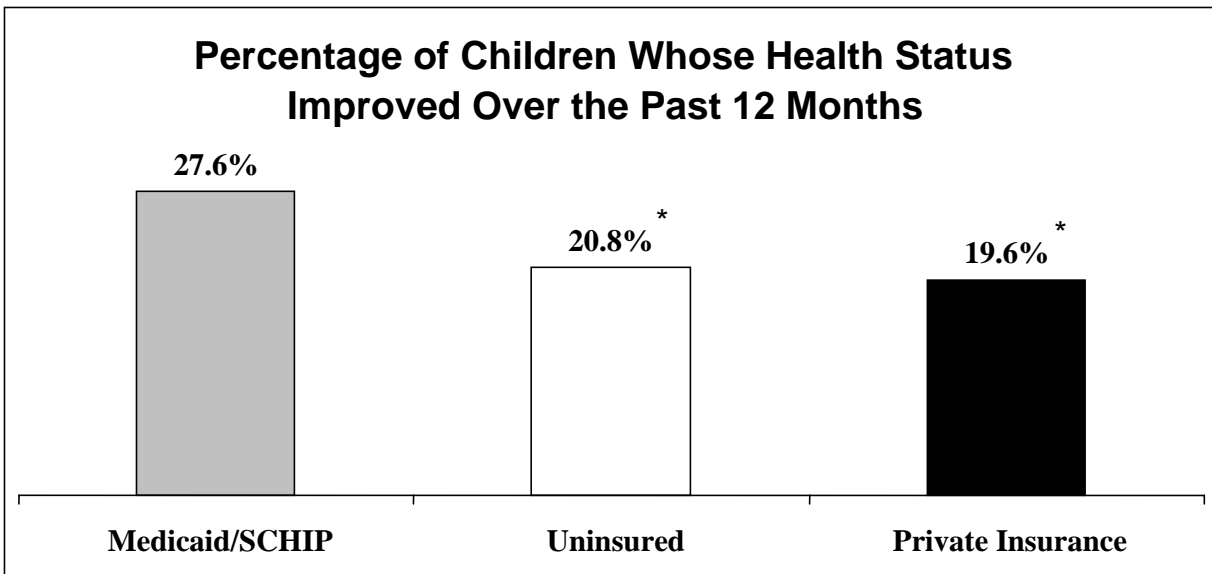
\*Difference from Medicaid/SCHIP is significant with 90% or better confidence.

Source: CDC 2003b, analyses of 2001 National Health Interview Survey.



## Figure 13 Improved Health Status

- By providing access to affordable medical and dental care, Medicaid and SCHIP can improve children's health.
- More than one-quarter of the children currently covered by Medicaid and SCHIP are in better health now than they were 12 months ago, as reported by their parents or caretakers.
- The share of publicly-insured children whose health has improved in the past year (28 percent) is higher than the shares for uninsured and privately-insured children (20 to 21 percent).
- These findings are consistent with recently published evaluations of the SCHIP programs in California, Kansas and Iowa. Each of these evaluations found that children's health status improved after children entered the programs (California Healthy Families Program 2002; Fox, et al. 2003; Damiano, et al. 2003).



\*Difference from Medicaid/SCHIP is significant with 90% or better confidence.

Source: CDC 2003b, analyses of 2001 National Health Interview Survey. See note at end.

## NOTES AND REFERENCES

Much of the data cited in this report is drawn from the 2001 National Health Interview Survey (NHIS), which is part of a long-running series of health surveys. NHIS is a nationally representative survey of the civilian non-institutionalized population of the United States and includes data on about 100,000 people in almost 40,000 families. NHIS is conducted by the National Center for Health Statistics, which is an agency of the Centers for Disease Control and Prevention (CDC). The information about children is generally reported by their parents or caretakers. As with any household survey, there may be errors or omissions in respondents' answers. For more detailed information, see CDC 2003b. In NHIS, like many other surveys, responses for children in Medicaid and SCHIP are combined because SCHIP programs are often administered as part of Medicaid, so parents may not be able to distinguish the programs.

*Note for Figure 1.* CDC presents data separately for children with incomes below the poverty line and children with incomes between 100 and 199 percent of the poverty line. We pooled the data and computed a weighted average for children with incomes below 200 percent of the poverty line, using weights based on the relative number of children in these income strata, as reported by the Current Population Survey in each year.

*Note for Figure 3.* The majority of states have income eligibility criteria for their SCHIP or Medicaid programs equal to 200 percent of the poverty line. Nine states (California, Connecticut, Georgia, Maryland, New Hampshire, New Jersey, New York, Vermont and Washington) establish income limits higher than 200 percent of the poverty line. The annual income reported in the Current Population Survey does not necessarily correspond with the period that a child participates in a health insurance program. For example, a child may be in SCHIP or Medicaid in January 2002 when his or her parents are unemployed and have a low income but leave the insurance program after a parent finds work. Although the family's overall income for 2002 may exceed 200 percent of the poverty line, the child's partial-year participation would still mean that the child counts as being on Medicaid or SCHIP during the year of the survey.

*Note for Figures 7 and 8.* The percentages of children with no usual source of care differ slightly in these two figures. This is because Figure 7 presents data from the 2001 NHIS, while Figure 8 pools data from both the 2000 and 2001 NHIS samples.

*Note for Figure 13.* CDC presents the improved health status data for three groups: those currently in fair or poor health, those in good health and those in very good or excellent health. We pooled data for all three categories by computing a weighted average and calculated the pooled standard errors to test for statistical significance. The trends for each category were similar.

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