

Improving Children's Health

A Chartbook about the Roles of
Medicaid and SCHIP

2007 Edition

by
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SUMMARY

This chartbook summarizes current knowledge about the health insurance coverage and health needs of low-income* children in the United States and the roles that Medicaid and the State Children's Health Insurance Program (SCHIP) — the joint federal-state, publicly funded health insurance programs for children — play in improving children's health care access and health status. Medicaid and SCHIP provide health coverage for over 30 million low-income children, opening doors to children and their families to affordable preventive, primary, and acute health care services.

This is a completely revised and updated version of a report originally issued three years ago (Ku and Nimalendran, 2004). Given current concerns about the pending reauthorization of SCHIP, it is relevant to provide clear and updated information about the important role these public insurance programs play in the lives of America's low-income children.

This report complements other recent reports about public insurance programs for children, such as the Kaiser Commission on Medicaid and the Uninsured's review of the evidence about health insurance for low-income people (2006) or its summary of SCHIP's first ten years (2007), the Congressionally-mandated evaluation of SCHIP by Wooldridge *et al.* (2005), or the series of reports by the Children's Health Insurance Research Initiative (which is sponsored by the Agency for Health Care Quality, the David and Lucile Packard Foundation, and the Health Resources and Services Administration).

Other new reports provide a wealth of useful information about SCHIP and children's health insurance coverage. To avoid duplication with those reports, this chartbook provides relatively little discussion of certain topics. Readers interested in information about states' eligibility and enrollment policies should refer to Cohen Ross *et al.* (2007), while those interested in SCHIP funding issues and shortfalls will find useful information in Park and Broaddus (2006), Broaddus and Park (2006), and Peterson (2006).

A substantial body of recent medical, health, and economic research, conducted by scholars across the nation, offers detailed information about the needs of low-income children and compelling evidence about the ways that public insurance programs help these children. Even so, it must be acknowledged that the research knowledge base about the effects of Medicaid and SCHIP remains incomplete. For example, it has not been possible to design and implement a random-assignment experiment of the effects of children's health insurance coverage that would be considered the "gold standard" of research evidence. Such a randomized study would probably not be considered ethically acceptable in any case. In addition, while health insurance coverage is critical, it is just one of the many determinants of children's health, including family environment and nutrition.

This report is organized into four sections, summarized below.

* In this document, "low-income" is defined as family income below 200 percent of the poverty line. In 2006, 200 percent of the poverty line was equal to an annual income of \$33,200 for a family of three or \$40,000 for a family of four (the poverty line is higher in Alaska and Hawaii).

A Thumbnail Sketch of Medicaid and SCHIP

Medicaid is a health insurance program for low-income people, including children, their parents, people with disabilities, and the elderly. Begun in 1965, Medicaid provides comprehensive health insurance for preventive, primary, and acute medical care, prescription drugs, and long-term care, delivered by a diverse array of health care providers, including hospitals, doctors' offices, clinics, pharmacies, and managed care plans.

In Medicaid, states must provide coverage to children below the age of 6 whose families have incomes at or below 133 percent of the poverty line and to children between the ages of 6 and 18 with incomes at or below the poverty line (\$16,600 for a family of three in 2006). States have the option to cover children with higher incomes in Medicaid.

The federal government establishes basic guidelines for Medicaid and pays 50-77 percent of the total cost. (States with lower per capita incomes receive higher federal matching rates.) States administer the program, establish most of the operational policies, and pay the remaining program costs.

Medicaid is an entitlement program; its funding expands or contracts when program needs or policies change. The Congressional Budget Office estimates that the federal government spent more than \$180 billion on Medicaid in fiscal year 2006 and served about 60 million people over the course of the year. This includes federal expenditures of about \$30 billion for health benefits for about 28 million children over the course of fiscal year 2006.

SCHIP was created by Congress in 1997 as an adjunct to Medicaid. It helps states provide health coverage to uninsured low-income children not eligible under Medicaid, typically those with incomes between 100 percent and 200 percent of the poverty line. (Some states also serve low-income pregnant women or parents with part of their SCHIP funds.) States may administer their SCHIP programs as expansions of Medicaid, as separate child health programs, or as a combination of the two. The legislative authorization for SCHIP expires after September 30, 2007; thus the program must be reauthorized in the near future if federal funding is to remain available.

SCHIP provides medical coverage for low-income children, but it does not provide long-term care. The range of medical benefits offered in separate SCHIP programs is usually broad but not as comprehensive as those offered to children in Medicaid.

Whether administered separately or as part of Medicaid, SCHIP is funded as a grant program with a federal funding cap. The federal government uses formulae to allocate funds to the states and to periodically redistribute unspent funds. The federal government pays 65-84 percent of the total cost of SCHIP, up to each state's limit; states pay the balance. Because the amount of federal funding that any state may receive is limited, states may experience shortfalls in federal funding for their SCHIP programs.

The federal expenditures for SCHIP were about \$5.5 billion in fiscal year 2006. The Centers for Medicare and Medicaid Services report that about 6 million children were served over the course of fiscal year 2005, of which 1.7 million were served in Medicaid expansions and 4.4 million were served in separate child health programs. In a typical month, more than 4 million children were covered.

SECTION 1

HEALTH INSURANCE COVERAGE OF LOW-INCOME CHILDREN

- The percentage and number of low-income children who are uninsured has fallen by more than one-third since 1997, when SCHIP legislation was enacted. The growth in Medicaid and SCHIP enrollment of low-income children more than offset the reduction in employer-sponsored coverage that occurred between 1997 and 2005. (Figures 1 and 2)
- About 7 out of every 10 uninsured children are already eligible for Medicaid or SCHIP. To make substantial headway in further reducing the number of uninsured children, it will be necessary to increase participation in these programs by eligible children and to ensure that sufficient federal and state funds are available to cover their health needs. (Figure 3)
- Most children covered by Medicaid or SCHIP are in *working* families that are unable to get or afford private health insurance for their children. (Figure 4)
- SCHIP covers children who would otherwise be uninsured. Most newly enrolled children were previously uninsured or had recently lost their Medicaid or private health coverage for involuntary reasons, such as parental job loss or a job or divorce. (Figure 5)
- Medicaid and SCHIP have helped about half of all low-income children in rural and urban areas alike. (Figure 6)
- White children, African American children, and Hispanic children have all experienced substantial reductions in rates of uninsurance in the past decade because of the expansion of the public programs. (Figure 7)
- Over the past decade, insurance coverage has eroded for immigrant children even as it has grown for children who live in native-born citizen families. Under a 1996 law, a large number of legal immigrant children are ineligible for federal coverage under Medicaid or SCHIP. (Figure 8)
- Children with special health care needs — those whose developmental, chronic, or behavioral health problems require specialized care — are especially reliant on Medicaid and SCHIP. (Figure 9)
- One of the most effective ways to bolster enrollment of eligible low-income children is to expand coverage for their parents. For parents, the typical income limit for publicly funded coverage is about one-third the typical income limit for children, but a number of studies show that when states expand parents' coverage, children's participation improves. (Figures 10 and 11)

SECTION 2

HEALTH NEEDS OF CHILDREN IN MEDICAID AND SCHIP

- Children served by Medicaid and SCHIP often have serious health problems. They are more likely to be rated as having fair or poor health than privately insured children. While children covered by the public programs are somewhat more likely to be in fair or poor health than those without insurance, substantial numbers of uninsured children with fair or poor health remain uninsured. (Figure 12)
- Publicly insured children are more likely to have asthma, learning disabilities, and/or health conditions that require regular treatment with prescription medications. Medicaid and SCHIP provide access to the medical care that can treat these problems and help children grow, function, and learn more effectively. Like other American children, publicly-insured children are often overweight and Medicaid and SCHIP may be able to do more to address this problem. (Figures 13-16)

SECTION 3

EFFECTS ON MEDICAL CARE ACCESS AND UTILIZATION

- One critical way to improve health access is to ensure that a child has a “medical home” or a usual place to receive medical care. Children covered by Medicaid or SCHIP are much more likely to have a medical home than children who are uninsured. Moreover, over the past decade the percentage of children who have access to a medical home has grown for children covered by public programs while declining for uninsured children. (Figures 17 and 18)
- Before joining SCHIP, African American and Hispanic children in New York were less likely than white children to have a usual source of care. One year after enrollment, these racial and ethnic disparities had largely been eliminated. (Figure 19)
- One of the most direct measures of access to medical care is whether a child has seen a doctor or other health professional in the past year. Children enrolled in Medicaid and SCHIP are much more likely than uninsured children to have seen a physician. (Figure 20).
- Children need preventive health care such as well-child visits, where doctors make sure that the child is immunized or check for health problems that might jeopardize the child’s development. Children covered by Medicaid or SCHIP are much more likely than uninsured children to have preventive health care and to keep up with recommended schedules of well-child visits. (Figures 21 and 22)
- Because children enrolled in Medicaid or SCHIP are typically in poorer health than other children, it is not surprising that they need to use emergency rooms more often than privately insured children. However, the use of emergency rooms by publicly insured children has declined by about one-quarter over the past decade. (Figure 23)
- Children insured by Medicaid or SCHIP are less than one-fifth as likely as uninsured children to

have unmet medical needs, which means that their families avoided getting medical care because of the costs. (Figure 24)

- Children enrolled in Medicaid or SCHIP have fewer unmet medical or dental needs than uninsured children. Moreover, a New York study found that although African American and Hispanic children were at greater risk than white children of having unmet needs *before* they entered SCHIP, these racial and ethnic disparities disappeared after one year of SCHIP coverage. (Figures 25 and 26).
- Although low-income children's access to dental care is insufficient, those who are continuously covered by public insurance are more likely to receive dental care than those who are continuously covered by private insurance. In addition, low-income children who are continuously covered by public insurance are much more likely to get dental care than children who are uninsured for part or all of a year. (Figure 27)

SECTION 4

EFFECTS IN IMPROVING CHILD HEALTH

- About one-quarter of children enrolled in Medicaid or SCHIP are in better health than they were a year ago, according to their parents or caretakers. This is a stronger rate of improvement than that of privately insured or uninsured children. (Figure 28)
- A research study in New York found that asthmatic children's health improves substantially after they have been covered in SCHIP for a year: they have fewer asthma attacks and are less likely to be hospitalized. (Figure 29)
- In California, parents reported improvements in their children's school performance after they had been enrolled in SCHIP for a year: the children were more likely to pay attention in class and were better able to keep up with school activities. Similarly, a Kansas study found that children missed fewer school days due to sickness after they were enrolled in SCHIP. (Figure 30)

THE CHALLENGES AHEAD

In sum, extensive evidence demonstrates that Medicaid and SCHIP have bolstered children's health insurance coverage, strengthened access to medical and dental care, and improved children's health. Other research indicates that improved child health may ultimately lead to better health when children grow up to become adults, so there could be more long lasting repercussions (Case *et al.*, 2005).

Unfortunately, the progress in children's health insurance coverage made over the past decade could slow or even slip backward. For example, new federal mandates that state agencies document the citizenship and identity of citizens applying for Medicaid, including children and even newborns,

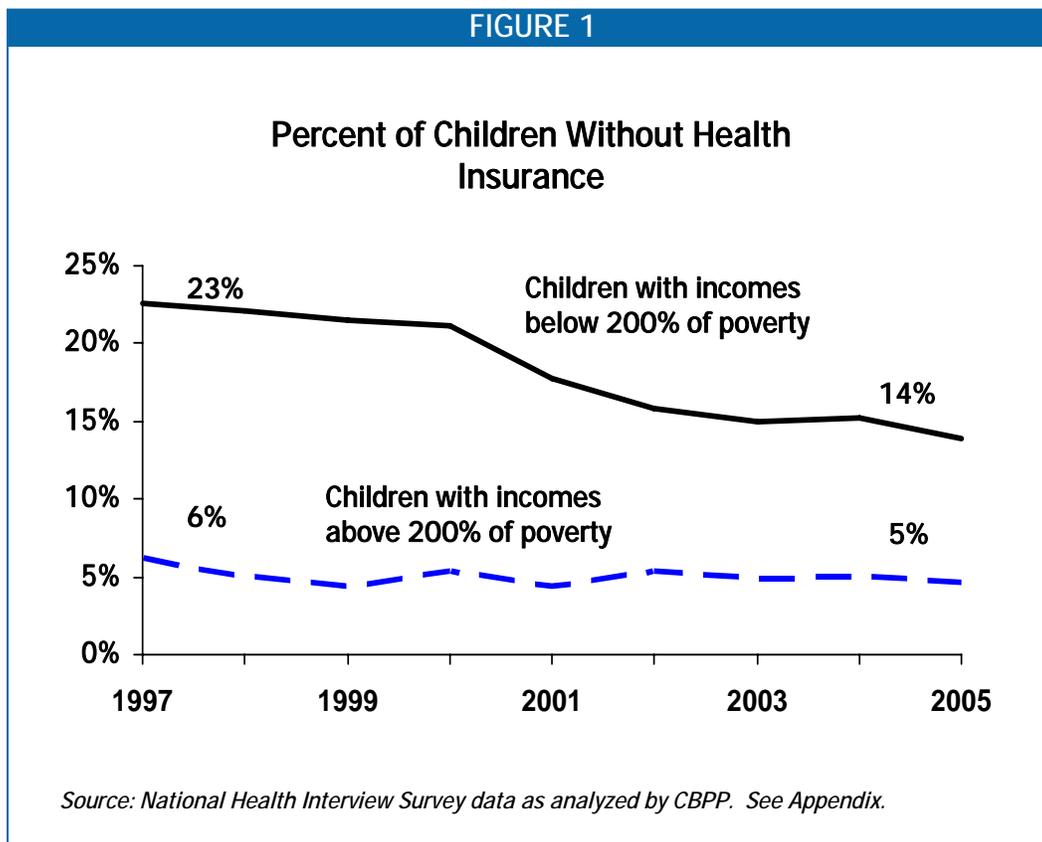
threaten to delay or deny coverage to tens of thousands of eligible low-income citizen children (Center on Budget and Policy Priorities, 2006; deLone, 2006; Cohen Ross 2007).

In addition, many states are facing shortfalls in their federal SCHIP funding levels that could begin as soon as mid-2007 (Park and Broaddus, 2006; Peterson, 2006). If these shortfalls are not filled, enrollment could fall substantially in the coming year. Furthermore, SCHIP is due for reauthorization in 2007, and if Congress freezes annual federal SCHIP funding in nominal terms for the next five years, funding shortages could lead 1.5 million or more children to lose coverage (Broaddus and Park, 2006).

Census data for 2005 indicate that about 9 million children 18 or younger are uninsured. In the coming year, Congress and the President have the opportunity to address these problems and to provide the additional resources that would strengthen the nation's system of health insurance coverage for low-income children so the nation can continue to reduce the number of children who lack health insurance and to improve their health.

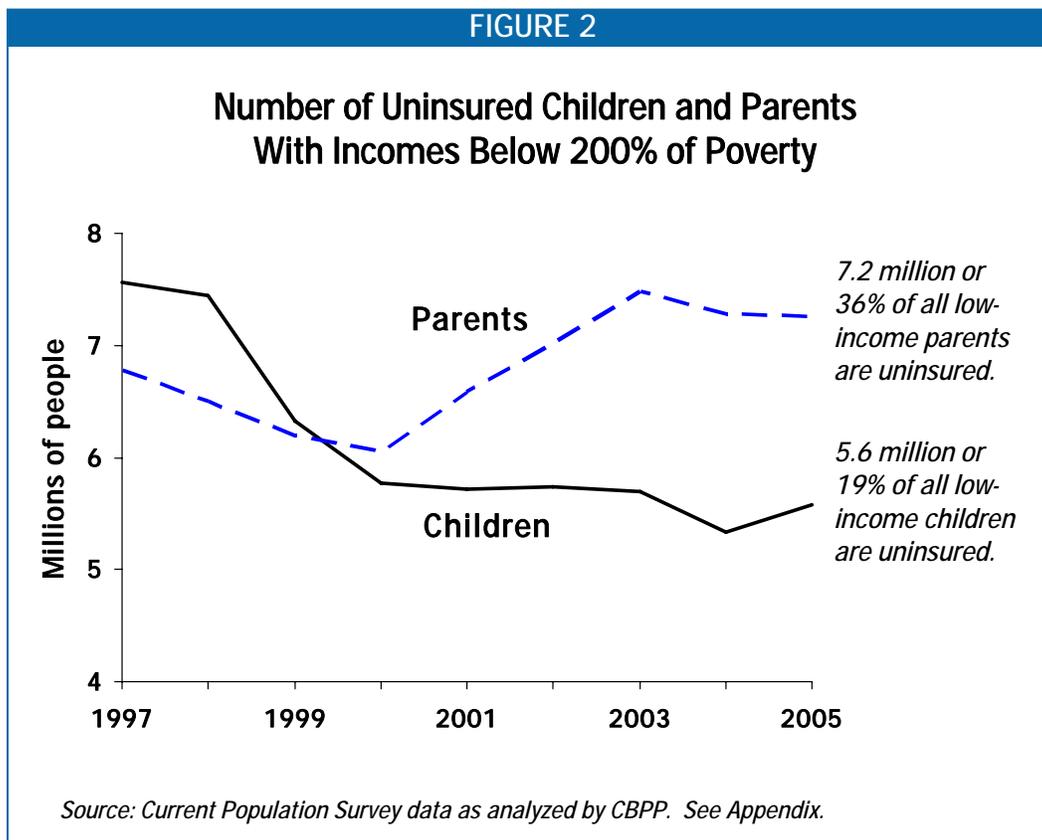
MEDICAID AND SCHIP HAVE REDUCED THE SHARE OF LOW-INCOME CHILDREN WHO ARE UNINSURED BY OVER ONE-THIRD

- 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.



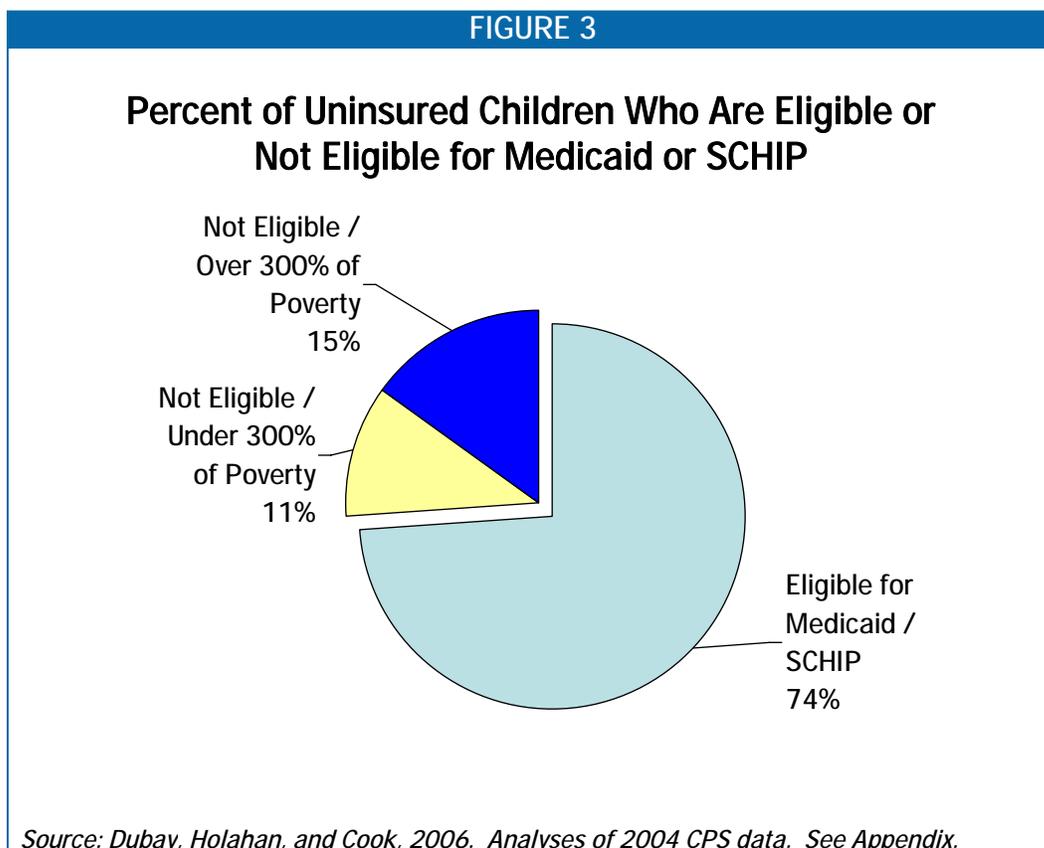
LOW-INCOME CHILDREN'S COVERAGE HAS IMPROVED, BUT PARENTS' COVERAGE HAS WEAKENED

- 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.)



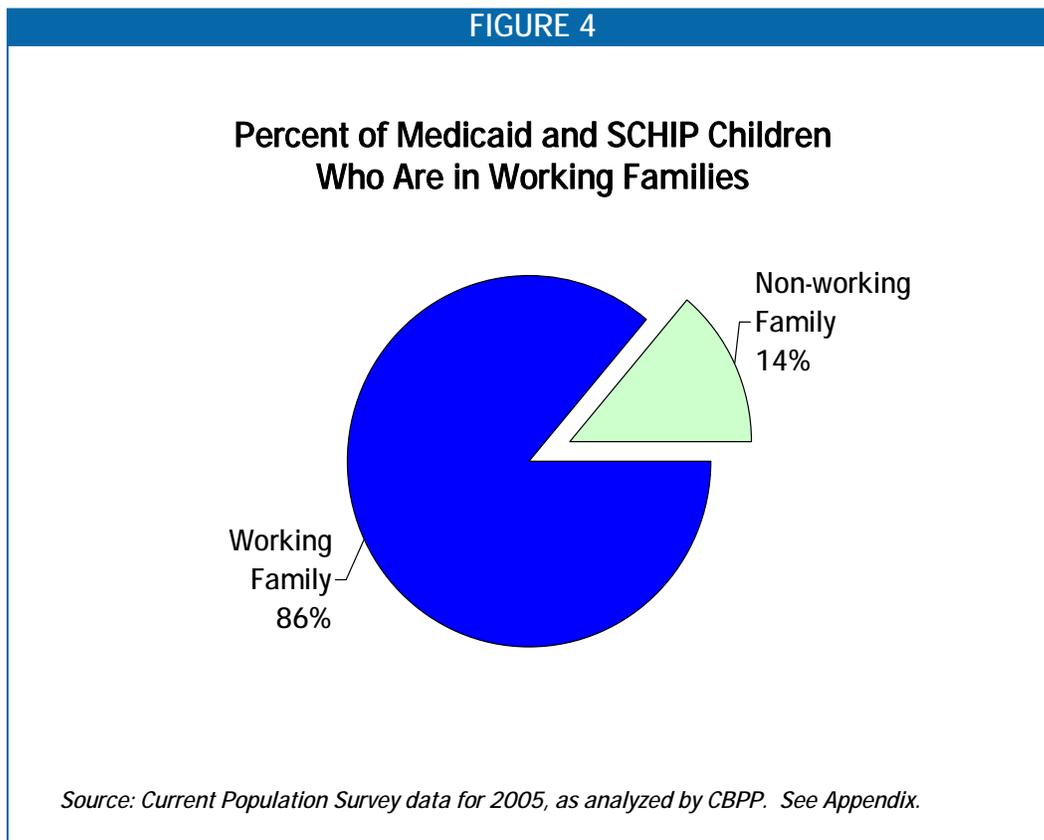
MOST UNINSURED CHILDREN ARE ELIGIBLE FOR MEDICAID OR SCHIP

- 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.



MOST CHILDREN COVERED BY MEDICAID OR SCHIP ARE IN WORKING FAMILIES

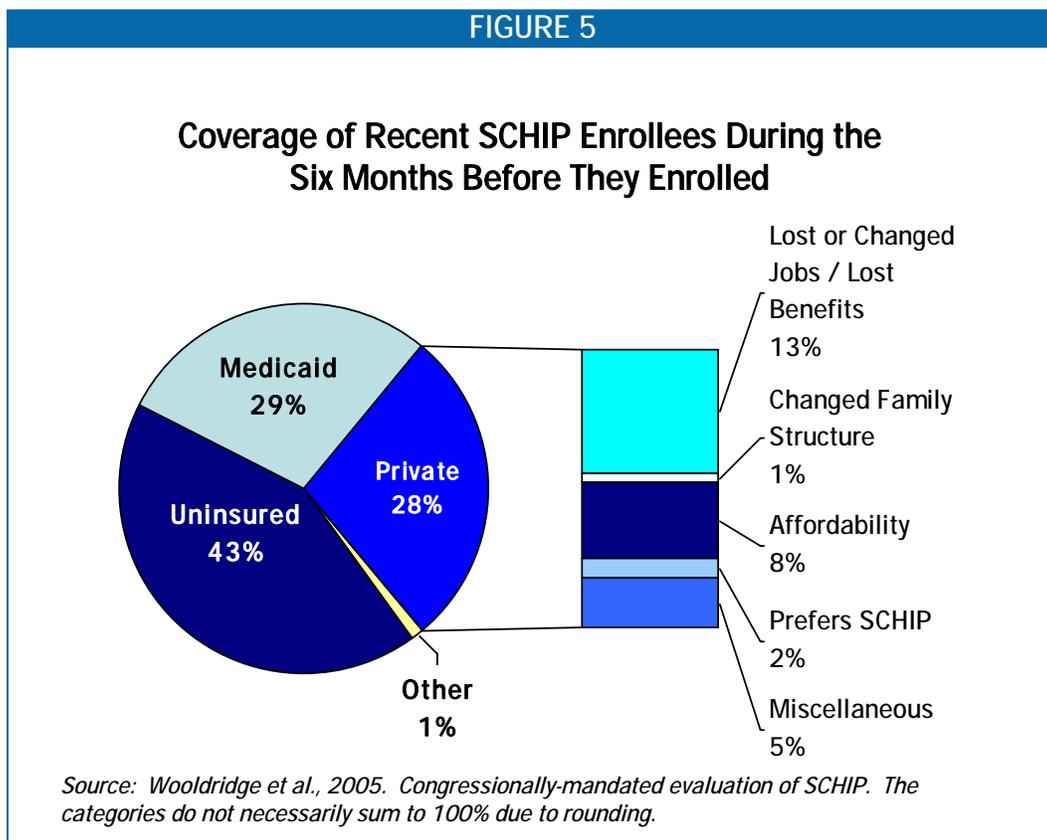
- About six out of every seven children on Medicaid or SCHIP have one or more working parents.
- A major reason why low-income children rely on Medicaid or SCHIP is that their parents are unable to attain affordable private health coverage for their children through the workplace. Many low-wage jobs 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.



SCHIP COVERS LOW-INCOME CHILDREN WHO WOULD OTHERWISE BE UNINSURED

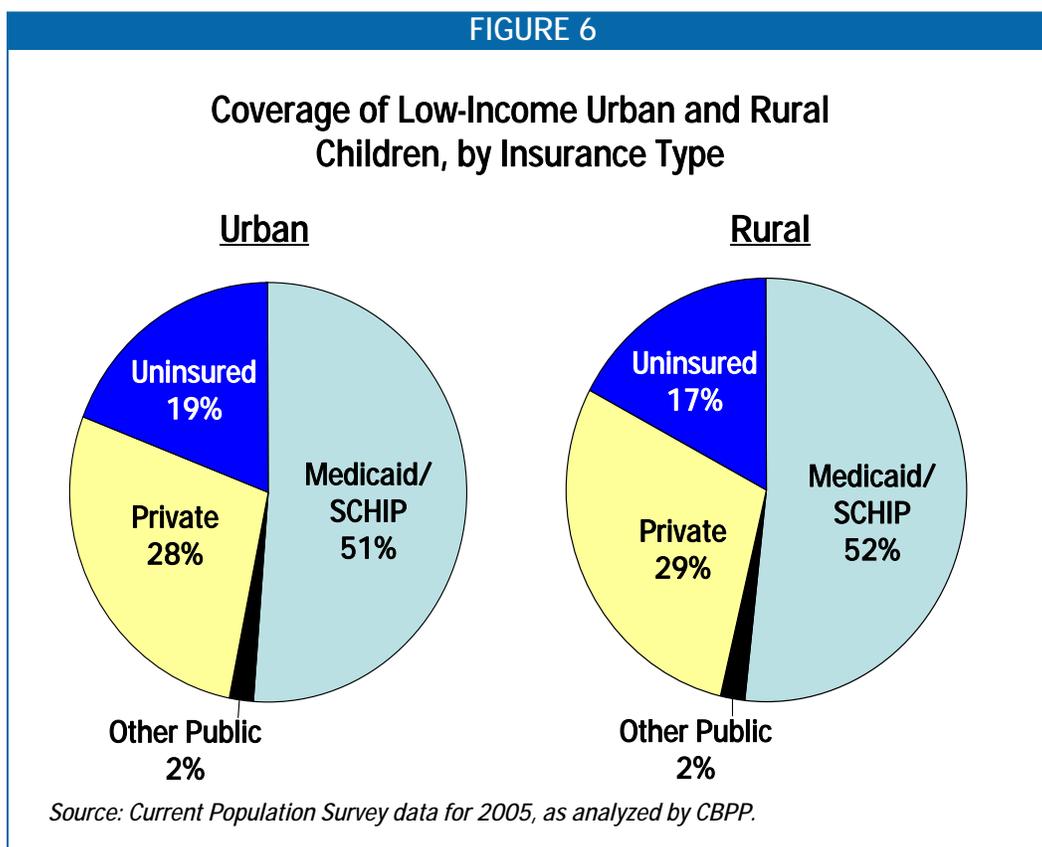
- A congressionally mandated evaluation of SCHIP found that most enrollees would have been uninsured if they were not covered by SCHIP (Wooldridge *et al.*, 2005).
- In ten states, researchers surveyed the insurance held by SCHIP children in the six months before enrollment. Almost half (43 percent) 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).

FIGURE 5



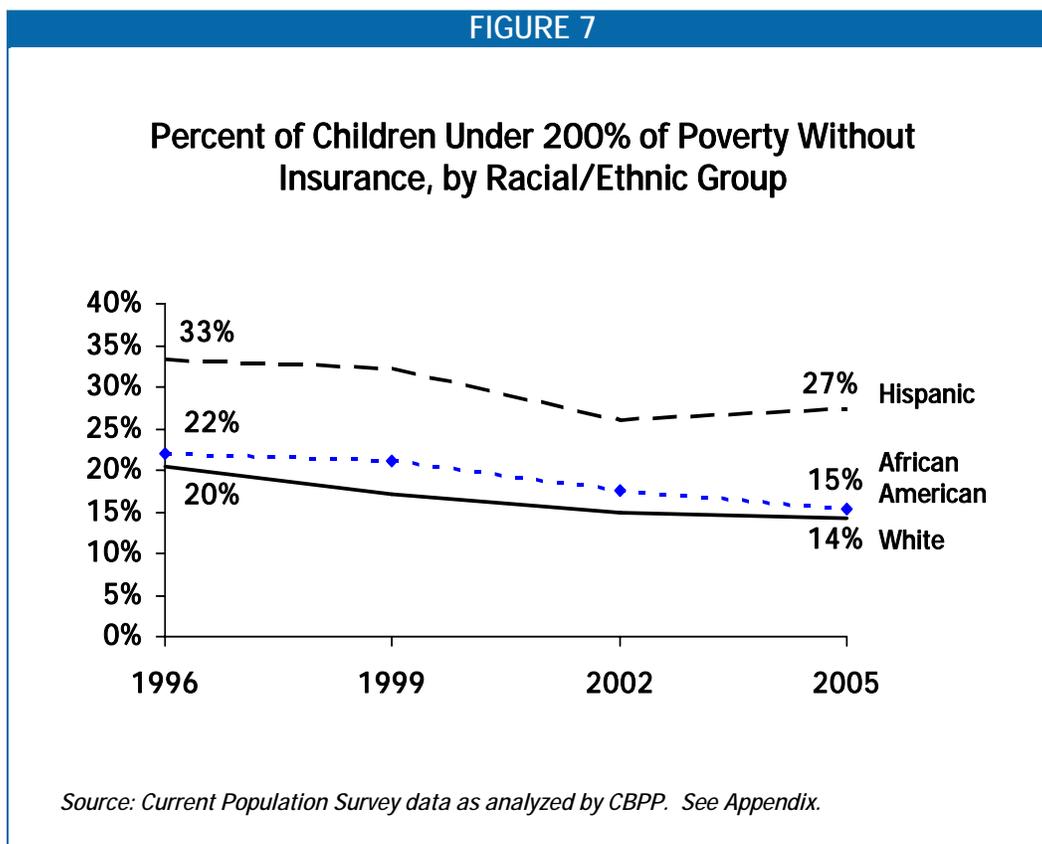
IN URBAN AND RURAL AREAS ALIKE, ABOUT HALF OF LOW-INCOME CHILDREN ARE COVERED BY MEDICAID OR SCHIP

- 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.



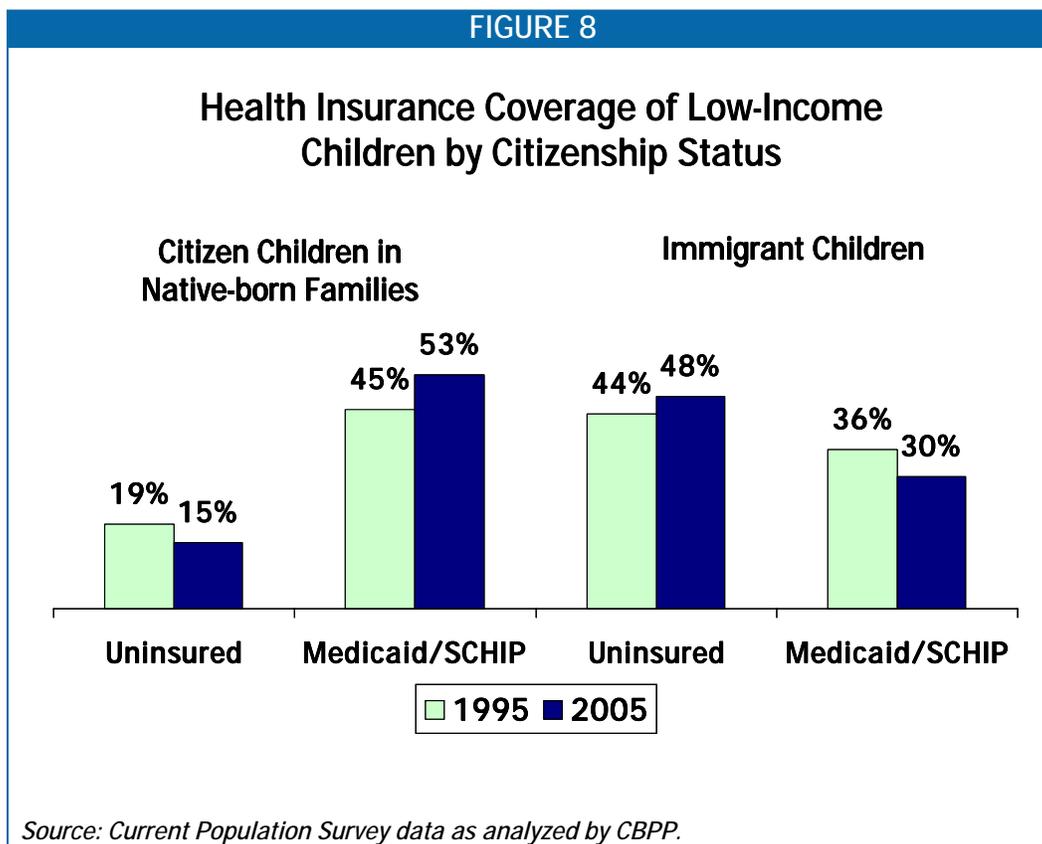
IMPROVEMENTS IN LOW-INCOME CHILDREN’S HEALTH COVERAGE HAVE HELPED WHITE, AFRICAN AMERICAN, AND HISPANIC CHILDREN ALIKE

- 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.



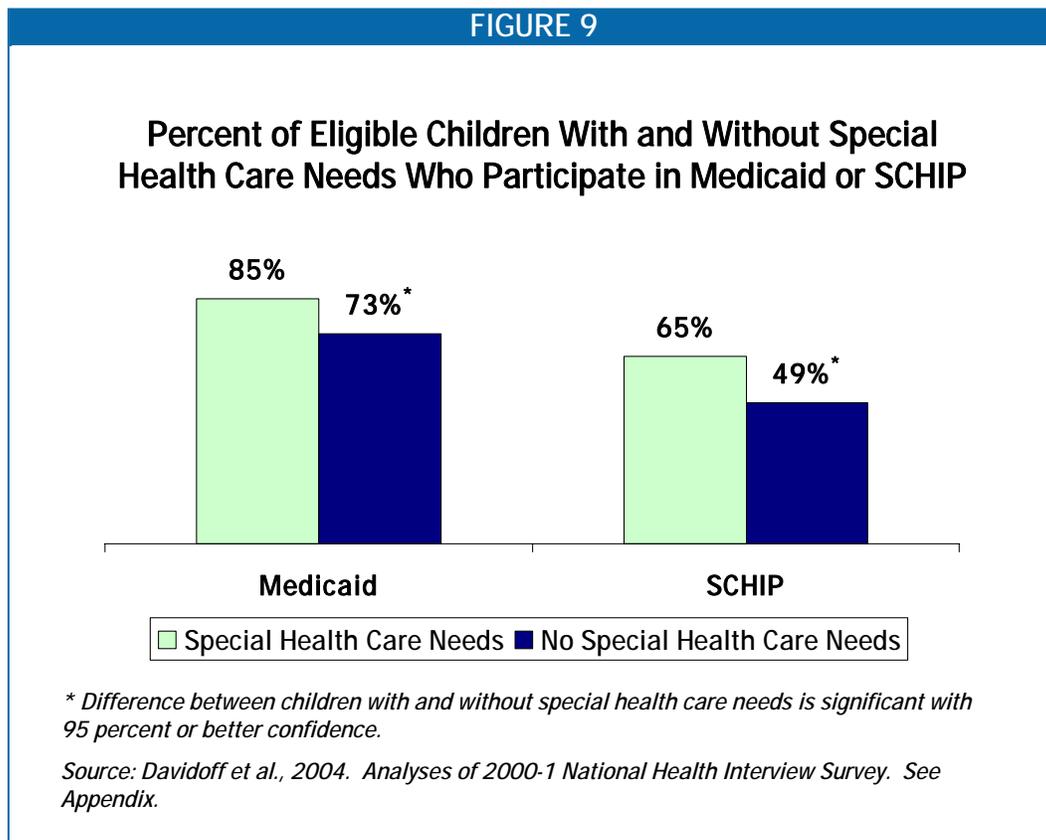
THE GAP IN COVERAGE BETWEEN CITIZEN AND IMMIGRANT CHILDREN HAS WIDENED

- 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.



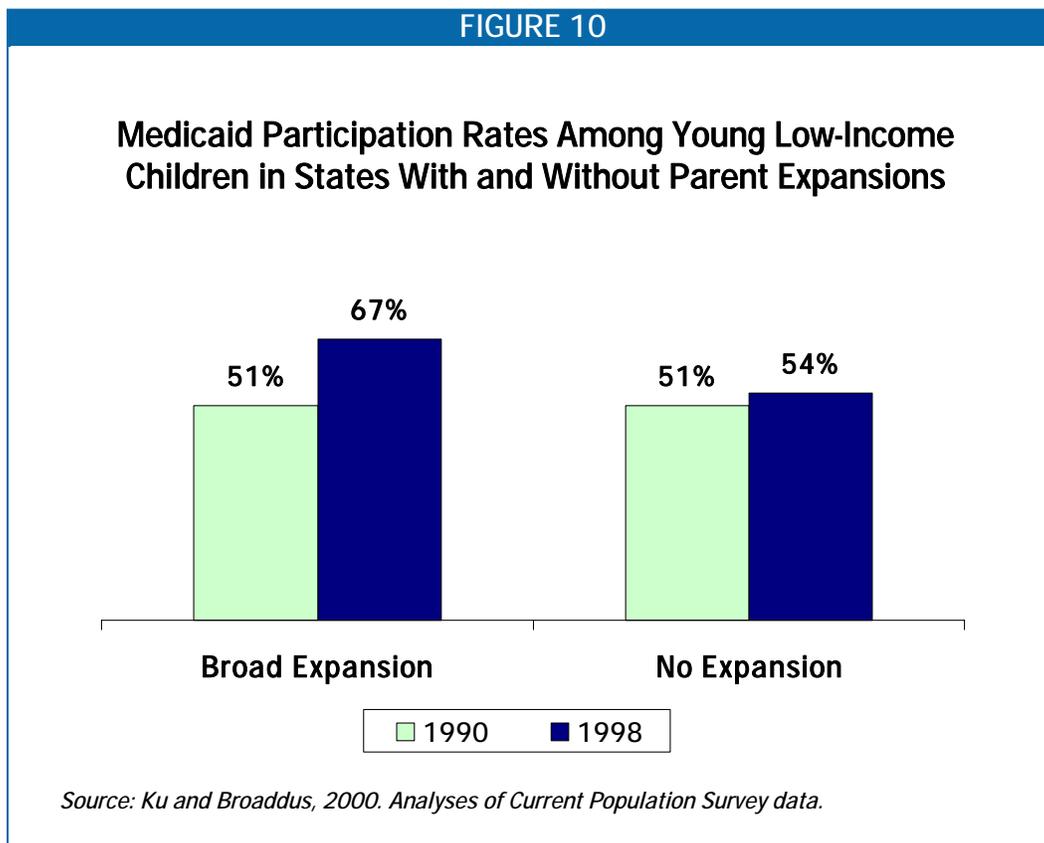
CHILDREN WITH SPECIAL HEALTH CARE NEEDS ARE PARTICULARLY RELIANT ON MEDICAID AND SCHIP

- 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).



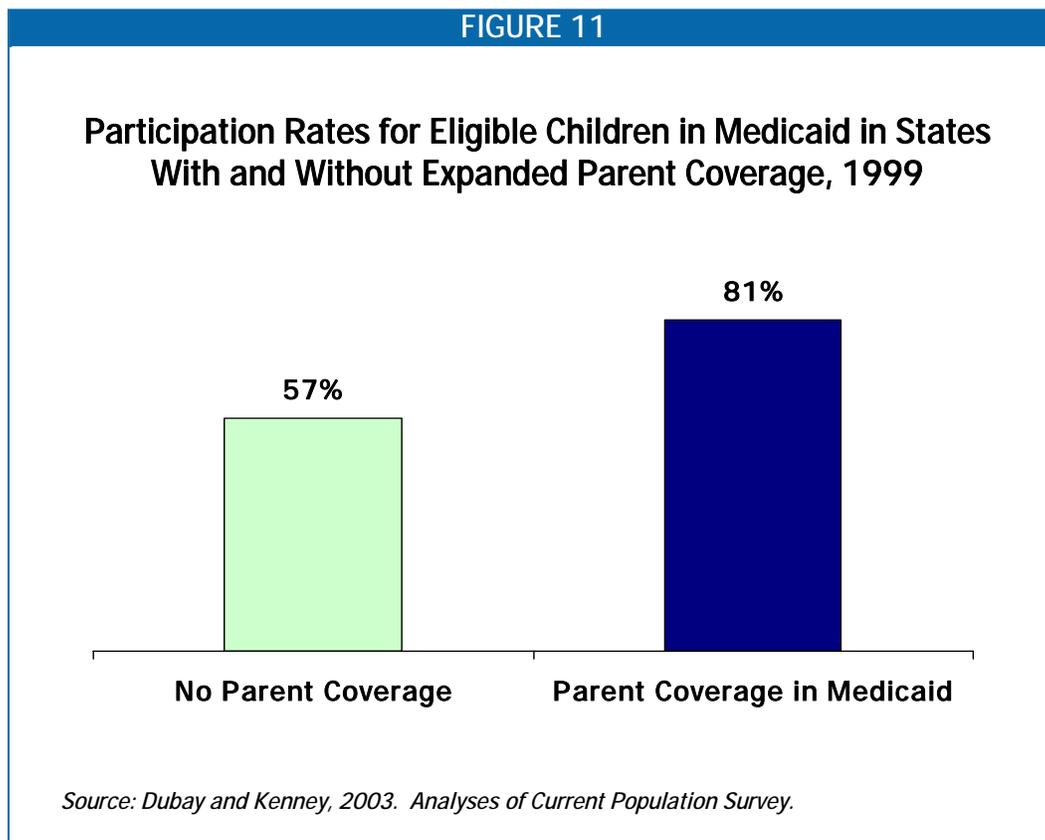
COVERING LOW-INCOME PARENTS INCREASES ENROLLMENT OF ELIGIBLE CHILDREN

- 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).



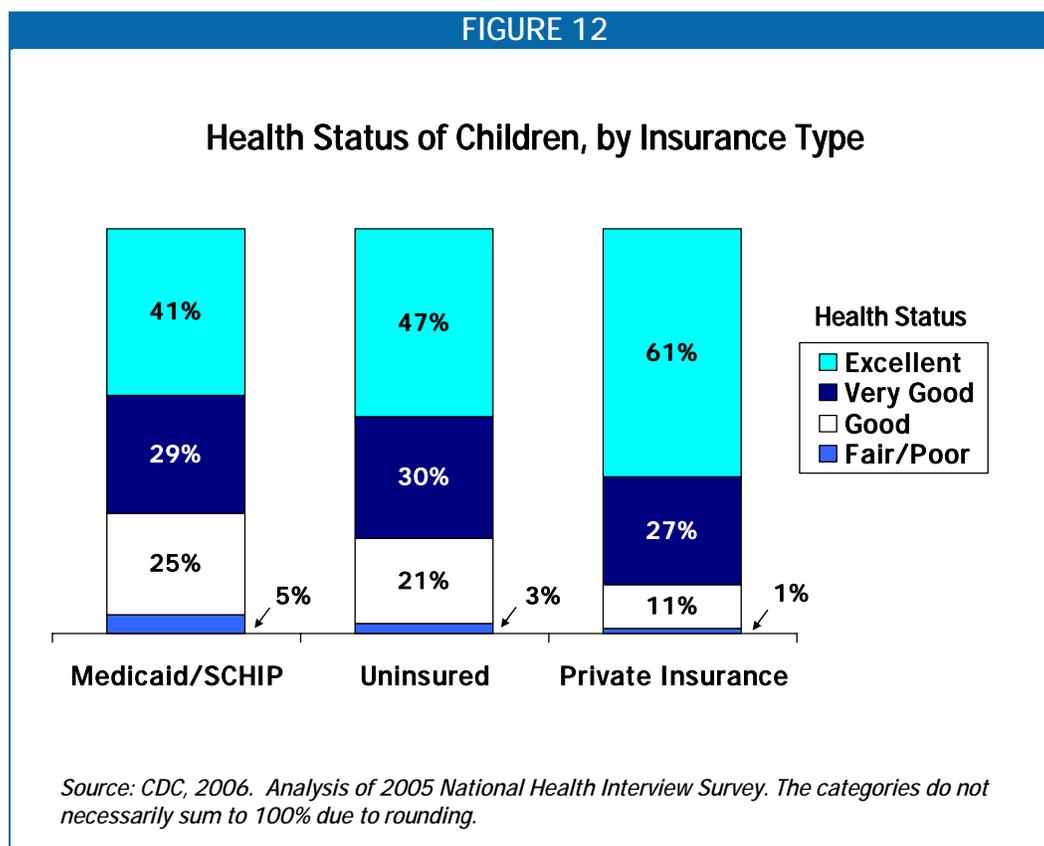
COVERING LOW-INCOME PARENTS INCREASES ENROLLMENT OF ELIGIBLE CHILDREN (CONTINUED)

- 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).



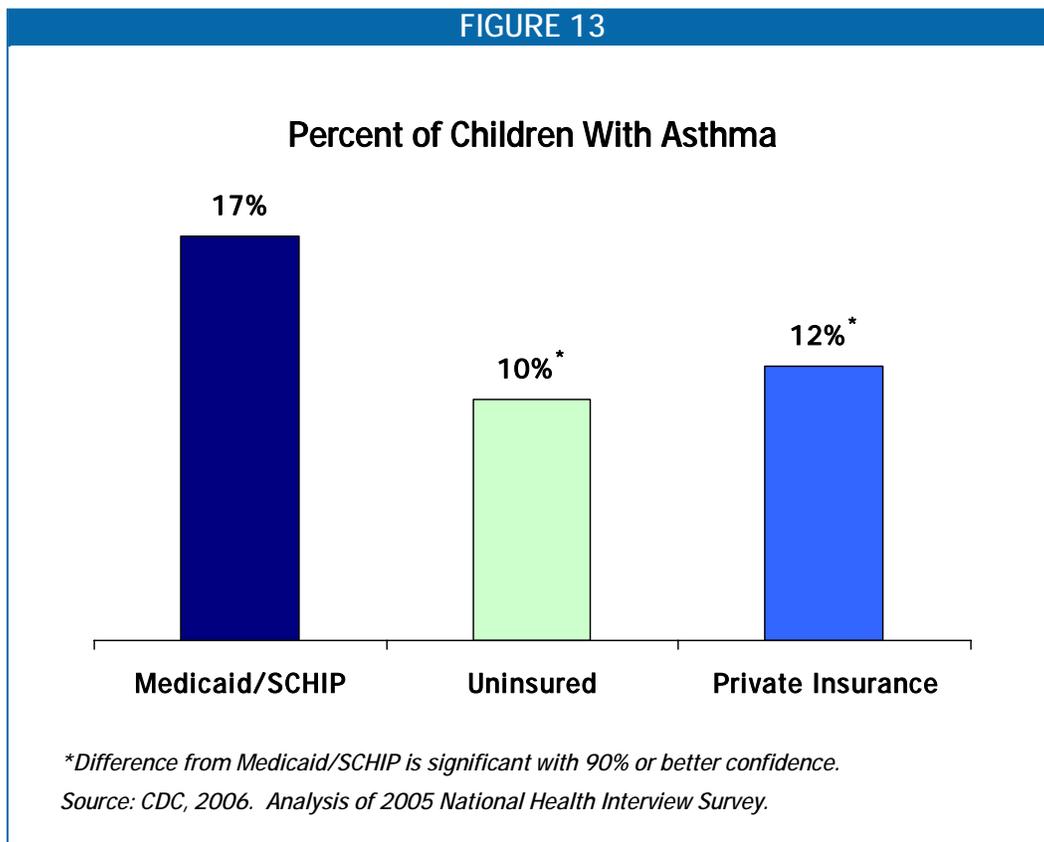
CHILDREN IN MEDICAID AND SCHIP ARE MORE LIKELY TO BE IN POOR OR FAIR HEALTH

- Children in Medicaid or SCHIP are about four times as likely to be in “poor” or “fair” health (as assessed by their parents or caretakers) as privately insured children, and about twice as likely to be in poor or fair health as uninsured children, according to data from the Centers for Disease Control and Prevention. Publicly insured children are also less likely than the other two groups to be in “excellent” health.
- Children in low-income families are greater risk of poor health because they are brought up in greater deprivation. In addition, parents are more likely to enroll their children in Medicaid or SCHIP when their children are sick or have health problems.
- As shown later in this report (Figure 28), parents report that their children enrolled in Medicaid or SCHIP are often in better health than they were a year before.
- Yet while Medicaid and SCHIP help address the health needs of many of the nation’s sickest children, many other children with fair or poor health remain uninsured.



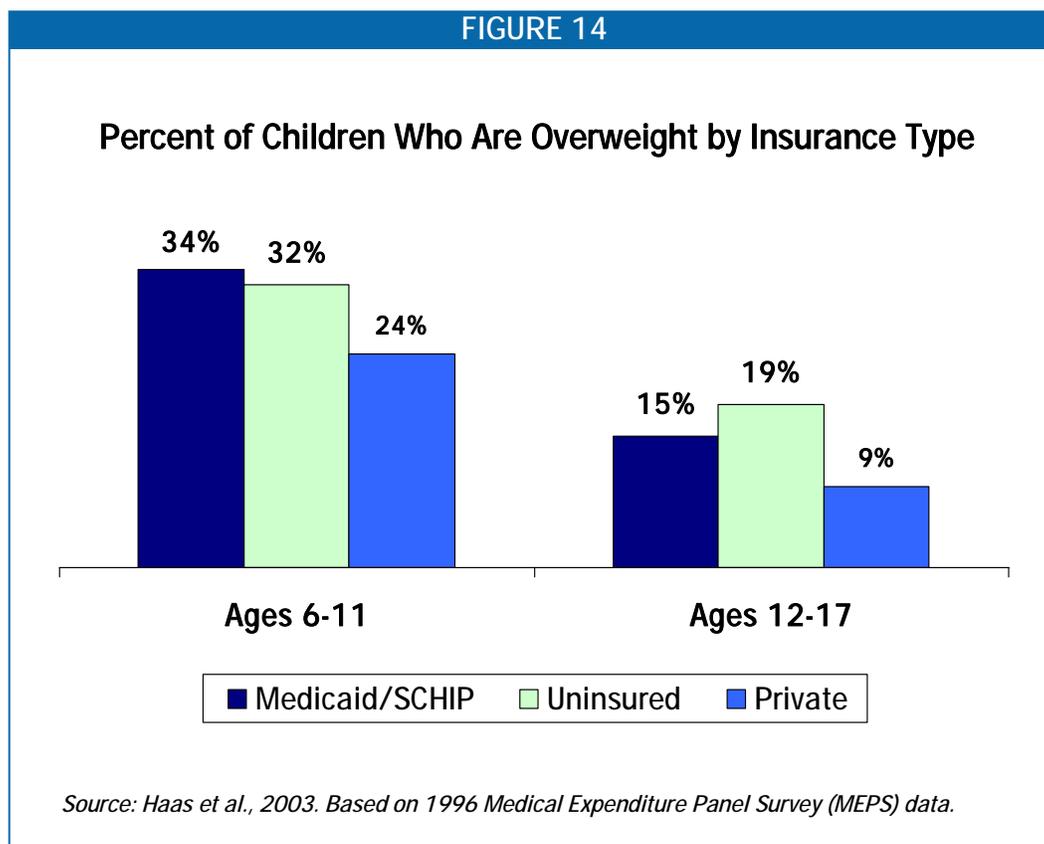
ASTHMA IS COMMON AMONG CHILDREN IN MEDICAID AND SCHIP

- Asthma, one of the most common and serious childhood diseases, is a leading cause both of pediatric hospitalizations and of school days missed (Center for Health Care Strategies, 2001).
- Publicly insured children are more likely to have been diagnosed with asthma than uninsured children and children with private insurance. About one-sixth of children served by Medicaid or SCHIP have been diagnosed as asthmatic at some point.
- Medicaid and SCHIP can provide access to primary medical care and to medications (e.g., inhalers) that ease asthma and prevent asthma attacks. (As Figure 29 shows, the health of children with asthma improves after they have been enrolled in SCHIP.) That, in turn, can avert unnecessary and expensive emergency room visits or hospital admissions.



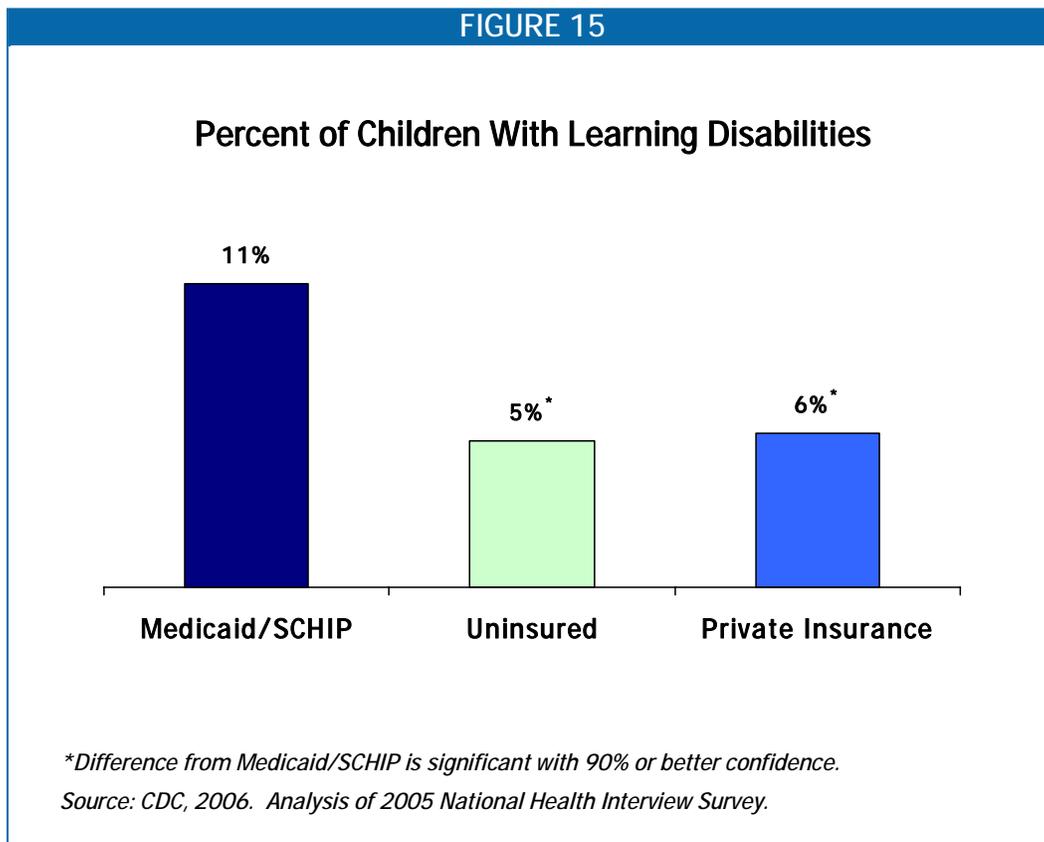
MANY CHILDREN COVERED BY PUBLIC INSURANCE ARE OVERWEIGHT

- A rising share of American children is overweight, which can lead to adult obesity as well as to chronic diseases such as diabetes or heart disease (Anderson and Butcher, 2006). Analyses of the 1996 Medical Expenditure Panel Survey indicate that a substantial share of publicly-insured children are overweight, as are a large share of uninsured and privately insured children (Haas *et al.*, 2003).
- Some of the differences in the percentages who are overweight are not related to insurance status, however, but are related to income, race/ethnicity and other characteristics of the children. After controlling for such factors, publicly insured children 6 to 11 were *not* more likely to be overweight than privately insured children, although differences for older children remained. (See Appendix)
- While Medicaid and SCHIP cannot directly affect children's diets or physical activity, health insurance programs may be able to do more to promote obesity prevention or treatment, such as coverage of counseling about nutrition or exercise (National Governors Association 2002).



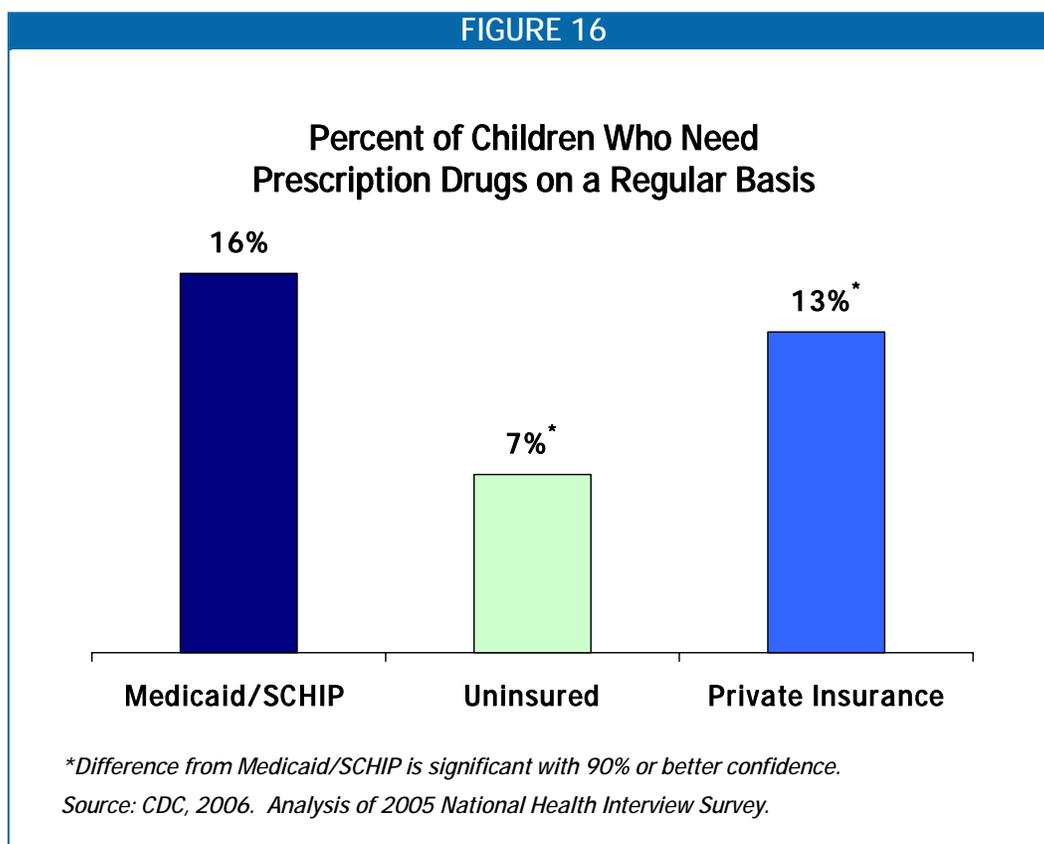
MANY CHILDREN IN MEDICAID OR SCHIP HAVE HEALTH PROBLEMS THAT MAKE IT MORE DIFFICULT FOR THEM TO LEARN

- Children covered by public insurance are more likely to have been diagnosed with learning disabilities than privately insured or uninsured children. Medicaid and SCHIP provide access to medical and behavioral care services that help these children and improve their opportunities to learn at school. (Figure 30 shows that SCHIP coverage has been associated with improved school performance.)
- Public insurance programs can serve as a financial bridge between schools and health care. In many cases, teachers, counselors, or other school personnel identify problems among schoolchildren, and Medicaid or SCHIP then covers the health care services these children need.



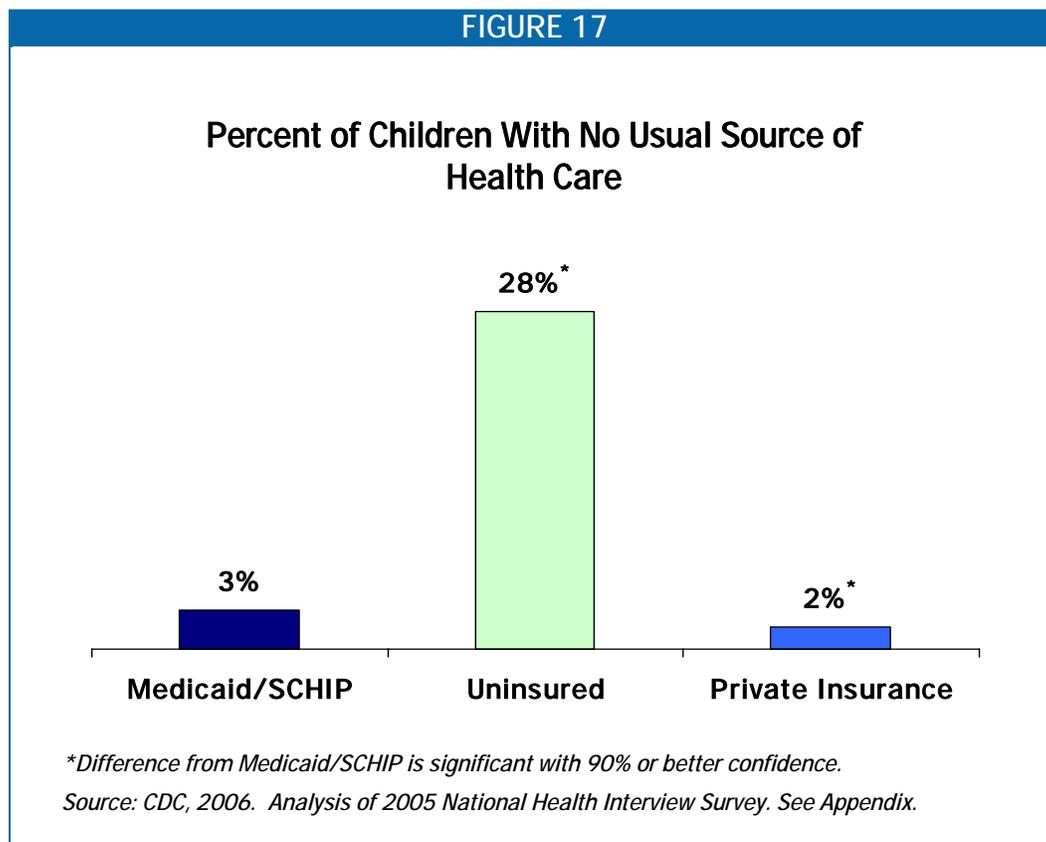
MANY CHILDREN IN MEDICAID AND SCHIP NEED MEDICATIONS REGULARLY

- Many children served by Medicaid and SCHIP have chronic health conditions or other special health care needs that require regular treatment using prescription drugs.
- Children served by public programs are more than twice as likely to have a medical problem that requires regular treatment (i.e., for three or more months) with medications than uninsured children. Publicly insured children are also more likely to have such medical conditions than privately insured children.
- Medicaid and SCHIP offer prescription drug coverage that helps these children get the medications they need. Limits on Medicaid or SCHIP enrollment, as well as policies that delay or interrupt coverage, increase the risk that these children will not receive needed medications.



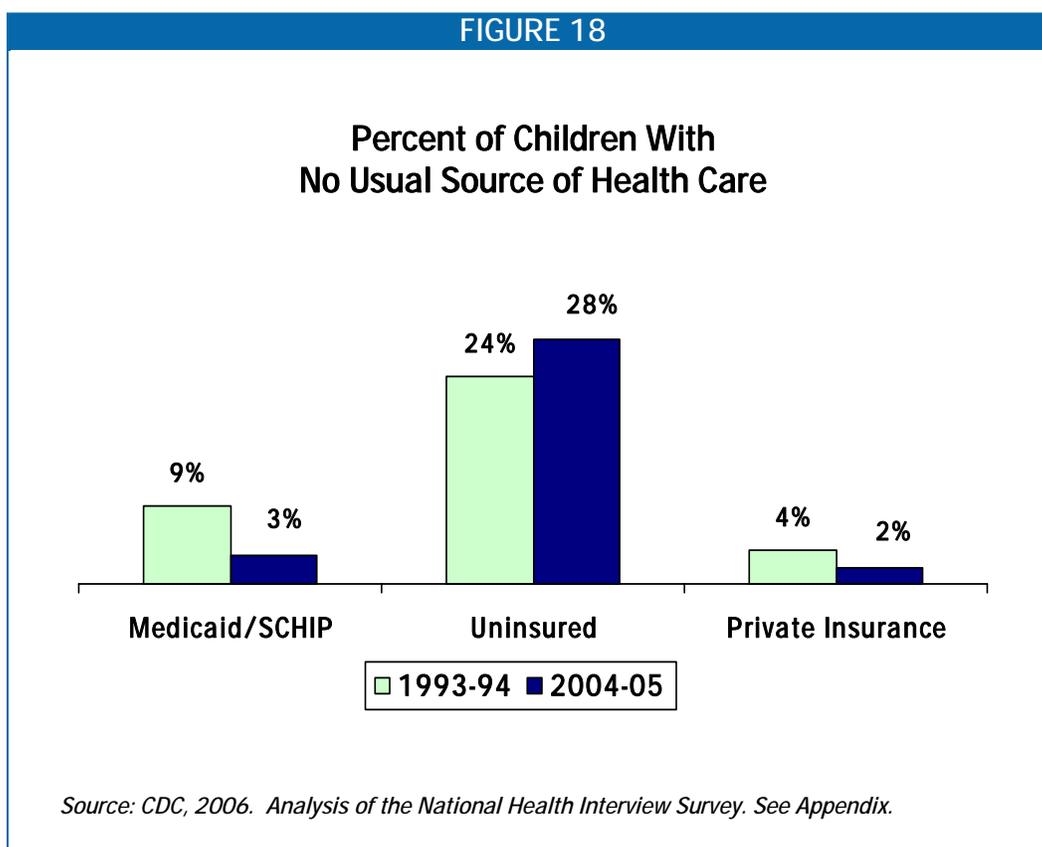
ALMOST ALL CHILDREN IN MEDICAID AND SCHIP HAVE A USUAL SOURCE OF MEDICAL CARE

- Medicaid and SCHIP help ensure that children have a “medical home” — a usual source of health care, such as doctor’s office, clinic, or health maintenance organization. This lets their families know where their children can get primary and preventive health care. Also, 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 children’s health care (Starfield and Shi, 2004).
- Children in Medicaid and SCHIP are far more likely to have a usual health care source than uninsured children, and about as likely to have a usual source of care as privately insured children.



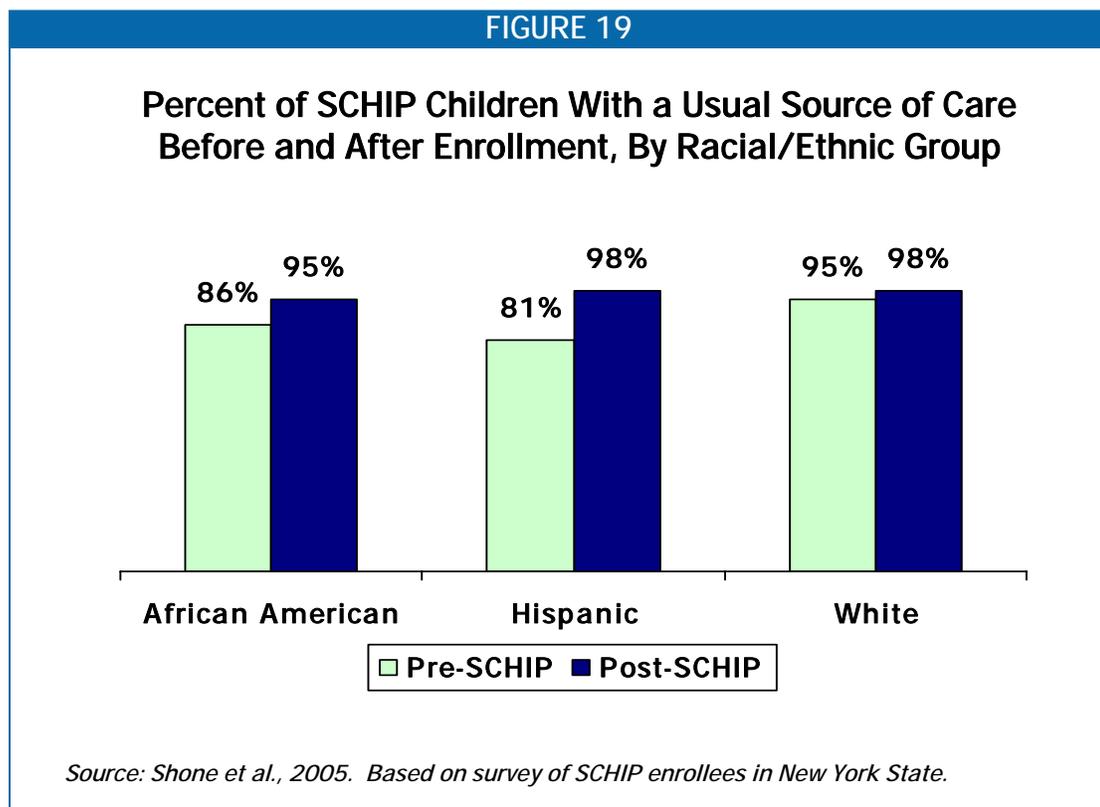
ACCESS TO A USUAL SOURCE OF CARE HAS IMPROVED FOR CHILDREN IN PUBLIC INSURANCE PROGRAMS

- The extent to which children covered by Medicaid or SCHIP have a medical home has improved over the past decade. Between 1993-4 and 2004-5, the percentage of children covered by Medicaid or SCHIP with a usual source of health care rose to a level similar to that of privately insured children.
- In contrast, uninsured children's access to a usual source of health care has worsened. Research indicates that physicians' willingness to provide charity care has dwindled in recent years. Thus, it has become increasingly important for children to have health insurance coverage in order to get medical care.
- Because Medicaid and SCHIP payment rates for physicians are often below the rates paid by other insurers, some physicians limit the extent to which they see patients covered by public programs. Nonetheless, almost all children served by public programs have a usual source of health care, and access to medical homes has improved in recent years.



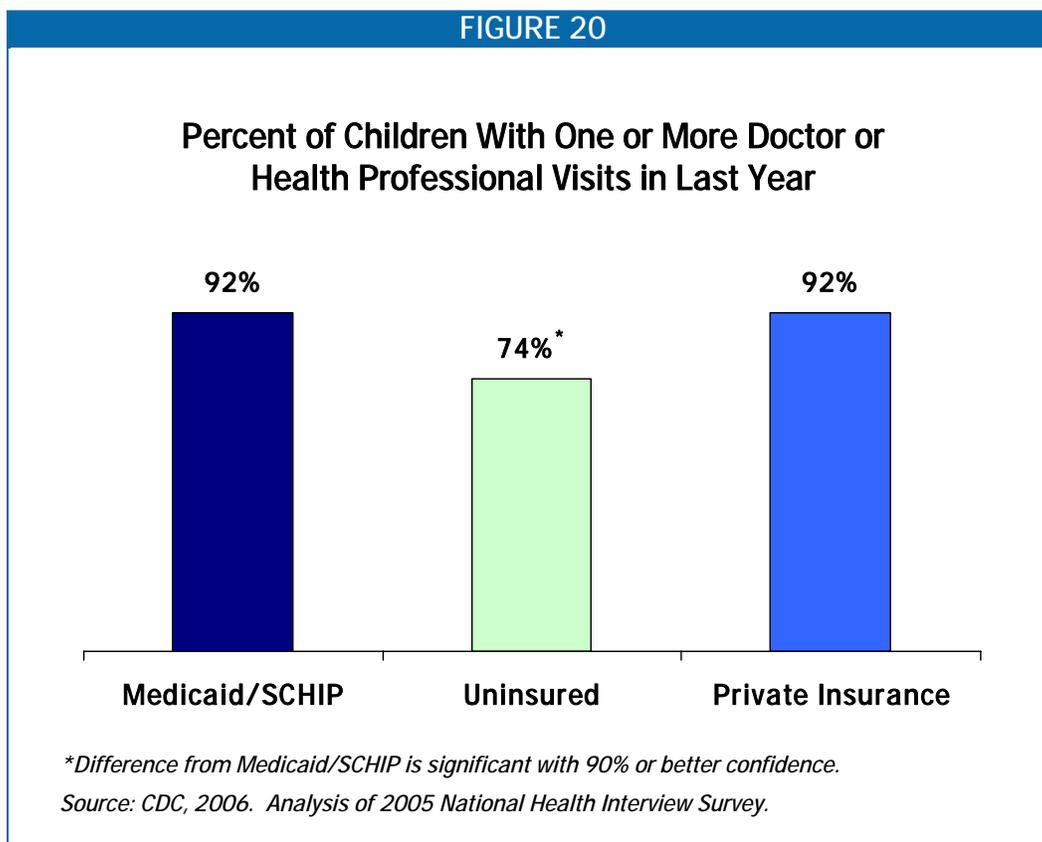
RACIAL AND ETHNIC DISPARITIES IN ACCESS TO A USUAL SOURCE OF CARE ARE REDUCED AFTER CHILDREN JOIN SCHIP

- In a study of New York State's SCHIP program, researchers examined how children's health care access and utilization changed after being covered by SCHIP for one year (Shone *et al.*, 2005).
- A significantly larger share of children had a usual source of care after one year of enrollment than when they enrolled.
- Prior to enrolling in SCHIP, African American and Hispanic children were much less likely than white children to have a usual source of care. After they joined SCHIP, these racial and ethnic disparities largely disappeared.



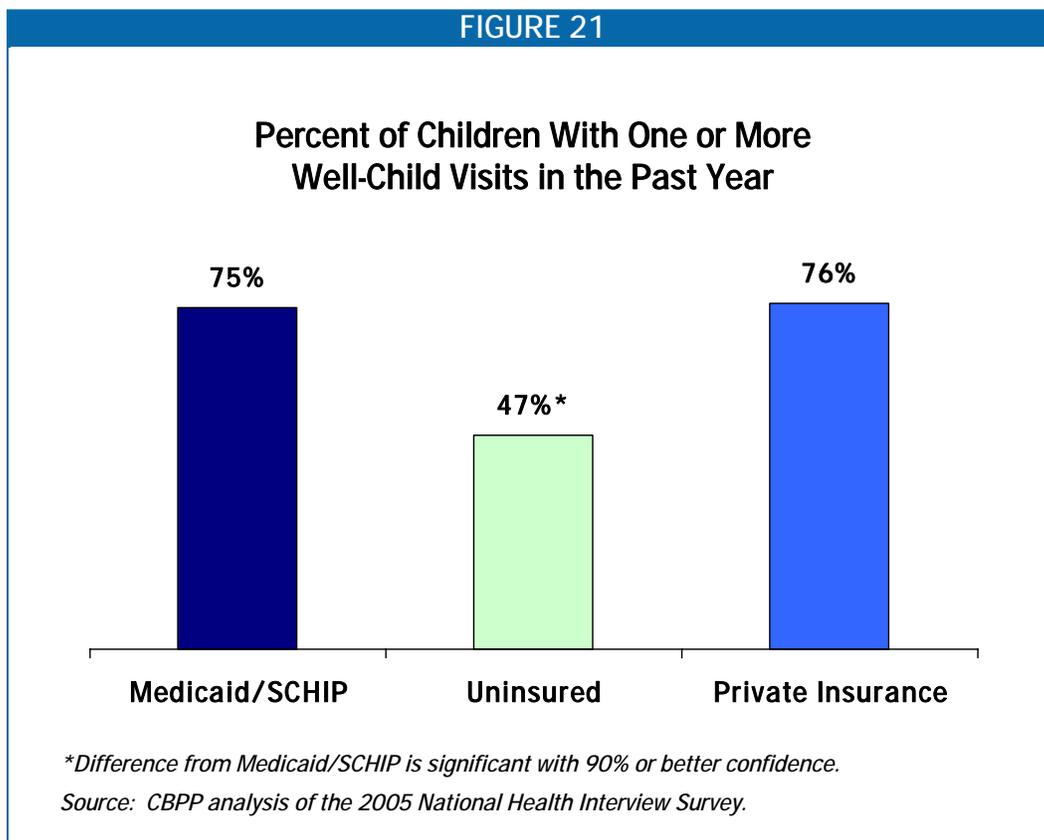
CHILDREN WHO ARE INSURED HAVE BETTER ACCESS TO CARE FROM PHYSICIANS

- Coverage by Medicaid or SCHIP is associated with improved access to primary medical care. Publicly insured children are about 25 percent more likely than uninsured children to have seen a physician or another health care professional in the last year. They are just as likely to have seen a doctor as privately insured children, who tend to have higher incomes.
- While many states' low Medicaid or SCHIP payment rates can reduce some physicians' willingness to care for Medicaid or SCHIP patients, the above data suggest that children covered by public programs are about as likely to see a doctor as privately insured children. Even so, many Medicaid or SCHIP children may have difficulties seeing physicians on a timely basis (Tang, Yudkowsky and Davis, 2003).
- An 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 similarly low-income children with private insurance (Dubay and Kenney, 2001). For low-income children, public programs may be more effective in providing care than private health insurance, which typically has higher cost-sharing and fewer benefits.



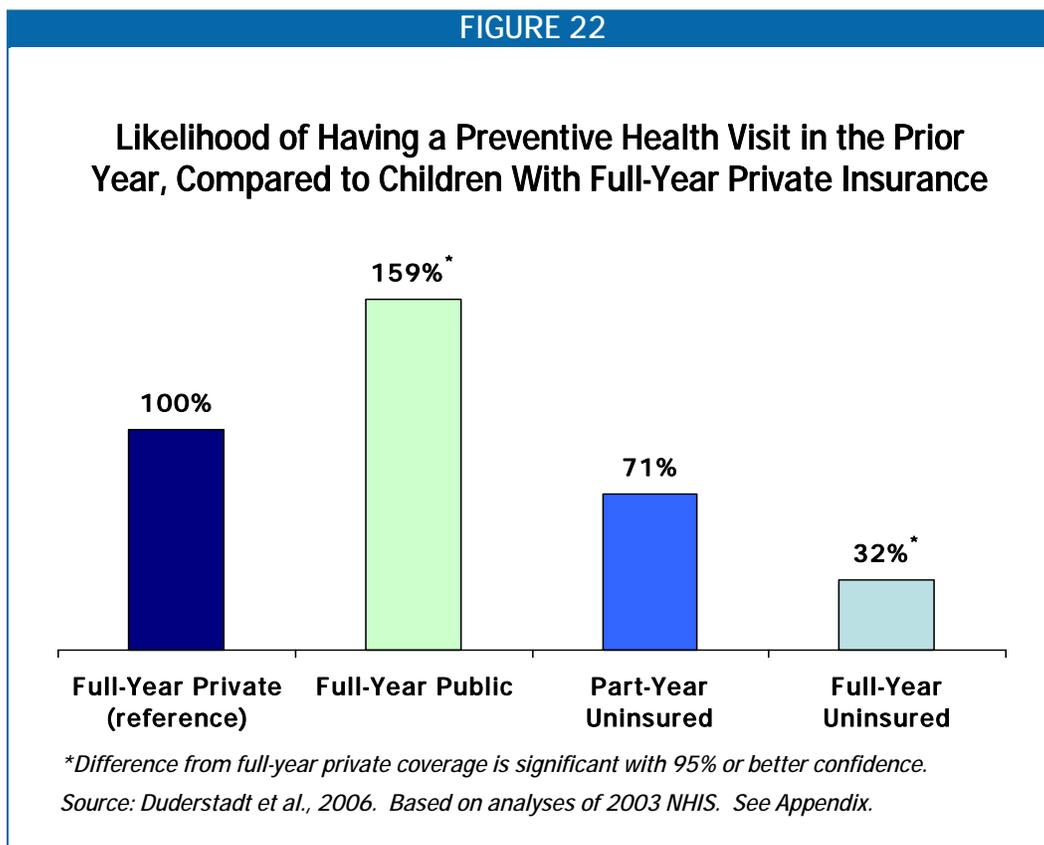
MEDICAID AND SCHIP CONTRIBUTE TO INCREASED USE OF PREVENTIVE HEALTH CARE BY CHILDREN

- The American Academy of Pediatrics recommends that children obtain regular preventive health care, or “well-child visits.” At such visits, children receive preventive health services (such as immunizations), are 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. Well-child visits are core elements of the health services offered to children by Medicaid and SCHIP.
- Children served by Medicaid and SCHIP are much more likely than uninsured children to obtain these important preventive health services. They receive well-child visits at rates similar to privately insured children.
- A federal study found that areas with greater Medicaid coverage experienced lower rates of preventable hospitalizations for children than areas with less Medicaid coverage (Billings and Weinick, 2003). These findings suggest that when children gain better access to primary and preventive care through public programs, they are less likely to be hospitalized for diseases like asthma or diabetes.



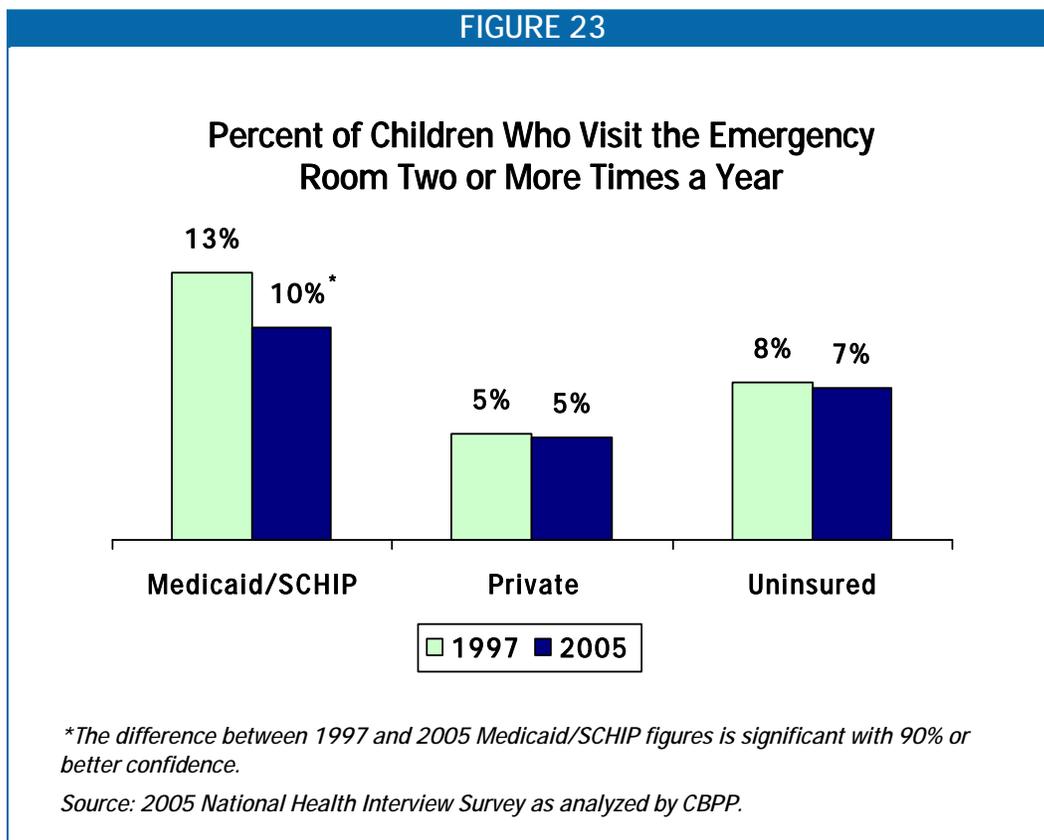
CONTINUOUS COVERAGE LEADS TO GREATER USE OF PREVENTIVE HEALTH CARE

- A University of California at San Francisco study of children with family incomes in the typical SCHIP income range (between 100 and 200 percent of the poverty line) found that children who had full-year coverage from Medicaid or SCHIP were more likely to have had at least one preventive health visit in the prior year than children who had full-year coverage from private insurance, after controlling for children’s health status, age, race, and other characteristics (Duderstadt *et al.*, 2006).
- In addition, children who were uninsured for part or all of the year were much less likely to have had any preventive health visits.
- These findings indicate that public coverage helps children get preventive health care and may even be more effective than private health insurance for this purpose. They also indicate that loss of insurance coverage — for even part of a year — can significantly impair access to preventive services.



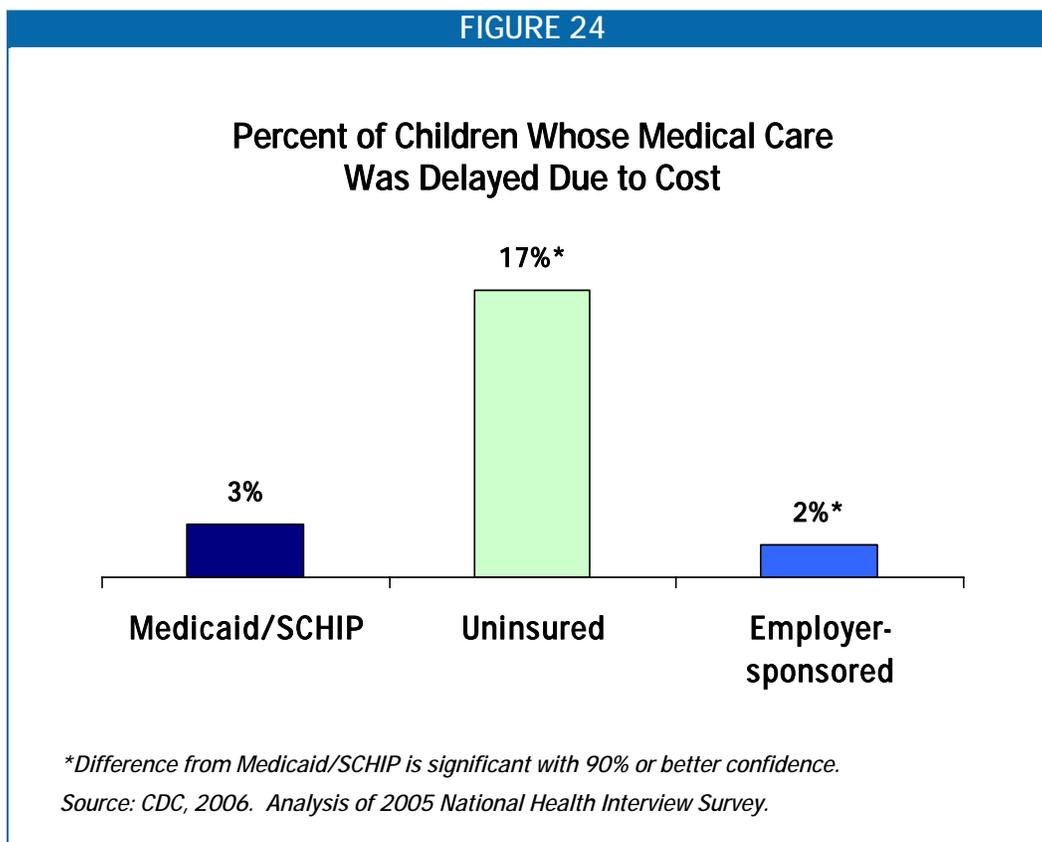
EMERGENCY ROOM USE AMONG CHILDREN ENROLLED IN MEDICAID AND SCHIP HAS BEEN FALLING

- Low-income children enrolled in Medicaid or SCHIP are more likely to use an emergency room than children with private insurance or those who are uninsured, according to data from the National Health Interview Survey. Since children enrolled in public insurance programs are often in poorer health than privately insured or uninsured children and sometimes have difficulties getting a medical appointment quickly, it is not surprising that they use emergency care more often.
- Nonetheless, emergency room usage of publicly insured children has declined over the past decade, as the percentage of children who visited an emergency room more than twice a year fell by about *one-quarter*. During the same 1997-2005 period, there was no appreciable change in emergency room use among privately insured or uninsured children.
- Many believe that both insured and uninsured patients make unnecessary use of emergency rooms and that better access to primary and preventive care would help address this problem. A possible reason for the reduction in emergency room use among publicly insured children may be that their access to primary care improved over the past decade. Public insurance programs made substantial progress in curbing emergency room use by children.



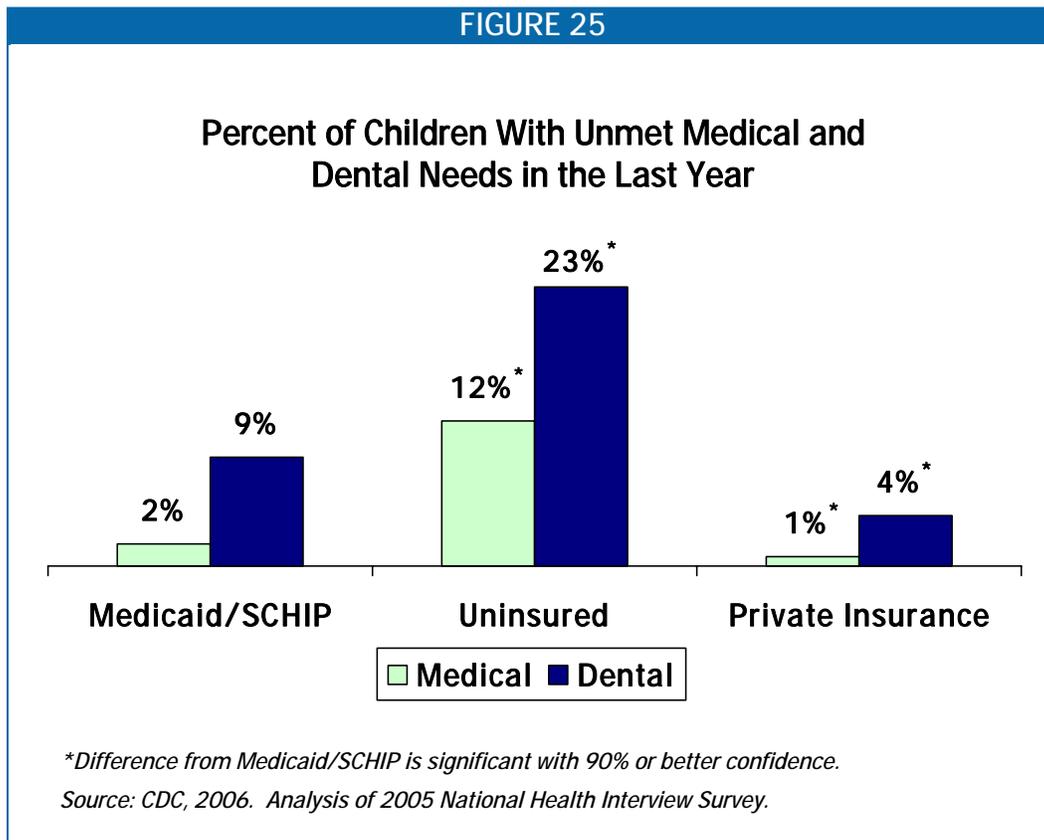
MEDICAID AND SCHIP REDUCE FINANCIAL BARRIERS TO HEALTH CARE AND ENCOURAGE TIMELY RECEIPT OF CARE

- Those who lack health insurance must pay more out-of-pocket for care and often cannot afford care. But if they avoid or delay care, diseases may become more severe, leading to poorer medical outcomes and higher medical costs when the diseases are finally treated.
- The National Health Interview Survey asked parents if they delayed getting medical care for their children because they were worried about how much it would cost. About one-sixth of the children who lacked health insurance had care delayed because of cost, but care was rarely delayed for children with Medicaid/SCHIP or private insurance.
- By reducing financial barriers to medical care, public insurance programs promote more timely use of medical care for children, including both preventive and primary health care services.



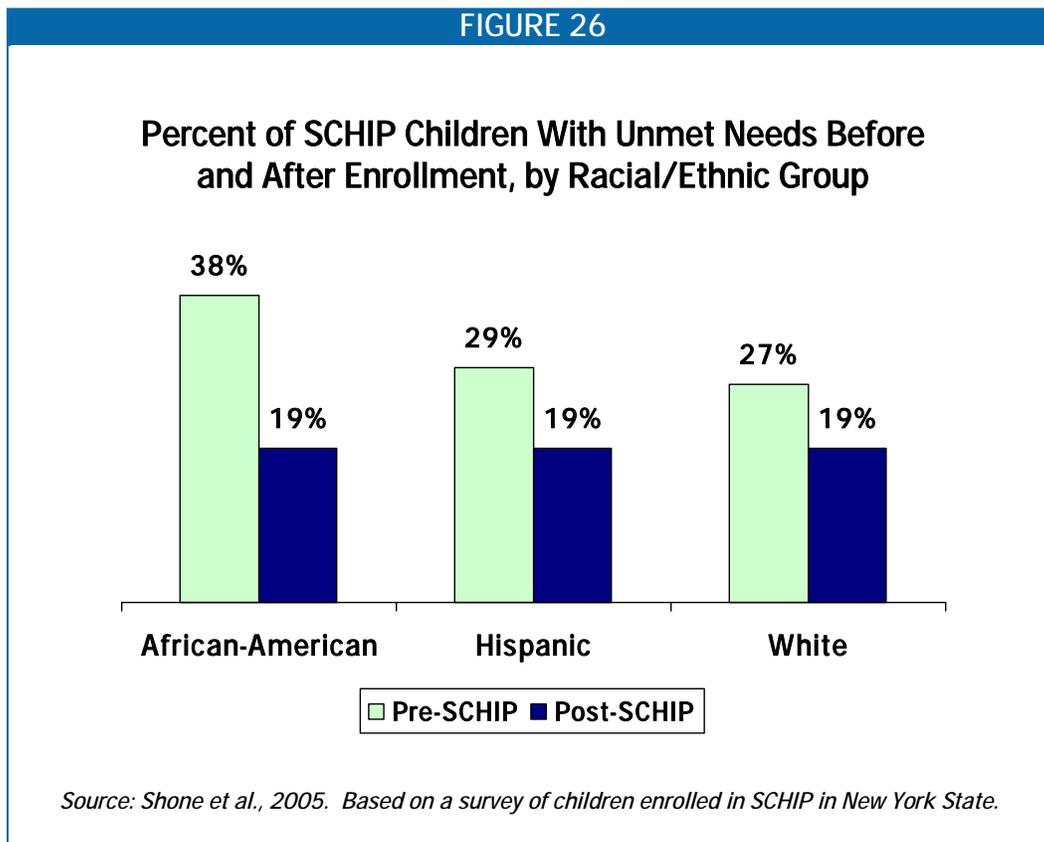
CHILDREN WITH MEDICAID OR SCHIP COVERAGE HAVE FEWER UNMET MEDICAL AND DENTAL NEEDS

- Children may have “unmet” medical or dental needs if they need care but do not get it because the family could not afford it. In some cases, unmet medical needs may lead to more serious medical conditions that require more intensive (and more expensive) medical treatment. For example, untreated juvenile diabetes may have severe consequences (e.g., a diabetic coma), which could require hospitalization or lead to permanent disabilities.
- National Health Interview Survey data show that uninsured children are six times as likely to have unmet medical needs, and more than two times as likely to have unmet dental needs, as children covered by Medicaid or SCHIP.
- Publicly insured children are more than twice as likely as privately insured children to have unmet medical or dental needs, but this is not surprising given the latter group’s much higher average incomes. (In addition, 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 it.)



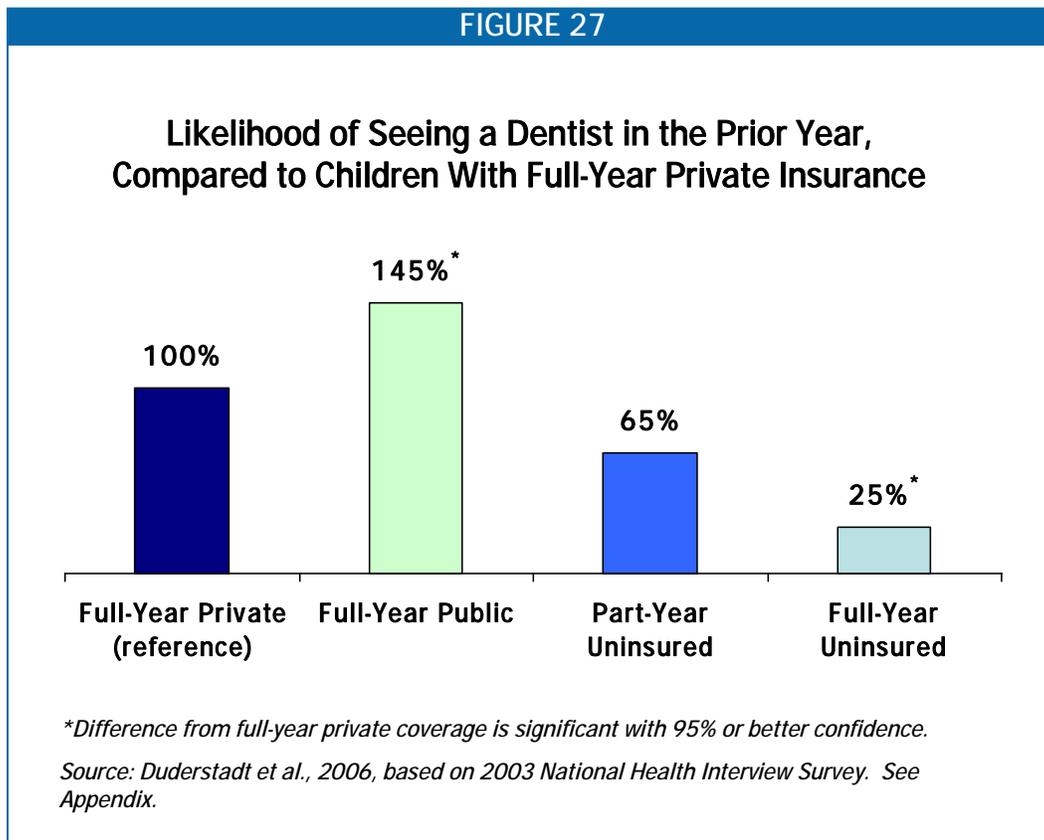
SCHIP ENROLLMENT ELIMINATED RACIAL AND ETHNIC DISPARITIES IN UNMET MEDICAL NEEDS

- A study of New York’s SCHIP program found that children were much less likely to have unmet medical needs (as reported by their parents) after having SCHIP coverage for one year (Shone *et al.*, 2005).
- In addition, while there were racial and ethnic disparities in unmet medical needs — particularly between Hispanic children and non-Hispanic white children — *before* the children entered SCHIP, there were no such disparities *after* they entered SCHIP.



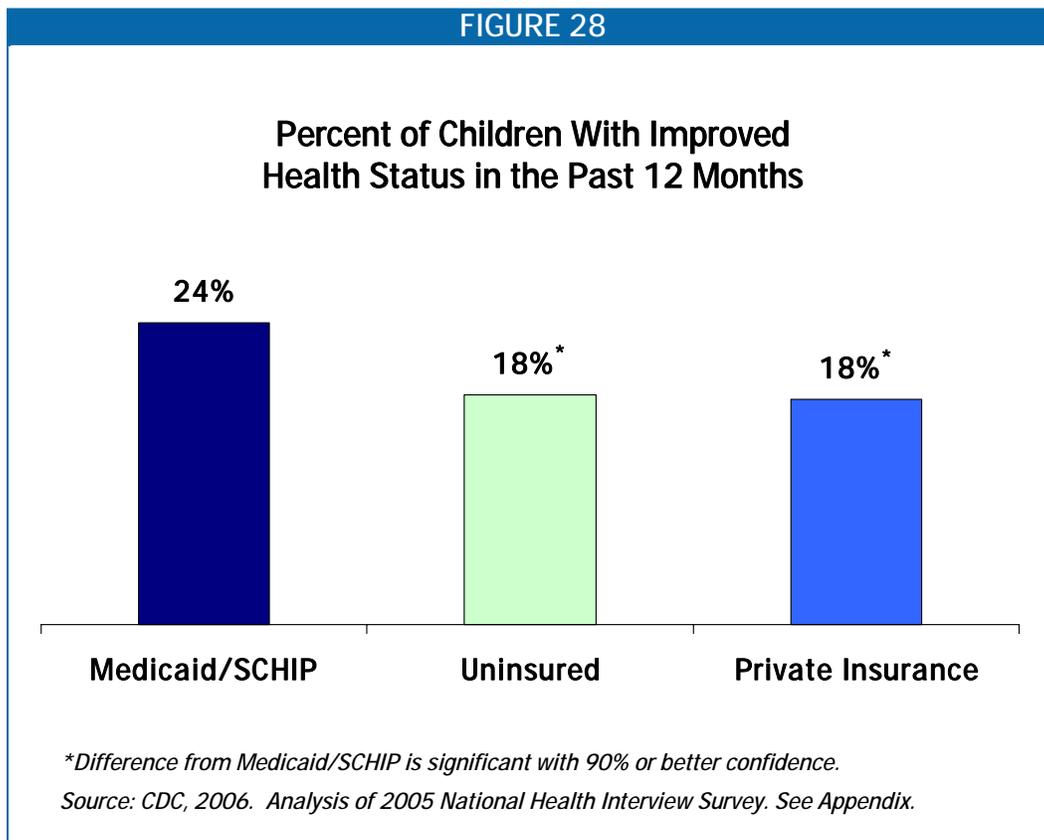
CONTINUOUS COVERAGE IMPROVES CHILDREN'S ACCESS TO DENTAL CARE

- 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 than uninsured children to have received dental care in the past year. All Medicaid programs are required to offer dental care for children, and almost all SCHIP programs offer dental benefits.
- A recent study found that low-income children with incomes between 100 percent and 200 percent of the poverty line who had continuous public insurance coverage over a year were more likely to have seen a dentist than children with continuous private coverage. It also found that the likelihood of seeing a dentist fell appreciably for children who were uninsured for part or all of the year (Duderstadt *et al.*, 2006). (The study controlled for differences in children's health status, age, race, and other characteristics.) These findings indicate SCHIP's importance in improving dental care for low-income children, as well as the need to provide *continuous* coverage for these children.
- Nonetheless, a large number of children covered by Medicaid or SCHIP fail to receive timely dental care. A number of organizations have suggested ways that states could strengthen access to dental care in Medicaid and SCHIP (Children's Dental Health Project, 2006; CHIRI, 2003; National Conference of State Legislatures, 2002).



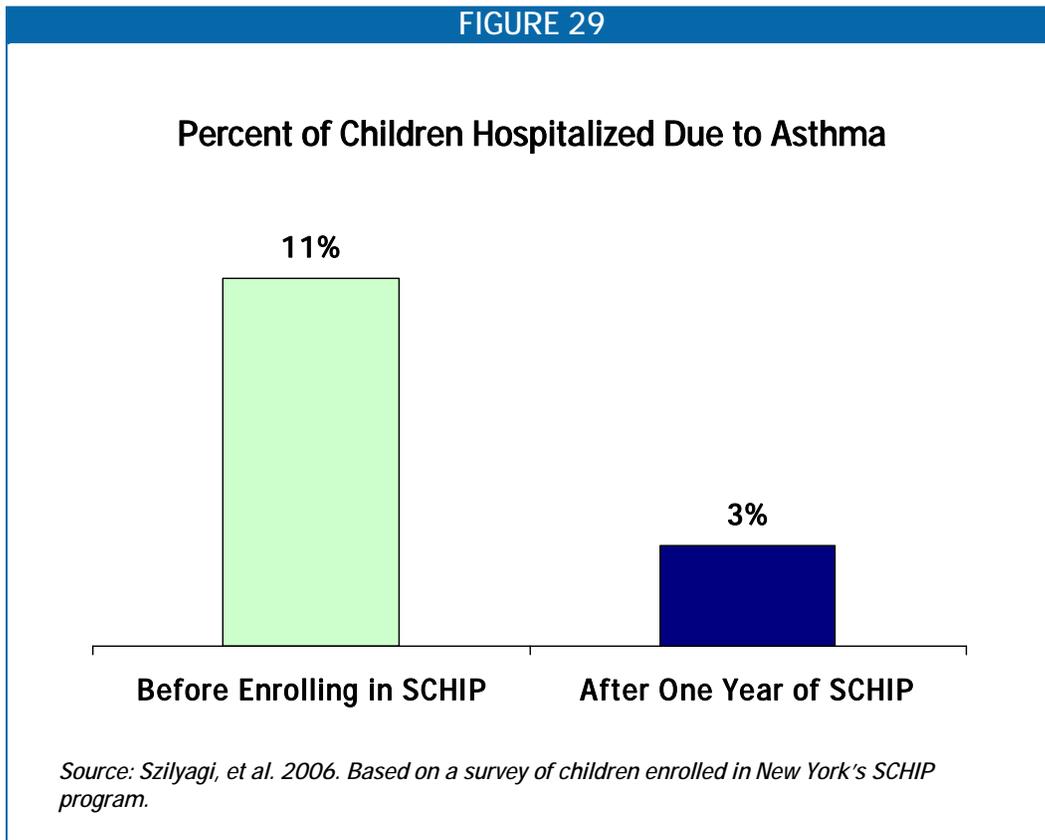
CHILDREN ENROLLED IN MEDICAID OR SCHIP HAVE IMPROVED HEALTH

- By strengthening access to affordable medical and dental care, Medicaid and SCHIP can improve children's health status. Data from the Centers for Disease Control and Prevention show that roughly one-quarter of the children covered by Medicaid and SCHIP are in better health now than they were 12 months ago, according to their parents or caretakers. This improvement exceeds the gains reported for uninsured and privately insured children. (Some parents report that their children are about the same or are in worse health than they were a year before; these percentages are smaller for children on Medicaid or SCHIP.)
- 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 program and were enrolled for a period (Managed Risk Medical Insurance Board, 2002; Fox *et al.*, 2003; Damiano *et al.*, 2003).



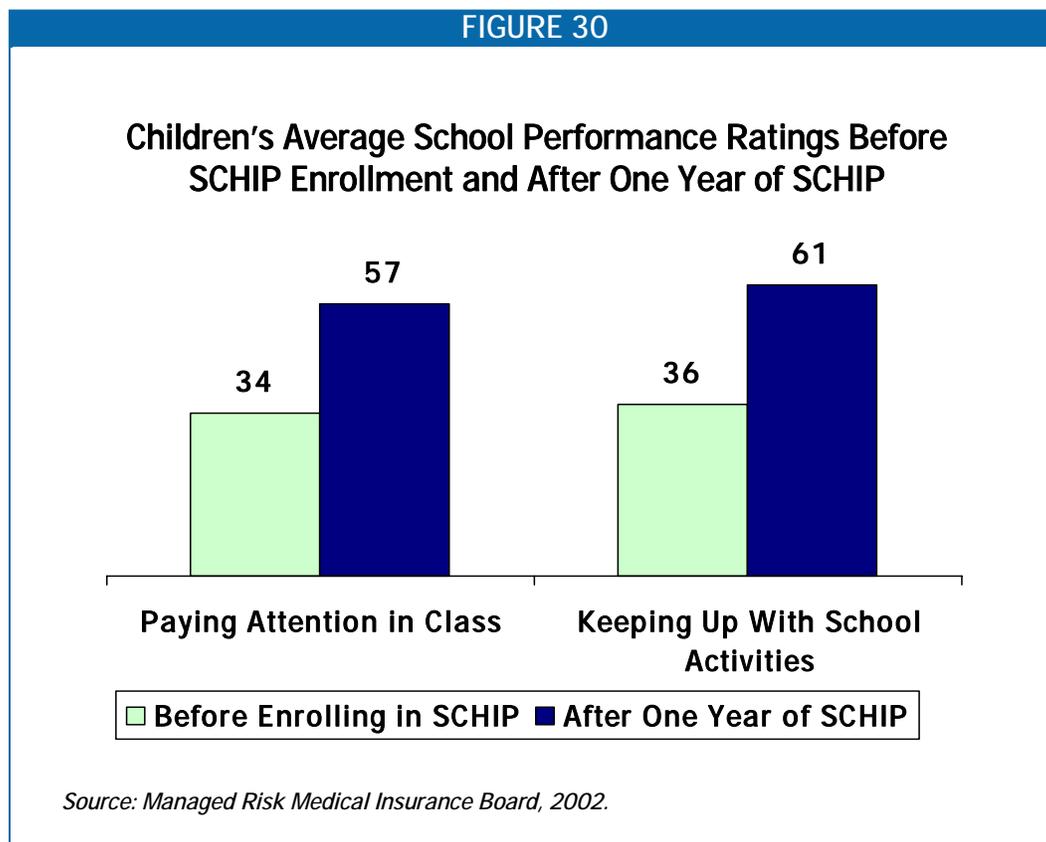
ASTHMATIC CHILDREN HAVE FEWER PROBLEMS AFTER BEING COVERED BY SCHIP

- Researchers in New York studied the medical care and medical status of asthmatic children just after enrollment in SCHIP and after they were covered for one year (Szilyagi *et al.*, 2006). They found that access to care for these children improved markedly after enrollment.
- The study also found that children had fewer asthma attacks after being enrolled in SCHIP for a year; the average number of attacks per year fell from 9.5 to 3.8. In addition, the proportion of children who were hospitalized due to asthma fell from by roughly three-fourths.
- Over two-thirds of the parents of children enrolled in SCHIP said their children’s asthma (as well as the care they received) was “better” or “more than better” than before, usually because their children now had coverage or affordable access to medications and medical care.



CHILDREN'S SCHOOL PERFORMANCE IMPROVES AFTER THEY ARE ENROLLED IN SCHIP

- An evaluation of California's SCHIP program found that parents reported improvements in their children's school performance improved substantially after they had been enrolled in SCHIP for one year (Managed Risk Medical Insurance Board, 2002). The average rating for paying attention in class climbed by more than two-thirds, as did the average rating for keeping up with school activities. (These ratings are based on a questionnaire completed by parents or caretakers, called the Pediatric Quality of Life Inventory.)
- An evaluation of Kansas' SCHIP program found that after children were enrolled in the program for one year, they missed fewer days of school due to illness or injury (Fox *et al.*, 2003).



APPENDIX

EXPLANATORY NOTES ABOUT THE DATA

The data cited in this report are drawn from a wide variety of sources, including new analyses and published research. Most of the data come from either the National Health Interview Survey (NHIS), conducted by the National Center for Health Statistics of the Centers for Disease Control and Prevention (CDC), or the Current Population Survey (CPS) of the U.S. Census Bureau. Both are long-running series of nationally representative surveys of the civilian, non-institutionalized population of the United States.

Both sets of surveys are based on detailed interviews in the sampled households; data for children are reported by their parents or caretakers. Like any household surveys, there may be errors or omissions in respondents' answers. Because Medicaid and SCHIP are often administered together and share the same name in many states, survey respondents are often unable to distinguish between the two programs. Thus, we pool together data for children in Medicaid and SCHIP, as most analysts do.

NHIS, which focuses on respondents' health status, health behaviors, and health care utilization, includes data on almost 40,000 families. For more detailed information, see CDC, 2006. The CPS examines a broad variety of economic and social characteristics of Americans, including health insurance coverage. We use data from the March supplements of the CPS, also called the Annual Social and Economic Supplement, which includes interviews from about 76,000 households. For more information about the CPS, see Census Bureau, 2006.

Figures 1 and 2. There are methodological differences in how the NHIS and CPS measure health insurance. The NHIS is conducted across all months of the year and asks about children's health coverage at the time of the interview. The CPS conducts interviews in March, asking whether a person had coverage at any time during the prior calendar year. For example, the March 2006 survey asked if a child was ever covered by Medicaid or SCHIP in calendar year 2005. Both the NHIS and CPS have made slight changes in methodology over the years, so trends across years are not completely comparable. For example, since 2000 the Census Bureau's modifications of the CPS have slightly reduced the number of children counted as being uninsured.

The NHIS data shown in Figure 1 are based on preliminary estimates as periodically reported by CDC. Those data report insurance coverage for children with incomes below the poverty line and between 100 and 200 percent of the poverty line. Our estimates pool these measures into a combined measure for those below 200 percent of the poverty line using methods recommended by CDC, based on the estimated share of children with incomes below 100 percent of the poverty line and between 100 and 200 percent of the poverty line. They exclude children with missing income data.

Figure 3. The analysis by Dubay, Holahan and Cook (2006) adjusts the CPS data for 2004 to account for the underreporting of Medicaid and SCHIP enrollment among children (i.e., discrepancies between the number of enrollees based on administrative data and the CPS). Because of this, the analysis estimates that there were 8.0 million uninsured children in 2004, while the unadjusted CPS data indicate that there were 8.5 million uninsured children in 2004 (and the

unadjusted CPS for 2005 indicates there were about 9 million uninsured children). The researchers, noting that the CPS does not include data about the legal status of immigrant children, estimate that 10 percent of the uninsured children who are listed as eligible for Medicaid or SCHIP may be undocumented immigrant children and thus eligible only for emergency Medicaid coverage, not full Medicaid or SCHIP coverage. Thus, if there was an adjustment for undocumented status, the percent of uninsured children who are eligible for Medicaid or SCHIP would be somewhat below 70 percent. There have been other estimates of the percentage of uninsured children who are eligible for public benefits which use different data bases or slightly different methodology. They also show that roughly 7 out of every 10 uninsured children are eligible for public benefits, although the precise estimate may vary from study to study.

Figure 4. We define a family as working if its annual earnings are greater than the earnings of an individual working half-time at the minimum wage (\$5.15 per hour in 2005), or more than \$5,150 per year.

Figure 9. The analyses by Davidoff *et al.* (2004) are based on simulations of the eligibility of children with and without special health care needs, using the 2000-2001 National Health Interview Survey and state eligibility rules in effect at the time. Medicaid eligibility is estimated on the basis of the eligibility rules in place before SCHIP was created; SCHIP eligibility is based on subsequent eligibility expansions, regardless of whether they were implemented through Medicaid or separate SCHIP programs. The participation rates are based on participation in public insurance programs among the children who are not enrolled in private health insurance or in other public insurance programs.

Figure 14. The data used by Haas *et al.* (2003) came from the 1996 Medical Expenditure Panel Survey and predate the creation of SCHIP. We have not been able to identify more recent studies about child obesity and health insurance status. In this study, after adjustment for factors like income, race/ethnicity, gender, and age, publicly insured children 6 to 11 years old were 23 percent less likely to be overweight than privately insured children, but the differences were not statistically significant. After the same statistical adjustments, publicly insured children 12 to 17 were still more likely to be overweight than privately insured children, with 95 percent or better confidence.

Figures 17 and 18. The percentages of children with no usual source of care differ slightly in these two figures because Figure 17 is based on the 2005 NHIS, while Figure 18 pools data from both the 2004 and 2005 NHIS samples and compares it to pooled data for 1993-94.

Figures 22 and 27. In these figures, if the likelihood (or odds ratio) is greater than 1.0, then the child was more likely to have a visit, but if it is below 1.0 the child was less likely to have a visit. The data reported by Duderstadt *et al.* (2006) present results as odds ratios regarding the risk that a child did *not* receive a preventive health visit or did *not* visit a dentist. To make these statistics easier to understand, we converted them to the odds ratios that a child received *at least one* preventive health visit or *at least one* dental visit. To do so, we calculated the inverse of each odds ratio.

Figure 28. CDC presents the improved health status data for three groups: those 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. NHIS does not ask how long children have been in Medicaid or SCHIP, so it is not possible to discern if they were enrolled for more or for less than one year.

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