

## COMMENTARY

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### Low-Income Children and Health Insurance: Old News and New Realities

ABBREVIATION. SCHIP, State Children's Health Insurance Program.

This supplement of *Pediatrics* presents a series of articles on the State Children's Health Insurance Program (SCHIP). These articles represent a unique collaborative effort among nationally recognized experts in child health services research, the Agency for Healthcare Research and Quality, The David and Lucile Packard Foundation, and the Health Resources and Services Administration. It is fair to say that these studies are appearing at a momentous time in the evolution of US child health policy. The central challenge that lies ahead is to ensure that their important findings make their way into the extraordinary debate over the future of US health policy that is underway now in the 108th Congress.

Enacted in 1997, SCHIP had as its central purpose the extension of publicly supported health insurance to uninsured low-income children whose family incomes exceeded Medicaid eligibility levels. SCHIP offered an alternative to existing Medicaid eligibility options for near-poor children whose financial circumstances placed them beyond the poverty level at which Medicaid coverage for children is mandatory; enactment of SCHIP reflected states' concerns regarding additional expansion of the Medicaid legal entitlement. The response to SCHIP was rapid and dramatic: within 3 years, all states had implemented the program<sup>1</sup> and by June 2002, enrollment had surpassed 3.6 million.<sup>2</sup> States used SCHIP funds to establish separate programs, expand Medicaid, or implement a combination of the 2 approaches.

SCHIP bears some similarities to its far-larger Medicaid companion, which in 2001 enrolled 17 million children.<sup>3</sup> Both programs enable states to secure federal matching funds to support health insurance for low-income children. Both envision comprehensive benefits coverage (Medicaid on a mandatory basis and SCHIP by option). Both emphasize outreach and enrollment assistance to families with children.

However, SCHIP and Medicaid also differ profoundly. Medicaid is a federal legal entitlement that contains 2 basic guarantees. First, all eligible and enrolled children will receive coverage for comprehensive, federally defined benefits. Second, within broad statutory limits, participating states will receive open-ended federal financial support regardless of the comprehensiveness of their programs or generosity of their eligibility levels. Thus, states that elect to invest extensively in children's health insurance gain a federal legal promise of full partnership in their plans.

SCHIP on the other hand eschews a state entitlement to open-ended financing in favor of aggregate, nationwide upper spending limits accompanied by elaborate formulas for reallocation of unspent state funds. Because SCHIP contains overall federal spending limits that could expose participating states to unfunded coverage obligations, the legislation specifically creates no legal entitlement for children. In recognition of the aggregate federal spending limit, federal law also gives states considerable flexibility over both benefit design and children's eligibility and enrollment rights. A state that elects to establish a separate SCHIP program rather than using its allotment to expand Medicaid can calibrate benefits to commercial insurance norms and limit coverage for chronic illness and disability. States also can use expanded cost-sharing techniques and, perhaps most important, can queue eligible children. In short, compared with Medicaid, SCHIP allows states far greater control over the amount of resources to be expended on the coverage of near-poor Medicaid-ineligible children in recognition of the federal government's own self-imposed constraints.

The articles in this supplement underscore several basic facts about this cohort of "SCHIP children." First, consistent with previous literature linking income and health status in children, the proportion of SCHIP-enrolled children who experience special health care needs, as measured by functional limitations and a higher anticipated or actual use of health care resources, is comparable or slightly higher than would be expected in the general population. This finding contrasts with one of the policy undercurrents that characterized the SCHIP debate and drove the decision to permit substantial flexibility in benefits across states, namely, that near-poor children enjoyed a health status that differed significantly from poor children and that a benefit plan designed along commercial norms would therefore be appropriate. These articles put to rest the notion that SCHIP enrollees need fewer services than other children. Similar to Medicaid agencies, SCHIP programs

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must be mindful of children with special needs. Even if, as several studies suggest, special needs do not always equate to elevated health care utilization, the presence of a substantial special-needs enrollee population underscores the importance of careful attention to benefit design, provider network selection and oversight, appropriate enrollment and retention techniques, quality-of-care measures that are sensitive to chronic illness and disability, and cost-estimation techniques that do not underestimate the true cost of coverage. Underestimating SCHIP's expense in the case of near-poor children can create the same types of access risks that reducing Medicaid coverage would produce for the poorest children, particularly in view of the extraordinarily modest sums of money that separate "poor" from "near-poor" children. Capping the number of eligible children with specific conditions (such as Florida's 300-child limit on those with severe mental health conditions under its special-needs SCHIP plan) threatens to simply leave the most disabled children unserved, underserved, or inappropriately served because they are assigned to programs that are less skilled in the management of high-need children.

A second major finding, and again, one that underscores the similarities rather than the differences between SCHIP and Medicaid children, involves poor children's access to alternative sources of health insurance and their vulnerability in times of economic decline. The articles collectively point to a group of children who, without SCHIP, would be pervasively uninsured unless they were eligible for Medicaid, thereby presumably allaying fears that SCHIP would somehow "crowd out" private coverage. This lack of prior coverage leaves little doubt about the essential nature of public financing for insurance for children whose family incomes are low but nonetheless above Medicaid eligibility levels. This finding holds despite the widespread prevalence of work among the families of SCHIP children and the fact that these studies gathered their data during a period of relatively strong economic performance. The relative paucity of alternative sources of health insurance coverage for near-poor children is consistent with other research showing the exquisitely sensitive link between family work status and employer-sponsored coverage for lower-income children. Many low-income workers are not offered insurance, and those who are generally cannot afford to exercise their Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation rights after job loss. For these children, public insurance largely is the norm. This fact calls into basic question the wisdom of any public policy that would limit the availability of federal subsidies in a manner that would lead to arbitrary cutoffs in enrollment unrelated to need. Despite their enormous importance, community health centers and the rest of the health care "safety net" cannot offset the impact of reductions in publicly-funded health insurance, let alone absorb the fiscal pressures that they would face in that circumstance.

A third similarity between SCHIP children and

those eligible for Medicaid confirms a major challenge and opportunity facing SCHIP programs: Racial and ethnic disparities among enrollees are substantial. Although a large proportion of SCHIP enrollees everywhere are white, many children in SCHIP are from minority groups and report higher rates of risk factors such as poorer health status, lack of a usual source of care, and prior periods of uninsurance. As has long been the case with Medicaid, SCHIP programs are in a position to take the initiative in minimizing racial and ethnic disparities in health care access. On the other hand, substantial reductions in the availability of coverage under SCHIP and Medicaid would raise troublesome questions of fairness across racial and ethnic lines.

SCHIP and Medicaid have become central to children's health coverage in this country. As noted in a report by the Kaiser Commission on Medicaid and the Uninsured,

"The increase in enrollment in SCHIP and Medicaid has been credited with increasing the number of children with health coverage and preventing an increase in the number of uninsured children. . . . [T]he number of uninsured children decreased as growth in primarily Medicaid, but also SCHIP, offset decreases in employer sponsored health coverage."<sup>2</sup>

These findings are not surprising given that SCHIP children may differ from their Medicaid counterparts by a matter of a few dollars of monthly family income. Moreover, an SCHIP child in 1 state might well be a Medicaid enrollee in another; indeed, in each 1 of the 5 states studied, SCHIP children have Medicaid siblings. The lack of any clear demarcation between Medicaid and SCHIP across states and sometimes even within a state is an important point to keep in mind as any change in either program is contemplated.

The findings from these articles regarding the depth of health care needs and the dependence on publicly funded insurance are crucial in any environment. In the current environment, they are urgent. The nation now is facing the widespread collapse of state investments in health, education, and social welfare programs under the weight of a pervasive and long-term economic slowdown. As the Americans most dependent on these investments to develop into productive citizens, children have the most to lose by the loss of these direct investments. And, where health coverage is concerned, these studies suggest that the children who lose support will be disproportionately from racial and ethnic minorities and burdened by special needs and a lack of alternative coverage. The question now becomes whether Congress will respond to this grim scenario with investment or funding-reduction policy. In January 2003, the Bush Administration in its fiscal year 2004 budget sketched out a plan to effectively replace most of Medicaid (and all of SCHIP) with 2 limited aggregate allotments to states. Over a 10-year time period, these allotments would significantly reduce federal funding to states. The only means by which such reductions could be absorbed without shifting tens of billions of dollars of financial responsibility onto state governments is to remove the very re-

quirements in both Medicaid and SCHIP that have made them the largest single combined insurer of children in the US and an absolutely essential source of insurance coverage for health and medical services necessary to address chronic illness and disability. Whether Congress pursues the administration's recommendations or rejects them in favor of a strategy of heightened investment in lower-income children and their families at a time of enormous national need remains to be seen.

One thing is certain: Pediatricians, as leading advocates for children and child health, could decisively influence the outcome of this deliberation through broad publication of research findings such as these and an unwavering attention to the next 2 years of federal and state health policy making. Of special importance will be ensuring that state legislators and members of Congress understand the practical, day-to-day importance of Medicaid and SCHIP to their families and children as well as the essential nature of both programs to the future and stability of pediatric care in the US. With Medicaid and SCHIP as the source of health insurance as of 2001 for nearly 1 in 4 US children,<sup>3</sup> the future of the pediatric health system generally is intertwined inextricably with decisions made at the federal level

regarding the future of government investment in child health.

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Sara Rosenbaum and Peter Budetti

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