ZERO TO THREE® POLICY CENTER

Ensuring Adequate Health Coverage for Infants and Toddlers: Reauthorization of the State Children's Health Insurance Program (SCHIP)

The science of early childhood development tells us that the years of infancy and toddlerhood are times of intense intellectual growth. During the first 36 months of life, the brain undergoes its most dramatic development as children acquire the ability to think, speak, learn and reason. At the same time, the need for health care during a child's first three years is more intense than at most other times in life. Cognitive, social-emotional, and physical development are inextricably linked during this stage of rapid growth so poor health in a very young child can lead to developmental problems in other areas and vice versa.

For the youngest children, regular health care can spell the difference between a strong beginning and a fragile start. The American Academy of Pediatrics recommends eight well-baby care visits with a pediatrician in the first year of life, with three more by the time the child reaches the age of three.[1] These visits focus on preventive pediatric health care, including vision, hearing, lead and developmental screenings; psychosocial/behavioral assessments; and promotion of proper oral health care. In addition, infants and toddlers also require 20 doses of vaccines before they are two years old to protect them against 12 preventable diseases.[2] Without health insurance, babies and toddlers are less likely to have a regular pediatrician, more likely to miss preventive health visits, and less likely to receive the full range of immunizations. The 21% of infants and toddlers who live in poverty are particularly at-risk for a variety of poorer outcomes and vulnerabilities, including health impairments, social-emotional problems, and diminished school success.

What is SCHIP?

Created in 1997, SCHIP is a joint federal-state program providing health insurance for low-income children and pregnant women who are financially ineligible for coverage through Medicaid.

SCHIP is the largest federal investment in health insurance since 1965. With $40 billion authorized over 10 years beginning in fiscal year 1998, the program currently reaches over 6.6 million children.

Most states provide coverage for uninsured children with family incomes from 100-200% of the federal poverty level ($21,200-$42,400 for a family of four in 2008). However, a few states have set higher income limits.

SCHIP, unlike Medicaid, is not an entitlement program, but a block grant with capped funding. As a result, the two programs differ in eligibility, benefits, and federal matching rates, yet they work hand-in-hand to provide coverage to low-income individuals and families.

In 2007, Congress twice attempted to enact legislation to renew the State Children's Health Insurance Program (SCHIP), which expired on September 30, 2007. After two Presidential vetoes, a short-term extension was put in place to continue funding the program through March 31, 2009. The extension did not modify existing policy, but did provide financial assistance to alleviate state funding shortfalls in the interim.

The upcoming months provide an opportunity to further advance and inform the reauthorization of this vital program. By building on the success of SCHIP and its companion health program, Medicaid, Congress can improve the access and quality of health care for infants and toddlers across the country.

★ FAST FACTS

- 8.1 million children are uninsured in the United States.[3] Nearly 11% of children under the age of three—1.4 million infants and toddlers—lacks health insurance.[4]
- Every 41 seconds, a baby is born without health insurance.[5] An American newborn has a 20% chance of being born to a mother who lacks health insurance.[6]
- More than 6.6 million children are currently enrolled in SCHIP.[7] An additional 6 million children are eligible for SCHIP or Medicaid, but have not been enrolled.
- Since 1998, thanks to SCHIP and Medicaid, the number of low-income uninsured children has fallen by more than one-third, even as employer-based coverage decreased and the overall rate of uninsured people grew.[8] However, in 2005, the number of uninsured children began to rise again (8.1 million vs. 8.7 million).[9]
- When compared to insured children, uninsured children are:
  - 13 times more likely to lack a usual source of health care;[10]
  - 3 times less likely to have seen a doctor in the last year;[11] and
  - 5 times more likely to have at least one delayed or unmet health care need.[12]

★ POLICY RECOMMENDATIONS

1. Expand Access to SCHIP and Provide Adequate Coverage for All Eligible Infants and Toddlers.

As Congress continues to consider the reauthorization of SCHIP, it must work to expand access to the program for all who are eligible and provide adequate coverage to ensure the healthy development of our youngest children. This is particularly important as publicly insured children are more likely to have chronic conditions requiring ongoing care, such as asthma, learning disabilities, and health conditions.[13] By insuring these children, we can safely and effectively manage conditions rather than relying on the nation's safety net for more expensive urgent care. In fact, children enrolled in SCHIP or Medicaid are 1.5 times more likely than uninsured children to receive well-child visits, immunizations, screenings, dental care, and other forms of preventive care, further reducing the need for more costly interventions later.[14]

At the same time, reauthorization of SCHIP must also maintain state flexibility in order to best serve local population needs and circumstances, building on their own lessons learned as well as those of other states. For example, in addition to providing coverage for primary health care, there has been a growing recognition of the importance of strengthening preventive care, as well as providing developmental, mental health, and dental services.

2. Fulfill the Congressional Commitment to Add $50 Billion in New Funding for SCHIP.

Unlike Medicaid, SCHIP is not an entitlement program, but a block grant program. As a result, it has a finite amount of funding, which must be distributed to states based on a complicated formula that takes into consideration the number of low-income children, the number of uninsured low-income children, and annual wages in the state's health care industry.

In the first few years of the program, federal allotments for SCHIP far outpaced actual expenditures as the program was just beginning and served fewer children. After those initial start-up years, however, expenditures quickly began to exceed funding. Although states have three years in which to use their allotments from any single fiscal year, the reduced allotments from the federal government quickly affected state programs, particularly in light of rising health care costs and an economic

downturn. In fact, in 2007, 14 states experienced funding shortfalls that jeopardized coverage for thousands of children.[15] If significant new funding is not appropriated for the program, 37 states could face a shortfall of $2 billion by 2012.[16] Stable and predictable funding is required in order to allow state CHIP administrators to adequately plan and effectively manage program maintenance and growth.

In the FY08 and 09 Budget Resolutions, Congress provided for $50 billion in reserve funds over five years for SCHIP, as long as appropriators offset the additional funding by reducing spending in other areas. With limited funding, states are forced to freeze or cut enrollment, restrict eligibility, increase premiums or co-pays, or reduce services and benefits, all at a substantial cost to young children and their families. In order to increase enrollment of qualified, but currently unenrolled children, adequate funding and outreach efforts must be put in place. Even maintaining current enrollment and services requires more money than is presently available. Simply continuing with the current average annual spending allotment of $5 billion would result in a decline in existing enrollment and contribute to an increase in the number of uninsured children.[17]

3. Streamline Application and Renewal Procedures to Remove Administrative Barriers to Accessing Health Insurance.

Two-thirds of the uninsured children living in the United States are eligible for SCHIP or Medicaid, but are not currently enrolled.[18] States must be provided with more flexible approaches to reach such children, including instituting and increasing the use of a streamlined application process ("Express Lane") that allows them to use financial information from other programs (such as Food Stamps or WIC) to enroll eligible children. In addition, adopting presumptive eligibility (allowing health professionals, Head Start and Early Head Start employees, child care providers, WIC coordinators, and community-based organizations to provide on-site SCHIP enrollment) will allow states to provide temporary coverage of pregnant women and children pending receipt of a formal application and final determination of eligibility. Other administrative barriers, such as asset tests, face-to-face interviews, mandatory waiting periods, and a recently added federal mandate to document citizenship status for Medicaid beneficiaries, should also be eliminated. This would allow states to focus more time and attention on expeditiously enrolling children in SCHIP and Medicaid and ensuring that they maintain adequate coverage during periods of fluctuating family incomes. In fact, evaluation data have shown that removing administrative barriers such as these results in retaining more families in the SCHIP program.[19]

4. Formally Rescind the Administration's August 17 CMS Directive.

In August of 2007, the Centers for Medicare and Medicaid Services (CMS) issued a directive to state CHIP administrators announcing a new policy that took effect on August 17, 2008.[20] The directive prohibits states from providing SCHIP coverage to children in families with incomes above 250% of the federal poverty level (FPL) unless they first prove that they have enrolled 95% of the children who are at or below 200% FPL, a threshold no state currently meets. In addition, states have to prove that the percentage of low-income children enrolled in private health insurance has not declined by more than 2% in the preceding five years. If states meet these first two criteria and choose to expand eligibility above 250% FPL, the CMS directive requires a second layer of criteria to be met: 1) children must be uninsured for 12 months before qualifying for SCHIP at the expanded eligibility level and 2) states must set the highest possible co-pays, premiums, and deductibles allowed under SCHIP. By the time an infant or toddler has waited the mandatory 12 months to gain SCHIP coverage at the expanded eligibility level, he or she has already missed nearly a dozen well-child visits and numerous immunizations, threatening not just their health, but the public's health as well.

Twenty-three states are directly affected by the directive because they either already serve children above 250% FPL or have authorized expansions of their programs.[21] With this directive, however, a new income limit for SCHIP is effectively established as states currently lack the resources and tools needed for outreach and enrollment to increase current participation rates. With uncertainty over the approval of changes to their current SCHIP plans, many states have scaled back planned changes or abandoned them altogether, leaving SCHIP administrators in a state of flux. According to the directive, those states that do not meet the conditions will be penalized with lower federal matching rates,[22] forcing states to increase their contribution to the program at a time when state budgets are seriously hampered by a weakening economy.

Although CMS stated in August of 2008 that they do not intend to take compliance action against states, the directive itself has never officially been repealed and no further guidance has been issued. The only way to ensure that such a restrictive policy does not threaten the health coverage of tens of thousands of our youngest children is to formally rescind the directive.

☆ RESEARCH

- **Lack of Adequate Health Insurance Increases Likelihood of Delayed or Unmet Health Needs.** Research shows that without adequate health insurance, infants and toddlers fall victim to a host of poor health outcomes. Uninsured children are almost five times more likely than insured children to have at least one delayed or unmet health care need[23] and less likely to have a regular pediatrician or medical home.[24] As a result, they are less likely to obtain preventive care or be diagnosed and treated early for illnesses, instead waiting until conditions are no longer manageable before seeking care in the Emergency Room (ER) of their local public hospital. In the last 50 years, the number of visits to ERs has increased more than 600% in the United States,[25] with children 0-18 accounting for over 31 million visits to the ER every year.[26] Children under the age of three represent the largest proportion of medically and injury-related ER visits in the country.[27] Estimates of the true cost of pediatric emergency care are difficult to assess; however, costs could range anywhere from $3.9 billion to $12.8 billion annually, with an average total cost of $6.5 billion.[28] Furthermore, half of all ER charges go uncollected and get passed on to consumers who are covered by private insurance.[29] With adequate health insurance and a consistent health care provider, families can avoid unnecessary and more expensive treatment in ERs, thereby reducing costs to all of society.

- **SCHIP has Improved Access to Care.** A congressionally mandated evaluation of SCHIP has shown that the program has had a positive effect on access to care. Between 1997 and 2003, the percentage of uninsured children declined by 2.7 percentage points.[30] For low-income children (below 200% FPL)—the very population targeted by SCHIP—the rate declined by an even greater margin: 5.1 percentage points.[31] Comparing the before-enrollment and after-enrollment experiences of children in the program has shown that SCHIP enrollees receive more preventive care (including dental and well-child care), have fewer unmet needs, and have better access to health care services and providers.[32] In fact, 91% of SCHIP enrollees had a usual source of medical care.[33] Consequently, SCHIP enrollees also had fewer ER visits than uninsured children (18% vs. 24%).[34] Furthermore, four out of five parents of children enrolled in SCHIP indicated that they felt their children received better health care than uninsured children.[35] Without SCHIP, researchers concluded that the rate of uninsured children would have actually increased by 3.3% while the number of uninsured children would have grown by 2.7 million.[36]

- **Poor Health Outcomes Affect Later School Success.** Health impairments and social-emotional problems also directly affect later school success. Children who are sick or hospitalized miss

more days of school and have trouble learning, resulting in lower grades and test scores and poorer cognitive development, school readiness, and success.[37] Children who start behind, stay behind. When developmental delays and health impairments are detected and treated early, children have a much better chance of school success. In fact, a study of California's Children's Health Insurance Program found that after one year of enrollment in the program, children were more attentive in class (57% after vs. 34% before) and more likely to keep up with their school activities (61% after vs. 36% before).[38]

About Us

The ZERO TO THREE Policy Center is a non-partisan, research-based, nonprofit organization committed to promoting the healthy development of our nation's infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at http://www.zerotothree.org/policy.

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