

# medicaid and the uninsured

February 2009

## THE IMPACT OF MEDICAID AND SCHIP ON LOW-INCOME CHILDREN'S HEALTH

Today, one-quarter of children in the U.S. and half of all low-income children receive their health coverage through Medicaid or the State Children's Health Insurance Program (SCHIP), the nation's major public coverage programs for low-income people. Medicaid covers 29 million poor and near-poor children and SCHIP covers 7 million additional low-income children.

Still, nearly 9 million children remain uninsured; most of these children are eligible for Medicaid or SCHIP but are not enrolled. Against the backdrop of the current debate surrounding the reauthorization of SCHIP, the budgetary pressures on public coverage programs from the economic downturn, and the interest in reducing the number of uninsured children, this policy brief reviews the literature and examines the impact of Medicaid and SCHIP on coverage, access to care, and health for the nation's low-income children.

The key points in the policy brief are:

**Medicaid and SCHIP have expanded health coverage among low-income uninsured children.** Between 1998 and 2007, the uninsured rate among low-income children fell by almost half, from 28 percent to 15 percent, due in part to coverage through these programs. This improvement in coverage of children occurred at the same time that coverage of adults in the U.S. was deteriorating.

**Public coverage has increased access to care.** Children covered by Medicaid or SCHIP are much more likely to have a usual source of care, and to have had a doctor visit and much less likely to have unmet needs, compared with uninsured children. Access to preventive and primary care is roughly equivalent between publicly and privately covered children, including children with special health care needs. Parents with a publicly insured child rarely report forgoing care for the child due to cost – no more often than parents with a privately insured child. Maintaining continuous coverage is important because even brief gaps in children's coverage are associated with reduced access to care and increased rates of unmet need and forgone care due to cost. Public coverage has also helped to narrow racial/ethnic disparities in access to care among children.

**But access challenges remain.** While publicly as well as privately insured children have high rates of access to primary and preventive care, system-wide shortages of pediatric specialists and dentists result in more limited access to these services. Low provider participation and payment rates in Medicaid compound these problems.

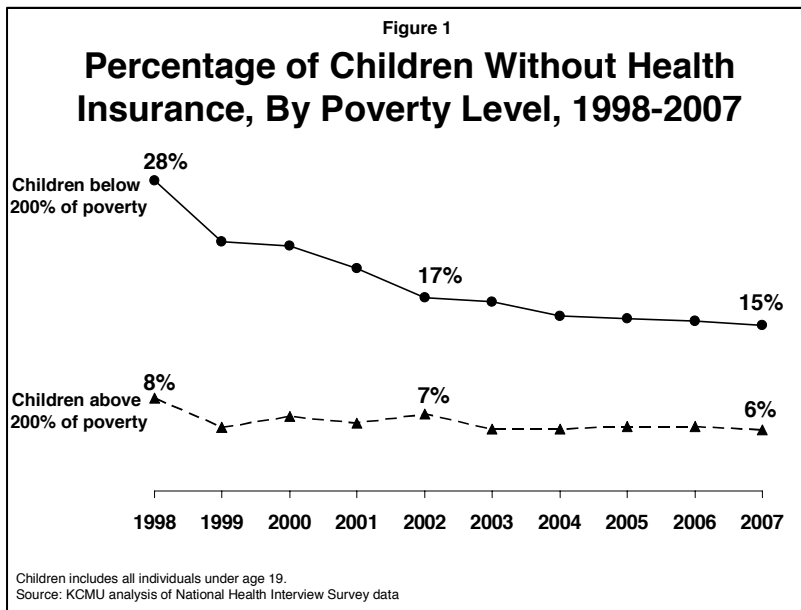
**Public coverage has improved quality of care and health outcomes.** Enrollment in public coverage is associated with improvements in the quality of care that previously uninsured children receive. For example, after being enrolled in New York's SCHIP, children with asthma had fewer emergency department visits and hospitalizations. Additionally, improvements in physical and social health outcomes, including school attendance, for both healthy and chronically ill children, have been linked to public coverage programs.

As federal and state actions to expand children's coverage move forward on many fronts, Medicaid and SCHIP offer the potential to reduce the number of uninsured children and improve the care and health of millions of low-income children.

## Medicaid and SCHIP increased rates of health coverage for low-income children.

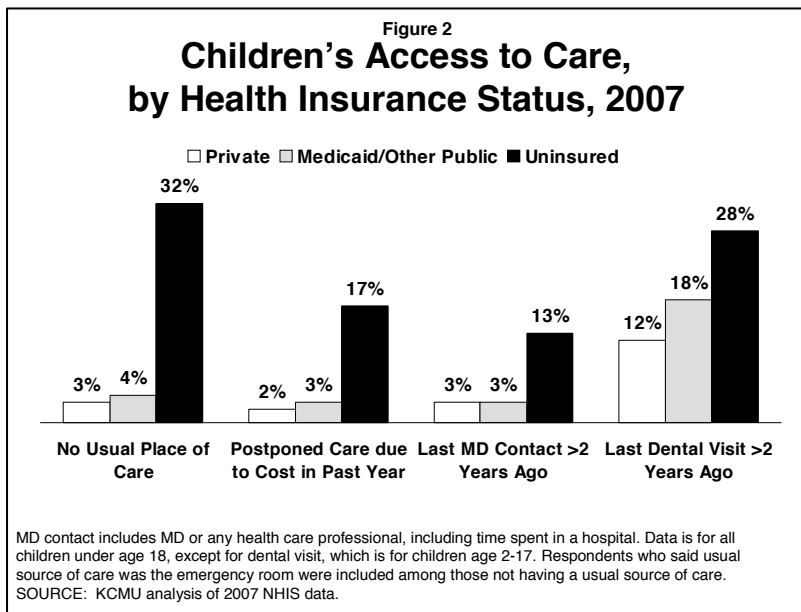
Medicaid and SCHIP have played a substantial role in expanding health coverage among low-income uninsured children. With the coverage available through these public programs, the uninsured rate among low-income children fell by almost half between 1998 and 2007, from 28 percent to 15 percent (Figure 1).

Between 2000 and 2004, while the number and rate of uninsured adults mounted steadily as employer-sponsored insurance (ESI) eroded, enrollment in Medicaid and SCHIP helped to offset ESI losses among low-income children; the number and rate of uninsured children actually fell. However, in 2005 and 2006, when enrollment in Medicaid and SCHIP did not rise, and ESI continued to decline, more children as well as adults became uninsured. In 2007, the increase in public coverage programs contributed to a decline of 570,000 in the number of uninsured children.

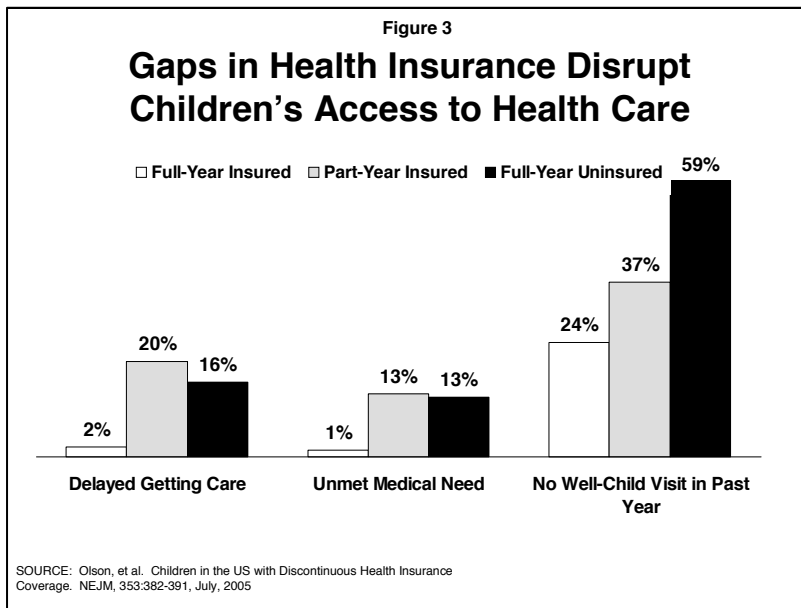


## Coverage improves access to care.

Uninsured children are much more likely than children covered by Medicaid and SCHIP to not have a usual source of care (32% versus 4%) (Figure 2). Having a usual source of care is strongly associated with better access to preventive and primary health care. The federally funded SCHIP evaluation found that access to care improved for uninsured children following their enrollment in SCHIP.<sup>1-2</sup> Other studies have confirmed that publicly covered children are significantly more likely than uninsured children to have seen a doctor or other health professional, had at least one well-child visit, and received dental care in the past year.<sup>3-8</sup> Children with Medicaid and SCHIP report access to preventive and primary care at levels roughly equal to those for children with private health insurance.<sup>9-10</sup>



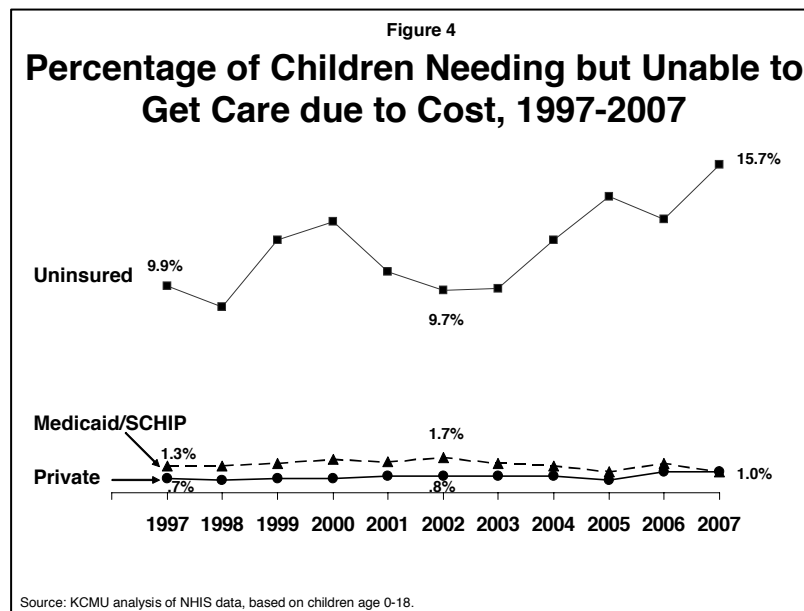
When health insurance coverage is lost, even for short periods of time, access to care can deteriorate (Figure 3). Parents of children insured for only part of the year report access problems at rates similar to those reported for children who are uninsured for the entire year. These access problems include unmet needs for care, delayed care, and doing without prescription drugs.<sup>11</sup> Disruptions in coverage for children covered by Medicaid and SCHIP can occur as a result of small fluctuations in family income or frequent reporting requirements in some states. Maintaining continuous coverage enables the full benefits of health coverage to be realized.



Children’s access to care is also affected by the coverage status of their parents. State programs that cover low-income parents along with their children have had greater success enrolling children. In addition, when whole families are insured, health coverage is more likely to be continuous, which in turn improves access to care and the use of preventive services.<sup>12-17</sup>

**Insurance makes care more affordable.**

Health care has become much less affordable for many in the past ten years, and the uninsured have been particularly hard hit. Medicaid and SCHIP have largely buffered the impact of this on low-income children. Nearly 16 percent of uninsured children in 2007 went without needed care because of its cost (Figure 4). In contrast, on par with privately insured children, parents of children insured by public programs rarely report forgoing a child’s care because they could not afford it (~1%).



**Public coverage helps reduce unmet health needs.**

Consistent with their better access, children covered by Medicaid and SCHIP have lower rates of unmet need for doctors’ care (including specialist care), prescription drugs, dental, and hospital care than uninsured children. Studies investigating the impact of Medicaid and SCHIP attribute some of the significant decreases in unmet need in the year following the enrollment of uninsured children to these two programs.<sup>18-23</sup>

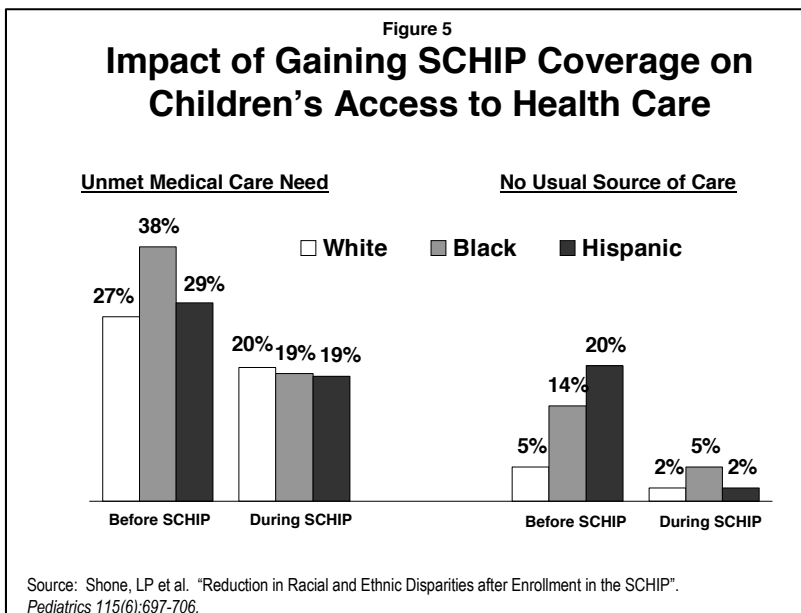
**Medicaid and many SCHIP plans provide support for comprehensive services for children with special health care needs.**

Nearly 4 in 10 children with special needs are covered by Medicaid. These children often lack access to other health coverage or require services that private insurance limits or excludes. Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, children in Medicaid are entitled to a comprehensive range of services and supports. (SCHIP benefits are more limited in many states.) Parents of children with special health care needs report having more unmet health needs than others. However, for those who have health insurance, levels of

unmet need are lower, and public coverage provides comparable access to private coverage, even among this challenging population to serve.<sup>24-25</sup>

**Public coverage helps reduce racial and ethnic disparities.**

Medicaid and SCHIP cover children from all racial and ethnic backgrounds and have made progress in helping to narrow racial/ethnic disparities in access to care among children. For example, in New York, following the enrollment of uninsured children in SCHIP, the rate of unmet need fell among children overall and previous racial/ethnic disparities in unmet needs largely disappeared (Figure 5).<sup>26</sup>



**Although Medicaid and SCHIP improve access to care, challenges remain.**

Children’s access to preventive and primary care in Medicaid and SCHIP is on par with access among children who have private insurance. However, under-use of recommended preventive and primary health services by children -- regardless of income and insurance status -- suggests that the need to improve children’s access to this care is a system-wide challenge.<sup>27-28</sup>

In the area of oral health, critical inadequacies in children’s access have emerged. Inadequacies in the supply and distribution of oral health care providers nationally, including a shortage of pediatric dentists, are compounded in Medicaid and SCHIP by low participation among dentists and the disproportionate burden of oral disease in the low-income population. Uninsured children who gain Medicaid or SCHIP coverage experience significant improvements in their access to dental care. Still, less than 30 percent of children in Medicaid obtain any dental care in a year and only 25 percent receive preventive dental care – half the corresponding rates for privately insured children.<sup>29-31</sup> Some states have succeeded in improving children’s access to dental care by boosting payment rates for dental services, increasing outreach and education about dental care, expanding the type of dental providers allowed to perform services (i.e. hygienists), and streamlining administrative and billing processes.

Medicaid’s comprehensive benefits for children are designed to ensure that children enrolled in the program – who include many of those with the most extensive health needs in the nation –

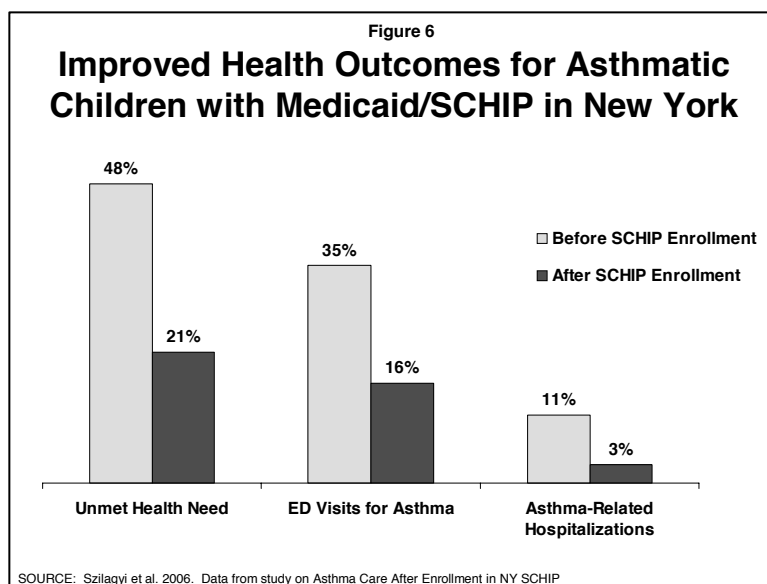
have access to the full range of services they need. However, lack of access to specialty care is a perpetual challenge in Medicaid. As with oral health, system-wide shortages of pediatric specialists and sub-specialists are at the core of this access problem, and limited provider participation in Medicaid compounds the problem within the program. Low provider participation is attributable primarily to generally low Medicaid payment rates, and providers also report that administrative burdens discourage them from accepting Medicaid.<sup>32</sup>

**Having health coverage is associated with improved quality and positive health outcomes for low-income children.**

**Better quality.** The quality of care that previously uninsured children receive improves once they obtain coverage. For example, a study of one state’s SCHIP program found that, following enrollment in SCHIP, children began to use a regular provider more consistently for their health needs (as opposed to using urgent care centers or emergency departments).<sup>33</sup> Also, children with asthma received better asthma care following their enrollment in public coverage, especially children who were previously uninsured. The benefits of improved asthma care extended to parents as well, as fewer worried about their children’s health after their obtain health insurance.<sup>34</sup>

**Better health.** Many factors contribute to health outcomes, but research shows that, when other differences are also taken into account, people with insurance — whether it’s private or public — have better health outcomes. Public coverage has positively affected the health of millions of low-income children. The most dramatic impacts of Medicaid and SCHIP on health are in early childhood. Significant declines in infant mortality and childhood deaths, as well as reductions in low birth weight, have been linked to expansions in eligibility for Medicaid and SCHIP.<sup>35-36</sup>

Studies that have examined health status before and after a child is enrolled in a public insurance program provide evidence of a more direct, causal relationship between public coverage and improved health. State and national surveys of parents have found that children are in better health after just one year of enrollment in Medicaid or SCHIP.<sup>37-39</sup> A study of children enrolled in California’s SCHIP program found that even those in the poorest health who were enrolled for two years had dramatic and sustained improvements in both physical and social health outcomes. Chronically ill children also showed clinically significant improvements in both types of health outcomes.<sup>40</sup> Findings from the New York SCHIP study show that the program led to marked improvements in health outcomes among children with asthma — one of the most common childhood diseases — including far fewer asthma attacks, reduced unmet health needs, and lowered rates of asthma-related emergency department visits and hospitalizations (Figure 6).<sup>41</sup>



***Improves school performance.*** Studies of SCHIP's impact have found an association between enrollment in the program and improved school performance among low-income children. Improvements include increased school attendance, greater ability to pay attention in class, improved reading scores, and increased ability to participate in school and normal childhood activities.<sup>42-44</sup>

## **Conclusion**

A large body of evidence demonstrates that coverage matters and that low-income children enrolled in Medicaid and SCHIP benefit from increased access to needed care. A growing literature also indicates that coverage leads to better health outcomes. As federal and state actions to expand children's coverage move forward on many fronts, Medicaid and SCHIP offer the potential to both reduce the number of uninsured children and improve the care and health of millions of low-income children.

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