Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP

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Executive Summary

The number of low-income children with health insurance coverage has increased over the past several years due largely to expansions of eligibility and efforts to promote enrollment of eligible children in Medicaid and the State Children's Health Insurance Program (SCHIP). Many states have found that by making it easier for families to enroll—expanding outreach efforts, coordinating outreach with programs such as the School Lunch program, simplifying applications, and reducing paperwork requirements—eligible children and families are, in fact, more likely to enroll. As the economy has weakened, however, some states have considered proposals to cut eligibility levels, eliminate outreach, and retract simplification procedures for children and families.

In the midst of the fiscal pressures that states are facing, it is easy to lose sight of the reasons why states and communities sought to expand coverage in recent years. This paper presents evidence on why it is important to maintain the gains that have been made over the past several years, and build on the improvements in Medicaid and SCHIP coverage for children and families. Substantial research evidence shows that expanding eligibility for and enrollment in Medicaid and SCHIP have important benefits for the children and families who are directly affected by the program, as well as for the communities in which they live.

Studies show that public coverage matters for children and families because it:

Promotes Access to Care

Key Finding: *Previously uninsured children who become enrolled in Medicaid have fewer unmet needs and fewer delays in getting needed care.* 24.1% of uninsured children had no usual source of care, compared to 6.1% of children covered by Medicaid; 8.3% of uninsured children did not receive or postponed care, compared to 2.5% of those with Medicaid; 28.2% of families of uninsured children were not confident about getting needed care, compared to 11.2% of families with children in Medicaid. Controlling for other factors, children with Medicaid were 26 percentage points more likely than uninsured children to have a well-child visit (Dubay and Kenney 2001).

Increases Use of Necessary and Appropriate Care

Key Finding: *Medicaid reduces the use of emergency rooms and reduces the rate of preventable hospitalizations.* Medicaid expansions increased access to primary care and reduced rates of preventable hospitalizations. The expansions increased the efficiency of health care delivery since most of the increased visits were to doctor's offices rather than emergency rooms. Between 1983 and 1996, the Medicaid expansions led to 22% fewer preventable hospitalizations, but 10% more hospitalizations overall as children's access to inpatient hospital care increased (Dafney and Gruber 2000).

Promotes Health and Improves Health Outcomes

Key Finding: *Medicaid expansions have been associated with reductions in infant mortality rates*. A 30% rise in the proportion of women eligible for Medicaid between 1979 and 1992 was associated with an 8.5% decline in state-level infant mortality (Currie and Gruber 1996b). *Loss of Medicaid can lead to reductions in health status*. Compared to those who remain insured, those who lose Medicaid and become uninsured are more likely to experience an adverse health effect due to access difficulties (9% to 14%), and more likely to report fair or poor health (11% to 18%) (Kasper, Giovannini, and Hoffman 2000).

Improves Families' Financial Security

Key Finding: *Low-income families of children enrolled in Medicaid spend considerably less out-of-pocket than families of uninsured Medicaid-eligible children.* Just 13% of families of children enrolled in Medicaid spent over $500 a year out-of-pocket on medical care expenses, compared to 30% of families with uninsured Medicaid-eligible children (Davidoff et al. 2000). *Families with Medicaid have more money available for spending on other necessities*. Many low-income families have difficulty affording basic necessities such as housing, food, and clothing. In a 1999 survey, more than 4 out of 10 adults and 50% of children in low-income families either worried a lot about or had difficulties paying for food. More than one in five low-income adults in the survey reported housing affordability problems (Zedlewski 2000). Medicaid helps relieves some of these hardships. An economic analysis of the effect of Medicaid on household spending suggested that being made eligible for Medicaid increased total

household consumption spending by 4.2%. Medicaid raised the annual consumption of eligible families by $538 in 1993 (Gruber and Yelowitz 1999).

Improves Families' Well-Being—Helps Children Learn and Participate in Normal Childhood Activities

Key Finding: *Public coverage for children enhances the ability of children to engage in normal activities of childhood*. Enrolling in public coverage was associated with significant decreases in the probability that children were limited in their usual activities. Although 15% of children who were previously uninsured for six months or more reported being limited in usual activities (e.g. limited sports activities—bike riding, rollerblading—because of fears of costs associated with injuries, schools and other organizations do not allow them to participate), after six months of enrollment, essentially no limitations related to health insurance coverage were reported (Lave et al. 1998, p. 1824). Compared to the uninsured, families of children in Medicaid are more likely to seek needed medical care for injuries (Overpeck and Kotch 1995).

May Promote Employment Among Parents

Key Finding: *Public coverage for children may increase women's employment.* Simulations suggest that extending health care coverage to all children of single mothers regardless of welfare status would induce a large percentage of these mothers to seek and accept employment. The proportion of single mothers employed would rise by 12 percentage points, from 59% before the simulated policy to 71% after the policy took effect (Wolfe and Hill 1995, p. 60). Another study that examined the impacts of Medicaid expansions for children found that raising the income limit for Medicaid for young children, and severing the link to welfare, substantially reduced the probability that women would participate in AFDC by 1.2 percentage points, and increased the probability of working by about 1 percentage point (Yelowitz 1995).

Beyond the impacts on beneficiaries and families, public coverage matters for states and communities as well. Medicaid and SCHIP:

Bring Federal Matching Funds Into States, Providing Fiscal Relief

Key Finding: Medicaid accounts for 15% of state general fund expenditures, but also accounts for 44% of all federal grant funds to states. A state cutting Medicaid enrollment and spending generally will lose more in federal funds than it saves in state funds (Wachino 2003). Nationally, 57% of Medicaid funds and 70% of SCHIP spending is financed with federal funds (Institute of Medicine 2003, p. 125).

Bring Federal Matching Funds Into States, Promoting Community Economic Development Through Jobs Creation and Income Growth

Key Finding: The Lewin Group estimates that, in fiscal year 2001, the rate of return per dollar invested in Medicaid ranged from $6.34 in Mississippi to $1.95 in Nevada. The average value of increased business activity generated from state Medicaid spending was $6 billion, and state Medicaid spending generated almost 3 million jobs with wages in excess of $100 billion. The average number of jobs was 58,785 per state, ranging from 300,352 in New York to 3,949 in Wyoming (Families USA 2003). Various state-specific studies have reached similar conclusions. In addition, a study based on national data found that for every 1% of the population added to Medicaid, state GDP rises by 0.033% (Gruber and Yelowitz 1999).

Help Assure Community Access to Care, Reducing Uncompensated Care Burdens on Providers and Localities, and Strengthening Local Providers' Capacity to Serve All People

Key Finding: Rising uninsured rates can worsen emergency department (ED) overcrowding and the financial status of ED operations, reducing the availability of ED services within a community, including the reduced availability of on-call specialists. A significant source of financial stress on regional trauma centers is the high proportion of uninsured patients they serve. Hospitals may decline to open a trauma center or may decide to close an existing trauma center in response to this financial stress. Further, relatively high rates of uninsurance are associated with reduced availability of on-call

specialty services to hospital emergency departments and the decreased availability of primary care providers to obtain specialty referrals for patients who are members of medically underserved groups (Institute of Medicine 2003, pp. 90-99).

Help Assure Community Health by Providing Access to Care for Low-Income Children and Parents at Risk of Communicable Disease, and Reduce Burdens on Public Health Departments to Provide Medical Services to the Uninsured

Key Findings: *Public coverage relieves burdens on public health departments to provide medical services and increases childhood immunization rates.* When New York State expanded children's insurance under a public program implemented prior to SCHIP, the statewide immunization rate rose from 83% to 88% for all children ages one to five. At the same time, the use of public health departments for immunizations declined, with more immunizations delivered in the medical home. Immunization visits to primacy care practitioners' offices increased by 27% and those to public health departments fell by 67% (Rodewald et al. 1997, Szilagyi et al. 2000).

Although it is easy to see why Medicaid and SCHIP may be targeted for spending cuts, since the programs account for a significant share of state spending, the choice to reduce the availability of public coverage is much more difficult once the full consequences of those choices are understood. These research findings begin to provide an objective foundation for state policymakers to evaluate the potential consequences of their choices. The bulk of the evidence suggests that public coverage has far-reaching positive health, economic, and social benefits for beneficiaries, families and communities, and that there are very real benefits to assuring the progress made in enrolling children and families is maintained.

Maintaining the Gains:
The Importance of Preserving Coverage in Medicaid and SCHIP

Significant gains in health insurance coverage for children have been achieved in recent years due largely to expansions of eligibility for public coverage and increased efforts to enroll eligible children and parents in Medicaid and the State Children's Health Insurance Program (SCHIP). Among children in low-income families (i.e. with incomes below 200% of the federal poverty level), the proportion covered by Medicaid or SCHIP increased by nearly 8 percentage points in four years, rising from 28.4% in 1997 to 36% in 2001. At the same time, the proportion of low-income children who were uninsured dropped from 47% to 42.3% (Cunningham, Hadley, and Reschovsky 2002).

There are at least three key lessons from this recent experience (as well as earlier experience with Medicaid expansions for children and pregnant women). The first is that expanding eligibility for public coverage can significantly reduce the number of uninsured. The second is that effectively reaching the uninsured requires a systematic investment of time and resources to identify children who may be eligible for public coverage, get them enrolled, and make it easy for them stay enrolled for as long as they are eligible. And a third lesson, the empirical support for which is reviewed in this paper, is that this coverage brings important health, economic and social benefits to the individuals and families who are the programs' direct beneficiaries, as well as to the broader communities in which they live.

How the Gains Were Made

The Medicaid program laid the groundwork for the recent coverage advances for children, with the phased-in eligibility expansions for poor and near-poor children that occurred in the late 1980s and early 1990s, but a new determination to enroll eligible children swept through the nation with the enactment of SCHIP. Prior to SCHIP, an estimated 4.7 million uninsured children were eligible for Medicaid but not enrolled (Selden, Banthin, and Cohen 1998). SCHIP provided states with new federal funding to cover low-income uninsured children and unleashed an unprecedented commitment to see that children eligible for Medicaid or SCHIP were actually enrolled in coverage. Those working to improve coverage results at the federal, state and local levels increasingly recognized that if child coverage goals were to be met,

eligibility expansions needed to be coupled with effective outreach and simplified and coordinated enrollment and renewal procedures.

Research conducted over the past several years consistently showed that low-income families faced real barriers to coverage; focus groups, surveys and other analyses documented that lack of information about eligibility and complicated application and renewal procedures were keeping eligible children out of coverage. More recently, as states have adopted many of the improvements suggested by these studies, research has begun to show that when enrollment barriers fall, participation grows [**Figure 1, Page 8**]. Simplified mail-in applications for Medicaid and SCHIP, reduced paperwork requirements for families, as well as outreach efforts targeted to children who are particularly likely to be eligible for coverage but not enrolled, and coordination with programs such as School Lunch are just some of the ways states have improved participation rates among eligible children and families. These strategies have long been permitted under federal Medicaid rules, but it took the push to achieve real coverage gains prompted by the enactment of SCHIP to cause a nationwide reexamination of policies and procedures that have kept eligible children and adults from accessing available public coverage. In addition, many states have taken advantage of newly available options to promote participation, including "presumptive eligibility" and "continuous eligibility." States have not solved all of the participation rate issues, but, until recently, they were well on their way toward finding and implementing those solutions.

Figure 1

Enrollment Barriers Limit Participation in Public Programs; When Enrollment Barriers Fall, Participation Rates Rise

Enrollment Barriers Limit Participation in Public Programs

- **Lack of information and application "hassles" are the main reasons families say they or their eligible children are not enrolled in coverage.** An Urban Institute study found that the main reasons why parents who had heard of Medicaid and SCHIP did not inquire about them for their low-income children were: they did not think they were eligible (30%), administrative hassles (14%), did not know enough about the programs (4%) (Kenney and Haley 2001; Kenney, Haley and Dubay 2001). Similar findings have been reported by the Kaiser Commission on Medicaid and the Uninsured (Perry et al. 2000), and in the congressionally mandated evaluation of SCHIP—based on surveys conducted in early 2001 (Wooldridge et al. 2003).

- **Many eligible children have not been enrolled in coverage programs due to "procedural" denials.** Studies have shown that large numbers of children are not enrolled in Medicaid because their families have been unable to make their way through long and complex applications, in-person interview requirements, and burdensome documentation requirements that often required several trips back and forth to the Medicaid agency. High rates of "procedural" denials were documented in studies conducted by the Southern Institute for Children and Families for years prior to the enactment of SCHIP (Shuptrine et al. 1988). Another survey found that 67% of children who were eligible but not enrolled had applied for coverage but were denied for "failure to follow procedures" (Perry et al. 2000).

- **Coverage renewal procedures also create barriers to continuous coverage for eligible children.** Many eligible children lose coverage when their coverage is up for renewal. In a Washington state survey, over 40% of those no longer enrolled said they were unaware they had to renew their enrollment. Over 70% of those no longer enrolled just assumed they were ineligible (Humphries 2003).

- **Lack of information about eligibility and enrollment barriers affect eligible adults as well as children.** In New York City, people who had enrolled in Medicaid post 9/11, after the process had been simplified, identified the reasons they had not applied for Medicaid in the past: one out of four thought they were ineligible, 13% said the application was too difficult, 10% didn't know about the program, and 4% said they did not have the necessary documents (Perry 2002).

- **Some parents are not able to enroll their children in Medicaid or SCHIP because of language barriers** (Summer, Carpenter and Kavanaugh 1999; Perry et al. 2000; Feinberg, Swartz, Zaslavsky, et al. 2002).

Continued on next page

Figure 1, continued

When Enrollment Barriers Fall, Participation Rates in Public Programs Rise

When Enrollment Barriers Fall, Participation Rates Rise

- **Most states have taken major steps toward promoting participation of eligible children.** As of January 2002, all but four states had dropped the interview requirement for enrolling children in Medicaid and SCHIP; 42 states and DC had 12-month reviews for enrolled children; 33 of 35 states with separate SCHIP programs used joint applications for Medicaid and SCHIP (though only 21 states had joint renewal forms). Only seven states used an asset test for children applying for Medicaid, and 13 states required no documentation for children applying for coverage other than immigration status (Cohen Ross, Cox 2003).

- **There is a strong relationship between both simplified procedures and expanded outreach and increased participation rates in Medicaid and SCHIP** (Mann et al. 2002). New York City dramatically simplified application process post 9/11 and saw equally dramatic results. In a four-month period, nearly 350,000 New Yorkers enrolled in Disaster Relief Medicaid (Perry 2002). Michigan had similar success when it simplified its application for Medicaid and SCHIP for children. From February 1998 to December 2001, 141,443 children were enrolled into MIChild (SCHIP) or Healthy Kids (Medicaid) in Michigan, 141% of the proposed target. An evaluation of the Michigan Covering Kids project found that the gains were attributable to Michigan's outreach and simplification strategies, including the mail-in application and self-declaration of income (Polverento et al. 2002). There was a significant increase in enrollment in Texas after the State adopted simplification measures in Medicaid for children. The number of children enrolled in September 2002 was 30% higher than the number enrolled in September 2001. Over the same time period, the enrollment of parents in Medicaid rose only 6% (simplification measures were not adopted for parents), indicating the rise in children's enrollment was due to the simplifications, not economic factors. In the 16 months before simplification, 57.5% of applications were successfully completed; this number jumped to 70.1% nine months after the simplification steps were implemented (Dunkelberg 2003).

- **After simplification steps have been implemented, some states have reported high levels of satisfaction among applicant families.** After Wisconsin simplified its family application (for Badgercare, the state's Medicaid and SCHIP program for families), allowed mail-in applications and simplified documentation requirements more than three-quarters of the families surveyed (76%) of reported that the form was easy to fill out, with 49% finding it "very easy." Seventy-nine percent indicated no problem obtaining the documentation needed for the application (ABC for Health 2002).

Continued on next page

Figure 1, continued

When Enrollment Barriers Fall, Participation Rates in Public Programs Rise

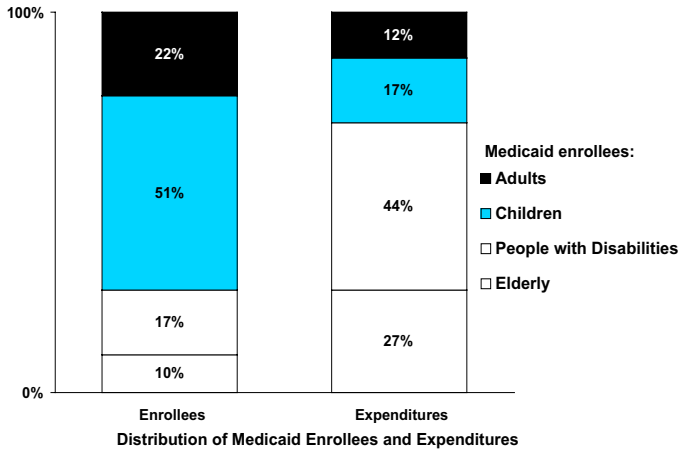
- **Simplification does not always have immediate effects; it often takes some time for people in the community to learn about the changes and respond**. Parents participating in a focus group in California thought they knew most of the information on Medi-Cal (California's Medicaid program), but much of what they knew was outdated and they were not aware of many new aspects of the program (such as short four-page applications that could be mailed in). Most of the information about Healthy Families (California's SCHIP program) was new to parents (Perry 2001).

Why Coverage Gains Are Now At Risk

When the economy was booming, most states moved forward steadily to promote participation in Medicaid and SCHIP. State budget problems have put this progress at risk. Faced with declining revenues and rising health care costs, many states are now looking for ways to reduce Medicaid and SCHIP spending as part of a strategy to resolve their budget crises. States are considering a number of cost-cutting actions, including reducing payments to providers, limiting the scope of benefits available to enrollees, increasing premiums and copayments, and limiting access to coverage (Holahan et al. 2003, Smith et al. 2003). The problem is that even though children and parents are the least costly group of people covered under Medicaid—accounting for nearly 75% of enrollees, but only 30% of costs [**Figure 2, Page 11**]—enrollment growth nevertheless increases state spending.

Figure 2

Children, Parents and Pregnant Women Account for Almost 75% of Medicaid Enrollees, But Less than 30% of Spending



Distribution of Medicaid Enrollees and Expenditures

SOURCE: CBO Estimates, March 2002

What's At Risk When Enrollment and Spending Are Cut?

As states consider options for constraining the growth of their Medicaid and SCHIP budgets, they risk losing the many benefits of that spending and the access to medical care services that it provides. In light of the difficult choices states now face, it is useful to review the evidence on the role of public coverage in promoting the health and well-being of children, families, and communities. This paper examines the strong research evidence on how public coverage enhances access to care, health, family finances, and quality of life. The paper also examines the evidence on Medicaid and SCHIP's importance to communities, focusing on the economic, health and social consequences of public coverage beyond the target population. The empirical research shows that health coverage for children and parents has far-reaching positive consequences for both beneficiaries and their communities.

Part I. Why Coverage Matters For Children and Families

For many poor and low-income children and families, the only source of affordable health insurance coverage is public coverage through Medicaid or SCHIP. Although most working age Americans and their families have private health insurance made available through an employer, low-wage workers are less likely than the better paid to have access to an affordable health insurance plan. Many low-income workers are in firms that do not provide health insurance benefits, others are in firms that offer a health plan, but are not eligible for benefits because they are new employees or because they work in part-time or temporary jobs. Others cannot afford the required employee premium contribution for coverage that is available.

Medicaid and SCHIP help to fill in the gaps left by the employment-based system, providing access to medical care, relieving financial burdens on families, and leading to improved health outcomes for eligible populations. A large number of research studies document the impact of Medicaid and SCHIP on access to care and the use of medical care, and, to a lesser extent, health outcomes. Studies also show that public coverage contributes in a very significant way to families' financial security and quality of life.

Why Public Coverage Matters to Children and Families

- ✓ Promotes access to care
- ✓ Increases use of necessary and appropriate care
- ✓ Promotes health and improves health outcomes
- ✓ Improves families' financial security
- ✓ Improves families' well-being—helps children learn and participate in normal childhood activities
- ✓ May promote employment among parents

Better Access to Care, Increased Use of Care and Better Health

Is health insurance coverage all that important for assuring the health and well-being of families and children? Won't doctors, hospitals and clinics provide medical care to those who need it, even if they are not enrolled in public coverage and remain uninsured? Although uninsured Americans often receive free care or pay for care out-of-pocket with their own funds, research studies show that the uninsured, including those who have recently lost Medicaid coverage, or those who are eligible for but not enrolled in public coverage:

- Have more limited access to medical care;
- Are less likely to receive any medical attention;
- Get less care when they do receive any care; and
- Suffer worse health outcomes as a result.

Research also shows that the previously uninsured who gain Medicaid are much better off once they are enrolled.

- They are more likely to have a doctor whom they see for regular medical care;
- They are more likely to get the services they need, including prescription drugs and immunizations; and
- They have a much easier time getting to see a specialist when they need one.

Several of the most important research studies in this area examine the experience of the late 1980s and early 1990s when the Medicaid program was expanded. The expansions initiated at both the federal and state levels extended eligibility for health insurance coverage through Medicaid to poor and near-poor pregnant and postpartum women, infants and children—targeting those in low-income working families not eligible for welfare's cash benefits. Studies of this period have sought to measure the impacts of the eligibility expansions on access to care, the utilization of care, the efficiency and effectiveness of health care delivery, and, most fundamentally, health outcomes. Other studies track the experience of people over time, and examine how public coverage affects individuals' ability to access needed medical care, focusing on the impact of gaining or losing Medicaid coverage.

Both kinds of studies demonstrate a clear causal link between enrollment in public health coverage programs and improved access to care. Among the key findings are that children, parents and pregnant women with public coverage are more likely than the uninsured to have a usual place where they go for medical care, and to have their usual source of care be a private

physician's office, rather than a hospital emergency room. They are also less likely to delay seeking care due to cost or insurance reasons and have fewer unmet needs. Key findings on access to care are reported in **Figure 3** below.

Figure 3

Public Coverage Promotes Access to Health Care

- **Previously uninsured children who become enrolled in Medicaid have fewer unmet needs and fewer delays in getting needed care**. More than 24% of uninsured children had no usual source of care, compared to 6.1% of children covered by Medicaid; 8.3% of uninsured children did not receive or postponed care, compared to 2.5% of those with Medicaid; 28.2% of families of uninsured children were not confident about getting needed care, compared to 11.2% of families with children in Medicaid. Controlling for other factors, children with Medicaid were 26 percentage points more likely than uninsured children to have a well-child visit (Dubay and Kenney 2001).

- **Uninsured Medicaid-eligible children are three times more likely to have an unmet health care need than are children enrolled in Medicaid**. Eighteen percent of uninsured children eligible for Medicaid had an unmet need for medical or dental care, compared to 6% of those enrolled in Medicaid. Nearly a quarter had no regular source of care, compared to 6% of the enrolled, most (56%) of the uninsured without a usual source of care reported lack of insurance as the reason (Davidoff et al. 2000).

- **Children enrolled in SCHIP report much less unmet need after a year's enrollment.** A study of the experience of children enrolled in the Kansas SCHIP program in 1999 found that while more than 50% reported unmet needs (medical, dental, prescription drug, etc.) prior to enrollment, only 17% still had any unmet needs at the end of the year. The proportion with any unmet needs for medical care fell from 18% to less than 2%, and the proportion with any unmet needs for dental care fell from 40% to 12% (Fox et al. 2003).

- **Previously uninsured children who enroll in public coverage are significantly more likely to have a regular physician and dentist whom they see for care.** Although most previously uninsured children had a regular physician, coverage increased the probability of having a regular physician from 89% at enrollment, to 99% 12 months after enrollment. The proportion having a regular dentist increased from 60% at enrollment to 85% 12 months after enrollment (Lave et al. 1998).

- **Medicaid improves access to prenatal care for pregnant women**. Prior to the Medicaid expansions of the mid to late 1980s and early 1990s, an estimated 29% of Medicaid-eligible women delayed initiating prenatal care—compared to 19% of noneligibles. Targeted eligibility changes in Medicaid substantially lowered the chances (by nearly 50%) that a pregnant woman would delay initiating prenatal care (Currie and Gruber 1996).

- **Medicaid significantly improves access to care for enrolled adults**. Compared to uninsured Medicaid-eligible adults (and controlling for other factors likely to affect access to care), adults enrolled in Medicaid are 26 percentage points less likely to lack a usual source of care, 16 percentage points less likely to have any unmet needs for medical care, and 19 percentage points less likely to have delayed seeking care due to cost (Davidoff, Garrett and Yemane 2001).

Continued on next page

Figure 3, continued

Public Coverage Promotes Access to Health Care

- **Loss of Medicaid coverage reduces access to medical care**. Two years after losing Medicaid, those who lost Medicaid were more likely than those who remained covered by Medicaid to: (1) lack a usual source of care (35% of those who lost Medicaid lacked a usual source of care, compared to 10% of those who remained in Medicaid); (2) encounter difficulty in obtaining medical care (22% of those who lost Medicaid, compared to 12% of those who remained covered); (3) be very dissatisfied with ability to obtain needed care (32% vs. 4%); and, (4) report no physician visits in the previous 12 months (36% vs. 25%) (Kasper, Giovannini, and Hoffman 2000).

- **Compared to uninsured low-income women, women with Medicaid have substantially better access to care across a range of indicators.** Women in Medicaid have less unmet need for medical or surgical services (8% of low-income women in Medicaid, compared to 20% of low-income uninsured women) or dental care (17% vs. 24%), are less likely to have no usual source of care (16% vs. 34%), are less likely to lack confidence in their ability to obtain needed care for their family (10% vs. 28%), and are less likely to be unsatisfied with the care once received (9% vs 19%) (Almeida, Dubay, and Ko 2001).

Those who are enrolled in public coverage are also more likely to use any medical care during the year than those who remain uninsured. Individuals with public coverage are more likely to see a physician at least once during the year, and of those with any physician visit, they see the doctor more often than the uninsured (i.e. the publicly covered who saw a doctor at least once have more physician visits per year than do the uninsured who saw a doctor at least once). Individuals covered by Medicaid are also more likely than the uninsured to be hospitalized during the year. Although an increase in the number of hospitalizations might not seem to be a desirable outcome, the research suggests that the increases in hospitalizations following enrollment in public coverage reflect an increase in necessary and appropriate access to care.

Research also shows that those who have Medicaid make better and more efficient use of the health care system. Too often, the uninsured rely on hospital emergency rooms for basic primary care. That care, by its very nature, is sporadic, and children and others with chronic conditions are especially at risk of adverse consequences of limited care and poor continuity of care. Especially among children, lack of access to primary and preventive care has been associated with high rates of "avoidable hospitalizations"—those that would not have occurred if patients had received effective, timely and continuous ambulatory care for certain chronic conditions, such as asthma. Research studies show that preventable hospitalizations declined with increases in public coverage for children, though hospitalizations for children increased in the aggregate due to improvements in access. Key findings on the amount and patterns of use of care for those with public coverage are shown in **Figure 4** on page 16.

Figure 4

Public Coverage Increases Health Care Utilization

- **Medicaid-enrolled children are more likely to receive care, and get more care, than uninsured Medicaid-eligible children.** Eighty-four percent of Medicaid enrolled children had at least one visit with a health care provider, compared to 69% of the eligible uninsured. Of those who had at least one visit, uninsured children had fewer visits (3.2) compared to children with Medicaid coverage (4.5 visits). The uninsured also were less likely to have had an inpatient hospital stay (2.3% of uninsured, compared to 4.5% of Medicaid-enrolled children) (Davidoff et al. 2000).

- **Medicaid significantly improves access to preventive and primary care and inpatient hospital care for children.** Medicaid expansions that doubled the proportion of children eligible for Medicaid between 1984 and 1992 were associated with a 50% reduction in the likelihood that a child had no doctor visit in the previous year, and increased the likelihood, by 42%, that children had a doctor visit in 52% for acute visits, and by 42% for total visits. The number of specialists seen during CHPlus was more than twice as high as before CHPlus. One third of parents reported improved quality of health care for their child as a result of CHPlus, and virtually none noted worse quality of care (Szilagyi et al. 2000).

- **Medicaid-enrolled adults are more likely to receive care, and get more care than do uninsured Medicaid-eligible adults**. Compared to the Medicaid-eligible uninsured, Medicaid enrolled adults were 18 percentage points more likely to have any physician or provider visit, 5 percentage points more likely to have 10 or more physician visits, 7 percentage points more likely to have any surgery, and 4 percentage points more likely to have any overnight hospital stay (Davidoff, Garrett, and Yemane 2001).

- **Medicaid reduces the use of emergency rooms and reduces the rate of preventable hospitalizations.** Medicaid expansions increased access to primary care and reduced rates of preventable hospitalizations. The expansions increased the efficiency of health care delivery since most of the increased visits were to doctor's offices rather than emergency rooms. Between 1983 and 1996, the Medicaid expansions led to 22% fewer preventable hospitalizations, but 10% more hospitalizations overall as children's access to inpatient hospital care increased (Dafney and Gruber 2000).

- **Low-income women with Medicaid are much more likely than the low-income uninsured to receive regular primary and preventive care.** Low-income women with Medicaid are more likely than the uninsured to have had at least one physician visit during the year (81% of Medicaid-enrolled women compared to 57% of uninsured low-income women), and more likely to have had at least one Pap smear in the past year (65% of Medicaid-enrolled women, compared to 43% of uninsured low-income women) (Almeida, Dubay, and Ko 2001).

- **Among teen mothers and high school dropouts, eligibility for Medicaid is associated with significant increases in the use of a variety of obstetric procedures.** Mothers who were uninsured prior to becoming Medicaid eligible were more likely to receive a variety of more intensive obstetric treatments, especially when the closest hospital had a neonatal intensive care unit. Increases in expected reimbursement for mothers who were previously uninsured expanded access to high-tech treatments, reducing inequities in access to these procedures across less disadvantaged and more disadvantaged mothers (Currie and Gruber 1997).

The evidence that public coverage produces improvements in health outcomes is somewhat weaker than the evidence that public programs expand access to care. Some studies find only weak or mixed evidence of Medicaid's impact on health status. For example, some studies suggest the Medicaid expansions of the late 1980s had no effect, or only limited effects, on health outcomes. Nationally, rates of low birthweight and very low birthweight hardly changed over the period of the Medicaid expansions (Howell 2001). Similarly, some have argued that Medicaid and SCHIP have done very little to narrow health disparities between low-income and higher-income children (Hughes and Ng 2003) [**Figure 5, Page 18**].

Nevertheless, although improvements in health outcomes may be difficult to detect, a number of other studies have found significant improvements in health outcomes to Medicaid eligibility expansions (though these findings are often limited to certain subpopulations within the broader Medicaid population), and other studies have shown significant reductions in health status are associated with the loss of Medicaid coverage. Some studies suggest that after Medicaid eligibility expansions in the late 1980s and early 1990s, infant mortality rates, the incidence of low birthweight and child mortality rates all fell significantly (Gruber 1997). Research also shows that expanded enrollment for children in Medicaid significantly reduced the rate of avoidable hospitalizations, suggesting that children were receiving needed primary and preventive care. More recent studies of those who have gained and lost Medicaid show that those who have lost coverage are more likely to have adverse health outcomes and those who gain coverage are more likely to report improved health status.

The fact that large socioeconomic disparities in access to care and health persist does not mean health insurance does not contribute to improved health outcomes. Many factors in children's and adults' social and physical environments influence health and well-being, but the fact that other policies could also have an impact on health should not obscure the important difference that publicly funded health insurance clearly makes. Having insurance is not merely a matter of convenience in getting and paying for health care; it is critical to assuring access to primary care physicians, specialists, hospital care and prescription drugs. Although the uninsured get at least some of the health care they need, research clearly demonstrates that those without insurance coverage get less care, receive less appropriate care than the insured, and experience worse health outcomes as a result.

Figure 5

Public Coverage Improves Health Outcomes

- **Expanding Medicaid appears to reduce infant mortality rates**. A 30% rise in the proportion of women eligible for Medicaid between 1979 and 1992 was associated with an 8.5% decline in state-level infant mortality (Currie and Gruber 1996b).

- **Targeted Medicaid expansions have been associated with significant declines in low birthweight.** Expansions to very low-income populations between 1979 and 1992 period, which increased eligibility by 30 percentage points, were associated with a 7.8% reduction in the incidence of low birthweight (Gruber 1997).

- **Marginal increases in treatment intensity for childbirth among Medicaid eligible women have large effects on infant health outcomes**. A 24% rise in eligibility for teen mothers and high school dropouts between 1987 and 1992 lowered infant mortality by 11% among those with access to a neonatal intensive care unit (Currie and Gruber 1997).

- **Increases in Medicaid eligibility at the state level are associated with significant reductions in child mortality.** The 15.1 percentage point rise in Medicaid eligibility between 1984 and 1992 was associated with a 5.1% decrease in child mortality (Gruber 1997).

- **Medicaid expansions decrease the incidence of ambulatory care sensitive hospitalizations among children.** Medicaid expansion reduced ACS hospitalizations among young children (ages two to six) from very low-income areas (with median family income less than $25,000). Medicaid expansions also improved the health of children ages two to six in near-poor areas (areas with a median family income between $25,000 and 30,000), but there was little evidence that the Medicaid expansions had an impact on the health of older children (ages seven to nine) (Kaestner, Joyce, and Racine 2001).

- **Loss of Medicaid leads to reductions in health status**. Compared to those who remain insured, those who lose Medicaid and become uninsured are more likely to experience an adverse health effect due to access difficulties (9% to 14%), and more likely to report fair or poor health (11% to 18%) (Kasper, Giovannini, and Hoffman 2000).

Some studies find only weak evidence of improved health status:

- **Medicaid expansions in the late 1980s lead to significant improvements in prenatal care utilization among women of low socioeconomic status, but the gap in newborn health between poor and non-poor populations persisted.** Between 1986 and 1993, rates of late initiation of prenatal care decreased by 6.0 to 7.8 percentage points beyond changes estimated for the 1980-86 period for both white and African American women of low socioeconomic status. For some white women of low socioeconomic status, the rate of low birth weight was reduced by 0.26 to 0.37 percentage points between 1986 and 1993 relative to the earlier period. Other white women of low socioeconomic status and all African American women of low socioeconomic status showed no relative improvement in the rate of low birth weight during the 1986-93 period (Dubay, Kaestner, Joyce et al. 2001).

- **Expansions in the Medicaid program produced greater reductions in uninsured rates among poor minority children than among poor white children, but poor children did not seem to experience significant changes in their use of health services and no change in their health status was found.** Among poor children between 1989 and 1995, uninsured rates declined by 4 percentage points for whites, 11 percentage points for blacks, and 19 percentage points for Hispanics. Medicaid rates for these groups increased by 16 percentage points, 22 percentage points, and 23 percentage points, respectively. The annual probability of seeing a physician increased 7 percentage points among poor blacks and Hispanics but only 1 percentage point among poor whites for children in good, fair, or poor health. Significant increases in numbers of doctor visits per year were recorded only for poor Hispanics who were in excellent or very good health, whereas significant decreases in hospitalizations were recorded for Hispanics who were in good, fair or poor health. Measures of health status remained unchanged for poor children over time (Racine, Kaestner, Joyce et al. 2001).

Financial Security

Medicaid and SCHIP also make a difference for the financial well-being of low-income children and families. Most of the children covered through Medicaid and SCHIP are in families with at least one working adult, but they typically do not have access to affordable employment-based health insurance. When they are enrolled in public coverage, low-income families are better protected from the economic hardship that can accompany an illness or injury requiring medical care. Families who are uninsured are at greater risk than the insured of high out-of-pocket medical spending due to injury or illness and its consequences (e.g. risk of impoverishment, bankruptcy, inability to afford other necessities, such as rent, food, clothing, utilities and transportation). By comparison, research suggests Medicaid and SCHIP contribute to the economic stability of low-income families, substantially reducing their out-of-pocket spending on medical care and thereby permitting them greater ability to afford other necessities including rent, transportation and child care expenses, which help them stay employed. Affordable public coverage also puts parents' minds at ease with respect to their ability to manage tight budgets and pay their bills. Key findings are reported in **Figure 6** below.

Figure 6

Public Coverage Reduces Family Financial Burdens

- **Being uninsured creates financial insecurity for families**. In a 2001 survey of the uninsured, half of the uninsured respondents reported problems paying for medical care during the year. More than one-third had been contacted by a collections agency. More than one in four currently uninsured adults reported medical bill problems so severe they had to change their way of life significantly to pay these bills: 70% said they had used all or most of their savings to pay medical bills; 64% had to borrow from a family member or friend; 27% took out a loan or mortgage on their home; 55% had problems paying for basic necessities such as food or rent (Duchon et al. 2001).

- **Low-income families of children enrolled in Medicaid spend considerably less out-of-pocket than families of uninsured Medicaid-eligible children**. Just 13% of families of children enrolled in Medicaid spent over $500 a year out-of-pocket on medical care expenses annually, compared to 30% of families with uninsured Medicaid-eligible children (Davidoff et al. 2000).

- **Families with Medicaid have more money available for spending on other necessities**. Many low-income families have difficulty affording basic necessities such as housing, food, and clothing. In a 1999 survey, more than four out of 10 adults and 50% of low-income families with children either worried a lot about or had difficulties paying for food. More than one in five low-income adults in the survey reported housing affordability problems (Zedlewski 2000) (See also Long 2003). Medicaid helps relieve some of these hardships. An economic analysis of the effect of Medicaid on household spending suggested that being made eligible for Medicaid increased total household consumption spending by 4.2% (Gruber and Yelowitz 1999).

Continued on next page

Figure 6, continued

Public Coverage Reduces Family Financial Burdens

- **Families of eligible but uninsured adults are much more likely to be burdened by out-of-pocket health care costs.** More than 21% of families with eligible but uninsured adults report spending between $500 and $2000 out-of-pocket on health care annually, compared to fewer than 10% of families with Medicaid-enrolled adults. Despite their very low incomes (more than three-fourths have income below 50% of the federal poverty level), more than 11% of families of the eligible uninsured report spending more than $2,000 out-of-pocket (Davidoff, Garrett, and Yemane 2001).
- **Medicaid substantially reduces out-of-pocket burdens for low-income patients with cancer.** Compared to the uninsured, nonelderly cancer patients with Medicaid used more health care services (and had higher overall medical expenditures), but paid less out-of-pocket for that care. During a six-month period, the average Medicaid patient with cancer paid just $165 out-of-pocket for medical care (with total medical care expenditures of $7,805); while the uninsured paid $1,343 on average (total spending on their health care was $4,806) (i.e. those with Medicaid paid 2.1% of costs out-of-pocket, while the uninsured paid 28% of costs) (Thorpe and Howard 2003).
- **Families with high out-of-pocket costs face access barriers**. Of those who spend more than 10% of income on direct health care expenses, 17% report going without needed care, and 20% report difficulty obtaining a service for financial or insurance reasons (Merlis 2002).
- **The importance of expanding insurance coverage is quite large relative to other factors that influence the use of medical care, such as family income.** For example, the relative value of Medicaid coverage is equivalent to an increase of family income from $10,000 to $50,000 (Gruber 1997).

Quality of Life

Public coverage also matters for families' psychosocial well-being. Having children enrolled in public coverage can reduce stress for parents who might otherwise be anxious or frightened about the prospect of raising children without health care coverage. Improved access and effective health care also can improve children's health status over time, which in turn may positively affect other aspects of children's lives (Lewit, Bennett, and Behrman 2003), including their ability to attend school and learn. Children with public coverage also may be more likely to engage in normal activities of childhood since having public insurance helps to assure that children receive treatment for injuries. Coverage for parents also matters since it lowers their stress and may enhance their ability to look for, accept and retain employment [**Figure 7, Page 21**]. For example, in a small-scale survey of welfare recipients in Nashville and Charlotte conducted in 1994, Medicaid coverage for children—such as child care benefits and transportation assistance—was cited as an important benefit for parents looking to make the transition from welfare to work. A significant proportion of both welfare recipients and parents newly in the workforce receiving Transitional Medicaid (21% and 43%, respectively) reported

that keeping Medicaid coverage for their children was the most important benefit enabling them to take a full-time job (Shuptrine, Grant, and McKenzie 1994, p. 28).

Figure 7

Public Coverage Improves Quality of Life

- **Public coverage improves children's school attendance and performance.** In a study of California's Healthy Families program (the state's SCHIP program), children enrolled in public coverage experienced a 68% improvement in measures of school performance (such as "paying attention in class" and "keeping up in school activities"), as well as improvements in other areas such as "forgetting things, missing school because not feeling well, and missing school to go to the doctor or hospital" (Children's Health Assessment Project 2002). The State of Missouri has reported similar findings (Missouri Department of Social Services 2001).

- **Public coverage enhances the ability of children to engage in normal activities of childhood.** Enrolling in public coverage was associated with significant decreases in the probability that children were limited in their usual activities. Although 15% of children who were previously uninsured for six months or more reported being limited in usual activities (e.g. limited sports activities—bike riding, rollerblading—because of fears of costs associated with injuries; schools and other organizations do not allow them to participate), after six months of enrollment, essentially no limitations related to health insurance coverage were reported or identified (Lave et al. 1998, p. 1824). Compared to the uninsured, families of children in Medicaid are more likely to seek needed medical care for injuries (Overpeck and Kotch 1995).

- **Public coverage lowers parents' stress.** Lack of health insurance is a major source of stress for families. Three-fourths of parents of children newly enrolled in SCHIP reported that lack of insurance made them "worried, scared or stressed out." More than a third indicated that lack of insurance led to financial difficulties within the family. After 12 months of enrollment, 61% of parents said they had less worry, and more security or peace of mind (Lave et al. 1998, p. 1824).

- **Public coverage may increase women's employment.** Simulations suggest that extending health care coverage to all children of single mothers regardless of welfare status would induce a large percentage of these mothers to seek and accept employment. The proportion of single mothers employed would rise by 12 percentage points, from 59% before the simulated policy to 71% after the policy took effect (Wolfe and Hill 1995, p.60). Another study that examined the impacts of Medicaid expansions for children found that raising the income eligibility level for Medicaid for young children, and severing the link to welfare, substantially reduced the probability that women would participate in AFDC by 1.2 percentage points, and increased the probability of working by about 1 percentage point (Yelowitz 1995).

Part II. Why Coverage Matters for Communities—Beyond the Target Population

Although poor health and limited access to health care have a most direct and profound impact on the uninsured families who are the direct beneficiaries of public coverage programs, there are a number of ways in which Medicaid and SCHIP affect the wider community and deliver important economic and social benefits beyond the target population. Most significantly, Medicaid's federal-state financing structure provides significant inflows of federal funds, reducing state and local financing burdens for services they might otherwise absorb with state and local funds and provide a general economic stimulus effect. Public programs, by reducing the number of uninsured and providing direct subsidies to providers, also help assure the economic viability of health care providers and help assure community access to care for all—insured and uninsured alike. Finally, Medicaid and SCHIP help facilitate the detection and treatment of communicable disease and thus contribute to public health.

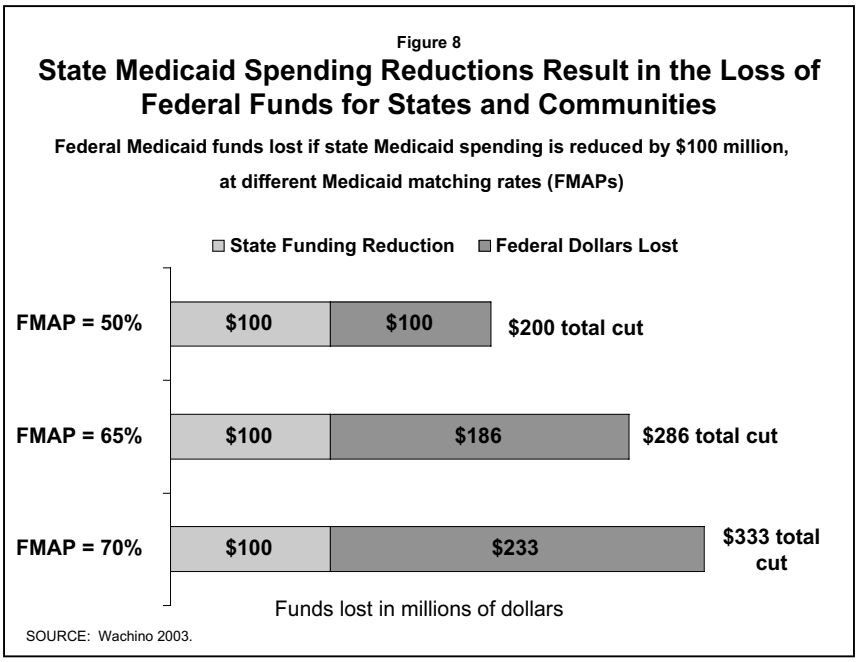
Why Public Coverage Matters for Communities

- ✓ Brings federal matching funds into states, providing fiscal relief
- ✓ Brings federal matching funds into states, promoting community economic development through jobs creation and income growth
- ✓ Reduces the number of uninsured
- ✓ Helps assure community access to care, reducing uncompensated care burdens on providers and localities, and strengthening local providers' capacity to serve all people
- ✓ Helps assure community health by providing access to care for low-income children and parents at risk of communicable disease and by reducing burdens on public health departments to provide medical services to the uninsured

Community Economic Impacts

The economic impacts of Medicaid and SCHIP on communities are perhaps the programs' most important, yet most frequently overlooked, spillover benefits. Medicaid accounts for 15% of state general fund expenditures, but also accounts for 44% of all federal

grant funds to states. A state cutting Medicaid or SCHIP enrollment and spending generally will lose more in federal funds than it saves in state funds (Wachino 2003) **[See Figure 8 below]**. Nationally, 57% of Medicaid funds and 70% of SCHIP spending is paid for by the federal funds (Institute of Medicine 2003, p. 125).



Medicaid has a significant effect on the national and state economies. Medicaid spending came to more than $257 billion in 2002, providing medical services to 47 million people and a critical source of funds to many health care providers and institutions. Medicaid accounts for 16% of total health care spending nationwide (Levit et al. 2003), and an even larger share of spending on long-term care—more than 40%. This spending matters for the viability of the medical sector, but it also has economic ripple effects throughout state economies, creating jobs that generate income, spending and tax revenue. In an era of tax cuts, it is worth remembering that government spending during recessions has important stimulative effects.

Medicaid and SCHIP also have important macroeconomic effects, acting as an "economic stabilizer" when the economy turns down. These funds go to the physicians, hospitals, clinics and nursing homes and other health care providers and institutions that provide services to Medicaid and SCHIP beneficiaries whose numbers grow when unemployment rises (Holahan and Garrett 2001). In many communities, medical care is an important and growing part of the economy. If providers do not receive funding for individuals under their care and

must absorb a greater amount of uncompensated care, the health care available to the broader community may be adversely affected, as discussed below. But reductions in payments to providers also reverberate throughout the economy: cut backs have a multiplier effect—reducing workers' earnings (especially earnings of low-wage workers in public hospitals, nursing homes and clinics). Recent estimates of the impact of Medicaid spending on income and employment in selected states demonstrate the importance of Medicaid for state economies. At least one study of national data also demonstrates the economic impact of Medicaid spending on state gross domestic product [**See Figure 9 below**].

Figure 9

Public Coverage Creates Jobs and Provides an Economic Stimulus to Communities

- A study based on national data found that for every 1% of the population added to Medicaid, state GDP rises by .033% (Gruber and Yelowitz 1999).
- Researchers at the University of South Carolina's Moore School of Business recently estimated that the current federal Medicaid matching funds injects $2.1 billion into the South Carolina economy, supporting over 58,000 jobs and generating $1.56 billion in income for the state. Consequently, if the state cut the Medicaid program by 4%, the state would lose 2,472 jobs and $60 million in income. Cutting Medicaid spending by 10% would mean a loss of 6,181 jobs and $150 million in income (Moore School of Business 2003).
- Researchers at the University of Utah's David Eccles School of Business estimate that Utah's contribution to Medicaid and SCHIP in fiscal year 2001 resulted in a federal match of $619 million that supported 16,818 jobs and generated $437 million in earnings for Utah workers. The federally funded part of SCHIP ($4 million) supported 560 jobs and provided $16 million in earnings. Further, for every $1 Utah spent for the Medicaid program in 2001, $0.12 was returned to the state's treasury through the generation of net new state tax revenue (Crispin-Little 2003)
- A recent study of the impact of Medicaid and CHIP funding in Texas found that Medicaid brings over $56 billion into the state, generating over $29 billion in state GDP and supporting over 474,000 jobs. CHIP contributes over $2.6 billion in expenditures, generates $1.4 billion in state gross product, and supports 16,276 jobs. Proposed reductions to Medicaid and CHIP spending in Texas would cost $8.2 billion in state gross product and 146,000 jobs (Perryman Group 2003).
- The Lewin Group estimates that, in fiscal year 2001, the rate of return per dollar invested in Medicaid ranged from $6.34 in Mississippi to $1.95 in Nevada. The average value of increased business activity generated from state Medicaid spending was $6 billion, and state Medicaid spending generated almost 3 million jobs with wages in excess of $100 billion. The average number of jobs was 58,785 per state, ranging from 300,352 in New York to 3,949 in Wyoming (Families USA 2003).

Further, although direct evidence is limited, some evidence shows that health insurance matters not only for workers, but also for their employers. Certain employers—those with a high proportion of low-wage and low-income workers—may receive substantial direct benefits from

Medicaid and SCHIP if their workers and dependents are eligible for and enrolled in public coverage. Since some small businesses may not be able to provide comprehensive and affordable health insurance to workers (Nichols et al. 1997), and since low-income workers may not be able to afford insurance even when it is offered, the public programs can help fill gaps in employment-based coverage. In addition, since workers with health insurance have better access to health care, get treated sooner and receive more effective care, employers may receive additional indirect benefits of public health care coverage through reduced absenteeism, enhanced worker productivity of workers and reduced turnover. Although there is little evidence on the benefits to employers of public coverage, a number of research studies suggest employee health has a significant impact on absenteeism and poor employee health generates productivity losses for employers (O'Brien 2003). Since coverage increases access to care and the likelihood workers will receive early treatment for illnesses and injuries, it is likely Medicaid has significant indirect benefits for some employers.

Cost Shifting and Strains on Other Resources

If individuals and families who would otherwise be enrolled in Medicaid or SCHIP remain uninsured, the problems that should have been addressed in the medical care system will not go away, but simply shifted elsewhere (Rowland and Tallon 2003). In addition to impacts on the community's health, there are likely to be unintended or unforeseen economic and social consequences of reductions in public health care coverage. For example, reductions in spending on primary care, prescription drugs and other sorts of medical care spending may be offset by increases in other care and services, such as emergency room use. When fewer children and parents are enrolled in Medicaid and SCHIP, uncompensated care burdens are likely to rise—burdens that represent a less efficient use of resources. Localities and safety net institutions generally, however, are even less capable than states and the federal government to finance the costs of caring for the uninsured.

<u>Medicaid cuts will shift costs to states and localities.</u>

The costs of poor health coverage and inadequate access to care may be shifted to communities in other ways that can be shortsighted from an economic perspective—with important cost implications for state and local budgets. For example, people with mental illness

who depend on Medicaid services to remain healthy in the community will seek services at mental health clinics and inpatient psychiatric hospitals, increasing burdens on state or locally-funded programs. Consequently, low participation rates in public coverage programs will not only increase family financial burdens, but also will increase costs to taxpayers and consumers of medical care who may end up paying more for their health care and in taxes to help meet local uncompensated care burdens. In addition, if Medicaid and SCHIP are not available, the cost of untreated disease and inadequate access to care (prenatal care, blood lead levels in children, treatment for chronic diseases and mental illness) can lead to higher costs down the line—both immediate costs and longer-term costs as the consequences of limited access to health care show up in higher spending on higher utilization of emergency rooms, special education, juvenile justice and adult prison system, for example.

Cuts in some Medicaid benefits may lead to higher spending on other covered services**.**

In some cases, Medicaid and SCHIP coverage reductions will have significant short-term effects, leading to higher costs elsewhere that also will put pressures on state budgets, without the benefit of federal matching payments. For example, efforts to constrain the growth of Medicaid prescription drug spending have been shown not only to adversely affect the health and well-being of beneficiaries, reducing their use of essential medications, but also had the unintended effect of raising Medicaid spending on nursing home care for chronically ill beneficiaries and inpatient psychiatric care and use of mental health clinics by patients with schizophrenia. When a limit was placed on the number of monthly prescriptions in the New Hampshire Medicaid program, increases in spending in mental health services and nursing home care after the cap was put in place more than offset the savings on prescription drug spending (i.e. there were no net savings to the Medicaid program as a result of the cap) [**Figure 10, Page 27**].

Figure 10

Unintended Consequences of Cost Containment

- **A study of the effect of a cap of three prescriptions per month found evidence of significant declines in the use of both essential and nonessential medications for a representative sample of the Medicaid population**. Following the implementation of a cap on prescription drugs in New Hampshire's Medicaid program, there was a 30% drop in number of prescriptions filled. Analyses of selected subgroups revealed that the heaviest prescription drug users experienced the largest declines. There was a 42% drop in the number of prescriptions filled for those who received multiple drugs (who were mostly elderly and disabled). This study, however, did not assess the clinical consequences of the access restrictions or changes in the use of other services (Soumerai et al. 1987).

- **Limits on access to prescription drugs for non-institutionalized patients with schizophrenia resulted in immediate reductions in the use of antipsychotic drugs, and cost shifting to other services that more than offset the prescription drug savings.** Following implementation of the New Hampshire cap, there were increases in community mental health center visits, and sharp increases in the use of emergency mental health services and partial hospitalization. All told, the estimated average increase in mental health care costs per patient during the cap exceeded the savings in drug costs by a factor of 17 (Soumerai et al. 1994).

Medicaid cuts may shift costs to other programs, such as IDEA and WIC, and limit the effectiveness of these programs**.**

Medicaid cuts also may have an important impact on other federal programs that assume that Medicaid will pick up the costs of medical services for program beneficiaries. The Individuals with Disabilities Education Act (IDEA), for example, requires states to provide children with disabilities a free appropriate public education in the least restrictive environment possible. IDEA does not provide states with a source of federal financing for the health care services children with special needs may have. If Medicaid coverage or participation is curtailed, in many cases services that had been covered by Medicaid would have to be picked up by the state or local community to remain in compliance with IDEA. For example, if Medicaid were to stop paying for a medical technician who provided medical services to a student during the school day, the state or local education agency may have to cover that cost.

Medicaid also matters for the operation of the WIC program—the Special Supplemental Nutrition Program for Women, Infants, and Children. WIC provides food and formula to low-income mothers and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating and referrals to health care. Unlike Medicaid, WIC is capped federal program; federal funding is not open-ended. In light of limited WIC funding, reductions in Medicaid coverage could potentially limit the reach of the WIC

funds. For example, some state Medicaid programs cover special infant formulas for children with special health care needs. If Medicaid were to stop covering the cost of expensive specialized infant formulas, the infant's family could seek assistance at a WIC clinic. Meeting the nutritional needs of one sick child (at a cost of, say, $25,000 per year) could reduce WIC's ability to help other children. At the same time, reduced WIC effectiveness could boost Medicaid costs. Studies have shown that women who participated in WIC during their pregnancies had lower Medicaid costs for themselves and their babies than did women who did not participate. WIC participation also was linked with longer gestation periods, higher birthweights and lower infant mortality (Avruch and Cackley 1995; Buescher et al. 1987).

Community Access to Care

In addition to the effects on community health and costs, decreased funding for health care for poor and low-income people is likely to affect the availability of medical care providers and services for the broader community, including those who have no health insurance and those with private health insurance. Similarly, evidence on the effects of Medicaid and SCHIP suggest expansions of public coverage are associated with reductions in emergency room use, which may help to alleviate the growing problem of emergency room overcrowding, and substantial shifts in hospitalizations that are not insured to hospitalizations that are financed by Medicaid (Dafney and Gruber 2000). In terms of broader community's access to care, public coverage helps to reduce the financial burdens on hospitals and clinics to provide free care to the uninsured, and helps to assure continued access to services for all patients, whether insured or uninsured. In a recent report, the Institute of Medicine concluded that "access to health services and consequent benefits are compromised for persons other than those who lack coverage" in communities with higher uninsured rates (IOM 2003, p. 1) [**Figure 11, Page 29**].

Figure 11

High Rates of Uninsurance Can Reduce Community Access to Care

Findings from the Institute of Medicine

- Serving a high or rising proportion of uninsured patients reduces the capacity of community health centers to provide ambulatory care to all of its patients—insured or uninsured.
- Rising uninsured rates can worsen emergency department (ED) overcrowding and the financial status of ED operations, reducing the availability of ED services within a community including the reduced availability of on-call specialists.
- A significant source of financial stress on regional trauma centers is the high proportion of uninsured patients they serve. Hospitals may decline to open a trauma center or may decide to close an existing trauma center in response to this financial stress.
- Relatively high rates of uninsurance are associated with reduced availability of on-call specialty services to hospital emergency departments and the decreased availability of primary care providers to obtain specialty referrals for patients who are members of medically underserved groups.

Source: Institute of Medicine 2003, pp. 90-99.

Community Health and Well-being

Poor health and limited access to medical care for poor and low-income families not only undermine the health of the beneficiaries who have lost their public coverage, but also the health of others who are not potential program beneficiaries. Impaired access to care means delays in detecting, treating and monitoring the transmission of infectious disease, which can put the broader community at risk of communicable diseases such as tuberculosis, vaccine-preventable illnesses (such as measles, whooping cough and rubella) and sexually transmitted diseases (including chlamydia, gonorrhea and syphilis). If public programs limit coverage for medical services for those at risk, the burden will shift to public health departments. This cost shift will, in turn, "place considerable demands on local health department resources and may divert funds from population-based public health activities" (IOM 2003, p. 13).

Is there evidence that Medicaid and SCHIP coverage contribute to the health of communities? Since health insurance facilitates access to immunizations for poor and low-income children, it is likely that reduced enrollment could contribute to higher rates of these vaccine-preventable illnesses. The Institute of Medicine (IOM) Committee on the Consequences of Uninsurance hypothesized that "the presence of sizable uninsured populations without reliable access to care means that both population immunization levels and communicable disease rates

are likely to be worse than they would otherwise be if everyone in the United States had health insurance. For example, underimmunization of children increases the vulnerability of entire communities to outbreaks of diseases such as measles, whooping cough and rubella" (IOM 2003, p. 148). Because the prevalence of communicable disease in any community depends on many factors other than the proportion of its citizens who are uninsured or who are covered by public health insurance, it is difficult to tease out the impact of Medicaid and SCHIP. Nevertheless, there is evidence that expansions of public coverage have contributed to better access to immunizations for children, and earlier diagnosis and better treatment for a range of conditions including tuberculosis and sexually transmitted disease. Key findings related to public coverage and consequences for public health are reported in **Figure 12** below.

Figure 12

Public Coverage Contributes to Community Health

- **Public coverage relieves burdens on public health departments to provide medical services and increases childhood immunization rates**. When New York State expanded children's insurance prior to SCHIP, the statewide immunization rate rose from 83% to 88% for all children ages one to five. At the same time, the use of public health departments for immunizations declined, with more immunizations delivered in the medical home. Immunization visits to primacy care practitioners' offices increased by 27% and those to public health departments fell by 67% (Rodewald et al. 1997) (Szilagyi et al. 2000).

- **The presence of sizable uninsured populations without reliable access to care means that both population immunization levels and communicable disease rates are likely to be worse than they would otherwise be if everyone in the United States had health insurance.** For example, underimmunization of children increases the vulnerability of entire communities to outbreaks of diseases such as measles, whooping cough and rubella (Institute of Medicine 2003).

- **Estimates of the impact of a California regulation to eliminate prenatal care for immigrant women suggested morbidity and costs due to sexually transmitted infection would rise, thereby offsetting anticipated savings.** Excess adverse outcomes of pregnancy were estimated to cost $5.1 to $9.2 million dollars in direct medical expenses, offsetting anticipated savings associated with the proposed 1996 regulation by 19.2% to 34.9%. This analysis does not include other costs of these sexually transmitted infections or costs associated with other aspects of diminished prenatal care, all of which could further offset anticipated savings (Kuiper et al. 1999).

Conclusion—Making the Case for Coverage

Rising health care costs, declining revenues and a greater need for public coverage fueled by the slow economy are creating pressures in every state to curtail Medicaid spending. However, as state officials look to Medicaid to achieve budget savings, they must weigh the trade-offs associated with those choices. Although it is easy to see why Medicaid is a target for spending cuts, since it accounts for a significant share of state spending, the choice to reduce the availability of Medicaid coverage is much more difficult once the full consequences of those choices are understood. Available research findings begin to provide an objective foundation for state policymakers to evaluate the potential consequences of their choices. The research clearly shows the direct impacts on beneficiaries' access to care, health, well-being, and financial security. More difficult to document, but as important, are all of the direct and indirect consequences of cuts for the broader community.

Just as much is known about the consequences of losing public coverage, much is also known about what it will take to assure that eligible children and parents receive coverage. Continued improvements depend on maintaining eligibility and on removing barriers to enrollment and retention. Research by the *Covering Kids* Communications Campaign found 5 out of 10 parents with uninsured children who qualify for SCHIP or Medicaid do not believe these programs apply to them, and 7 out of 10 parents say they would enroll their children in SCHIP or Medicaid if they knew they qualified (Covering Kids 2002). To assure public coverage programs accomplish their goals, strategies are needed to assure families learn about coverage programs, and processes and procedures are needed to make it less burdensome for children and families to apply, enroll and stay enrolled for as long as they are eligible. A broad range of strategies, including a single application for both Medicaid and SCHIP, the ability to submit applications by mail rather than applying in a welfare office, elimination of the asset tests, allowing 12-month renewal periods and continuous eligibility for children, simplified renewal procedures and presumptive eligibility, and coordinating enrollment with other public benefit programs, have been shown to have real value (Cohen Ross and Cox 2003; Cohen Ross and Hill 2003; Ku and Cohen Ross 2002).

In recent years, many have questioned whether low-income families, including those with little or no prior contact with public benefit programs, would be willing to enroll their children in

Medicaid or SCHIP. Those questions can now been laid to rest. States have found most families are eager to enroll *if* the process is simple and dignified. Much has been accomplished over the past few years to address the so-called stigma issue, but even after policies have changed, it has taken time for families to learn coverage is available and easy to access. Backsliding on these efforts not only would set back the progress made to enroll the eligible uninsured and to help them access care, it also would reverberate through the economy and set back health improvement goals for years to come.

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