Special Executive Summary Edition

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

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Note to the Reader

This special executive summary edition of Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP is made available by the Covering Kids & Families National Program Office at the Southern Institute on Children and Families. The executive summary provides a succinct, informative overview of the full report and serves as a resource on the importance of preserving Medicaid and SCHIP coverage for America's uninsured children and families. The full report may be downloaded at www.coveringkidsandfamilies.org.

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 as outlined below:

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 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%. 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.

References

ABC for Health. 2002. Report on the Simplified Medicaid/Badger Care Application Survey, prepared for the Wisconsin Division of Health Care Financing.

Almeida, R. A., L. C. Dubay, and G. Ko. 2001. Access to Care and Use of Health Services by Low-Income Women. Health Care Financing Review 22, no. 4:27-47.

Avruch, S. and A. P. Cackley. 1995. Savings achieved by giving WIC benefits to women prenatally. Public Health Reporter 110, no. 1: 27-34.

Buescher, P. A., C. Smith, J. L. Holliday, and R. H. Levine. 1987. Source of prenatal care and infant birth weight: the case of a North Carolina county. American Journal of Obstetrics and Gynecology 156, no. 1: 204-10.

Children's Health Assessment Project. 2002. Health Status Assessment Project-First Year Results, Data Insights Report No. 10. Managed Risk Medical Insurance Board. Accessed April 12, 2003. Available from www.mrmib.ca.gov/MRMIB/HFP/PedsQLYr2CHHS.pdf.

Cohen Ross, Donna and Laura Cox. 2003. Enrolling Children and Families in Health Coverage: The Promise of Doing More. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Cohen Ross, Donna and Ian T. Hill. 2003. Enrolling Eligible Children and Keeping them Enrolled. Future of Children 13, no. 1: 81-97.

Covering Kids. 2002. Helpful Statistics. Accessed May 1, 2003 from www.coveringkids.org/communications.

Crispin-Little, Jan. 2003. Economic Impact of Medicaid and CHIP on the Utah Economy. Salt Lake City: University of Utah.

Cunningham, Peter J., Jack Hadley, and James D. Reschovsky. 2002. The Effects of SCHIP on Children's Health Insurance Coverage. Washington, DC: Center for Studying Health System Change.

Currie, Janet and Jonathan Gruber. 1996a. Health Insurance Eligibility, Utilization of Medical Care, and Child Health. Quarterly Journal of Economics 111, no. 2: 431-66.

Currie, Janet and Jonathan Gruber. 1996b. Saving Babies: The efficacy and cost of recent changes in the Medicaid eligibility of pregnant women. Journal of Political Economy 104, no. 6: 1263-96.

Currie, Janet and Jonathan Gruber. 1997. The Technology of Birth: Health Insurance, Medical Interventions, and Infant Health. Cambridge, MA: National Bureau of Economic Research.

Dafney, Leemore and Jonathan Gruber. 2000. Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansions and Child Hospitalizations. Cambridge, MA: National Bureau of Economic Research.

Davidoff, Amy, Bowen Garrett, Diane M. Makuc, and Matthew Schirmer. 2000. Medicaid eligible children who don't enroll: health status, access to care, and implication for Medicaid enrollment. Inquiry 37, no. 2: 203-18.

Davidoff, Amy, Bowen Garrett, and Alshadye Yemane. 2001. Medicaid-Eligible Adults Who are Not Enrolled: Who Are They and Do They Get the Care They Need? Washington, D.C.: Urban Institute.

Dubay, L. and G. M. Kenney. 2001. Health care access and use among low-income children: who fares best? Health Affairs 20, no. 1: 112-21.

Dubay, L., T. Joyce, R. Kaestner, and G. M. Kenney. 2001. Changes in prenatal care timing and low birth weight by race and socioeconomic status: implications for the Medicaid expansions for pregnant women. Health Services Research 36, no. 2: 373-98.

Duchon, Lisa, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. 2001. Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk. New York: Commonwealth Fund.

Dunkelberg, A. 2003. Simplified Eligibility for Children's Medicaid in Texas: A Status Report at Nine Months. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Families USA. 2003. Medicaid: Good Medicine for State Economies. Washington, DC.

Feinberg, E., K. Swartz, A. Zaslavsky, et al. 2002. Language Proficiency and the Enrollment of Medicaid eligible Children in Publicly Funded Health Insurance Programs. Maternal and Child Health Journal 6(1):5-18.

Fox, M. H., J. Moore, R. Davis, and R. Heintzelman. 2003. Changes in reported health status and unmet need for children enrolling in the Kansas Children's Health Insurance Program. American Journal of Public Health 93, no. 4: 579-82.

Gruber, Jonathan. 1997. Health Insurance for Poor Women and Children in the U.S.: Lessons from the Past Decade. In Tax Policy and the Economy, ed. James M. Poterba. Cambridge: MIT Press.

Gruber, Jonathan and Aaron Yelowitz. 1999. Public Health Insurance and Private Savings. Journal of Political Economy 107, no. 6, Part 1: 1249-1274.

Holahan, John and Bowen Garrett. 2001. Rising Unemployment and Medicaid. Health Policy Online. Washington, DC: Urban Institute.

Holahan, John, Joshua M. Weiner, Randall R. Bovbjerg, Barbara A. Ormond, and Stephen Zuckerman. 2003. The State Fiscal Crisis and Medicaid: Will Health Programs be Major Targets? Overview. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Howell, E. M. 2001. The impact of the Medicaid expansions for pregnant women: a synthesis of the evidence. Medical Care Research and Review 58, no. 1: 3-30.

Hughes, Dana C. and Sandy Ng. 2003. Reducing Health Disparities Among Children. Future of Children 13, no. 1: 153-67.

Humphries, J. 2003. Retaining Medicaid-Eligible Children in King County, Washington: A Survey Study, Thesis Presentation, March 20, 2003. Institute of Medicine. 2003. A Shared Destiny: Community Effects of Uninsurance. Washington, DC: The National Academies Press.

Kaestner, R., T. Joyce, and A. Racine. 2001. Medicaid eligibility and the incidence of ambulatory care sensitive hospitalizations for children. Social Science & Medicine 52, no. 2: 305-13.

Kasper, J. D., T. A. Giovannini, and C. Hoffman. 2000. Gaining and losing health insurance: strengthening the evidence for effects on access to care and health outcomes. Medical Care Research and Review 57, no. 3: 298-318; discussion 319-25.

Kenney, G., and J. Haley. 2001. Why Aren't More Children Enrolled in Medicaid or SCHIP? Washington, DC: Urban Institute.

Kenney, G., J. Haley and L. Dubay. 2001. How Familiar are Low-Income Parents with Medicaid and SCHIP? Washington, DC: Urban Institute.

Ku, Leighton and Donna Cohen Ross. 2002. Staying Covered: The Importance of Retaining Health Insurance Coverage for Low-Income Families. New York: The Commonwealth Fund.

Kuiper, H., G. A. Richwald, H. Rotblatt, and S. Asch. 1999. The communicable disease impact of eliminating publicly funded prenatal care for undocumented immigrants. Maternal and Child Health Journal 3, no. 1: 39-52.

Lave, J. R., C. R. Keane, C. J. Lin, E. M. Ricci, G. Amersbach, and C. P. LaVallee. 1998. Impact of a children's health insurance program on newly enrolled children. Jama 279, no. 22: 1820-5.

Levit, K., C. Smith, C. Cowan, H. Lazenby, A. Sensenig, and A. Catlin. 2003. Trends in U.S. health care spending, 2001. Health Affairs 22, no.1:154-64.

Lewit, Eugene M., Courtney Bennett, and Richard E. Behrman. 2003. Health Insurance for Children: Analysis and Recommendations. Future of Children 113, no. 1: 5-29.

Long, Sharon. 2003. Choosing Among Food, Housing and Health Insurance. Washington, DC: Urban Institute.

Mann, Cindy, David Rousseau, Rachel Garfield, Molly O'Malley. 2002. Reaching Uninsured Children through Medicaid: If You Build it Right, They Will Come. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Merlis, Mark. 2002. Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity. New York: Commonwealth Fund. Missouri Department of Social Services. 2001. Since MC+ Began. Jefferson City, Missouri.

Moore School of Business, University of South Carolina. 2003b. The Economic Impact of Lost Federal Medicaid Spending on the State of South Carolina. Division of Research, Moore School of Business, University of South Carolina. Accessed April 15, 2003. Available from http://www.dhhs.state.sc.us/pdf/medicaidimpact.pdf.

Nichols, Len, Linda Blumberg, Gregory Acs, Cori Uccello, and Jill Marsteller. 1997. Small Employers: Their Diversity and Health Insurance. Washington, DC: Urban Institute.

O'Brien, E. 2003. Employers' benefits from workers' health insurance. Milbank Quarterly 81, no. 1: 5-43.

Overpeck, Mary D. and Jonathan B. Kotch. 1995. The Effect of U.S. Children's Access to Care on Medical Attention for Injuries. American Journal of Public Health 85, no. 3: 402-4.

Perry, Michael. 2001. Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families Programs. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Perry, Michael. 2002. New York's Disaster Relief Medicaid Insights and Implications for Covering Low-Income People. Washington, DC: Kaiser Commission on Medicaid and the Uninsured and the United Hospital Fund of New York.

Perry, Michael, R. Valdez, and C. Chang. 2000. Medicaid and Children Overcoming Barriers to Enrollment. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Perryman Group. 2003. Medicaid and the Children's Health Insurance Plan: An Assessment of their Impacts on Business Activity and the Consequences of Potential Funding Reductions. Waco, TX: The Perryman Group.

Polverento, G. and G. Cline. 2002. Covering Michigan's Kids, Final Evaluation Report. Center for Advancing Community Health

Racine, A. D., R. Kaestner, T. J. Joyce, and G. J. Colman. 2001. Differential impact of recent Medicaid expansions by race and ethnicity. Pediatrics 108, no. 5: 1135-42.

Rodewald, L. E., P. G. Szilagyi, J. Holl, L. R. Shone, J. Zwanziger, and R. F. Raubertas. 1997. Health insurance for low-income working families. Effect on the provision of immunizations to preschool-age children. Archives of Pediatric and Adolescent Medicine 151, no. 8: 798-803.

Rowland, D. and J. R. Tallon, Jr. 2003. Medicaid: Lessons from a decade. Health Affairs 22, no. 1: 138-44.

Selden, T. M., J. S. Banthin, and J.W. Cohen. 1998. Medicaid's problem children: eligible but not enrolled. Health Affairs 17, no. 3:192-200.

Shuptrine, Sarah, Vicki C. Grant, and Genny G. McKenzie. 1994. Study of the Relationship of Health Coverage to Welfare Dependency. Columbia, SC: Southern Institute on Children and Families.

Shuptrine, Sarah, Vicki C. Grant, and Genny G. McKenzie. A Study of the AFDC / Medicaid Eligibility Process in the States, for the Southern Regional Project on Infant Mortality, Southern Governors Association and the Southern Legislative Conference, April 1988.

Smith, Vernon, Kathy Gifford and Rekha Ramesh, Health Management Associates and Victoria Wachino, Kaiser Commission on Medicaid and the Uninsured, for the Kaiser Commission, January 2003.

Soumerai, S. B., J. Avorn, D. Ross-Degnan, and S. Gortmaker. 1987. Payment restrictions for prescription drugs under Medicaid. Effects on therapy, cost, and equity. New England Journal of Medicine 317, no. 9: 550-6.

Soumerai, S. B., T. J. McLaughlin, D. Ross-Degnan, C. S. Casteris, and P. Bollini. 1994. Effects of a limit on Medicaid drug-reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia. New England Journal of Medicine 331, no. 10: 650-5.

Summer, Laura, Mary Brecht Carpenter, and Laura Kavanaugh. 1999. Successful Outreach Strategies: Ten Programs that Link Children to Health Services, Washington, DC: Health Resources and Services Administration, Maternal & Child Health Bureau.

Szilagyi, P. G., J. Zwanziger, L. E. Rodewald, J. L. Holl, D. B. Mukamel, S. Trafton, L. P. Shone, A. W. Dick, L. Jarrell, and R. F. Raubertas. 2000. Evaluation of a state health insurance program for low-income children: implications for state child health insurance programs. Pediatrics 105, no. 2: 363-71.

Thorpe, Kenneth E. and David Howard. 2003. Health Insurance and Spending Among Patients with Cancer. Health Affairs Web Exclusive. Accessed April 9, 2003. Available from: www.healthaffairs.org / WebExclusives / 2203Thorpe.pdf.

Wachino, Victoria. 2003. Medicaid Retreat? Budget pressures put recent state progress at risk. State Government News. January 2003.

Wolfe, Barbara L. and Steven C. Hill. 1995. The Effect of Health on the Work Effort of Single Mothers. Journal of Human Resources 30, no. 1: 42-62.

Wooldridge, Judith et al. 2003. Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program. Washington, DC: Mathematica Policy Research.

Yelowitz, Aaron S. 1995. The Medicaid Notch, Welfare Supply, and Labor Force Participation: Evidence from Eligibility Expansions. Quarterly Journal of Economics 110, no. 4: 909-39.

Zedlewski, Sheila. 2000. Family Economic Well-Being: Snapshots of America's Families. Washington, DC. Urban Institute.

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