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SCHIP Will Not Improve Quality of Kids' Health Care

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Continuing its effort to override President Bush's veto, Congress wants to expand income eligibility for the State Children's Health Insurance Program (SCHIP) into the middle class, even though the program was designed to provide health coverage to low-income children. That approach would end existing private health insurance coverage for millions of children—more so as eligibility is ratcheted up the income scale.

Overlooked in the current debate over SCHIP expansion is the impact it would have on the quality of children's health care, particularly among families who already have superior private insurance coverage. Expanding SCHIP is not the same as improving health care for America's children. In fact, SCHIP has not performed well in terms of stable coverage, access to primary care and preventive services, and the quality of care.

The Role of Medicaid. SCHIP was created in 1997 with the intention of providing health insurance coverage for uninsured children in low-income families who earned too much to qualify for Medicaid. States are given a fairly wide degree of programmatic flexibility in deciding how SCHIP works within their borders. Under current law, they can expand existing Medicaid programs, set up a separate SCHIP plan, or use a combination of the two. Nine states, plus the District of Columbia, currently have a Medicaid expansion; 18 have a separate plan; and 23 states have a combination of the two.

While such programmatic flexibility allows state officials to craft particular solutions for their individual problems, it also makes program evaluation more difficult. Although estimates of state-level SCHIP data can be gleaned from single-state reports or multi-state comparisons, these estimates are difficult to compare, because programs differ substantially from state to state in terms of eligibility levels, premiums, renewal processes, and other design attributes.

Quality of Care Under SCHIP. Despite the empirical limitations described above, the available evidence shows that SCHIP has not performed well in terms of providing high-quality care. For example:

- *Lack of Continuity in Coverage and Care.* Studies that have attempted to evaluate the coverage offered by SCHIP programs largely rely on information from current beneficiaries. Although millions of American children have health insurance through public, government-sponsored programs, some 4.4 million children who are eligible for Medicaid and an additional 1.7 million who are eligible for SCHIP remain uninsured, indicating the inability of the state programs to sign up all eligible children.[1] In fact, Medicaid-eligible children account for more than half of all uninsured children in the United States.[2]

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While much is made of the well-documented instability of employment-based coverage, the instability of public coverage is often ignored. Children enrolled in SCHIP and Medicaid, for example, often do not stay enrolled. According to a recent analysis in *Health Affairs*, a prominent journal of health policy, one-third of all uninsured children in 2006 had been enrolled in Medicaid and SCHIP in 2005; and among those uninsured who were eligible for government coverage in 2006, "at least 42 percent had been enrolled in Medicaid or SCHIP the previous year."[3]

A relatively high proportion of SCHIP enrollees drop out of the program, disrupting their health care and adding to the administrative burden of other health care systems, including clinics and hospital emergency rooms. A comparative study of SCHIP in Kansas, Oregon, New York, and Florida, for example, found unenrollment rates of roughly 20 percent within a year of enrollment.[4] Another study found that 13 percent of children enrolled in the New Jersey non-Medicaid SCHIP plans unenrolled within 9 months, and 34 percent within 18 months.[5]

While many health policy analysts and medical specialists bemoan the consequences of instability and "churning" in the employment-based market, Congress should recognize that the same phenomenon is widespread in public programs, affecting states and localities, health plans, health care providers, and consumers.[6] Data based only on current beneficiaries gives an incomplete picture of SCHIP performance. An accurate picture of SCHIP's performance must include the large number of children who unenroll from the program as well as the children who are eligible but remain uninsured. Children who have intermittent coverage have limited access to quality care and are less likely to have a regular source of care than those with stable health care coverage.

- *Poorer Access to Care.* The majority of children in the United States receive their preventive health care from private, primary-care pediatricians or family practitioners. It is therefore critical to have the participation of pediatricians in private office settings in SCHIP to ensure access to quality care. However, a detailed 2002 study published in *Pediatrics*, a professional medical journal, found state-to-state variations in the willingness of private primary care pediatricians to accept Medicaid patients. These variations were related to the level of physician payment and the administrative burden involved.[7] In addition, only two-thirds of physicians accepted all SCHIP and Medicaid patients, with office-based primary care pediatricians less likely to accept patients than those in safety net settings. Physician participation in SCHIP and Medicaid varies markedly among states, and states with

1. L. Kenney Cuttler, GM, "State Children's Health Insurance Program and Pediatrics: Background, Policy Challenges, and Role in Child Health Care Delivery," *Archives of Pediatric and Adolescent Medicine* (July 2007), 161 (7): 630–633.
2. L. Dubay, J. Guyer, C. Mann, and M. Odeh, "Medicaid at The Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward," March/April, 2007, *Health Affairs*, 26 (2): 370–381.
3. Benjamin D. Sommers, "Why Millions of Children Eligible for Medicaid and SCIP are Uninsured: Poor Retention Versus Poor Take-Up," *Health Affairs*, Web Exclusive, July 26, 2007, pp. w560–w567.
4. A. W. Dick, R. A. Allison, S. G. Haber, C. Brach, and E. Shenkman, "Consequences of States' Policies for SCHIP Disenrollment." *Health Care Financing Review* (2002), 23 (3): 65–88.
5. Jane E. Miller, Dorothy Gaboda, Joel C. Cantor, Tami M. Videon, and Yamalis Diaz, "Demographics of Disenrollment from SCHIP: Evidence from New Jersey KidCare," *Journal of Health Care for the Poor and Underserved*, February 2004, 15, (1): 113–126
6. L. Summer and C. Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies," The Commonwealth Fund, June 2006, at *www.commonwealthfund.org/publications/publications_show.htm?doc_id=376823#areaCitation.*
7. Steve Berman, Judith Dolins, Suk-fong Tang, and Beth Yudkowsky, "Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients," *Pediatrics*, 2002, 110 (2): 239-48

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the lower quartile of Medicaid payments had substantially lower physician participation rates.

- *Greater Reliance on Hospital Emergency Rooms.* Data from the Centers for Disease Control (CDC) show that Medicaid and SCHIP enrollees are twice as likely as the uninsured and four times as likely as those who have private insurance to use the emergency department for non-urgent problems. This is another indication that access to primary care for persons in public health programs is inadequate.[8] Expanding SCHIP to children at higher income levels will only add to the fiscal burden on state health care programs, making adequate physician reimbursement even more difficult and exacerbating the problem. This is especially true if, as the Congressional Budget Office (CBO) predicts, a large number of children who now have private insurance drop that coverage in favor of public programs.[9]
- *Questionable Quality of Care.* Increasing eligibility levels for SCHIP is not the same as providing better health care to children. Few studies have examined health outcomes for patients as they relate to enrollment in SCHIP. Most states have reported on at least one of four quality measures for their SCHIP programs. However, inconsistencies in measurement and reporting remain, and the four measures currently reported are limited in scope. While there is a paucity of direct data, one indication of quality of services is the level of satisfaction of recipients with the care they receive. The level of patient and family satisfaction is strongly correlated with the level of payment in the state program. This is particularly troublesome for states like New Jersey, where Medicaid fees are among the lowest in the nation and payment for child-specific services is only 31 percent of Medicare fees.[10]

A Better Policy. Instead of disrupting existing private health coverage for middle-class families, Congress should help these families keep their coverage while focusing government programs on poor children. A sound policy would involve three elements:

- *First*, reauthorize SCHIP for uninsured children in families with incomes at or below 200 percent of the federal poverty level (FPL), or $41,300 for a family of four, while improving outreach efforts to enroll eligible children who do not have private health insurance coverage.
- *Second*, provide tax relief for middle-class families with annual incomes between 200 percent and 300 percent of the FPL, or $41,300 to $61,950 for a family of four, to help them to keep or get private health insurance coverage for their children. Such a policy would reduce churning in the private insurance market, enhance portability of coverage, and secure greater continuity of care.
- *Third*, provide incentives for the states to find more efficient ways of using existing federal and state funds to increase insurance coverage.[11] Such a policy is embodied in The More Children, More Choices Act of 2007, sponsored by Sens. Mel Martinez (R–FL) and George Voinovich (R–OH) in the Senate and Reps. Marilyn Musgrave (R–CO) and Tom Price (R–GA) in the House of Representatives.[12]

8. Linda F. McCaig and Eric W. Nawar, "National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary," Centers for Disease Control and Prevention Advance Data from Vital and Health Statistics No. 372, June 23, 2006, at *www.cdc.gov/nchs/data/ad/ad372.pdf* (May 10, 2007).
9. For a detailed discussion of the phenomenon of "crowd-out," see Paul L. Winfree and Greg D'Angelo, "SCHIP and 'Crowd-Out': The High Cost of Expanding Eligibility," Heritage Foundation, *WebMemo* No. 1627, September 20, 2007, at *www.heritage.org/Research/HealthCare/wm1627.cfm.*
10. Kaiser Family Foundation, State Health Facts.org, at *www.statehealthfacts.org/comparetable.jsp?ind=195&cat=4.*
11. For a detailed discussion of child health care reform, see Stuart M. Butler, Ph.D., and Nina Owcharenko, "SCHIP Plus a Tax Credit: A Compromise Health Insurance Plan for Kids," Heritage Foundation *WebMemo* No. 1652, October 1, 2007, at *www.heritage.org/Research/HealthCare/wm1652.cfm.*
12. For a discussion of this approach, see Robert E. Moffit, Ph.D., "The More Children, More Choices Act of 2007: Middle-Class Tax Relief for Families with Kids," Heritage Foundation *WebMemo* No. 1681, October 29, 2007, at *www.heritage.org/Research/HealthCare/wm1681.cfm.*

Conclusion. The available evidence shows that SCHIP has not performed well in terms of health care coverage, access to care, and quality of services. Congress should be aware of the hazards of disrupting the superior private health coverage of millions of American families and should instead focus on helping poor families with children, stabilizing and expanding the coverage of those who have insurance through the private sector, and improving the quality of health care for all children in America.

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