

Addressing the Problem of Uninsured-but-eligible Children: A Policy Approach

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INTRODUCTION

The issue of uninsured and underinsured children remains serious. Data from the 2006 Kids Inpatient Database of the Agency of Healthcare Quality and Research suggest that children who lack insurance are at a greater risk to die during inpatient stays than those who have private insurance.¹ This association is consistent with numerous other studies, which demonstrate that uninsured children have reduced access to and lower utilization of basic medical services.^{2,3} The solution is to provide health insurance to these children.

Certainly, the infrastructure to do so is in place. Government-run programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), have increased the coverage of children over the past decade. Furthermore, the role of these public insurance options in filling the gaps of private insurance coverage has increased; expansions and redefinitions have increased the percentage of children covered by public insurance from 21.3% in 1996 to 32.8% in 2007.⁴ However, encouraging as this increase might appear, the trends discount that the total number of uninsured children remains significant - more than 7 million in 2008.⁵ Even more troubling is that nearly 75% of these uninsured children are eligible for either SCHIP or Medicaid, yet remain unenrolled.⁶

Increasing coverage for these uninsured-but-eligible (UBE) children remains an important and practicable goal. We shall discuss a range of options to tackle the administrative and structural barriers to enrollment propose solutions in this commentary.

IMPROVING RETENTION AND TAKE-UP

The numerous reasons for non-enrollment in public programs such as SCHIP and Medicaid include distrust of and unfamiliarity with the programs, the complexity of navigating the system and required paperwork, unawareness of the programs' existence, and unaccommodating enrollment rules.⁷ The preponderance of UBE children has been attributed to two main factors: poor retention leading to disenrollment, and poor initial take-up.

In 2006, a third of uninsured children nationwide were shown to be enrolled in either Medicaid or SCHIP the previous year, indicating that retention was a major issue.⁸ One factor inhibiting retention is the renewal process. States that switched toward a process requiring proof of qualification from the applicant have experienced disenrollment rates nearly ten times greater than those without such requirement.⁹ One possible solution to this is the suggestion of pre-printed forms with patient information from the previous year's enrollment.¹⁴ Additionally, we propose that state employment data be used to identify families with children who could be at risk being uninsured or disenrollment and that notices be sent prior to the renewal period.

Tied with the problem of poor retention due to renewal is the increasing frequency of renewal periods, which also leads to disenrollment.¹⁰ Several states, including California, faced with impending limitations on strained SCHIP budgets, have proposed more frequent re-enrollment periods, which increase the risk of foregone deadlines and subsequent disenrollment from SCHIP.¹⁰ Hence, we propose that periods between re-enrollment be fixed at one year without any pause of coverage. Furthermore, states should institute a fixed reenrollment date for all SCHIP beneficiaries. Marketing this date to beneficiaries would ensure that any ensuing confusion is diminished. Beneficiaries would have a minimum of 12 months after the start of coverage without needing to reenroll. In case beneficiaries enroll fewer than 12 months before the fixed reenrollment date, they can wait until the next reenrollment period before needing to reenroll.

In order to increase the take-up of eligible children who are not yet in the system, we propose that states and the federal government invest in community-based efforts towards increasing awareness of public programs among potential beneficiaries. "Covering Kids and Families," a campaign instituted in 2006 by the Robert Wood Johnson Foundation, used television ads, phone hotlines, and community events to raise awareness of public coverage.¹¹ The federal government should provide grants to encourage these types of community awareness efforts on a national scale.

STREAMLINING THE SYSTEM

In establishing SCHIP, the Balanced Budget Act of 1997 allowed three options for the creation of public programs for children: a targeted expansion of Medicaid, the creation of a separate SCHIP program, and varying combinations of both.¹² With states given the freedom to choose, an amalgam of SCHIP programs has arisen with various degrees of federal-state partnerships, distinct funding and reimbursement structures, and a multitude of eligibility requirements. For example, SCHIP income eligibility in Idaho is 185% of the federal poverty level, while in Pennsylvania, eligibility for the same program is 300% of the FPL.¹³ Furthermore, withdrawal rates among children previously enrolled in either Medicaid or SCHIP have been shown to be 45% higher in states that run the two programs separately.¹⁴

We propose that federal and state governments prepare to combine Medicaid for children and SCHIP under one administrative unit. Streamlining the programs would help cut the administrative costs of running them separately and incorporate shared resources, such as databases of beneficiaries. Furthermore, running joint applications and reenrollment requests for Medicaid and SCHIP, already done in most states, would

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reduce much lingering confusion among applicants. Computer systems can be configured to automatically sort the applicant toward the appropriate program.

PRIMARY CARE AND REIMBURSEMENT REFORM

We also propose to reform the reimbursement mechanisms of SCHIP to favor pediatricians and other primary care physicians. Primary care and preventive medicine play a crucial role in not only increasing the overall wellness of the children but also reducing costly avoidable pediatric hospitalizations.¹⁵ We urge that states be allowed to explore creative means of SCHIP reimbursement, including capitation methods like those employed in managed care that favor pediatricians and primary care providers. The federal government should provide oversight and advice but allow states flexibility in experimenting with new reimbursement structures. Moreover, states can mandate periodical primary care visits for children under SCHIP. States can offer additional loan forgiveness for medical school graduates who become primary care practitioners, similar to those in place under various National Health Service Corps programs.

We believe that states should be the main experimenters in reimbursement reform, as they have greater leverage over local SCHIP policies and can act as laboratories for primary care and insurance reform.¹⁶ We also believe that states' experimentation with reimbursement would not interfere with streamlining or assimilation, as states' autonomy is still maintained under our proposals and the states can explore innovative policies while reorganizing their administration of public programs. Overall, primary care reform should accompany SCHIP reform, especially since the primary care system, including the pediatricians, will need to handle effectively and efficiently the additional patients after any increased coverage.

FUNDING

Successful implementation of our plan will no doubt require a great amount of financial capital. However, it is important to note that the proposed changes do not call for a structural or fiscal expansion of the SCHIP or Medicaid program. Rather, we want to make the existing programs more efficient. We strongly believe that our plan will use more effectively the money already allocated to SCHIP by the Congressional Budget Office, and would not require a significant amount of additional funding.

In particular, savings in the system will arise from the diminished administrative costs of redundant paperwork and processing. With combined Medicaid and SCHIP administration, there exists the potential for more savings due to economies of scale. Furthermore, increased coverage of children who previously would have been uninsured will likely reduce their reliance on the emergency department as a source of primary care and thus, many preventable hospitalizations. Providing insurance to currently uninsured children has been shown to be cost-effective, with up to an additional \$36,330 per Quality-Adjusted-Life-Year.¹⁷ On a scale of millions, this would amount to significant cost savings.

CONCLUSION

The subject of providing health insurance for children has been debated for decades, even with the February 2009 passage

of a SCHIP expansion bill. Despite the political wrangling, it does appear that in the minds of voters and in the current political environment, further SCHIP reform is politically feasible. In Washington, SCHIP expansion and reform enjoy unusual bipartisan support.¹⁸ According to Mark Peterson of the University of Pennsylvania, the early years of the Obama presidency are a historic moment conducive toward reform, especially in health care. Obama enjoys much political support and inherits a strong mandate, despite the condition of the economy.¹⁹ Furthermore, Peterson notes that primary care reform, like children's health insurance, generally has bipartisan support, which strengthens the feasibility of our plan, since we target both systems. Combined with our dual emphasis on federal oversight and states' experimentation, our plan will be agreeable for both political parties and many constituencies. For example, elements of our plan can be used to build bipartisan support for or add to the current health care reform proposals. Even outside the current debate, the issue of uninsured-but-eligible children deserves its own attention, and in our opinion, holds high stakes for America's health care system and the lives of its future generations.

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