Poverty and Child Health: SCHIP policy brief

Executive Summary

Poverty in America is a growing concern as one in five children grow up in poverty. Poverty leads to negative impacts on a child’s life such as negative education and cognitive outcomes, social and emotional development, economic outcomes as adults, and health outcomes. Children in poverty are more prevalent for negative health outcomes from birth. Children living in poverty are also more likely to suffer chronic health problems such as asthma or anemia. Children in poverty are disproportionately exposed to risk factors, including environmental toxins, inadequate nutritious, maternal depression, parental substance abuse, trauma and abuse, violent crime, divorce, low quality child care, lead exposure and other health hazards (Moore et. al, 2009). Lack of insurance coverage was found to be a much more important risk factor for incomplete immunization coverage than just poverty. Lack of health insurance leads to decreased access to care and less preventative care being utilized which would include immunizations (Becton et. al, 2008). Children in poor households also have higher rates of chronic conditions (Magnuson & Votruba-Drzal, 2009).

State Children’s Health Insurance Program (SCHIP) was developed and implemented to help address the health concerns that children, who live below the 200 percent poverty line, face due to lack of insurance coverage. The SCHIP program was developed in 1997 and reauthorized twice since that time to continue to provide insurance to millions of children who did not qualify for Medicaid and could not afford private health insurance. Prior to the development of SCHIP, only 11 states provided medical coverage for children in families up to 185 percent of the federal poverty level, it now plays an important role in providing medical insurance for millions of children in America.

Background

SCHIP legislation can be traced back to 1996 when the State of Massachusetts developed a children’s health insurance plan that year. Senator Ted Kennedy (D, MA) advocated for this type of program to be implemented nationally to provide health care coverage for children of the working poor. He introduced a bill in October 1996 that would provide health care coverage for children in poverty. This health care coverage would be funded by a cigarette tax increase. Hillary Clinton, First Lady, was also passionate about expanding health care to children at this time. President Clinton introduced this idea to the nation during his 1997 State of the Union Address. He proposed a new health initiative for children, providing medical coverage for up to 5 million children in American (Working to Strengthen SCHIP, 2008). Senator Orin Hatch (R, UT) co-sponsored this bill introduced by Senator Ted Kennedy. This bill did not pass, as it did comply with the existing balanced budget agreement that had been made between Congress and the White House. The bill was reintroduced in June 1997. Organizations such as the Children’s Defense Fund and the Girl Scouts of America advocated for this bill to be passed.

SCHIP was passed and signed into law by President Bill Clinton on August 5, 1997 (Working to Strengthen SCHIP, 2008). SCHIP is part of the Balanced Budget Act of 1997 (KFF, 2009). It allocated around $20 billion over 10 years to help states insure children in low-
income families receive medical coverage when they were ineligible for Medicaid and could not afford private insurance. In the SCHIP program, states had the option of providing the coverage through Medicaid or a separate program or the combination of the two. According to the Commonwealth Fund, SCHIP is like the Medicaid program as in state payments for child health assistance under SCHIP qualify for federal matching payments. It is estimated that the program is funded 70% by the federal government and 30% by the states (2007). The SCHIP program expanded access of public healthcare to many American children who qualified but is limited to those children who fall below 200 percent of the federal poverty line.

Since SCHIP was created as a 10-year program, to continue past 2007, it needed to be reauthorized. HR.976 and HR3963 were passed by Congress but vetoed by President George W. Bush. In 2008, President Bush signed HR3584 into law, which expanded SCHIP through March 2009 (Covey et al., 2008). The House approved a 4.5-year extension of SCHIP by a vote of 289 to 139 in January 2009 and President Barak Obama signed it into law on February 4, 2009 (Inglehart, 2009). Republicans opposed SCHIP back in 1997 and again in 2009 as the proposals included a federal cigarette tax increase to fund the program (Inglehart, 2009).

Data

The SCHIP program has improved access to public health insurance for eligible children; however, it is only successful if individuals who are eligible enroll are knowledgeable of the program and apply. In 2008, 4.7 million children (65% of the uninsured) were eligible for but not enrolled in Medicaid or CHIP due to individuals not being aware of the program or the difficulty in applying for it (Morrissey, 2012). In order to address this issue, incentives were added in the 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) if states could boost enrollment in public health insurance for children. More than half of the 50 states chose to increase coverage through outreach programs and a more simplified enrollment process (Morrissey, 2012). Uninsured rates among children have declined by 7% from 1997 to 2012 (see chart below).

![Uninsured Rates Among Nonelderly Adults and Children, 1997-2012](image)

Medicaid and SCHIP plays a significant role in the lives of children of color and low-income children. These programs have helped reduce racial and ethnic disparities in health care coverage. CHIP and Medicaid cover more than half of Hispanic children (52%) and Black
children (56%), compared to about one-quarter of White (26%) and Asian (25%) children (Paradise, 2014). 33% of racial minorities (Hispanic, Black, and Asian) were uninsured in the year 2012 (see below chart).

Without this option for health insurance, millions of children would not have access to adequate medical care. Access to medical care provided by Medicaid and SCHIP is comparable to private insurance. Many Medicaid and SCHIP programs are served through Managed care plans and provide preventative care as required by the ACA, as well as physician and hospital benefits, vision and dental care, outpatient and inpatient mental health service, and therapies such as physical, occupational, speech and language.

Recommendations

Currently, SCHIP is only funded through fiscal year 2015 so a reauthorization will soon need to be considered. The implementation of SCHIP has improved health care access for children of the working poor in America and has improved the health outcome of these children through affordable public health care. Health outcomes for children enrolled in the program have improved which will have a long lasting effect on their health as adults. While there has been limitations of the program, it has been successful in providing services to the children that are eligible.
If SCHIP is not reauthorized, million of children will soon face barriers to medical health coverage as they will fall in the gap between being eligible for medicaid coverage and being able to afford coverage through a marketplace or an employer. Parents may not be able to receive tax credits for medical coverage through a marketplace if they have access of healthcare through an employer even if it is not “affordable” and could prevent their ability to afford such coverage. Currently, SCHIP programs are matched at higher rates than medicaid which results in a higher cost of the program but there is a limit to how much funding states received as it is capped. SCHIP is currently funded by a 70% match wher as Medicaid is A concern for reauthorization would be the funding necessary for it to continue which would require additional federal funds. The offset to this cost is that if it is not passed, medicaid costs would increase.

Further steps need to be taken to increase awareness of the program availability, reduce the eligibility waiting period, streamline the enrollment process for simplicity, and the social stigma of receiving state provided medical insurance in order to increase the number of children enrolled in the program who are eligible. Another barrier with this program is the availability of providers to accept new patients which hinders children’s access to care. Access to dental care is very difficult for children who receive medicaid or SCHIP coverage as many providers do not accept that form of insurance. Incentives could be made in the new reauthorization to combat this issue

Resources


