

AN EXPLORATION OF MEDICAID/SCHIP EXPANSION IMPLEMENTATION AND CHILD MORTALITY

A CASE STUDY OF FOUR STATES

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OVERVIEW

Numerous studies have examined policy expansions made to Medicaid and the State Children's Health Insurance Program (SCHIP) to increase enrollment among low-income children and pregnant women. Previous research has well documented that Medicaid expansions for pregnant women and infants are effective in improving access to care and health outcomes (Howell, 2001; Dubay et al. 2001; Currie et al. 1994; Baldwin et al, 1998). However, the impacts of coverage expansions on the health outcomes of children are not as well known. One factor that may contribute to the insurance status of children is the socioeconomic status of the child's family. According to the Kaiser Family Foundation in 2007, 36 percent of the United States population is considered "low-income" - falling 200 percent of the federal poverty line¹. The Kaiser Family

Foundation also notes that in 2006-2007, 23 percent of the nation's children age 18 and under are living in poverty (below 100 percent FPL). Likewise, in 2006-2007 about 11 percent of children were uninsured. Of these, most were considered low-income. Expansion of health care coverage to children is widely recognized as a policy priority and as a result remains a focus of policy initiatives at the national- and state- level.

This study examines national- and state-level Medicaid/ SCHIP expansions over 20 years from 1985-2005. I explore a possible association between these expansions and childhood mortality trends- an ultimate indicator of health outcomes. This research project investigates: (1) whether increases in Medicaid expansions at the federal level influence national childhood mortality rates, and (2) whether state-level Medicaid/SCHIP expansions are associated with a decline in child mortality rates

¹ 2007 HHS Poverty Guidelines state that persons in a family or household of three in the 48 contiguous states and the District of Columbia makes at or below \$17,170.

within states. The analysis was performed by tracking policy expansions and childhood mortality trends over a twenty-year period using available literature, and the Multiple Cause of Death Mortality dataset from the National Vital Statistics System.

INTRODUCTION

Since its inception during the Great Society era, Medicaid has increased access to health services for millions of low-income children. Medicaid began in 1965 as an individual entitlement program to help cover low-income individuals who had no health insurance or inadequate health insurance. Medicaid now is the largest public health insurance provider in the US, insuring 26.6 percent of all children in 2005-2006. In fact, over half of all Medicaid enrollees are children (Kaiser Family Foundation, 2007). Today, expanding health insurance for low-income children remains a top health policy priority in the United States.

Initially, Medicaid primarily served people who qualified for the Aid to Families with Dependent Children (AFDC) cash assistance program. The income eligibility cutoffs for the program typically were set below the poverty line in many states (J. Currie et. al. 2005). The link between Medicaid and AFDC was weakened in the late 1980s. During this period, the federal government extended Medicaid policy options to states and passed mandates “specifying eligibility criteria based on income in relation to federal poverty guidelines” (Klemm, 2000). For infants, children, and pregnant women, this legislation introduced Medicaid income-eligibility levels that were significantly higher than most state AFDC payment levels. These new Medicaid income eligibility levels were indexed to the cost of living – a departure from the policy under AFDC.

The Deficit Reduction Act (DEFRA) of 1984 required states to cover children² up to age 5 in

families whose household income met state AFDC and resource standards. The DEFRA also required states to cover first-time pregnant women, and pregnant women living in 2-parent unemployed families that met state AFDC income and resource standards. Expanding upon requirements set by the DEFRA, the Omnibus Reconciliation Act of 1986 (OBRA ‘86) allowed states to cover pregnant women and young children up to age 5 in families with household incomes at or below 100 percent of federal poverty level. More options were provided to states with the Omnibus Reconciliation Act of 1987 (OBRA ‘87), which allowed states to cover pregnant women and infants in families with household incomes at or below 185 percent of federal poverty level. Notably, OBRA 1987 also allowed states to cover children up to age 8 in families below 100 percent of poverty. The Medicare Catastrophic Coverage Act of 1988 (MCCA) then converted most of these coverage expansion options for states into mandates (Klemm, 2000). The Omnibus Reconciliation Act of 1989 (OBRA ‘89) mandated states to cover children under the age 6, along with pregnant women, in families at or below 133 percent of poverty. The Omnibus Reconciliation Act of 1990 (OBRA ‘90), required states to phase in over time coverage for children ages 6 through 18 in families with incomes at or below 100 percent of poverty by 2002.

Two key pieces of legislation passed in the mid-late 1990s, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the Balanced Budget Act of 1997 (BBA), significantly influenced the direction of Medicaid. PRWORA (1996) successfully de-linked eligibility for cash assistance from Medicaid by replacing the AFDC program with a block grant program known as the Temporary Assistance for Needy Families (TANF). PRWORA also established “Section 1931”, a family coverage category that required states to cover families who were already insured under the July 1996 AFDC standards. In addition, PROWRA allowed higher income eligibility thresholds.

² born after September 30, 1983

Table 1

50 States/DC Mortality Rates Quintiles (1987)		
Quintile	State	Mortality Rate Range per 100,00 children
1	RI, CT, HI, MA, ND, WI, NE, VT, NH, MN, ME	29.4 - 37.5
2	NJ, NY, PA, VA, SD, OH, MD, IA, DC, IL	37.6 - 39.8
3	OR, KY, CO, UT, MO, IN, WV, CA, WA, NV	39.9 - 44.3
4	ID, KS, MT, NC, MI, TX, SC, GA, DE, AL	44.3- 50.3
5	TN, LA, FL, OK, AR, AZ, MS, WY, NM, AK	50.4 – 65.6

However, despite the goals set forth by PRWORA, there has been evidence that many eligible families did not retain their Medicaid benefits (Klemm, 2000; Garrett et. al. 2000). In 1997, the Balanced Budget Act established the State Children’s Health Insurance Program (SCHIP), a block grant program through which states could provide health insurance coverage for uninsured, low-income children who were ineligible for Medicaid. Under the introduction of SCHIP, states were presented with two program options: (1) implement SCHIP expansion through their Medicaid programs, or (2) create a separate SCHIP program through Title XXI of the Social Security Act (Kaiser Commission on Medicaid and the Uninsured, 2008; Klemm, 2000).

Additionally, national initiatives by philanthropic and advocacy organizations that work through state and local coalitions to increase public health among the uninsured, low-income children and adults (e.g. Covering Kids and Families) also contributed to an increase in enrollment. These initiatives helped by simplifying Medicaid/SCHIP enrollment and renewal processes, conducting outreach efforts, and coordinating existing health care coverage programs (Walls et. al. 2006). National initiatives, together with Medicaid/SCHIP, have helped significantly reduce the number of low income uninsured children in the US.

Many studies investigate the influence of Medicaid expansions on pregnant women, infants, and adults. However, there has been limited research on the association between Medicaid expansions and childhood health outcomes. Children are dependent on their parents and the environment surrounding them, and have little to no control over their circumstances. For this reason, it is important to extend health coverage to children who would otherwise go uninsured, and to understand the extent to which health policy influences child health outcomes. Such understanding provides insight into the successes, as well as the shortcomings of government health programs. Medicaid/SCHIP policies determine eligibility requirements that influence program enrollment and potentially increased access to health care services, which may lead to better health outcomes. Therefore, we posit that as Medicaid expansions have been implemented, child mortality rates have decreased over time.

APPROACH/METHODS

The complexity of the Medicaid program is most profound when analyzing the varied state

eligibility requirements, enrollment procedures, and coverage benefits. This case study analyzes four

Table 2

Four Selected States & Association Between Child Mortality Rates and Expansion Rate		
	Early Adopters of Medicaid Expansions	Late Adopters of Medicaid Expansions
High Child Mortality	AR	OK
Low Child Mortality	RI	NH

states selected based on statewide mortality rates for children ages 1 to 18 years³ and estimated rates of Medicaid/SCHIP coverage expansion implementation. This analysis was then compared with a timeline of federal policy changes to determine any association between the mortality trends and Medicaid expansions. The selection process for choosing the four states was accomplished through use of both expert opinion and quantitative methods. I calculated child mortality rates for all 50 states and the District of Columbia using National Vital Statistics data, obtained for the National Bureau of Economic Research website (<http://www.nber.org/data/multicause.html>) and Census Bureau Population archives data (<http://www.census.gov/popest/archives>). Child death counts from 1985 to 2005⁴ were divided by the total child population total, ⁵ in the given year and then multiplied by 100,000. State childhood mortality rates for all causes of death were then divided into quintiles (see Table 1).

³ Throughout this paper, children will refer to persons between the ages of 1 and 18 years. It does not include infants. Infants were excluded from this study because they tend to have higher mortality rates than most other ages.

⁴ Data source: Vital Statistics NCHS Multiple Cause of Death Data

⁵ Data Source: Census Bureau Population Archives

To estimate the rate at which states expanded their Medicaid/SCHIP program, I use income thresholds, upper age limits, and effective dates for coverage expansions for children (Hill, 1998). An ordered, simultaneous sort of data then allowed for categorization of states based on (in order of significance):

1. size of expansion(s) in terms of child age (the difference in age of children covered by the expansion);
2. expansion cutoff difference (the increase of upper income eligibility threshold in terms of percent federal poverty level that was facilitated by the expansion); and
3. the year in which the expansion occurred.

I cross-referenced these three criteria with state child mortality rate rankings to yield four states representing “high” and “low” child mortality levels, and “early adopters” and “late adopters” of Medicaid/SCHIP expansions from 1985 to 1991 (see Table 2). I used the period between 1985 and 1991 because it provided a frame within which the first nationwide Medicaid expansions began to occur.

Upon selection of the four states, I obtained mortality rates – excluding any external causes of death – for each state for each year from 1985 to 2004⁶. External causes of death are categorized by the International Statistical Classification of Diseases and Related Health Problems ICD -9 and ICD-10 as non-disease related deaths such as unintentional injuries, accidents, suicide, and homicide⁷. I exclude external causes of death from all mortality rates in this analysis as it is thought that internal causes (such as infectious diseases), have a

⁶ All causes of death were used only for the selection process of the four states used in this study and for benchmarking mortality rates.

⁷ The ICD- 9 codes used in the analysis for internal causes of death were 001-799 and the ICD-10 codes used in the analysis were A16-R99.

Table 3

1986 & 2003 Percent Change of Internal Causes of Death for the US and Four Case Study States			
State	Internal Causes of Death (per 100,000 children)		
	1986	2003	% Change
Total U.S.	16.8	12.2	-27.4
Arkansas	17.4	15.6	-10.3
Oklahoma	16.2	13.7	-15.4
New Hampshire	14.0	8.1	-42.1
Rhode Island	13.0	9.5	-26.9

more direct connection with the health care- seeking practices and services that are the focus of this paper.

There were a total of 10,481 mortality rate observations for children. Since mortality rates can be statistically unstable, I calculated a three-year rolling average for each state, resulting in the exclusion of 1985 and 2004 as years shown in the trends below (see Table 3). I then conducted four state case studies to better understand individual state initiatives and mandates for Medicaid/SCHIP health coverage expansion.

NATIONAL-LEVEL CHILD MORTALITY TRENDS

From 1985 to 2004, child mortality rates have steadily decreased from 16 per 100,000 children in 1985 to 11 per 100,000 in 2004 (see Figure 1). This decline in mortality rates may be associated with the series of Medicaid expansions mandated by the federal government from 1984 to 1990. These federal mandates both required and allowed states to expand their Medicaid programs. Over the same time period, there was a 27.4 percent decrease in child mortality rates due to internal causes of death in the United States.

Arkansas and Oklahoma – states with high child mortality rates at baseline – had a relatively low decrease in child mortality rates when compared

with New Hampshire and Rhode Island – the two states with low child mortality rates at baseline. From 1986 to 2003, Arkansas, an early adopter of Medicaid, only experienced a 10.3 percent decline in mortality rates overtime, whereas Rhode Island, also an early adopter of Medicaid expansions, had a 26.9 percent decrease in child mortality rates overtime.

When comparing the states that adopted Medicaid expansions later, Oklahoma had only a 15.4 percent decrease in child mortality over time. New Hampshire experienced the largest decrease in mortality among the four states studied, with a 42.1 percent decline in child mortality rates (Table 3).

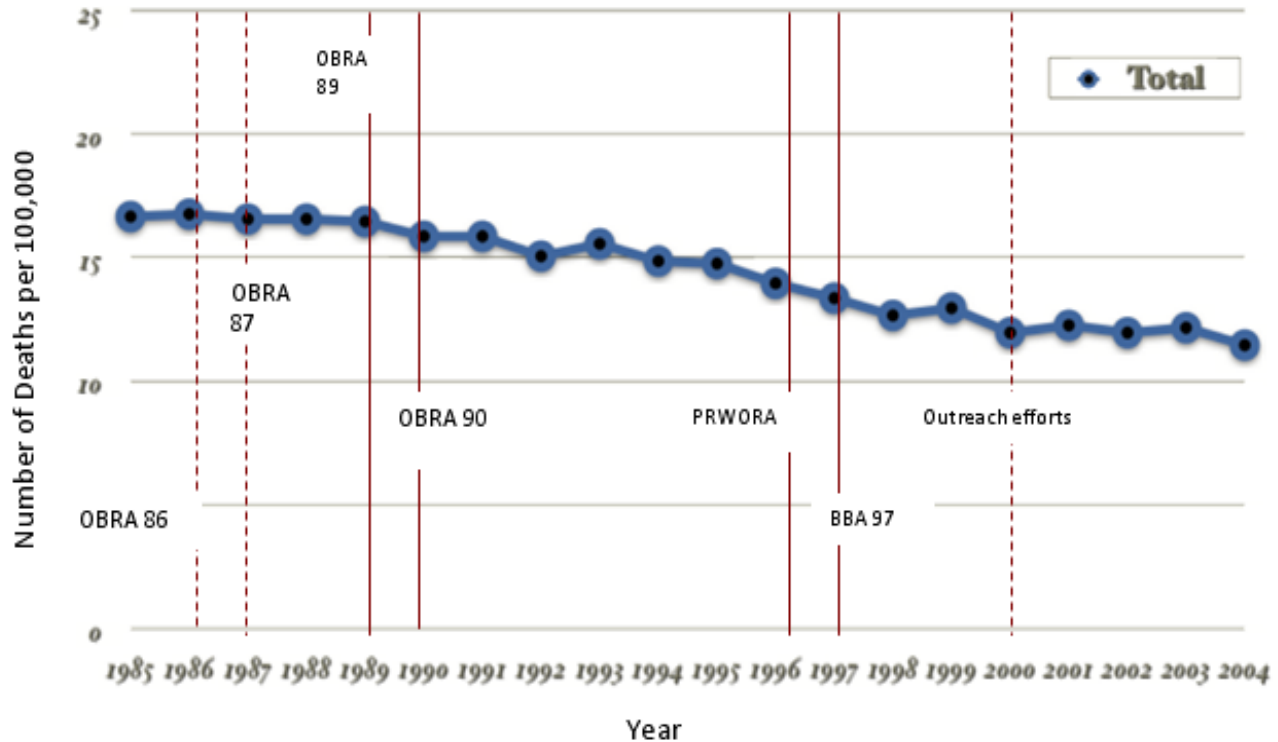
STATE-LEVEL CHILD MORTALITY TRENDS

The state child mortality rates for internal causes of death, and state Medicaid/SCHIP programs were examined for Arkansas, New Hampshire, Rhode Island, and Oklahoma. An overall decrease in child mortality rates was observed among states with low baseline child mortality rates (Rhode Island and New Hampshire) and with high baseline child mortality rates (Oklahoma and Arkansas). This decrease in mortality rates over time may be associated with national-level and/or state-level Medicaid/SCHIP expansion policies. However, this observed decrease among mortality rates may also be associated with the implementation of related policies, environmental changes, and other public health interventions that occurred during the 20-year time frame. I also examine eligibility indicators, such as 12-month continuous eligibility, self-declaration of income, and waiting period in order to understand what type of expansions each state made (see Table 4).

RHODE ISLAND

In 2006, Rhode Island had a child poverty rate of 19 percent. Among the states included in this study, Rhode Island – an “early adopter” of Medicaid expansions – had the lowest baseline for childhood

Figure 1: United States National Mortality Rates



mortality rate in 1985, with 29.4 per 100,000 deaths for children for all causes of death and 13.0 per 100,000 deaths for children excluding external causes of death. Rhode Island continued to exhibit a downward trend in childhood mortality rates until 1988. After 1998, mortality rates appeared to increase significantly and peaked in 1993 with an all-time high child of 15.9 per 100,000 children. From 1994 forward, Rhode Island’s child mortality rate declined and continued to do so through 2003, leveling off at a mortality rate of 9.5 per 100,000 children.

In 1994, the state of Rhode Island implemented RItE Care as a Medicaid expansion under the Section 1115 Medicaid Waiver. As of 2005, the program covers children from birth up to age 19, as well as pregnant women with incomes up to 250 percent of poverty. (RI Department of Human Services, March 2008) Rhode Island offers a health insurance premium assistance program called RItE Share, which began in 2001, that assists families in obtaining health insurance coverage through their employer (or spouse’s employer). (RIHS March 2008) RItE Care has a federal funding match rate of

68.8 percent, an upper income eligibility limit of 250 percent of poverty, and does not support presumptive eligibility or self-declaration of income for applicants (Table 4). January 1999 marked the beginning of Rhode Island’s outreach campaign (Brewster, 2001). Rhode Island simplified the Medicaid application process by offering a continuous eligibility guarantee for 12 months in order to reduce the likelihood that an enrolled child would have breaks in coverage or be dropped from the program for failure to complete paperwork. Additionally, reapplication information is sent out to families for updates in enrollment information 60 days in advance of the coverage renewal date. Implementation of Rhode Island’s comprehensive Medicaid outreach, enrollment, and retention policies may be associated with the state’s success in decreasing child mortality.

NEW HAMPSHIRE

Similar to Rhode Island, New Hampshire also experienced a significant decline in child mortality from 1986 to 2003. New Hampshire’s 1986 child mortality rate was slightly higher than Rhode Island at 14.0 per 100,000 deaths, and 2003 child mortality

rate was slightly lower at 8.1 per 100,000 children. In 2006, New Hampshire had a child poverty rate of approximately 9 percent.

New Hampshire has a combined Medicaid/SCHIP program that receives a federal funding match rate of 65 percent. In addition to the OBRA federal mandates, New Hampshire made progress at the state-level in expanding coverage for children. In 1989, a state mandate created a new coverage group, which provided home care for children with severe disabilities. In 1991, New Hampshire then took the initiative to provide medical assistance to children under the age of 22 who reside in designated receiving facilities (NH Medicaid Annual Report SFY 2007). In 1994,

New Hampshire implemented three key state mandates and initiatives, one of which increased income limits for poor pregnant women and children⁸ to 170 percent of poverty. That same year, New Hampshire modified their application process by introducing a shortened application form, mandated an increase in income limits for poverty

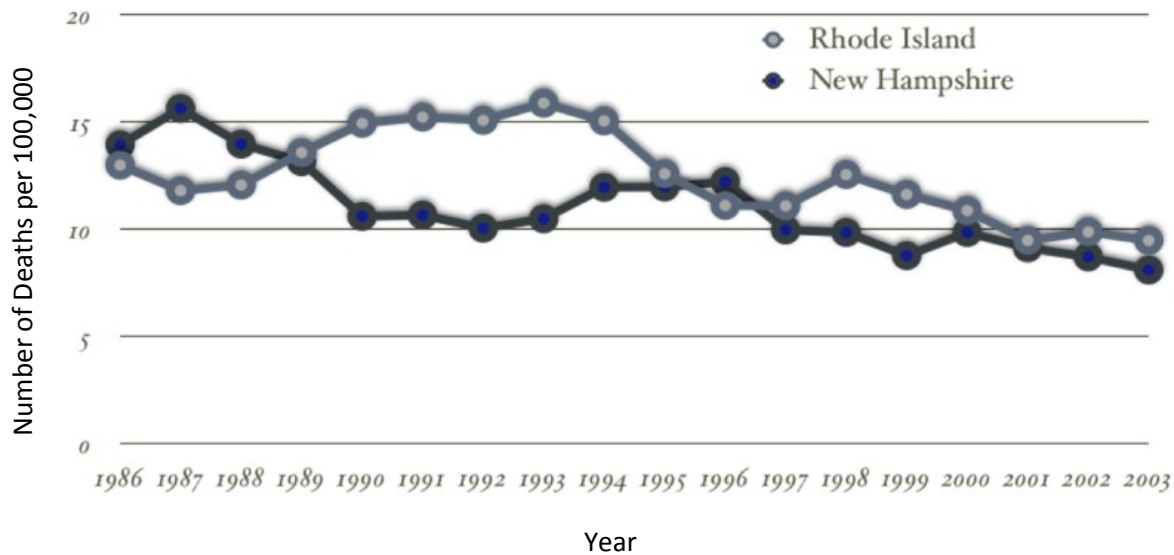
level groups⁹ to 185 percent of poverty, and expanded health coverage for children through age 18. Additionally, New Hampshire underwent a conversion from “full-month” Medicaid coverage to date-specific eligibility, wherein “if the individual is eligible at anytime during the month, the individual is eligible for the month” (NHMAR SFY 2007).

New Hampshire, along with Rhode Island and 19 other states set income eligibility for Medicaid/SCHIP coverage at a level greater than 200 percent of poverty. This group of states also set an upper income eligibility limit at 300 percent of poverty (Hall, 2005b). In 2001, the state also implemented outreach, enrollment, and retention programs such as eligibility re-determination every 12 months, and distribution of applications and brochures in public schools (see Table 4)(Ward, et al., 2007).

ARKANSAS

Between 1986 and 2003, Arkansas’ child mortality rates declined slightly, from 17.4 per 100,000

Figure 2: States with Low Baseline Child (ages 1-18) Mortality Rates



⁸ This refers to children in poverty born after September 30, 1983.

⁹ Poverty level groups include pregnant women, children and disabled persons living under the poverty line.

children to 15.6 per 100,000 children. Arkansas, a state with 28 percent of its children living in poverty in 2006, is considered an “early adopter” of Medicaid expansions. The state’s early actions and efforts to expand health coverage for children may be associated with the observed decline in mortality rates over time. In September 1997, ARKids First was implemented as a Medicaid expansion, extending health care coverage to uninsured children up to 200 percent of poverty. Arkansas then adopted a modest SCHIP-funded Medicaid expansion program in 1998, which extended full Medicaid coverage to a small cohort of teenage children who were at or below 100 percent of FPL and not already included in federal mandatory populations. In 2000, the state also adopted a series of policies designed to increase coordination between its public health insurance programs in effort to further de-stigmatize Medicaid for children. Thus, the ARKids First program expanded to include traditional Medicaid (AACF 2007).

As a result of ARKids, SCHIP, and other state-level initiatives, “Arkansas is now considered a national leader in reducing its ranks of uninsured children, from over 20 percent in 1997 to 10 percent today, with nearly 65,000 Arkansas children receiving coverage through SCHIP.” (AACF 2007). Likewise,

Arkansas has become one of 23 states with a 200 percent FPL upper eligibility threshold for health coverage (Hall, 2005a). The state’s observed success in increasing eligibility and enrollment is due to numerous outreach, enrollment, and retention efforts, such the introduction of mail-in applications, self-declaration of income and assets, removal of the asset test requirement, and outreach and campaigning with school administrators, school nurses, and hospitals to enroll children, as well as media campaigns (Hall, 2005a)(Table 4).

OKLAHOMA

In 2006, 26 percent of Oklahoma’s children lived in poverty. From 1985 to 2004, there was a decrease in Oklahoma childhood mortality rates, from about 16.2 per 100,000 child deaths to about 13.7 per 100,000 child deaths. In 1993, Oklahoma passed two bills that allowed the state to convert its fee-for-service” Medicaid program to a managed care delivery system. (OHCA 2005) In 1995, Oklahoma implemented SoonerCare Plus, a Medicaid managed care program to provide an “enhanced” benefits package to uninsured children. In 1996, Oklahoma received approval of a Medicaid expansion waiver that allowed the

Figure 3: States with High Baseline Child (ages 1-18) Mortality Rates

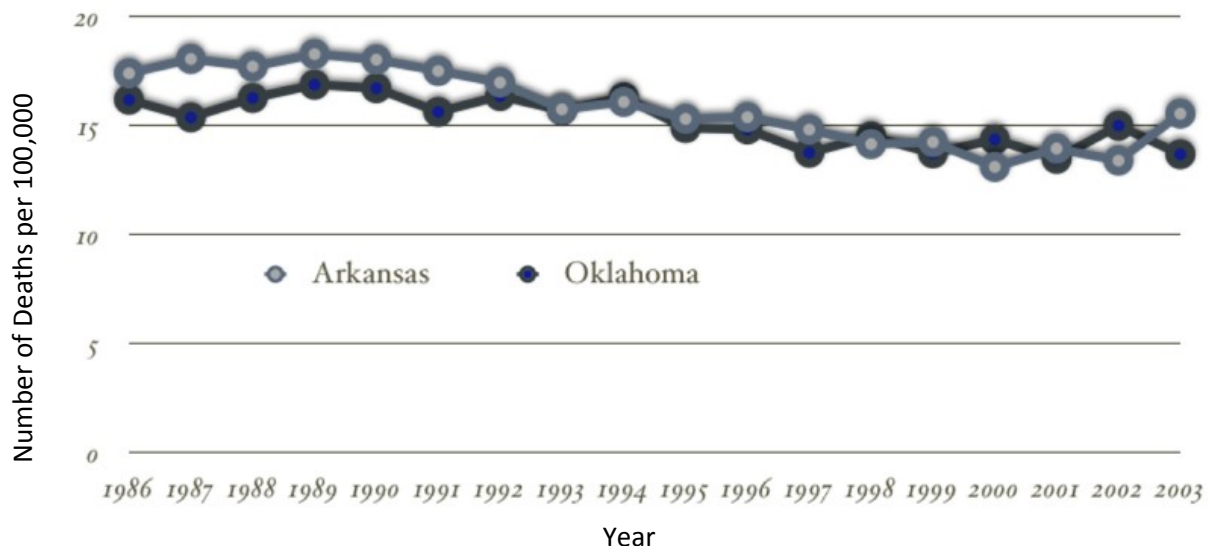


Table 4

2008 Snapshot of State Medicaid/SCHIP Programs				
State	Arkansas	Oklahoma	Rhode Island	New Hampshire
<i>Medicaid Expansion vs. Separate SCHIP Program</i> ¹⁰	<i>Medicaid Expansion</i>	<i>Medicaid Expansion</i>	<i>Separate SCHIP</i>	<i>Medicaid Expansions</i>
Percentage of Uninsured Children	8.4%	13.3%	6.6%	7.1%
Percentage of Low-Income Children	56%	51%	36%	22%
Percentage of Children Living in Poverty	28%	26%	19%	9%
Percentage of Children Enrolled in Medicaid	43.8%	32.4%	29.1%	16.6%
Federal Funding ¹¹ Match Rate	82.3%	79.1%	68.8%	65%
Premium Income Level	--	--	133%	185%
Upper Income Eligibility Limit	200%	185%	250%	300%
12-month Continuous Eligibility	No	No	No	No
Presumptive Eligibility	No	No	No	Yes
Self-declaration of Income	Yes	Yes	No	No
Frequency of Renewal	12 months	12 months	12 months	12 months
Assets Test	No	No	No	No
Waiting Period	6 months	No	No	6 months
Coverage for Immigrant Children	No	No	No	No

state to implement SoonerCare Choice, a primary care provider case management program that allows the state to contract “directly with primary care providers throughout the state to provide basic health care services” (OHCA 2005). SoonerCare does not provide 12-month continuous eligibility

¹⁰ Kaye, Neva, et al. *Charting CHIP III: An Analysis of the Third Comprehensive Survey of State Children’s Health Insurance Programs*, National Academy for State Health Policy. (September 2006). <http://www.chipcentral.org>.

¹¹ Unless otherwise specified, the data sources used are: Center for Children and Families. (2008). *Facts and Statistics: Medicaid and SCHIP Programs*. <http://ccf.georgetown.edu/index/facts-statistics>; and The Kaiser Family Foundation, *State Health Facts (2006-2007)*. <http://www.statehealthfacts.org>.

or presumptive eligibility options although it does allow applicants to self declare their income. Over the years, both SoonerCare programs have grown significantly, in part due to the Oklahoma state legislature’s “mandate to expand Medicaid eligibility to include children from birth to age 18 at 185 percent of the Federal Poverty Level” (OHCA 2005). However, since 1996 Oklahoma has not expanded coverage from 185 percent FPL, and has made the least amount of progress with regard to health coverage expansions for children of the four states examined. Oklahoma does not offer 12-month continuous eligibility, presumptive eligibility options, or coverage for immigrant children. However, the state has made progress with eliminating the waiting period and allowing applicants the option of self-declaration of income.

DISCUSSION AND CONCLUSION

The four state Medicaid/SCHIP programs examined in this study represent a few of the many Medicaid/SCHIP programs and policies that exist across the United States in terms of Medicaid/SCHIP programs and policies. Examination of the population of low-income children who are potentially eligible for Medicaid/SCHIP programs yields trends by geographical region, and not the rate of coverage expansions as suspected. For the two northern states, about 36 percent of Rhode Islander children and about 22 percent of New Hampshire's children are low-income (below 200 percent of poverty) (Center for Children and Families, 2008). In contrast, the southern states in this analysis – Arkansas and Oklahoma – have much higher percentages of low-income children. Currently, about 56 percent of Arkansan children and about 51 percent of Oklahoman children are considered low-income (below 200 percent of the poverty) (Center for Children and Families, 2008).

Overall, all four states have relatively small population sizes compared to the rest of the nation, which may contribute to the observed unstable mortality rates during 1986 to 2003. The issue of small population size may also explain the dramatic increase in observed Rhode Island childhood mortality rates between 1989 and 1995. Mortality rates from the NCHS vital mortality statistics reports¹² shows that mortality rates can be unstable for states with small populations. Likewise, for all states it is difficult to establish causation between mortality rates and Medicaid expansions because the study is limited in its control for other factors (e.g. health-seeking behaviors income, class, education, race/ethnicity) that may influence health outcomes, as well as the effect of health on health insurance, and the effect of some other aspect on both health

insurance and health status (Levy et. al., 2001). In effort to determine a plausible relationship between insurance and health outcomes, future research should consider as many contributing factors that may influence health outcomes.

This study was not able to determine a causal relationship between the rate of Medicaid coverage expansion implementation and rate of child mortality over time. Nonetheless, observed childhood mortality rates for the nation and the selected four states decreased within the same time frame as significant federal and state Medicaid expansions. This supports the hypothesis that health care coverage expansions may lead to better access to health care services, and improved health outcomes for children. Moreover, this project contributed to improved understanding of the effects of eligibility and expansions on child mortality rates, and provided the groundwork for a continuing project being conducted by Urban Institute research staff.

¹² Mortality rates from the NCHS were used for benchmarking mortality rates for all four states.

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