

# Issue Brief

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CHAPIN HALL  
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## The Quiet Revolution in Health Care Coverage for Illinois Children

LAWRENCE B. JOSEPH

During the 1990s, medical assistance for low-income children in Illinois (and other states) underwent a quiet revolution. This revolution was shaped by a series of major policy developments at the national level: federal mandates for expansion of Medicaid coverage to all children in families below the federal poverty line; federal welfare reform legislation, which “delinked” Medicaid from the welfare system; and the State Children’s Health Insurance Program (SCHIP), which gave states new options for extending eligibility beyond federal Medicaid mandates. The convergence of these policy changes has resulted in a fundamental transformation in health care coverage for children — a shift from welfare-based to income-based eligibility. Many more children are now eligible for either Medicaid or SCHIP, and the composition of medical assistance caseloads has changed dramatically. The quiet revolution also presents ongoing policy challenges, which include reducing disparities in coverage of low-income children and parents and closing the gap between eligibility and actual enrollment.<sup>1</sup>

### Welfare-Based and Poverty-Related Eligibility

For several decades, the principal Medicaid eligibility pathway for children was the welfare system. From the inception of the Medicaid program in 1965, recipients of Aid to Families with Dependent Children (AFDC) were automatically entitled to Medicaid benefits. Because Medicaid coverage was tied to AFDC, maximum cash benefit levels in each state determined the boundaries of Medicaid eligibility; states with less generous AFDC programs had relatively lower Medicaid enrollment for children. Moreover, AFDC benefits in most states did not keep pace with inflation, which effectively lowered income eligibility limits for Medicaid (see Kronebusch, 2001).

Delinking Medicaid from the welfare system actually began in the 1980s and early 1990s with a series of federal mandates for states to expand eligibility based on family income rather than on ties to the AFDC program. In 1988, states were required to phase in Medicaid coverage for infants and pregnant women in families with incomes under 100 percent of the federal poverty level (FPL), regardless of whether they were receiving AFDC. This was superseded a year later, when Congress established mandatory coverage for children under age 6, as well as pregnant women, with family incomes below 133 percent of FPL. Most significant in the long run was 1990 legislation that mandated

1313 EAST 60TH STREET  
CHICAGO, IL 60637  
TEL: 773-753-5900  
FAX: 773-753-5940

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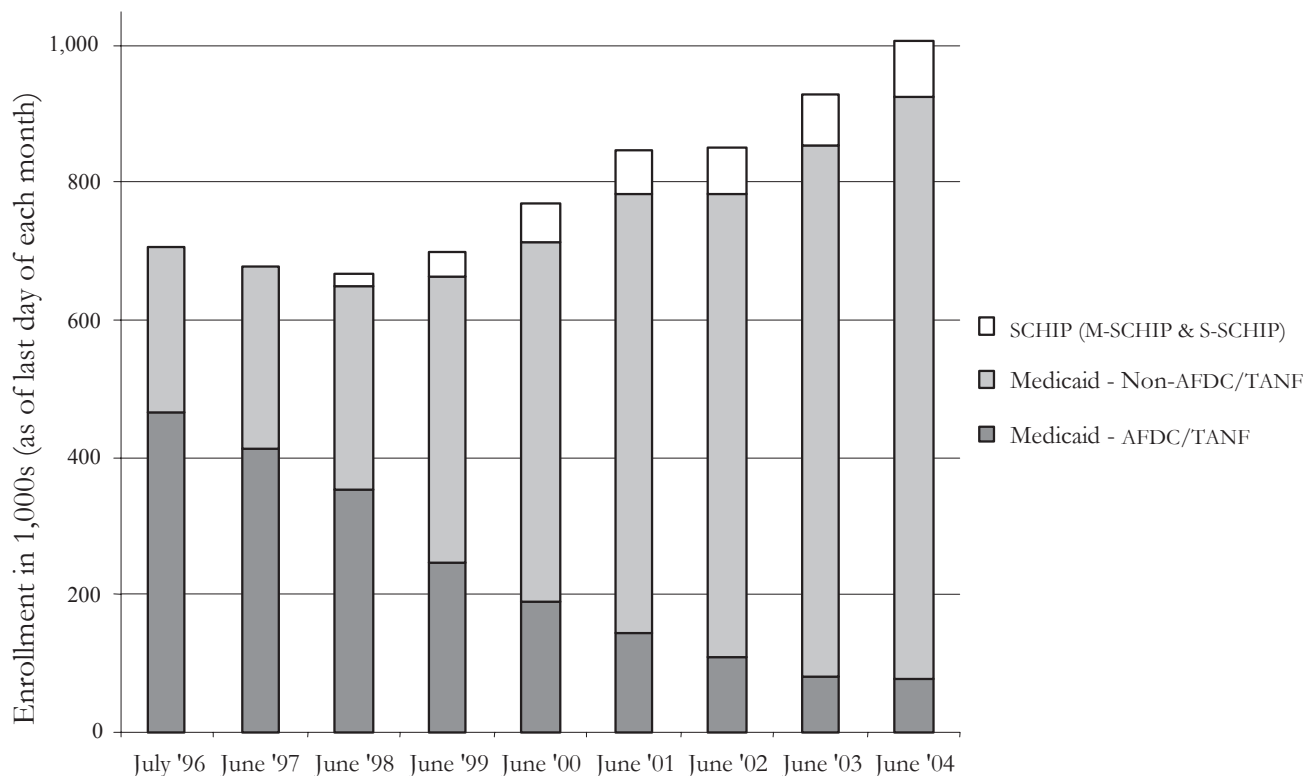
incremental expansion of Medicaid coverage for older children (ages 6 through 18) in families with incomes up to 100 percent of FPL. The eligibility expansion began with children born after September 30, 1983, with one age cohort added each year, which meant that coverage would reach all 18-year-olds in 2002. These various laws also gave states options for setting higher income eligibility limits for children.

### Medicaid and Welfare Reform

The 1996 federal welfare reform law, which replaced AFDC with Temporary Assistance for Needy Families (TANF), completed the process of delinking medical assistance from family income assistance. Children enrolled in TANF were not automatically eligible for Medicaid, although the legislation preserved the Medicaid entitlement for families that would have met AFDC eligibility standards in their state in July 1996. Many states, including Illinois, still chose to provide Medicaid coverage for all TANF families. The formal delinking of Medicaid and welfare made Medicaid eligibility considerably more complicated, especially for TANF leavers. Plummeting welfare caseloads in the mid-1990s were paralleled by declining Medicaid enrollment among low-income children, as many families did not realize that they could still receive Medicaid benefits.

Concern about the drop-off in Medicaid enrollment led the federal government to issue directives for states to maintain Medicaid coverage for TANF leavers who remained eligible for the program. After 1998, Medicaid enrollment of low-income children in Illinois began to rebound, as the continuing decline in TANF caseloads was offset by enrollment growth in other coverage groups, especially children in poverty-related eligibility categories (see Exhibit 1). The net result was a dramatic change in the composition of medical assistance caseloads. In June 1996, AFDC children represented two-thirds of Medicaid children in Illinois. In June 2001, less than 20 percent of low-income children in the state’s medical assistance program were from TANF families.<sup>2</sup>

**Exhibit 1: Illinois Medicaid and SCHIP Enrollment of Children in Low-Income Families, 1996-2004**



**Note:** Data for June 2004 are preliminary. **Source:** Illinois Department of Public Aid, Bureau of Rate Development and Analysis.

## Medicaid and SCHIP

The SCHIP program, enacted in 1997, offers federal matching funds to provide coverage for children whose family incomes exceed a state's Medicaid eligibility standards. Like Medicaid, SCHIP is jointly financed by the federal government and the states, but the federal share of funding for SCHIP (65% in Illinois) is higher than for Medicaid (50% in Illinois). States have three basic options in their use of SCHIP funds: expanding Medicaid coverage (M-SCHIP), instituting a separate state child health program (S-SCHIP), or combining both approaches. Under S-SCHIP programs, states are allowed to offer more limited service coverage, to require co-payments and monthly premiums from families, and to establish enrollment caps and waiting lists. The federal upper-income limit for SCHIP is generally 200 percent of FPL, although it can be higher for states that previously had generous income-eligibility standards in their Medicaid programs.

In 1998, Illinois established both M-SCHIP and S-SCHIP programs. M-SCHIP covers children in families up to 133 percent of FPL. The upper income limit under S-SCHIP was initially set at 185 percent of FPL, but was raised to 200 percent of FPL in July 2003. SCHIP enrollment in Illinois increased four-fold between June 1998 and June 2004, although SCHIP still accounted for less than one-tenth of total medical assistance enrollment of low-income children (see Exhibit 1). The direct impact of SCHIP on health insurance coverage for Illinois children has been much smaller than the impact of regular Medicaid eligibility for poverty-related groups. Nonetheless, SCHIP has had important spillover effects on Medicaid. States are required to screen SCHIP applicants to determine whether they meet regular Medicaid eligibility standards, and SCHIP outreach efforts and simplified application procedures have facilitated enrollment in Medicaid (Ellwood, Merrill, and Conroy, 2003). In December 2001, about 64,000 Illinois children were enrolled in SCHIP, but another 97,000 were enrolled in the regular Medicaid program through SCHIP outreach initiatives (OAG, 2002).

## The Unfinished Revolution

Until the 1990s, nearly all children in the Medicaid program were from AFDC families, which usually meant single-mother families. Consequently, the stigma of "welfare," as well as various state policies and administrative practices that constrained AFDC participation, also became attached to the Medicaid program. This link was weakened by the federal mandate for incremental expansion of Medicaid eligibility for children and was eventually severed by the 1996 federal welfare reform law. By the end of September 2002, when poverty-related eligibility expansion was complete, there were uniform minimum eligibility standards for low-income children nationwide, regardless of family structure (i.e., single-parent vs. two-parent households) or welfare status. Eligibility became tied to the federal poverty level, which varies according to family size and is adjusted annually to account for inflation. The quiet revolution has been abetted by the SCHIP program, which has enabled states to further extend health coverage for low-income children and has also encouraged the enrollment of eligible children in Medicaid (see Kronebusch, 2001; Mann, Rowland, and Garfield, 2003).

Although Illinois has not been at the forefront of efforts to go beyond minimum federal mandates, the state has been making substantial progress in expanding health coverage for children, especially in the past several years. In February 2000, the state exercised the option of providing 12 months of continuous Medicaid and SCHIP eligibility for children, regardless of changes in family income or work status. In May 2004, Illinois instituted "presumptive eligibility" for children, which provides temporary coverage while their applications are being processed. In June 2004, combined enrollment of children in Medicaid and SCHIP exceeded one million, which was more than 50 percent higher than it had been six years earlier (see Exhibit 1).

One by-product of changes in Medicaid eligibility for children has been the emergence of disparities in coverage for children and parents. As TANF caseloads declined, adult caretakers were much less likely than their children to find alternative paths to Medicaid coverage. In Illinois, Medicaid enrollment of low-income children began to

rebound after 1998, but enrollment of low-income adults continued through the end of the decade. In October 2002, under a federal waiver, Illinois began to use SCHIP funds to cover parents of low-income children. The income eligibility limit for parents was initially set at 49 percent of FPL and was raised to 90 percent of FPL in July 2003 and to 133 percent of FPL in September 2004.<sup>3</sup>

Both the significance and the limitations of Medicaid and SCHIP eligibility expansion are revealed in the latest data from the U.S. Census Bureau on health insurance coverage. The recent economic downturn saw a steady decline in employer-sponsored health insurance. However, for low-income children (i.e., those in families below 200% of FPL), this trend was offset by increases in Medicaid and SCHIP coverage (Holahan and Ghosh, 2004). As a consequence, the nationwide proportion of low-income children without health insurance dropped from about 22 percent in 2000 to 20 percent in 2003.<sup>4</sup> At the same time, lack of health insurance coverage is still more prevalent among children in poverty than among those with family incomes between 100 percent and 200 percent of FPL (see Exhibit 2). Poor children are more likely to be covered by Medicaid or SCHIP but less likely to have employment-based or other types of health insurance (Holahan and Ghosh, 2004). Data for 2003 also show the substantial coverage gap between low-income children and their parents (see Exhibit 2).

**Exhibit 2: Children and Parents Without Health Insurance, 2003**

	Percent uninsured	
	Children	Parents
All income levels	11.8%	16.4%
Low-income (< 200% of FPL)	20.3%	37.3%
< 100% of FPL	22.8%	43.3%
100-199% of FPL	17.4%	33.1%

**Source:** Holahan and Ghosh, 2004, based on data from the U.S. Bureau of the Census, Current Population Survey.

**Conclusion**

Despite several years of serious fiscal stress, with state revenues shrinking and more people falling below income limits for medical assistance, most states have maintained their eligibility expansions for low-income children. Many states, however, have curtailed outreach activities and/or reintroduced procedural barriers to enrollment in both Medicaid and SCHIP. Cost-cutting measures have also included rescinding 12-month continuous eligibility for children and reducing coverage for low-income parents. Fiscal pressures have led some states to institute enrollment freezes in their SCHIP programs or to raise S-SCHIP premiums and co-payments. During 2003-2004, Illinois was one of only six states that actually expanded SCHIP eligibility (Ross and Cox, 2004; Hill, Stockdale, and Courtot, 2004).

Reducing the gap between eligibility and actual enrollment in both Medicaid and SCHIP will be an ongoing policy challenge. One consequence of delinking is that most children eligible for medical assistance are no longer enrolled automatically through the welfare system. Factors that continue to impede Medicaid and SCHIP enrollment include misinformation about availability of coverage, complexity of eligibility standards, and parental reluctance to seek public assistance or participate in government programs (Holahan, Dubai, and Kenney, 2003; Ross and Hill, 2003; Kronebusch and Elbel, 2004). The quiet revolution in health care coverage for low-income children is not yet complete.

## Notes

<sup>1</sup> In the context of Medicaid and SCHIP enrollment, this issue brief defines “low-income children” as children whose eligibility is based on family status (e.g., receipt of cash assistance) or family income. The discussion does not include two other (and much smaller) groups of Medicaid children: those in the disabled eligibility category and those receiving federally funded foster care or adoption assistance.

<sup>2</sup> For comparative analysis of Medicaid enrollment trends in Illinois and other states, see Joseph, 2004.

<sup>3</sup> The federal waiver allows the state to extend eligibility up to 185 percent of FPL. For a more detailed discussion of enrollment trends for adults in low-income families, see Joseph, 2004.

<sup>4</sup> Three-year moving averages for Illinois show a similar trend. The proportion of low-income children without health insurance was 22.1 percent in 1998-2000 and 19.6 percent in 2001-2003.

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