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SCHIP
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Since SCHIP was enacted in 1997, rates of uninsurance have dropped among children, particularly those in low-income households.

Five Things Everyone Should Know about SCHIP

Lisa Dubay, Ian Hill, and Genevieve Kenney

In August 1997, Congress enacted the State Children's Health Insurance Program (SCHIP), with bipartisan support, as Title XXI of the Social Security Act. SCHIP gives states a higher federal match than Medicaid—that is, a higher federal contribution for every dollar of state funds spent on the program. In contrast to Medicaid, however, SCHIP's federal contribution is not an open-ended entitlement, but is capped (as a block grant) at \$40 billion over 10 years.

SCHIP gives states an opportunity to build on the poverty-related expansions initiated under Medicaid in the late 1980s, by expanding coverage to children with family incomes too high to qualify for Medicaid, using Medicaid, a separate program, or some combination of the two. Choosing the option of separate programs allows states more flexibility in program design. Recently, states were also given the opportunity to expand SCHIP coverage to parents using waiver authority.

Five years into SCHIP, qualitative evaluations have provided early positive evidence regarding SCHIP and its operations. We are also seeing reductions in uninsurance among low-income children, particularly those with family incomes of 100 to 200 percent of the federal poverty level (FPL), the income range targeted by SCHIP expansions. While this news is encouraging, it is troubling that over a quarter of all poor children (defined as having family incomes below 100 percent of FPL) remain uninsured and their uninsurance rates do

not appear to be dropping. Fully addressing the uninsurance problem among children will depend critically on the availability of both state and federal funds earmarked to address this issue.

This brief discusses five key points about SCHIP as we mark the five-year anniversary of its enactment. The information presented here draws upon research conducted under the Urban Institute's SCHIP evaluation, which is part of the Institute's *Assessing the New Federalism* project.

States Have Taken Advantage of SCHIP's Flexibility

The Title XXI statute creating SCHIP affords states considerable flexibility in designing their child health programs—a factor that helped make SCHIP attractive to state policymakers and fueled its rapid adoption by states.¹ All states were given flexibility to set income eligibility limits up to 200 percent of FPL or higher² and to choose to either expand Medicaid or create a separate child health program. All states were also free to publicize the availability of new coverage and simplify enrollment procedures as they wished. Other SCHIP provisions gave additional flexibility to those states that chose to create SCHIP programs separate from Medicaid—including allowing them to adopt more limited benefit packages than the Medicaid package in that state; allowing them to impose cost sharing at significantly higher levels than

allowed by Medicaid; allowing them to cap enrollment; and adopting various options to prevent SCHIP from crowding out existing private health insurance.³ How states have been using their new flexibility is summarized briefly below.

Higher Income Eligibility

Following Congress's cue, 27 states adopted expansions to 200 percent of FPL. Thirteen opted to cover children in families with even higher incomes, and 11 set income eligibility limits below 200 percent of FPL. Most of those states expanding coverage *above* 200 percent set their limits between 200 and 250 percent. Some went significantly higher, however, with the highest thresholds in New Jersey (350 percent), and Connecticut, Missouri, New Hampshire, and Vermont (each 300 percent). States setting income limits *below* 200 percent are almost equally divided between those covering children in families with incomes between 151 and 200 percent of FPL, and those only covering children at 150 percent of FPL or below. Importantly, SCHIP has generally equalized eligibility coverage across children of different age groups (Ullman, Hill, and Almeida 1999); historically, Medicaid has had more generous coverage policies for younger children.

The Medicaid–Separate Program Option

Nearly one-third of the states—16 to be precise—chose to build exclusively upon existing Medicaid programs. Case studies have found that policymakers in these states generally held high opinions of their Medicaid programs and saw Medicaid expansions under SCHIP as the most efficient and effective means for increasing children's coverage (Hill 2000). In contrast, 35 states created separate programs, using them either alone or in combination with Medicaid expansions. These states were spurred by SCHIP's funding cap and by interest in developing a product that was "more like private insurance." While 19 states officially adopted "combination"

programs, these initiatives often began with relatively small expansions of Medicaid and were followed by the adoption of larger separate programs, which received the lion's share of policymakers' attention (Hill 2000).⁴

Outreach

States received explicit encouragement from the federal Health Care Financing Administration, now the Centers for Medicare and Medicaid Services (CMS), to publicize the availability of new health coverage through outreach and to facilitate children's enrollment into SCHIP and Medicaid by using the available flexibility to simplify application procedures (CMS 2001). In response, states have invested unprecedented resources in outreach—typically using statewide media campaigns to raise public awareness and more targeted, community-based efforts to reach and enroll families. Furthermore, streamlined enrollment is now the norm across the nation, with states using short and simple application forms to jointly determine eligibility for SCHIP and Medicaid, permitting families to submit applications by mail, dropping assets tests from the process, and reducing the documentation parents must submit with their applications. Efforts to simplify Medicaid enrollment procedures have not kept pace with those of SCHIP, but there has been significant "spillover" of these strategies to Medicaid—making Medicaid application also much simpler than in years past (Cohen Ross and Cox 2002).

The Separate Programs Choices

States adopting Medicaid expansions under Title XXI were required to extend to SCHIP enrollees the same comprehensive benefit packages offered under their Title XIX Medicaid program. States with separate programs, however, were permitted to provide more limited benefits, as long as they met certain minimum benchmark standards. In fact, separate SCHIP programs have consistently been found to cover a broad range of preventive, primary,

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and acute care services (Hill and Snow forthcoming). One-third of all states with separate programs chose to cover the full Medicaid benefit package for SCHIP enrollees. At least six others designed policies to ensure that Medicaid-equivalent coverage could be extended to children with special health care needs (Hill, Lutzky, and Schwalberg 2001; Riley and Pernice 2001). In other states, however, the few services most often left out of the separate programs' packages (e.g., case management services) are those often needed by children with chronic needs, potentially adversely affecting the most needy children (Rosenbaum et al. 2001). Thus, while separate programs have adopted broad benefit packages, gaps in coverage may pose problems for children with special health care needs.⁵

While states opting to expand Medicaid were required to follow that program's cost sharing rules (which generally prohibit cost sharing for children without special waiver authority), states implementing separate programs were allowed to impose premiums, copayments, and other forms of cost sharing in any combination, as long as the total did not exceed 5 percent of a family's annual income. Of the 33 states that initially had separate programs, 27 imposed either monthly premiums or annual enrollment fees (22 of the 27 states) or copayments on selected services (20 states) (Riley and Pernice 2001). Qualitative information from case studies and focus groups suggest that premiums and copayments are "affordable" and set at "nominal" levels (Hill, Hawkes, and Harrington forthcoming; Riley et al. 2002). At current cost sharing levels, it is highly unlikely that families with even the highest-need children will incur total cost sharing approaching the 5 percent cap set by the federal government; however, it will be important to assess whether even these cost sharing requirements are posing hardships to families (Markus, Rosenbaum, and Roby 1998).

While states creating separate programs were required to take steps to help ensure that their child health programs did

not substitute for existing private insurance, the federal government did allow them to adopt a range of measures to prevent crowd out. The majority—27 of 33 initial separate programs—used waiting periods (almost all six months or less with exceptions for job loss and the like) during which previously insured children must be uninsured before they are permitted to enroll in SCHIP. Many states also identified cost sharing as an anti-crowd out measure, figuring that premiums would create a financial disincentive to switch coverage. Other states were only required to monitor the degree to which crowd out was occurring and impose waiting periods if crowd out reached an unacceptable level (Lutzky and Hill 2001).

SCHIP Funds Are Plentiful to Date, but May Run Short

SCHIP was funded as a block grant with approximately \$40 billion in federal funds made available to states for fiscal years 1998 through 2007.⁶ While an average of \$4.0 billion was allocated per year, the allotment started at \$4.2 billion and then fell to \$3.1 billion for fiscal years 2002, 2003, and 2004.⁷ States were given three years to spend each year's allotment, after which unspent funds were to be redistributed to states whose spending outstripped their allotment.⁸

Controversy about both the size of the overall allotment and the formula used to allocate funds across states has raged since the beginning. One concern was that states could have difficulty using their whole federal allotment—given the restrictions on who could be covered with Title XXI funding, particularly the exclusion of children already eligible for Title XIX (Ullman, Bruen, and Holahan 1998). This exclusion is particularly binding for states such as Minnesota and Washington that had already expanded Medicaid to cover children with family incomes up to 200 percent of FPL before enactment of SCHIP. Expansion of SCHIP eligibility thresholds above 200 percent of FPL and the advent of Title XXI waivers to cover parents has

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increased states' ability to use up their federal SCHIP dollars.⁹ Other concerns revolved around the fact that the allocation of federal dollars to states was based on data from the Current Population Survey, which, among other issues, is known to be imprecise in its estimates of uninsurance, particularly for less populous states.

Figure 1 shows federal allotments and spending under SCHIP in the first five years of the program.¹⁰ In the first three program years, states spent only a small fraction of the federal funds available to them. But by the fifth year (FY 2002), annual spending was projected to reach \$3.5 billion, exceeding the federal allotment for that year. Because SCHIP spending was so low in the early years, cumulative spending under SCHIP by the end of FY 2002 is projected to be \$11.0 billion lower than the sum of the federal allotments from the first five years of the program. At the same time, however, the Congressional Budget Office projects federal funding shortfalls in SCHIP in the coming years, because of lower allotments and the fact that states have three years to use a given allotment before other states

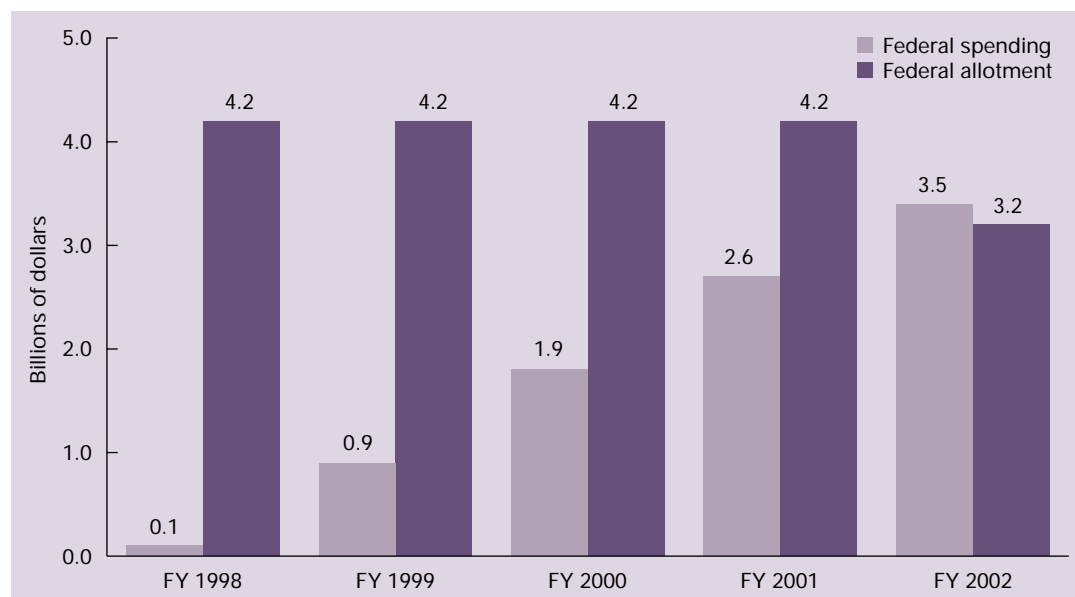
can gain access to any unspent funds. The Center on Budget and Policy Priorities projects that by 2007 as many as 18 states could have spending levels that outstrip the federal dollars available to them (Park, Ku, and Broaddus 2002). Moreover, unless new legislation is passed, as much as \$3.2 billion could revert to the Treasury by the end of FY 2003, removing it from the total available for future spending under SCHIP (Park et al. 2002).¹¹

Following SCHIP, Uninsurance Has Been Reduced

Since SCHIP was enacted in 1997, rates of uninsurance have dropped among children, particularly among children in low-income households (Holahan and Pohl 2002; Mills 2001). Moreover, there have been substantial declines in uninsurance for near-poor children, those with incomes between 100 and 200 percent of FPL (Dubay and Kenney forthcoming a). It was near-poor children that the SCHIP legislation specifically targeted, even though states could choose either to cover children with incomes above 200 percent of FPL or not to cover all near-poor children.

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FIGURE 1. Federal SCHIP Spending versus Federal Allotment, by Fiscal Year



Source: Centers for Medicare and Medicaid Services for FY 1998–FY 2001 spending figures.

Note: FY 2002 federal spending data is projected spending.

Between 1996 and 2000, the *number* of uninsured near-poor children fell by a little over a million.¹² The *rate* of uninsurance among this group also declined, from 23.3 percent to 17.5 percent (figure 2). This decline is probably because of both enrollment of eligible children in SCHIP and greater Medicaid participation among those previously eligible, as a result of increased outreach and eligibility simplification. During this period, the share of near-poor children covered by Medicaid or SCHIP increased by 7.6 percentage points, climbing from 16.2 to 23.8 percent. The share of near-poor children with other types of coverage (employer, CHAMPUS/Medicare, and private non-group) remained relatively constant. The increases in Medicaid and SCHIP coverage for near-poor children and the concomitant decline in uninsurance is encouraging, especially in the absence of major declines in employer-sponsored coverage.¹³ But 2.7 million children in SCHIP's near-poor target group remain uninsured, the vast majority of whom are eligible for Medicaid or SCHIP.

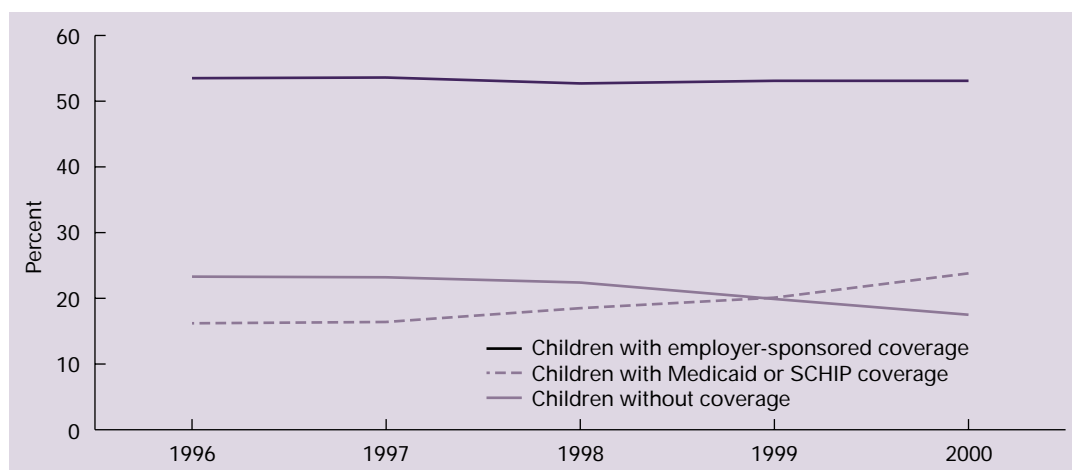
For poor children, the rate of uninsurance and its trend are much less encouraging (Dubay and Kenney forthcoming b). While most children living in poverty were already eligible for public coverage through Medicaid before expansions under

SCHIP, it was hoped that all the attention and enthusiasm generated for SCHIP would also lead to coverage improvements for poor children. However, the uninsurance rate for poor children has been stagnating at around 27 percent from 1996 to 2000 (Dubay and Kenney forthcoming b) (figure 3). The most recent data suggest that 27.3 percent of all poor children and 24.9 percent of poor citizen children are uninsured, *despite* the fact that all citizen children in this income range were eligible for Medicaid or SCHIP in 2000. Poor children constitute 21 percent of all children, but almost 46 percent of uninsured children (Holahan, Dubay, and Kenney forthcoming).

SCHIP and Medicaid Could Cover Most Uninsured Children

Since states have used SCHIP to make many more uninsured children eligible for public health insurance, about 23 percent of all uninsured children and only 16 percent of low-income uninsured children are not eligible for public coverage (Dubay, Haley, and Kenney 2002).¹⁴ At least half of the latter would remain ineligible even if all SCHIP programs raised eligibility to 200 percent of FPL because of restrictions

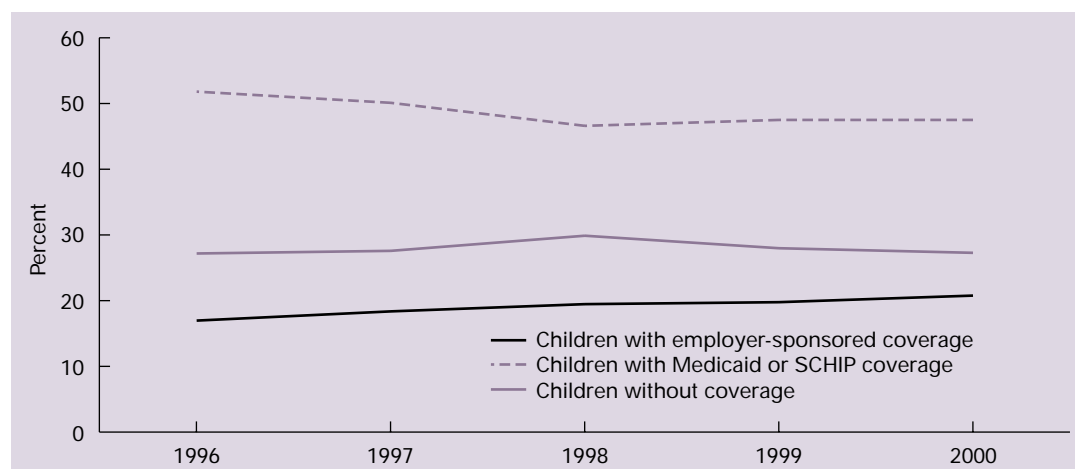
FIGURE 2. Insurance Coverage Improving for Near-Poor Children



Sources: 1997 through 2001 Current Population Surveys.

Note: Near-poor children are those with incomes from 100 to 200 percent of FPL.

FIGURE 3. Insurance Coverage Stagnating for Poor Children



Sources: 1997 through 2001 Current Population Surveys.

Note: Poor children are those with incomes less than 100 percent of FPL.

on coverage of certain immigrant groups (such as undocumented aliens) under Medicaid and SCHIP.

All in all, Medicaid and SCHIP provide a broad health safety net for children. Half of all American children currently live in families that meet the income requirements for public coverage (Dubay, Haley, and Kenney 2002). In the event of a further economic downturn or further erosion of private coverage, these programs could protect an even greater share of the nation's children.

Importantly, many more still-uninsured children are eligible for Medicaid than for SCHIP. Of the 8.9 million uninsured children in 1999, for example, 4.6 million were eligible for Medicaid versus 2.3 million for SCHIP. Thus, making substantial further inroads into the child uninsured problem hinges on increasing Medicaid participation.

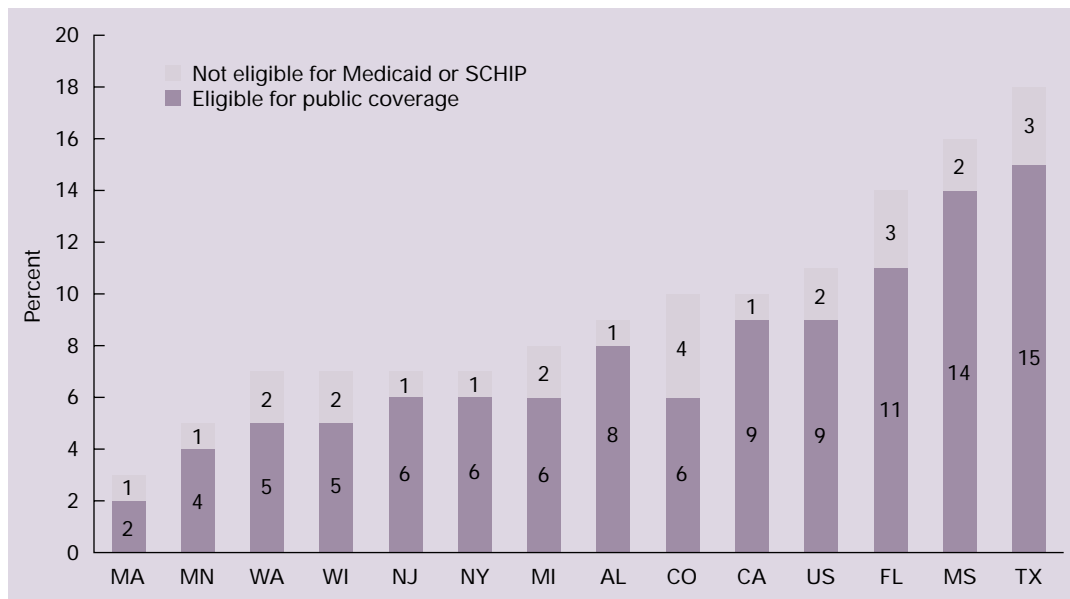
As of 1999, 68 percent of all eligible citizen children without private coverage participated in Medicaid or SCHIP (Holahan et al. forthcoming).¹⁵ The highest participation rate—79 percent—was found for children eligible under the TANF/welfare-related category, while participation rates were lower for higher-income children eligible for Medicaid (64 percent), and for those eligible for SCHIP (45 percent)

(Dubay, Kenney, and Haley 2002).

Participation rates for both Medicaid and SCHIP have probably risen since 1999, given that SCHIP and Medicaid enrollment and renewal processes have improved and enrollment in SCHIP has grown (Cohen Ross and Cox 2000; Smith and Rousseau 2002). The millions of uninsured low-income children who remain make it clear, however, that participation in Medicaid and SCHIP is not universal.

Eligible children with fewer health care needs, or with parents who are immigrants or who have more negative views about welfare programs, participate at lower rates than other children (Dubay, Kenney, and Haley 2002). Children who are very young or who have functional limitations are more likely than other children to participate in Medicaid and SCHIP. At the same time, however, many eligible children who are in poor health or who have activity limitations still lack coverage, making it clear that need alone does not govern a family's coverage decision. For citizen children with noncitizen parents, there may be concern that a child's participation might threaten the immigration status of the parents. For children whose parents view welfare negatively, the issue may involve general family reluctance to participate in government programs.

FIGURE 4. Uninsurance Rate among Citizen Children by State and Eligibility for Medicaid/SCHIP Coverage



Source: 1999 National Survey of America's Families, using 2000 SCHIP eligibility rules.

Participation in Medicaid and SCHIP also varies substantially across states (Dubay, Kenney, and Haley 2002). In 1999, Medicaid participation rates among eligible citizen children ranged from 59 percent to 93 percent across 13 states studied in depth; SCHIP participation rates varied even more widely.¹⁶ Massachusetts is a standout for both Medicaid and SCHIP, with participation rates at 90 percent and above. Large cross-state differences in participation persist, even when a host of demographic and socioeconomic characteristics have been taken account of, suggesting that state-specific program characteristics may be driving factors.¹⁷

Increasing participation is key to equalizing uninsurance rates across states. The uninsurance rate among citizen children varies dramatically across the 13 states, ranging from a low of 3 percent in Massachusetts to 19 percent in Texas in 1999, as shown in figure 4.¹⁸ In contrast, there is little variation across states in the share of children that are uninsured and ineligible for Medicaid or SCHIP (which varies from one to four percentage points). Therefore, by increasing participation

among children eligible for Medicaid and SCHIP, not only would uninsurance decline considerably nationally, but state variation in uninsurance rates would also be reduced.

Further Improvements Are Needed in Both Medicaid and SCHIP

States wanting higher participation rates need to reckon with the fact that the causes of uninsurance among eligible but unenrolled children are complex (Kenney and Haley 2001; Kenney, Haley, and Dubay 2001). The various reasons parents give for not enrolling their children include (1) insufficient knowledge—that is, not knowing the programs exist, particularly the newer separate SCHIP programs, and/or that their child is eligible and that welfare is not a prerequisite for Medicaid/SCHIP enrollment; (2) administrative hassles associated with enrollment—for example, complicated application forms or documentation requirements, transportation, or language barriers; and (3) not wanting public insurance coverage for

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their children or feeling such insurance is not needed. States also need to recognize that the families of many eligible children without current coverage have experience with the programs—as indicated by the fact that 29 percent of low-income uninsured children had either recently disenrolled from public coverage or begun (but not completed) the enrollment process in the previous year.

The problem of uninsured children can only be fully solved by increasing efforts to enroll more eligible children and extending either federal or state program eligibility to currently ineligible immigrant children. The enrollment and re-enrollment processes may themselves pose particular problems for poor families, requiring further simplifications to the Medicaid programs and more funding for community-based outreach workers charged with helping families navigate the application and reapplication processes. Broadening eligibility to cover more immigrant children would require changing federal eligibility policies or expanding state-funded efforts.

Addressing these issues requires additional resources, but emerging funding problems and the recent economic downturn may make it difficult for states to attack these issues. The question is whether states can preserve and even build upon the gains they have made in providing insurance coverage to children, when state budgets are under so much strain (Holahan, Wiener, and Lutzky 2002; Ornstein 2002). To date, it appears that most SCHIP programs are being preserved intact, at least through this round of budget cuts (Fox, Reichman, and McManus 2002; Howell, Hill, and Kapustka forthcoming). Some states have made or are contemplating cutbacks, but they are still the exception.

Another effect of state budget woes is that the momentum that had been building to cover parents of eligible children appears to be stalling. All states have the option to cover such parents under their Medicaid programs and many can obtain the higher SCHIP match for such coverage

using SCHIP or HIFA waivers (Howell et al. 2002). This is a particularly crucial concern, because recent evidence shows that covering parents increases participation among children (Dubay and Kenney 2002). Since insured children with uninsured parents obtain fewer health care services, both curative and preventive, than those with insured parents (Davidoff et al. 2002), covering parents may be critical to ensuring that children enroll and obtain appropriate services.

Conclusion

Ultimately, of course, SCHIP will be judged not only by how many children gain health insurance coverage. It will also be judged by whether and how these coverage gains translate into improvements in the health and well-being of low-income children and their families. As state experience with SCHIP continues, it will be critical to examine whether both SCHIP- and Medicaid-eligible children have been able to gain access to high-quality care, and the extent to which such gains are experienced across the broad spectrum of low-income children.

Notes

1. It took just over two years for every state and the District of Columbia to develop and submit state plans, obtain federal approval, and implement SCHIP initiatives (Ullman et al. 1999).
2. Title XXI identified children living in families with incomes below 200 percent of the federal poverty level (FPL) as the target population for SCHIP. For states with upper income thresholds that were already approaching or surpassing 200 percent of FPL, the law also said that states could adopt coverage levels up to 50 percentage points above whatever upper limits were in place at the end of March 1997, the year SCHIP was created. Finally, states were also given federal permission to expand upper income limits even higher by “disregarding” additional amounts of family income, a practice already permitted by Medicaid under Section 1902(r)(2).
3. For further information on states’ options under Title XXI, see Alan Weil, “The New Children’s Health Insurance Program: Should States Expand Medicaid?” (Washington, D.C.: The Urban Institute, 1997).

Half of all American children currently live in families that meet the income requirements for public coverage.

4. Two states (Maryland and South Dakota) recently expanded their SCHIP programs to include a separate component. The statistics provided in the following sections on benefits, cost sharing, and waiting periods pertain to the 33 states that initially developed separate programs, and do not pertain to Maryland and South Dakota. Because the federally mandated phase-in of Medicaid poverty-level coverage of adolescents will be complete in October 2002, fewer combination programs will remain at that point. Many states that began as combination programs by virtue of accelerating poverty-level coverage of adolescents have had those populations absorbed by Medicaid.
5. Hill et al. (2001), in conducting case studies of numerous states' programs, found little anecdotal evidence that children with special health care needs were not receiving needed care under separate SCHIP programs. This promising finding, however, will be more rigorously evaluated in future quantitative research.
6. Allotments to states are based on state-specific estimates of the number of low-income uninsured children, the number of low-income children, and health care costs relative to other states (Kenney, Ullman, and Weil 2000).
7. The funding pattern seemingly provides funding for a fully mature program beginning in October 1997, just two months after SCHIP was enacted, which explains in part why states have accumulated such large unspent SCHIP balances. In addition, the reduced funding levels for FY 2002–FY 2004 were a result of overall budget constraints associated with balancing the federal budget. See Kenney et al. (2000) for a fuller discussion of these issues.
8. In December 2000, Congress passed a measure that allowed states to retain a portion of their unspent FY 1998 and FY 1999 allotments through FY 2002 and reallocated the remainder to the 12 states that had fully expended their FY 1998 allotment. Since unspent funds remain from FY 1998 and FY 1999, unless Congress acts, those funds will revert to the Treasury.
9. More recently, CMS has approved waivers under the Health Insurance Flexibility and Accountability Initiative (HIFA) that propose to use SCHIP funds to cover childless adults. The General Accounting Office (GAO) has argued that this is in violation of the SCHIP statute and that using SCHIP funds to cover parents may be problematic as well (GAO 2002).
10. Spending for FY 2002 is based on reported spending from the first quarter of FY 2002 and actual spending for FY 2001. Projected spending for FY 2002 was either four times the first quarter's FY 2002 spending or total spending from FY 2001, whichever was greater.
11. In August 2002, the Children's Health Insurance and Protection Act of 2002 was introduced by Senators Rockefeller, Chafee, Kennedy, and Hatch. The Act raises the SCHIP allotments for FY 2003 and 2004, allows expiring unspent funds to be retained by states, and attempts to redistribute funds to states with projected federal funding shortfalls. While no other legislation is pending, the National Governors Association has developed a policy position on SCHIP funding that would allow states with unspent funds more time to hold on to those funds (National Governors Association 2002).
12. The number of children in this income group also fell. However, 87 percent of the decline in the number of uninsured children was because of the decline in the rate of uninsurance.
13. These trends in coverage do not necessarily indicate that the SCHIP program led to the declines in uninsurance or that there was little substitution of public for private coverage. However, the trends in uninsurance observed for this group are significantly different from those of potential comparison groups, suggesting that the SCHIP program did reduce the rate of uninsurance among this group of children and that substitution was minimal (Dubay and Kenney forthcoming a).
14. Recent estimates by Holahan and Pohl (2002) using the Current Population Survey attempted to take into account both growth in enrollment up through December 2002 and underreporting of public coverage. Thus, their estimates imply both greater participation in Medicaid and SCHIP and lower eligibility for Medicaid and SCHIP among those children who remain uninsured. Their estimates imply that 58 percent of all uninsured children are eligible for either Medicaid or SCHIP. As participation increases in these programs, the share of uninsured children who are not eligible for either program should decline.
15. For details on the method used for calculating participation rates, see Dubay, Kenney, and Haley 2002.
16. The 13 states were Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. SCHIP participation rates were examined in 8 of the 13 states—Minnesota, Mississippi, Texas, Washington, and Wisconsin were omitted because their SCHIP expansions either were small in scope or had not yet been implemented when the 1999 National Survey of America's Families was administered.
17. This is underscored by the finding that states providing broader public coverage to parents have higher participation rates among children.
18. Importantly, neither Mississippi nor Texas had implemented their separate SCHIP program at the time of the 1999 NSAF survey. The share of all

children who are uninsured and eligible for Medicaid or SCHIP in these states has likely declined since the implementation of their programs.

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Many eligible children who are in poor health or who have activity limitations still lack coverage, making it clear that need alone does not govern a family's coverage decision.

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