

**HEALTH COVERAGE FOR LOW-INCOME POPULATIONS: A COMPARISON OF MEDICAID AND SCHIP**

Medicaid is often compared to the State Children's Health Insurance Program (SCHIP) because both programs provide health coverage to low-income populations. However, the populations served, the coverage offered and the structure of these programs differ in very important ways. Despite these differences, recent changes related to cost sharing and benefits included in the Deficit Reduction Act of 2005 (DRA) allow states to apply some SCHIP-like principles to the Medicaid program. This issue brief examines the similarities and difference between Medicaid and SCHIP as well as the implications of applying some SCHIP design features to the Medicaid program.

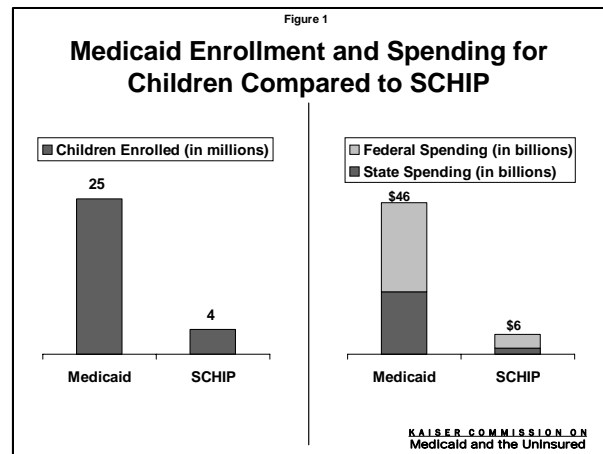
**OVERVIEW OF MEDICAID AND SCHIP**

Enacted in 1965 under Title XIX of the Social Security Act, Medicaid was created to provide health care coverage to blind and disabled individuals and families with dependent children receiving cash assistance. It has expanded over time and is now an important source of health and long-term care coverage for 39 million low-income children and their families and 13 million elderly and persons with disabilities.

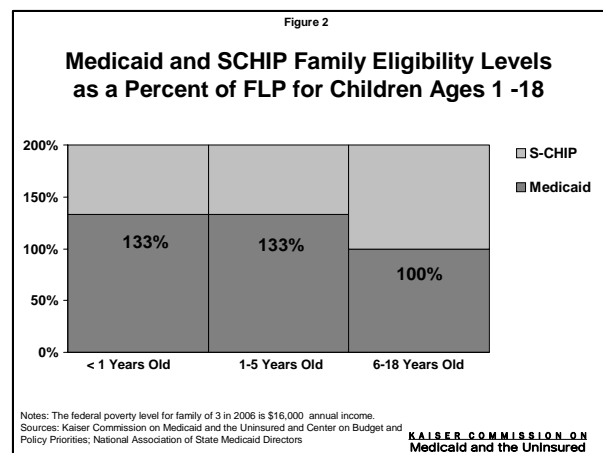
Created as part of the Balanced Budget Act of 1997, SCHIP builds on Medicaid to provide insurance coverage to uninsured, low-income children above Medicaid income eligibility thresholds, typically up to 200 percent of the Federal Poverty Level (FPL). States are permitted to use SCHIP funds to create a separate SCHIP program, expand their Medicaid program, or adopt a combination approach. Currently, 18 states operate separate SCHIP programs only, 11 states plus the District of Columbia expanded Medicaid only, and 20 states rely on a combination approach. Almost 30 percent of children enrolled in SCHIP are enrolled in Medicaid expansion programs.

**Size and Scope of the Programs.** The Medicaid program dwarfs SCHIP in terms of program size and role in the health care system. Medicaid has a broad, multi-faceted role covering 52 million beneficiaries (about 25 million are children) at a total cost of nearly \$300 billion, state and federal funds, in 2004 of which about \$46 billion is for children. Additionally, Medicaid accounts for over 40 percent of all federal revenue to states. By comparison, SCHIP has a more limited health insurance role, covering 4 million low-income children and about 335,000 adults at a cost of \$6 billion (in state and federal funds) in 2004. (Figure 1)

Both programs are countercyclical meaning that during economic downturns, program enrollment tends to expand. During the recent recession from 2000 to 2004, enrollment of children in Medicaid and SCHIP grew by almost 5 million. In the states where we have children's enrollment data for each program, Medicaid accounted for nearly 80 percent of this enrollment growth.<sup>1</sup>



**Population Served.** Medicaid covers a diverse and low-income population, including many individuals with complex health care needs. Over half of all non-elderly Medicaid beneficiaries have incomes below the federal poverty level (\$16,000 for a family of 3 in 2006), while nearly all children in SCHIP come from families with incomes between 100 and 200 percent of FPL. (Figure 2)



Many elderly and disabled beneficiaries enrolled in Medicaid have chronic or complex health conditions that require

extensive use of health care and long-term care services. Individuals on Medicaid are in poorer health and require more health care services. Compared to children eligible for SCHIP, children in Medicaid are twice as likely to report being in fair or poor health and are more likely to have a chronic health condition.<sup>ii</sup> Low-income families covered by Medicaid have higher rates of asthma and other chronic illnesses and children on Medicaid are at higher risk of experiencing developmental disabilities and delays.<sup>iii</sup>

## DIFFERENCES IN PROGRAM DESIGN

While both Medicaid and SCHIP offer federal financial assistance to states for health coverage of children in low-income families, three key program design features differ between the two programs: financing, benefits and cost-sharing.

## FINANCING

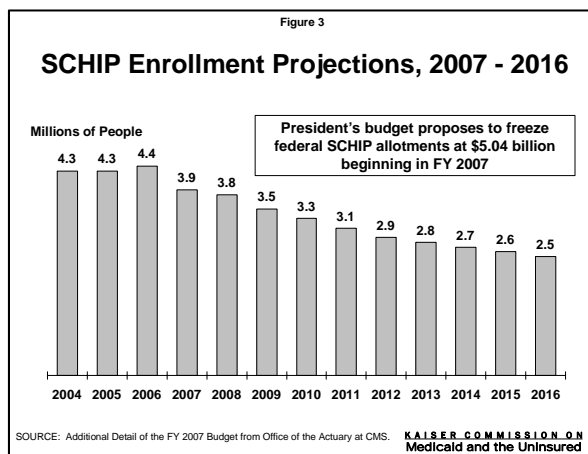
**Key Differences.** Both Medicaid and SCHIP are administered by the states within broad federal guidelines. Under both programs, the federal government matches state spending on eligible program beneficiaries according to an annual formula driven match rate. Federal funds for Medicaid match state spending and are guaranteed with no pre-set limits. Under SCHIP federal funds are capped, nationwide, and each state operates under a formula-driven allotment. Federal funds match state spending up to the allotment. The SCHIP program is set to expire in 2007 and will need to be reauthorized while the Medicaid program does not require reauthorization.

Related to Medicaid and SCHIP financing structures is the nature of the entitlement. Medicaid guarantees an entitlement to states for financing as well as to individuals, meaning all eligible beneficiaries are entitled to a defined set of benefits. With SCHIP, the entitlement is to the states for a specific amount of funding. Under separate SCHIP programs, beneficiaries are not entitled to coverage, even if they meet eligibility requirements; nor do they have an entitlement to a defined set of benefits. In the absence of an individual entitlement, states can control SCHIP spending by capping enrollment, a strategy that is not available under Medicaid, except through 1115 waivers. During the past five years, 8 states have imposed enrollment caps and as of June, 2005 three states (FL, MT and UT) had SCHIP enrollment caps in place.

The matching rates for Medicaid and SCHIP are determined using a formula based on states' relative per capita income. To encourage participation among the states, the federal government assumed a larger share of SCHIP financing, offering enhanced (relative to Medicaid) matching payments. On average, the federal government's share of Medicaid spending is 57 percent, but it is 70 percent under SCHIP.

**What are the implications of SCHIP Financing for Medicaid?** The SCHIP capped financing structure allows the federal government to limit the extent to which it will share in the costs of health care for uninsured low-income children, but capped financing limits program flexibility to meet changing needs. In aggregate, SCHIP spending was less than total allotment levels in the early years of the program; but, when the SCHIP allotment levels fell from \$4.2 billion to \$3.1 billion in 2002, spending exceeded annual allotment levels.

Federal funding levels set for a ten-year period are not sufficiently flexible to accommodate changes that affect demand for the program, such as economic downturns. With rates of private insurance coverage continuing to decline, demand for publicly financed coverage is likely to increase. As a result, Medicaid enrollment is expected to grow. If, however, federal funding for SCHIP is held constant (as proposed in the President's FY 2007 budget proposal) then SCHIP enrollment will decline and the number of uninsured children will increase unless states finance coverage for these children through Medicaid or with state-only funds. (Figure 3) According to the Congressional Research Service (CRS) 18 states are expecting SCHIP funding shortfalls in FY 2007.



The enhanced SCHIP matching rate provided incentives to states to expand coverage for children, showing that the federal-state funding partnership is a powerful lever to accomplish national health objectives. However, even after numerous legislative changes, the formulas for targeting funds to states have been problematic, leaving some states with more funds than they could spend and other states needing additional funds to keep up with program costs and enrollment. The provisions in SCHIP law to "redistribute" SCHIP funds from states unable to spend their full allotments to states that exceeded their funding allotments have created complexity and unpredictability in program financing that have led to numerous legislative changes to fix the formula. Despite these changes, last year \$1 billion in SCHIP funds reverted to the federal treasury while many children remained uninsured but eligible for public coverage.

If capped financing created challenges for SCHIP, a program that covers a relatively small, healthy and low-cost population, the potential for misalignment of funds, funding shortfalls, and disruptions to care is far greater for Medicaid. Lessons from the SCHIP program show that caps on federal Medicaid spending could leave more children without coverage and that the imprecision of any funding formulas will lead to poorly targeted distribution of funds for states.

## BENEFITS

**Key Differences.** Before the DRA, states were required to cover certain mandatory services, but could also cover a broader set of optional services. States also had flexibility to determine the amount, duration and scope of the services they provide under the program. For example, states must cover hospital and physician services, but they can set hospital length of stay or annual visit limits. States were required to offer covered services to all Medicaid beneficiaries in every region of the state. The DRA allows states to replace the existing Medicaid benefits package for children and optional adults with "benchmark" coverage. Benchmark coverage is similar to options allowed under the SCHIP program. However, states would be required to provide "wrap around" benefits coverage for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children.

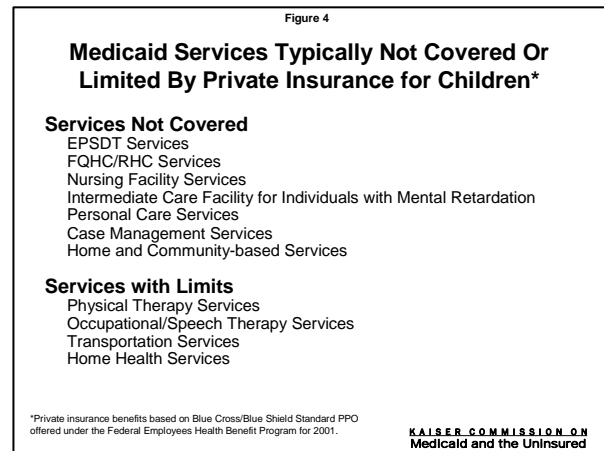
Under SCHIP, states must provide benchmark coverage, benchmark-equivalent coverage, or other coverage approved by the Secretary as appropriate for uninsured low-income children. Benchmark coverage is defined as substantially equal to the benefits provided by the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option; a health benefits plan offered by the state to its own employees; or a plan offered by an HMO with the largest commercial enrollment in the state. In this way, the SCHIP benefit package is modeled on private insurance.

**What are the implications of SCHIP Benefit Design for Medicaid?** The federal SCHIP benefits standards and now the options available under DRA for Medicaid provide states a great deal of flexibility in setting the benefits package. These options could be much less comprehensive than benefits under Medicaid prior to the DRA. For example, many states are now offering catastrophic health coverage to their employees, which under federal rules would be an acceptable SCHIP benefits plan.

Restricting the current Medicaid benefits package could lead to reduced access to needed care, especially for children with special health care needs, the elderly and persons with disabilities who utilize services beyond the SCHIP limits or services not typically covered under SCHIP plans. Under current law in Medicaid, services may be covered for any individuals enrolled in the program only if they are medically necessary. If benefit package limitations are implemented in Medicaid, Medicaid beneficiaries are unlikely to have the

resources to pay for services no longer covered, forcing them to forego needed care or to seek care from safety-net clinics or hospitals that are already straining under the burden of providing uncompensated care.

Even the more comprehensive SCHIP benchmarks typically do not cover several key benefits that are either mandated or covered at state option under Medicaid including EPSDT, long-term care, Federally Qualified Health Center (FQHC) and many rehabilitative services.<sup>iv</sup> (Figure 4)



Through the EPSDT benefit, Medicaid provides children access to a broad range of screening and treatment services, promoting more uniform and comprehensive coverage for children across all states. EPSDT requires states to provide children access to services such as physical and mental health therapies, dental and vision care, personal care services, and durable medical equipment that are often not covered or are strictly limited under SCHIP plans. Without Medicaid many children, especially those with disabilities and other special needs, would lose access to needed services. The EPSDT mandate further broadens access to services by applying a less restrictive medical necessity standard than what is typically applied in SCHIP. Under EPSDT, services are deemed medically necessary if they ameliorate or correct a condition or illness. For states that opt to provide benchmark benefits to children under Medicaid, it will be important to monitor to evaluate if the EPSDT wrap-around coverage will provide children the same access as under Medicaid before the DRA options.

The passage of the Family Opportunity Act included in DRA that allows families with incomes under 300 percent of FPL to buy into Medicaid to access health coverage for disabled children. This legislation recognizes that private insurance options are typically not affordable or do not cover the necessary services for individuals with special needs.

## COST SHARING

**Key Differences.** Historically, states were not allowed to impose cost sharing or premiums on any children under 18 (mandatory or optional), for any service in Medicaid. Starting

March 31, 2006, the DRA gives states flexibility under Medicaid to impose new or higher cost sharing amounts for most beneficiaries. Individuals under the poverty level could face nominal cost sharing (determined by the Secretary) that could increase at the rate for the medical component of the consumer price index; individuals between 100 and 150 percent of the FPL could face copayments of 10 percent of the cost of services increasing to 20 percent for individuals with incomes between 150 and 200 percent of the FPL. Mandatory children and pregnant women are still exempt from cost sharing for services except for copayments for non-preferred prescription drugs.

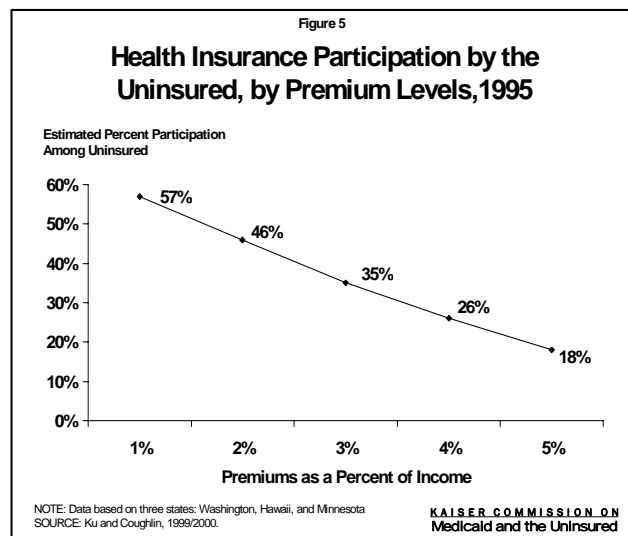
States are also allowed to impose premiums for individuals with incomes above 150 percent FPL. Total cost sharing (including premiums) can not exceed five percent of an individual's income determined on a quarterly or monthly basis. The DRA also allows states to make cost sharing enforceable meaning that providers or pharmacists could deny services or access to drugs if a beneficiary cannot pay the cost-sharing amount at the point of service.

Under SCHIP, states may charge families premiums and may require copayments, although cost sharing amounts cannot exceed 5 percent of annual family income. States face greater restrictions on imposing cost sharing on children with lower family incomes. For children with incomes below 150 percent of the federal poverty level, states cannot charge more than \$16 per month for premiums or more than \$5 per service. Cost sharing in SCHIP is enforceable, allowing providers to deny services for failure to pay copayments.

**What are the implications of SCHIP Cost Sharing for Medicaid?** A large body of research, as well as recent experience with Medicaid 1115 waivers and SCHIP, shows that premiums and cost sharing can create barriers to obtaining or maintaining coverage, increase the number of uninsured, reduce use of essential services, and increase financial strains on families who already devote a substantial share of their incomes to out-of-pocket medical expenses.<sup>v</sup> Studies show that health insurance participation steadily declines when premiums are imposed, particularly at low levels of income. (Figure 5) Families, not the states, are responsible for keeping track of cost sharing amounts and whether they hit the 5 percent cap under SCHIP and now under Medicaid. This record-keeping can be difficult for families, particularly when income and expenses vary throughout the year.

It is argued that requiring individuals to share in the cost of their care will encourage more appropriate utilization of services, but available research indicates that when health status differences are taken into account, Medicaid beneficiaries use about the same amount of services as the low-income privately insured population even though they face lower out-of-pocket costs.<sup>vi</sup> Any additional cost burden, especially for a very low-income population, could result in

decreased use of essential services, which would be especially hard on those with chronic conditions. Increased cost sharing is likely to shift costs to safety net providers who have a mission to serve individuals regardless of ability to pay. Much of the savings expected from increased cost sharing are attributable to utilization decline and the savings from imposing premiums are largely attributable to enrollment declines.



## CONCLUSION

Medicaid and SCHIP together have proven successful at helping to reduce the number of uninsured low-income children and moderate the increase in the uninsured population as employer-based coverage declines. While the programs have similar objectives, there are critical differences in the underlying structure of the two programs. Medicaid beneficiaries tend to be poorer and sicker than the children in SCHIP. Applying SCHIP-like principles for benefits and cost sharing to Medicaid could have serious implications for beneficiaries who have greater health needs and are more likely to be chronically ill. The changes the DRA made to Medicaid in these areas will require careful monitoring to assess the beneficiary implications if states adopt these changes.

Typical of capped financing programs, SCHIP financing has proven problematic in terms of overall funding levels and in targeting funds across states. Unlike the capped financing in SCHIP, the guaranteed federal match with no pre-set limits has enabled Medicaid to respond effectively to economic downturns, emergencies and epidemics in a way that would be unachievable with capped federal resources. Differences in Medicaid and SCHIP, in terms of the population covered, program design and financing structure, will need to be weighed as discussion over the future of Medicaid and SCHIP reauthorization proceed.

Additional copies of this publication (#7488) are available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).

**Appendix A**  
**Comparison of the Medicaid and SCHIP Programs for 2004**

	<b>MEDICAID</b>	<b>SCHIP</b>
<b>GROUPS COVERED</b>	<p>Low-income children            Low-income parents and pregnant women            Low-income children and adults with disabilities            Low-income elderly ( 65 years of age +)            Children and adults with incomes above limits but with high medical expenses and who “spend down” to Medicaid</p>	<p>Children with incomes above Medicaid standards who do not have private health coverage.</p> <p>Some parents and other adults through Waivers (this option is no longer available based on the Deficit Reduction Act of 2005)</p>
<b>NUMBER OF ENROLLEES</b>	<p>52 million total, including:            25 million children            14 million other adults including pregnant women            8 million persons with disabilities            5 million elderly</p>	<p>4.4 million children            (including 1.8 million in Medicaid expansion Programs)</p>
<b>COSTS</b>	<p>\$288 billion (\$170 B federal; \$118 B state)            \$46 billion for children (\$27 B federal; \$19 B state)</p>	<p>\$6 billion (\$4.2 B federal; \$1.8 B state)</p>
<b>FINANCING</b>	<p>Open ended entitlement; enrollment caps prohibited            Regular match rate</p>	<p>Block grant; enrollment caps permitted            Enhanced match rate</p>
<b>SCOPE OF COVERAGE</b>	<p>Comprehensive range of federally defined benefits, including EPSDT, dental, mental health, prevention or EPSDT wrap-around coverage for states opting to provide benchmark coverage</p>	<p>State-defined within broad federal benchmark coverage requirements            – large variation state to state</p>
<b>COST SHARING AND PREMIUMS</b>	<p>Cost sharing is not permitted for mandatory children under 18 and pregnant women (except that states may impose nominal copayments for non-preferred drugs). Cost sharing also prohibited for preventive services (i.e. well-child and immunizations) for children under 18.</p> <p>States have the option to impose copayments of 10% of services for individuals 100-150% FPL and 20% of services for individuals 150-200% FPL.</p> <p>States can impose premiums for children with incomes above 150% FPL.</p> <p>Limited to 5% of family income every month or after every quarter.</p> <p>Providers can deny services for failure to pay cost sharing</p>	<p>Limited to no more than 5% of family income annually. Below 150% FPL, premiums cannot exceed \$16/month, copayments limited to \$5</p> <p>No cost sharing on preventive services (i.e.well-child and immunizations)</p> <p>Providers can deny services for failure to pay cost sharing</p>

<sup>i</sup> Data compiled by Health Management Associates from state enrollment reports

<sup>ii</sup> Byck, G., “A Comparison of the Socioeconomic and Health Status Characteristics of Uninsured, State Children’s Health Insurance Program-Eligible Children in the United States with Those of Other Groups of Insured Children: Implications for Policy” *Pediatrics*, Vol. 106, No. 1, July 2000.

<sup>iii</sup> Differences that Make a Difference. CCF Georgetown Health Policy Institute, October 2005.

<sup>iv</sup> Rosenbaum, S., Marcus, A., Sonosky, C. “Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP.” *Journal of Health and Biomedical Law*. March 2005

<sup>v</sup> Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations. KCMU, March 2003

<sup>vi</sup> Medicaid: A Lower-Cost Approach to Serving a High-Cost Population. KCMU, March 2004.