THE KAISER COMMISSION ON
Medicaid and the Uninsured

January 2007

A DECADE OF SCHIP EXPERIENCE AND ISSUES FOR REAUTHORIZATION

The State Children's Health Insurance Program (SCHIP) was created nearly a decade ago as part of the Balanced Budget Act of 1997 (BBA). Together with Medicaid, SCHIP has helped to dramatically reduce the number of low-income uninsured children by expanding eligibility levels and simplifying application procedures. Coverage gains helped to increase access to health services for millions of children. Despite these achievements, nine million children remain uninsured, many of whom are currently eligible for public programs.

Estimates show that current funding levels are not adequate to maintain current enrollment levels causing enrollment declines over the next five years. In FY 2007 seventeen states are expected to face funding shortfalls, despite last minute legislation in 2006 that partially addressed this issue.

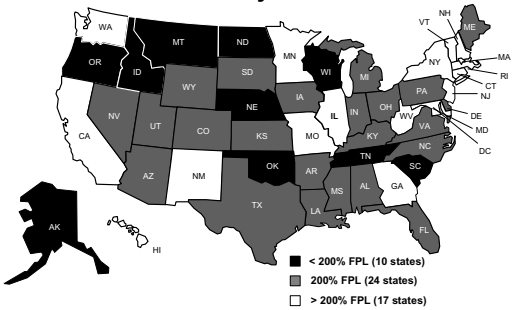
SCHIP must be reauthorized by Congress for funding to continue beyond FY 2007. The level of aggregate federal funding is likely to dominate the reauthorization discussions in the 110th Congress, but other issues such as eligibility for SCHIP, scope of benefits and other program issues could also emerge. This brief explores some lessons learned and highlights key reauthorization issues.

PROGRAM OVERVIEW

Created as Title XXI of the Social Security Act, SCHIP builds on Medicaid to provide insurance coverage to "targeted low-income children" who are uninsured and not eligible for Medicaid, typically from families with incomes up to 200 percent of the Federal Poverty Level (FPL) or $33,200 per year for a family of three in 2006. Forty-one states cover children in families with incomes up to or above 200 percent of FPL under Medicaid or SCHIP. (Figure 1)

Figure 1

Children's Eligibility for Medicaid/SCHIP by Income, July 2006



*The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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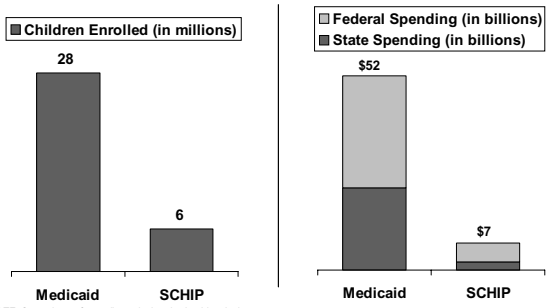
States have the option of using SCHIP funds to create a separate SCHIP program, expand their Medicaid program, or adopt a combination approach. Currently, 18 states operate separate SCHIP programs, 11 states plus the District of Columbia expanded Medicaid, and 21 states rely on a combination approach (Table 1). In 2005, SCHIP covered 6 million low-income children during the course of the year and about 4 million at any point in time with annual costs of $7 billion (in state and federal funds), much smaller in scope than coverage for 28 million children under Medicaid. Compared to Medicaid, SCHIP enrollees though still low-income tend to have higher incomes and better health status. (Figure 2)

Figure 2

Medicaid Enrollment and Spending for Children Compared to SCHIP, 2005



NOTE: State share of spending calculated using historical averages.
SOURCE: Kaiser Commission estimates based on March 2006 CBO Baseline and CMS Statistical Enrollment Data System (SEDS) data for ever-on SCHIP enrollment, 2006.

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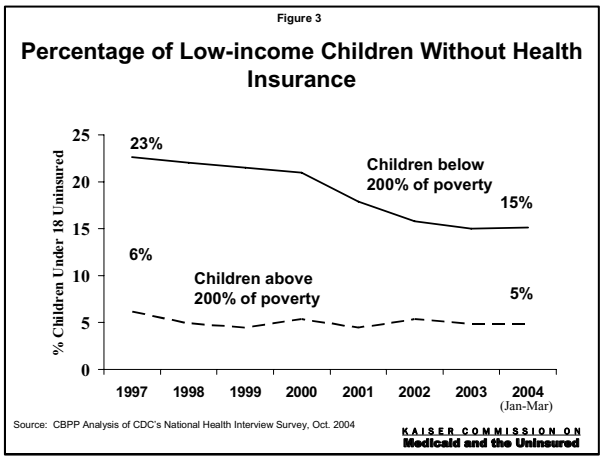
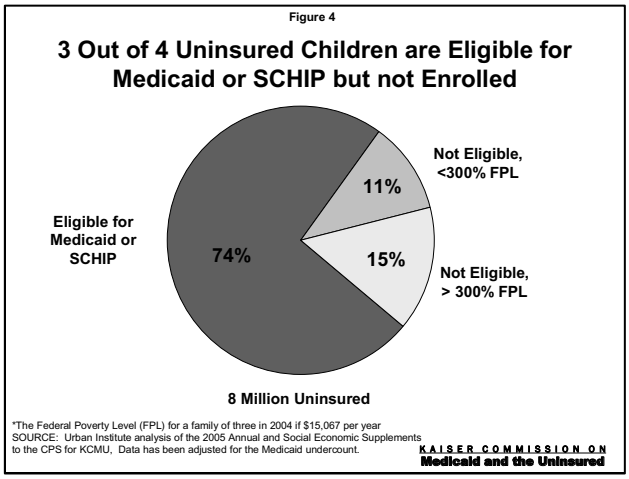
WHAT WE LEARNED

1. ***SCHIP, with Medicaid, helped to reduce the number of low-income uninsured children, but many children remain uninsured.***

The percentage of low income uninsured children fell by one-third since 1997. Largely driven by expansions in Medicaid and the implementation of SCHIP, the percentage of children without health insurance has fallen by about one-third (from 23 percent to 15 percent) from 1997 to 2004. (Figure 3) This decline occurred despite falling rates of employer sponsored coverage over the period, especially during the economic downturn from 2000 to 2004. As employer sponsored coverage continued to fall in 2005, the number of uninsured children rose for the first time since 1998, nearly eliminating any coverage gains from the previous four years. Near poor children (between 100 and 200 percent of FPL) experienced the greatest increase in uninsurance rates from 2004 to 2005.



Despite gains in coverage for children, nine million children are still uninsured. The share of uninsured children varies by state from a high of 20.4 percent in Texas to a low of 5.6 percent in Massachusetts. The number of uninsured children is a function of eligibility levels for public programs, state enrollment practices, participation rates and the availability of affordable private coverage. Estimates show that three out of four of these children are eligible for Medicaid or SCHIP but not enrolled. (Figure 4)



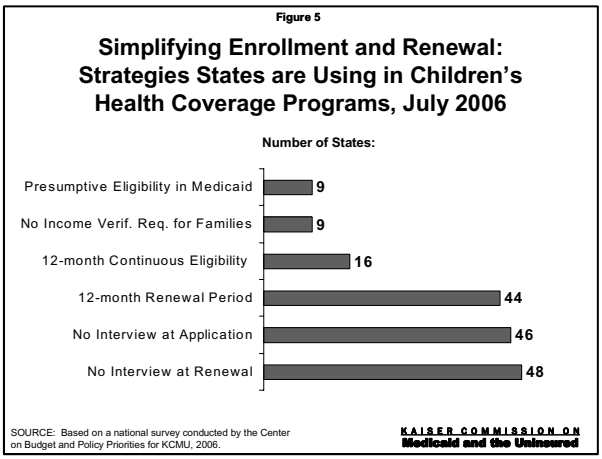
The primary reasons that eligible children remain uninsured are related to gaps in knowledge (many families have not heard of program or the parent does not think the child is eligible) and enrollment barriers. Research shows that non-white children are more likely than white children to be uninsured. These statistics suggest that alternative outreach strategies could be used to target specific groups of children.

Some groups of children such as legal immigrants living in the country for less than five years and illegal immigrants are not eligible for Medicaid or SCHIP except on an emergency basis even if they meet other income requirements; however immigrant children make up a small percentage of the number of uninsured. More than 96 percent of the nine million uninsured children are U.S. citizens leaving less than four percent as legal or illegal non-citizens.[i] Changes to federal policy would be required to allow these excluded children to participate in the program. While children who are US citizens are eligible, the immigration status of parents may dampen participation Medicaid and SCHIP.

2. States increased outreach and eligibility simplification efforts for both Medicaid and SCHIP to expand coverage; however, state fiscal pressures and new citizenship and identity documentation requirements run counter to these efforts.

Implementation of SCHIP spurred enrollment of children in both SCHIP and Medicaid. First, the goals of outreach and expanded coverage were embodied in the SCHIP statute. Second, many states chose to implement SCHIP programs by expanding Medicaid. Almost 30 percent of children enrolled in SCHIP were enrolled in Medicaid expansion programs. Third, intense outreach for SCHIP generated many new applications. The SCHIP statute requires states to "screen and enroll" children in Medicaid if they apply for SCHIP but meet Medicaid eligibility thresholds. Through these requirements, many applicants were found to be eligible for Medicaid. Finally, many states made efforts to streamline enrollment processes including the adoption of a joint application for Medicaid and SCHIP.

Other simplification procedures such as the elimination of the asset test, elimination of the face-to-face application interview, 12-month continuous eligibility, and self-declaration of income were adopted for children applying for both Medicaid and SCHIP. Today, many more states have adopted these simplifications for children but not for adults or other Medicaid populations. (Figure 5)

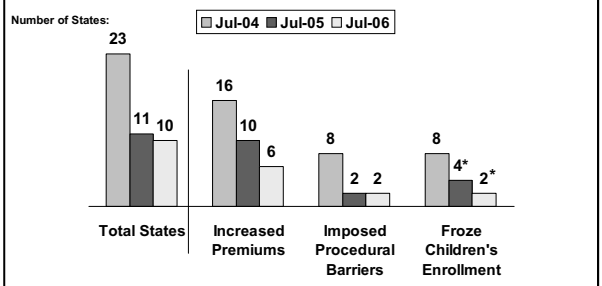


Faced with intense fiscal pressure during the recent economic downturn, some states adopted strategies to limit enrollment in Medicaid and SCHIP. While states turned to eligibility cuts as a last resort, due to the severity of the economic downturn many states implemented enrollment barriers to dampen participation and reduce enrollment.

Some barriers such freezing enrollment or imposing wait lists are not allowed under the Medicaid program, but were options used by states under their separate SCHIP programs to control spending. States also cut back on program outreach efforts during this time. As states witnessed the negative effects of some of these changes and as revenues started to recover in 2005 and 2006, several states are reversing some of the enrollment barriers put in place during the economic downturn. (Figure 6)

Figure 6

States Imposing Enrollment Barriers for Children (July 2005 – July 2006)



*Three of the four states that froze enrollment at some time between July 2004 and July 2005 unfroze enrollment by the end of the survey period (July 2005). As of Sept. 2006 there was a enrollment freeze in UT's SCHIP program and TN had an enrollment freeze in its Medicaid waiver program for children.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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The Deficit Reduction Act of 2005 included a provision that requires Medicaid enrollees to provide proof of citizenship to obtain or retain coverage. These new provisions do not specifically apply to SCHIP, but do apply in states that have used Medicaid expansions for SCHIP. These provisions are likely to create new barriers for Medicaid enrollees and move in the opposite direction from many simplification efforts that have worked to encourage enrollment. Some state data already show significant negative enrollment impacts from these new requirements.

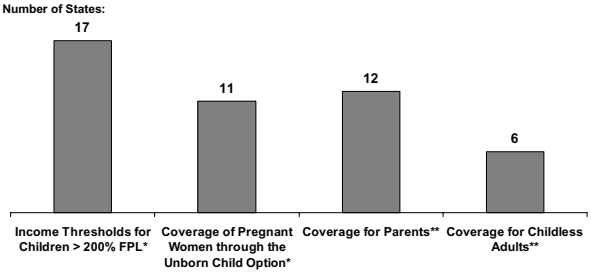
The ability for states to do appropriate program outreach is linked to available program funding. The Administration called for additional funding for a new "Cover the Kids" initiative to increase outreach efforts in the 2006 and 2007 budget proposals, but this initiative was not funded. Without additional federal dollars to support on-going program costs, it seems unlikely that states would embark on aggressive new outreach campaigns.

3. *Through waivers, SCHIP covers some pregnant women and parents, but coverage beyond these groups has been controversial.*

The original SCHIP legislation permitted the Secretary of HHS to allow "Section Demonstration 1115" waivers for alternative uses of SCHIP funds. In July, 2000, CMS issued SCHIP waiver guidelines permitting states to use SCHIP funds, under certain circumstances, to cover pregnant women and parents. Studies show that enrolling parents can promote increased coverage of children. In September, 2002, HHS issued rules allowing states to spend SCHIP funds to cover unborn children and the Bush Administration also extended the waiver policy to allow states to use SCHIP funds to cover childless adults. Twelve states have waivers approved to use SCHIP funds to cover parents, five states have waivers to cover childless adults and eleven states use SCHIP funds to cover pregnant women through the option to define a fetus as an unborn child. (Figure 7)

Figure 7

SCHIP Coverage Choices



NOTE: The number of states covering children > 200% includes IL even though these children are not explicitly covered with Title XXI funds.
SOURCE: *National survey conducted by the Center on Budget and Policy Priorities for KCMU data as of July 2006. **Data from CMS as of January 2007 regarding waivers approved. Not all waivers are implemented and some have very low enrollment.

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The expansion of SCHIP coverage for adults was always controversial because some argue that unused funds should be redirected to cover more uninsured children. The DRA prohibits any new SCHIP waivers to cover childless adults, but does not prohibit coverage expansions for parents of Medicaid or SCHIP kids. As states face funding shortfalls, the issue of who can or should be covered using SCHIP funds could re-emerge as an issue.

4. *Coverage through Medicaid and SCHIP increases access to care; however, compared to Medicaid, separate SCHIP programs have fewer benefits and additional cost sharing which can create some barriers to needed care.*

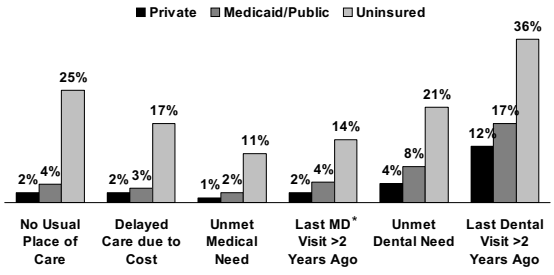
Children with Medicaid or SCHIP have access that is similar to private insurance coverage looking at measures of well-child visits, doctor visits and dental visits. Studies examining the effects of SCHIP show that children, even those with special health care needs, newly enrolled in SCHIP have improved access to care as measured by reductions in unmet health care needs, increased use of preventive care and an increased likelihood to have a regular source of care.[ii] (Figure 8)

Studies also show that even with SCHIP coverage, children with special health care needs had more unmet needs than those without special needs.[iii] Under SCHIP, states must provide health care services equivalent to a benchmark plan; however, even using the more comprehensive benchmarks, there are several key benefits that are either mandated or covered at state option under Medicaid that are not typically

covered under stand-alone SCHIP plans. This includes Early and Periodic Screening, Diagnosis and Treatment (EDSDT) services, long-term care services, Federally Qualified Health Center (FQHC) services and many rehabilitative services. Through the EPSDT benefit, Medicaid provides children coverage for a broad range of screening and treatment services, creating more uniform and comprehensive coverage for children across all states. EPSDT requires coverage for services including physical and mental health therapies, dental and vision care, personal care services, and durable medical equipment that are often not covered or are limited under SCHIP plans. Because of the EPSDT, Medicaid often serves as the safety-net coverage program for children with disabilities or other special needs.

Figure 8

Children's Access to Care, by Health Insurance Status, 2004



* MD or any health care professional, including time spent in a hospital. All estimates are age-adjusted.
Source: National Center for Health Statistics, CDC. 2006. Summary of Health Statistics for U.S. Children: National Health Interview Survey, 2004

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Medicaid has been the foundation for children's coverage and the safety-net of children with special needs who require services not typically covered by private insurance or SCHIP. This critical role that Medicaid plays is a factor to be considered in the upcoming SCHIP reauthorization discussions. The strong base of coverage from Medicaid and adequate funding to support those who are currently covered as well as those who are eligible but not enrolled in SCHIP are key components of the nation's commitment to provide health coverage to all children.

States also have more flexibility under SCHIP to impose premiums and cost sharing. The DRA allowed for more flexibility around cost sharing, but mandatory children (children under poverty) are generally exempt from any new cost sharing requirements. A large body of research 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.[iv] Under SCHIP cost sharing cannot exceed 5 percent of family income, however, families, not the states, are responsible for keeping track of cost sharing amounts and whether they hit the 5 percent cap. This record-keeping can be difficult for families, particularly when income and expenses vary throughout the year.

5. ***Capped financing in SCHIP helped to limit federal spending, but there has been a mismatch in the amount of aggregate funding available and in the distribution of funds across states.***

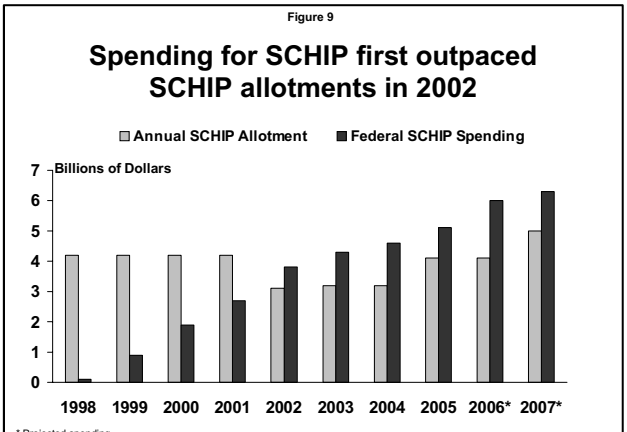
Capped financing for SCHIP helped to meet the federal spending targets that were part of the overall budget reconciliation bill that established the program. Under both Medicaid and SCHIP, state spending for eligible beneficiaries and eligible services is matched by the federal government. But, federal funds for Medicaid are guaranteed with no pre-set limits, while under SCHIP federal funds are capped, nationwide with state-by-state allocations. Thus, each state operates under an individual cap. As a result, SCHIP does not guarantee eligibility while Medicaid guarantees an individual entitlement, meaning all eligible beneficiaries are entitled to a defined set of benefits.

The matching rate for both programs is 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. The availability of new federal spending allotments in addition to an enhanced SCHIP matching rate provided incentives to states to expand coverage for children.

Federal funding levels set for a ten-year period may not be sufficient to meet program needs or demands. Pre-set funding levels are not sufficiently flexible to accommodate changes that affect demand for the program, such as economic downturns. In aggregate, SCHIP spending was less than total allotment levels in the early years of the program; but, when the SCHIP programs matured and statutory-set allotment levels dropped from $4.2 billion to $3.1 billion in 2002, spending exceeded annual allotment levels. (Figure 9)

Figure 9

Spending for SCHIP first outpaced SCHIP allotments in 2002



* Projected spending
SOURCE: "SCHIP Original Allotments: Funding Formula Issues and Options", October 2006. Congressional Research Service.

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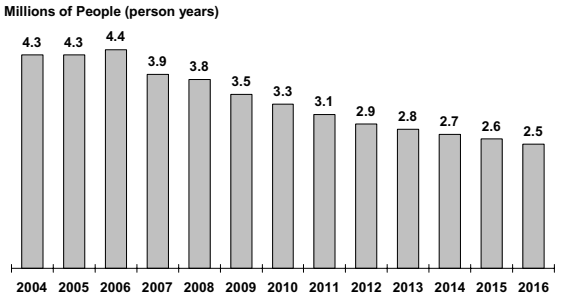
With rates of private insurance coverage continuing to decline, demand for publicly financed coverage is likely to increase. If, however, federal funding for SCHIP is held constant at $5 billion annually then SCHIP enrollment is expected to decline and contribute to an increase in the number of uninsured children. Some children may get covered by Medicaid after a state exhausts their SCHIP funds. Federal revenue of $13 to $15 billion over the next five years is estimated to be required to maintain current SCHIP enrollment levels.[v] (Figure 10)

Figure 10

SCHIP Enrollment Projections Assuming Federal SCHIP Allotments Frozen at $5 Billion Annually



SOURCE: Additional Detail of the FY 2007 Budget from Office of the Actuary at CMS. Accounts for children funded by enhanced federal matching and does not include children covered by Medicaid after enhanced funding is exhausted.

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In October 2006 the Congressional Research Service (CRS) estimated that 17 states were expecting SCHIP funding shortfalls in FY 2007 of just over $900 million. These shortfalls were partially offset by legislation at the end of 2006 that would redistribute existing unspent SCHIP funds. However, further action is needed to fully resolve the 2007 shortfalls (expected to be $716 million)[vi] and going forward more states are expected to face shortfalls.

The formulas for targeting funds to states have been problematic. The SCHIP distribution formula left 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 lead to numerous legislative changes to fix the formula. Despite these changes, just over $1 billion in unspent SCHIP funds reverted to the federal treasury in 2004 because some states were not able to spend their allotments within the legislated time frames while many children remained uninsured but eligible for public coverage. Some states had already expanded coverage for children so it was difficult to spend SCHIP allotments, but other states with high numbers of uninsured children left large amounts of money on the table, despite the enhance federal matching rate.

Other funding formula issues include debate about the use of the Current Population Survey as the data source for state estimates of low-income children and low-income uninsured children. Some argue that the CPS data are not accurate and not stable for state estimates. The SCHIP distribution formula also uses a state cost factor based on wages to target more funds to states with higher costs of providing care; there is concern that wages are not an appropriate measure of costs. Finally, the SCHIP distribution formula is based on combination of the low-income children and low-income uninsured children. Some argue that including uninsured children in the formula penalizes states for successfully enrolling children in coverage programs.

ISSUES TO CONSIDER FOR REAUTHORIZATION

Together Medicaid and SCHIP have demonstrated that expanded eligibility, effective outreach, simplified application procedures and the availability of federal matching dollars all contribute to successful efforts to expand coverage to children; however, more needs to be done to reach eligible, but not enrolled children.

As states continue to administer their SCHIP programs and as federal policy makers debate reauthorization, it is clear that a number of barriers remain on the path of reducing the number of uninsured children. Progress will depend on the amount and targeting of program funding, and the ability to remove barriers to coverage such as premiums and cost sharing or documentation requirements.

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[i] The Uninsured: A Primer. KCMU, October 2006.
[ii] Genevieve Kenney and Debbie Chang. "The State Children's Health Insurance Program: Successes, Shortcomings and Challenges". *Health Affairs.* Volume 23, Number 5 (2004)
[iii] "Does SCHIP Benefit All Low-Income Children?" *Child Health Insurance Research Initiative (CHIRI).* December 2004
[iv] Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations. KCMU, March 2003
[v] Freezing SCHIP Funding in Coming Years Would Reverse Recent Gains in Children's Health Coverage. CBPP, November 2006
[vi] SCHIP Provisions of HR 6164 (NIH Reform Act of 2006). CRS Report, December 12, 2006

Table 1. SCHIP Data by State: Program Type, 2007 Funding & Spending, and % Uninsured Children

($ in millions)	Program Type	FY2007 Allotment	Funding Available in FY 2007	2007 Spending Estimates	2007 Spending / 2007 Allotments	FY2007 Shortfall *	% Uninsured Children 2005
United States		**$4,988**	**$9,131**	**$6,473**	**1.30**	**-$927**	11.4%
Alabama	S	$74	$139.70	$103.90	1.40		6.1%
Alaska	M	$12	$15.70	$25.10	2.18	-$9	9.2%
Arizona	S	$128	$130.80	$125.60	0.98		16.3%
Arkansas	C	$49	$125.80	$52.00	1.05		9.4%
California	C	$791	$1,259.80	$1,083.40	1.37		13.6%
Colorado	S	$72	$177.30	$63.50	0.89		14.3%
Connecticut	S	$40	$111.00	$22.70	0.57		8.2%
Delaware	C	$11	$29.10	$9.80	0.88		11.9%
District of Columbia	M	$12	$28.40	$8.40	0.72		7.6%
Florida	C	$296	$572.90	$374.60	1.27		17.2%
Georgia	S	$166	$194.30	$312.10	1.88	-$118	11.9%
Hawaii	M	$15	$31.40	$23.50	1.54		5.6%
Idaho	C	$24	$62.30	$24.40	1.00		10.9%
Illinois	C	$210	$238.20	$482.80	2.30	-$245	11.2%
Indiana	C	$94	$210.50	$76.10	0.81		9.6%
Iowa	C	$36	$41.50	$57.60	1.59	-$16	6.1%
Kansas	S	$37	$63.80	$51.80	1.42		6.9%
Kentucky	C	$70	$143.10	$81.20	1.16		7.9%
Louisiana	M	$90	$131.20	$135.10	1.51	-$4	8.7%
Maine	C	$15	$25.30	$25.80	1.70	-$1	7.2%
Maryland	C	$67	$80.70	$148.10	2.21	-$67	9.5%
Massachusetts	C	$73	$88.40	$218.20	2.98	-$130	5.5%
Michigan	C	$149	$214.00	$184.60	1.24		5.9%
Minnesota	C	$49	$54.80	$86.40	1.78	-$32	6.5%
Mississippi	S	$61	$94.00	$133.10	2.20	-$39	13.1%
Missouri	M	$72	$82.00	$109.90	1.52	-$28	8.4%
Montana	S	$16	$32.50	$16.90	1.08		15.4%
Nebraska	M	$22	$23.20	$34.70	1.58	-$12	6.1%
Nevada	S	$52	$134.30	$33.00	0.63		15.8%
New Hampshire	C	$11	$29.20	$7.60	0.70		6.3%
New Jersey	C	$105	$123.40	$279.90	2.66	-$157	10.9%
New Mexico	M	$52	$132.60	$60.70	1.17		17.9%
New York	S	$341	$740.60	$380.70	1.12		8.0%
North Carolina	C	$136	$163.80	$181.50	1.33	-$18	11.6%
North Dakota	C	$8	$12.70	$10.70	1.39		9.6%
Ohio	M	$158	$248.80	$184.30	1.17		8.3%
Oklahoma	M	$71	$128.50	$82.40	1.16		14.5%
Oregon	S	$57	$122.90	$60.30	1.06		10.9%
Pennsylvania	S	$174	$338.10	$177.80	1.02		9.4%
Rhode Island	C	$14	$20.10	$63.40	4.53	-$43	7.6%
South Carolina	M	$71	$153.00	$62.40	0.88		9.5%
South Dakota	C	$10	$11.60	$14.20	1.37	-$3	9.0%
Tennessee	M	$98	$256.80	$29.10	0.30		9.7%
Texas	S	$558	$1,462.70	$444.70	0.80		20.4%
Utah	S	$41	$84.90	$38.80	0.96		11.9%
Vermont	S	$6	$15.50	$3.40	0.59		5.9%
Virginia	C	$94	$173.70	$112.10	1.19		8.8%
Washington	S	$80	$209.30	$32.10	0.40		8.0%
West Virginia	S	$28	$57.90	$37.40	1.36		8.7%
Wisconsin	M	$70	$91.00	$98.00	1.41	-$7	6.7%
Wyoming	S	$7	$17.90	$7.10	1.03		10.9%

a) Data on program type from CMS testimony to Senate Finance Subcommittee on Health Care, July 25, 2006

b) Data on allotments, spending and shortfall estimates from CRS, State Children's Health Insurance Program: A Brief Overview. 10/12/2006 and CRS Report: SCHIP Original Allotments: Description and Analysis. 10/31/2006.

***Note**: State estimates from Dec. show that 14 states are expected to have shortfalls in 2007 totaling $1 billion; these detailed spending projections are not available. After accounting for legislative changes included in HR 6164, the projected shortfall for FY 2007 is expected to fall to $716 million according to CRS Report: SCHIP Porivisions of HR 6164 (NIH Reform Act). 12/12/2006.

c) % uninsured children from KCMU, The Uninsured: A Primer. October 2006

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Medicaid and the Uninsured

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