kaiser commission on medicaid and the uninsured
KEY FACTS
THE HENRY J. KAISER FAMILY FOUNDATION

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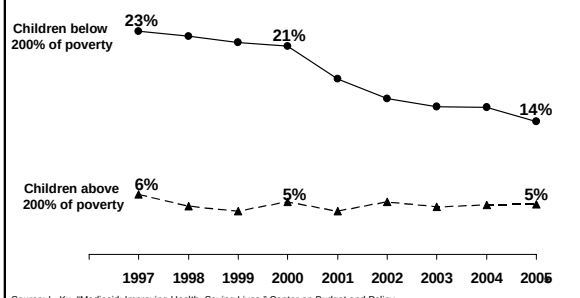
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) AT A GLANCE

The State Children's Health Insurance Program (SCHIP) was established as Title XXI of the Social Security Act nearly a decade ago as part of the Balanced Budget Act of 1997 (BBA). Together with Medicaid, SCHIP provides a safety-net for health insurance for low-income children and has helped to significantly reduce the number of low-income uninsured children. (Figure 1)

Figure 1

Percentage of Children Without Health Insurance, By Poverty Level, 1997-2005



Source: L. Ku, "Medicaid: Improving Health, Saving Lives," Center on Budget and Policy Priorities analysis of National Health Inverview Survey data, August 2005.
* Survey method change in 2005 affects comparison with earlier years slightly. Children less than 18 years old.

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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). Medicaid underpins SCHIP and covered 28 million low-income children in 2005. SCHIP must be reauthorized by Congress in 2007 for federal financing to continue. The level of aggregate federal funding and the distribution of funding across the states are likely to be key areas of debate as the SCHIP reauthorization discussions get underway.

HOW IS SCHIP ADMINISTERED?

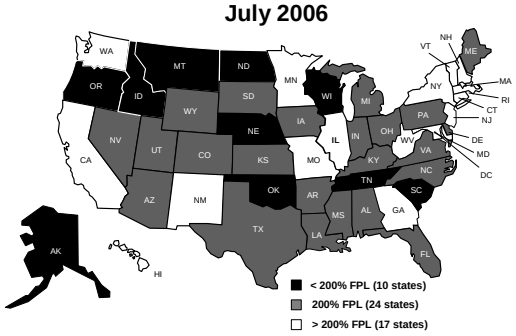
Like Medicaid, SCHIP is administered by the states within broad federal guidelines. States can use SCHIP funds to create a separate SCHIP program, expand their Medicaid program, or adopt a combination approach. Currently, 18 states operate separate SCHIP programs, 11 states plus the District of Columbia expanded Medicaid, and 21 states rely on a combination approach.

WHO IS ELIGIBLE FOR SCHIP?

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 $2,767 per month for a family of three in 2006. Forty-one states cover children up to or above 200 percent of FPL under Medicaid and/or SCHIP. (Figure 2)

Figure 2

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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Unlike Medicaid, children covered under separate SCHIP programs, 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. Federal law requires states to "screen and enroll" children in Medicaid if they apply for SCHIP but meet Medicaid eligibility thresholds.

The original SCHIP legislation permitted the Secretary of HHS to allow "Section Demonstration 1115" waivers for alternative uses of SCHIP funds. Through waivers eight states use SCHIP funds to cover parents, four states cover childless adults and 11 states use SCHIP funds to cover pregnant women through the option to define a fetus as an unborn child.[i] The Deficit Reduction Act (DRA) enacted in February 2006 prohibits any new SCHIP waivers to cover childless adults.

WHAT SERVICES ARE COVERED?

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.

Stand-alone SCHIP plans do not cover a number of services covered by Medicaid including Early and Periodic Screening, Diagnosis and Treatment (EDSDT) services. Through the EPSDT benefit, Medicaid provides children coverage for a broad range of screening and treatment 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 with no other options. When states use SCHIP to expand Medicaid they must use the mandated Medicaid benefits package, which includes EPSDT.

WHAT ARE THE RULES AROUND COST SHARING?

States have options to impose cost sharing and/or premiums within certain limits for children covered under SCHIP. 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 under SCHIP. Total cost sharing amounts cannot exceed 5 percent of annual family income. Under SCHIP cost sharing can be enforceable, meaning that providers can deny services for failure to pay copayments. In a move to make Medicaid look more like SCHIP, the DRA allowed for more flexibility around cost sharing in Medicaid; however, mandatory children (children under poverty) are generally exempt from these new requirements. Research shows that premiums and cost sharing for low-income populations can create barriers to obtaining or maintaining coverage and reduce use of essential services.[ii]

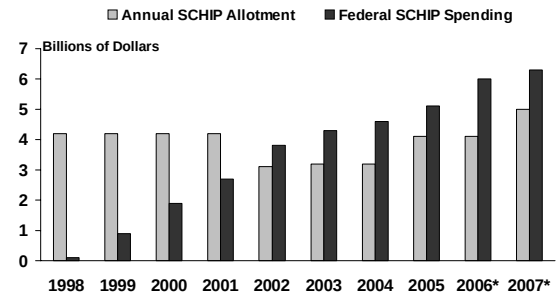
HOW IS SCHIP FINANCED?

Like Medicaid, the federal government matches state spending on eligible program beneficiaries; however, under SCHIP funds are capped, nationwide, and by state so federal funds match state spending up to the allotment. The matching rates for Medicaid and SCHIP rely on a formula based on states' relative per capita income. To encourage states to participate in SCHIP, the federal government assumed a larger share of SCHIP financing by paying an 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.

When SCHIP was established, federal SCHIP allotments were established for ten years. The funding stream was designed to hit certain budget targets that were part of the larger budget reconciliation bill that included SCHIP. In aggregate, SCHIP spending was less than total allotment levels in the early years of the program; but, when the SCHIP programs matured and allotment levels fell from $4.2 billion to $3.1 billion in 2002, spending exceeded annual allotment levels. Many states support their current programs with roll-over funding drawing on unused portions of prior year allotments. (Figure 3)

Figure 3

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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The formula that allocates SCHIP funds across states is based on each state's share of low-income and low-income uninsured children as well as a state cost factor based on wages. There is a provision in the SCHIP law to "redistribute" SCHIP funds from states unable to spend their full allotments within three years to states that exceeded their funding allotments. The formulas for distributing and redistributing SCHIP funds have been controversial and there have been several legislative changes to the original statute to change these formulas. States that implement SCHIP through a Medicaid expansion program can continue to receive federal matching dollars at the lower Medicaid matching rate if they exceed their SCHIP allotment.

WHAT ARE THE KEY ISSUES 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. As policy makers begin to discuss SCHIP reauthorization, several states are expected to face shortfalls by the end of FY 2007 and more states will face shortfalls in the future. Estimates indicate that over the next five years $13 to $15 billion over current levels will be required to maintain current SCHIP enrollment levels.[iii] Additionally, new census data show that over nine million children remain uninsured, the majority of them are currently eligible for Medicaid or SCHIP but not enrolled. The level of funding and the distribution of funds to states will be important SCHIP reauthorization issues and will affect efforts to reduce the number of uninsured children.

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[i] Data from a national survey conducted by the Center for Budget and Policy Priorities for KCMU and KCMU SCHIP enrollment reports
[ii] Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations. KCMU, March 2003
[iii] Freezing SCHIP Funding in Coming Years Would Reverse Recent Gains in Children's Health Coverage. CBPP, November 2006