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Family Coverage Under SCHIP Waivers

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Executive Summary

As states move forward with health coverage initiatives and the Congress takes action to reauthorize the State Children's Health Insurance Program (SCHIP), attention at both the national and state level has been focused on expanding coverage, particularly for children. Coverage of parents has also been part of the discussion, including the use of SCHIP funds to cover parents under waivers. SCHIP coverage generally "sits on top" of a state's Medicaid coverage. States have the option to expand Medicaid coverage to children and parents above federal minimum levels and receive federal Medicaid matching funds. SCHIP offers states an enhanced federal matching rate (relative to the Medicaid rate) to cover children, subject to state and national caps on SCHIP funds. However, the enhanced SCHIP matching rate is not available for states to cover parents except through a waiver. Currently, eleven states cover parents with SCHIP funds. This paper examines these eleven programs and considers them within the context of the states' efforts to cover children. The information is based on a survey of these eleven states that was conducted in March-April 2007.

Waiver authority was included in the original SCHIP law, and longstanding federal waiver policy has allowed coverage of parents with SCHIP funds.

The 1997 SCHIP law authorizes the Secretary of HHS to grant waivers that are consistent with SCHIP's objectives. Waivers permit states to use SCHIP funds in ways that are not otherwise allowed by the law. In 2000, based on research showing the benefits for children of parent coverage, federal SCHIP waiver guidelines were issued permitting family coverage under certain conditions. In 2001, the Bush Administration released a broader waiver initiative, called the Health Insurance Flexibility and Accountability (HIFA) initiative, which encouraged waivers that used Medicaid and SCHIP funds to cover uninsured adults and emphasized initiatives that increased the role of private plans. Waivers approved pursuant to both sets of guidelines require states to prioritize children's coverage and do not allow states to close enrollment or decrease eligibility for children while the waiver is in effect. The early SCHIP waivers also required states to take actions aimed at increasing children's enrollment in Medicaid and SCHIP, such as enrollment simplifications.

The eleven SCHIP waivers covering parents fall into three categories that reflect different rationales for the waiver initiatives.

Each of the eleven states that currently cover parents through an SCHIP waiver have differing circumstances that help shed light on why they sought their SCHIP waiver. In general, the states fall into one of three groups, which reflect the rationales of their waivers:

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- The two states characterized as "Early Leaders in Children's Coverage" in Table 1 had little ability to use their SCHIP funds for children because they had already expanded children's coverage through Medicaid; their waivers enabled them to access their SCHIP allotments to cover parents. These states extend eligibility and comprehensive benefits to all uninsured parents who fall within their waivers' income eligibility ranges.
- The four "Family Coverage" states pursued their waivers with a goal of increasing coverage and improving care for children by covering families. These states also extend eligibility and full benefits to all uninsured parents who fall within their waivers' income eligibility ranges.
- The remaining five states have more "Limited Expansions" focused on reducing adult uninsured rates. They generally target subgroups of parents, such those who work for small businesses, and offer limited benefits or subsidies ("premium assistance") for private coverage.

Table 1:
SCHIP Family Coverage Waivers and Children's Medicaid/SCHIP Eligibility Limits

	Children's Medicaid/ SCHIP Limit (% FPL)	SCHIP Parent Coverage				
		Eligibility (% FPL)	Restricted to Subgroups?	Enrollment as of 12/31/06	Ever-Enrolled FFY 2006	Benefits
Early Leaders in Children's Coverage						
Minnesota	275%[1]	100-200%	No	18,649	34,313	Medicaid/SCHIP
Rhode Island	250%	100-185%	No	12,077	20,771	Medicaid/SCHIP
Comprehensive Family Coverage Initiatives						
Arizona	200%	101-200%	No	14,269	24,769	Medicaid/SCHIP
Illinois	200%	36-185%	No	129,994	209,622	Medicaid/SCHIP
New Jersey	350%	35-115%	No	79,523	88,401	Medicaid/SCHIP
Wisconsin[2]	185%	100-185%	No	38,994	70,227	Medicaid/SCHIP
Expansions with Limited Eligibility/Benefits						
Arkansas	200%	19-200%	Yes	n/a	n/a	Limited
Idaho	185%	35-185%	Yes	164	277	Limited
Nevada	200%	86-200%	Yes	n/a	n/a	Limited
New Mexico	235%	37-200%	Yes	2,260	2,756	Limited
Oregon	185%	0-185%	No[3]	4,513	7,306	Limited
Enrollment Totals				**300,443**	**458,442**	

[1] Infants are covered up to 280% FPL.
[2] Children and parents are eligible up to 185% FPL, but they may remain enrolled with income up to 200% FPL.
[3] Income-eligible parents are eligible for a subsidy for the purchase of group or individual private coverage. However, enrollment in individual coverage is sometimes closed; during these periods, eligibility is restricted to parents with access to group coverage.
Notes: These eligibility limits do not reflect income disregards. Arkansas and Nevada were implemented after December 2006 and, thus, do not have any enrollment to report.
Source: State reported data, March-April 2007.

Nationwide, SCHIP parent enrollment is relatively small, but the coverage helps fill a major coverage gap for low-income parents.

As of December 31, 2006, nationwide, about 300,000 parents were enrolled under SCHIP, and about 460,000 parents were "ever-enrolled" at some point during the 2006 Federal Fiscal Year. This number is lower than other estimates of the number of adults ever-enrolled in SCHIP-

funded coverage over a year because it does not include pregnant women or childless adults covered under SCHIP waivers. (The Congress prohibited future SCHIP waivers to cover childless adults in the Deficit Reduction Act of 2005.) The highest enrollment is in the "Early Leader" and "Family Coverage" states, reflecting their broader eligibility and that these waivers have been in place for a longer period of time. The limited waivers have lower enrollment, reflecting more recent implementation and eligibility restrictions. As shown in Table 1, in all eleven states, the parents who are covered have incomes below 200% of poverty, and, in six of the eleven states, the parents gaining coverage under the waivers include those who are very low-income (below 50% of poverty or $692 per month for a family of three in 2006). Parents at these income levels have few other coverage options.

SCHIP parent coverage represents a fraction of children's SCHIP and Medicaid coverage.

When considering SCHIP parent coverage relative to states' efforts to cover children, it is useful for a number of reasons to examine children's enrollment within the broader context of SCHIP and Medicaid. Some of the waiver states cover a relatively small number of children through SCHIP, because they had already significantly expanded children's coverage through Medicaid before SCHIP was adopted. Comparing SCHIP-funded parent enrollment to SCHIP-funded child enrollment in these states overlooks the fact that these states had limited ability to access their SCHIP funds for children as well as the progress these states had already made in covering children through Medicaid. Further, in a number of the states, SCHIP parent eligibility starts at an income level that is well below where SCHIP eligibility for children begins and, as such, the children of SCHIP parents are often covered through Medicaid, not SCHIP. This is because SCHIP eligibility "sits on top" of Medicaid, and Medicaid eligibility levels are generally much higher for children than for parents.

Examining states' enrollment levels within the broader context of a state's coverage for children under both SCHIP and Medicaid finds that SCHIP parent coverage represents just a small fraction of children's coverage. As of December 31, 2006, the six "Early Leader" and "Family Coverage" states (those with the largest parent enrollment) together covered about 294,000 parents through SCHIP compared to roughly 3.3 million children in SCHIP and Medicaid.

Parent coverage leads to gains in enrollment and access to care for children while also improving access to care for the parents themselves.

The research literature consistently shows that family coverage leads to increases in enrollment and access to care for children. Enrollment data and evaluations conducted by some of the waiver states support these findings. Further, by covering previously uninsured parents, the waivers have led to significant improvements in parents' access to care as well.

In sum, over the past decade, SCHIP parent waivers have been approved based on findings that they promote children's coverage and as part of efforts to reduce the number of uninsured. The data in this report show that, nationwide, SCHIP parent enrollment is relatively small, but the coverage provided through the waivers helps fill a major coverage gap for low-income parents. Given the income levels of parents covered through waivers and that low-income parents have high uninsured rates, with more than one in three lacking coverage, it is likely that in the absence of this coverage these parents would be uninsured. The states' experiences also illustrate the close relationship between parent and child coverage and access to care and the importance of family coverage for both parents and their children.

INTRODUCTION

There has been increased focus on expanding health coverage as a number of states have moved forward with broad coverage expansion initiatives and the Congress takes action to reauthorize the State Children's Health Insurance Program. Coverage of children is the primary focus of SCHIP reauthorization and many of the state expansion proposals. However, coverage of low-income parents, including some states' use of SCHIP funds to cover low-income parents under Section 1115 waiver authority, has also been part of the policy discussion. Overall, low-income parents have high uninsured rates and are much more likely to be uninsured than their children because they have very limited access to both private and public coverage.[1] Nationally, in 2005, more than one in three (36%) low-income non-elderly parents (below 200% of poverty) was uninsured, compared to 19% of low-income children.[2]

As of April 2007, eleven states were using SCHIP funds to cover parents through waivers.[3] This paper examines these programs and considers SCHIP coverage of parents within the context of the states' coverage for children. The information is based on a survey of the states with parent waiver programs conducted in March-April 2007. This paper does not address other waivers that allow SCHIP coverage for pregnant women and childless adults. (The Congress prohibited further SCHIP waivers for childless adults under the Deficit Reduction Act of 2005.)

FEDERAL SCHIP WAIVER POLICY

The law that established SCHIP in 1997 specifically authorized SCHIP waivers under "Section 1115" waiver authority.[4] Through Section 1115 SCHIP waivers, the Secretary of Health and Human Services can permit states to use SCHIP funds in ways that are not otherwise permitted by the law. This waiver authority is broad under law, limited only by the requirement that the waiver be "consistent with the objectives" of the program.[5] However, in practice, SCHIP waiver authority is also bounded by the limits of a state's available SCHIP funds.

In July 2000, two years after states began to implement their SCHIP programs, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) issued SCHIP waiver guidelines.[6] Referring to the objectives of SCHIP, the guidance advised states that the Secretary would "consider demonstration proposals that will expand coverage and improve enrollment, health care outcomes, and access to health care services for children." Noting that family coverage met this objective and was anticipated by the SCHIP law,[7] the guidelines permitted parent coverage waivers if a state could show that that it was "effectively" covering children targeted by the SCHIP law.[8] The guidelines also permitted waivers to cover pregnant women, but advised that the Secretary would not approve SCHIP waivers to cover other adults.[9] Consistent with the waiver guidance, the terms of the first SCHIP waivers included specific conditions for each state aimed at promoting effective enrollment of eligible children in both SCHIP and Medicaid and they prioritized children's coverage (see box). Further, the waivers prohibited the states from closing enrollment or decreasing eligibility for children in SCHIP while the waiver was in effect.

Rhode Island: An Example of Requirements to Promote Enrollment of Children Under Early SCHIP Parent Waivers

The original terms and conditions for Rhode Island's parent SCHIP waiver required that the state not close enrollment, institute waiting lists, or decrease eligibility for children covered under SCHIP while the waiver was in effect. Further, the waiver required the state to implement at least three of the following policies and procedures in its child health programs (Medicaid and SCHIP) in order to promote enrollment of eligible children:

- Use of a joint, mail-in application and common application procedures
- Procedures that simplify the coverage renewal process by allowing families to establish their child's continuing eligibility by mail
- Elimination of assets test
- Twelve-month continuous eligibility
- Presumptive eligibility

In August 2001, the Bush Administration released new Section 1115 waiver guidance for its Health Insurance Flexibility and Accountability (HIFA) initiative. The guidance was not limited to SCHIP, but was part of a broader waiver initiative "to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources."[10] Initiatives that increased the role of private plans were particularly encouraged.[11] With respect to SCHIP funding for adult coverage, the HIFA initiative maintained the earlier policy of allowing states to use SCHIP funds to cover parents and pregnant women. It also overrode the earlier waiver policy by permitting states to use SCHIP funds to cover childless adults. Congress later stopped further SCHIP waivers for childless adults as part of The Deficit Reduction Act of 2005.[12]

Like the earlier parent coverage waivers, the terms and conditions of the HIFA SCHIP parent waivers require states to prioritize children's coverage and prohibit states from closing enrollment and decreasing eligibility for children (see box). Unlike the earlier waivers, the HIFA SCHIP parent waivers do not require states to take specific actions aimed at enrolling eligible children. Further, as explained below, a number of the HIFA SCHIP parent waivers are more limited in scope than earlier waivers.

Arizona: An Example of Requirements to Prioritize Children's Coverage Under a HIFA SCHIP Waiver

The terms and conditions of Arizona's HIFA SCHIP waiver require that if the state's SCHIP funding is insufficient to cover both children and parents, it must first use available SCHIP funding to cover costs associated with SCHIP children. Further, the state may not close enrollment, institute waiting lists, or decrease eligibility standards for children covered under its SCHIP program while the waiver is in effect.

WHY STATES SOUGHT TO COVER PARENTS WITH SCHIP WAIVERS

SCHIP coverage generally "sits on top" of a state's Medicaid coverage. States have the option to expand Medicaid coverage to children and parents above federal minimum levels and receive federal Medicaid matching funds. SCHIP offers states an "enhanced" federal matching rate that is higher, and more favorable to states, than the Medicaid matching rate, which prompted states to expand coverage for children (see box). Prior to SCHIP, only a few states had expanded

coverage for children (except for infants) above the federal minimum eligibility standards, but, with SCHIP's higher matching rate, every state adopted optional expansions for children and, as of 2006, 41 states covered children to at least 200% of poverty.[13] Some states expanded coverage by raising Medicaid eligibility levels, others created separate SCHIP programs, and some combined these two approaches.

The Enhanced Federal Matching Rate Under SCHIP

Like Medicaid, the federal government helps to finance coverage under SCHIP by providing "matching" payments. Under SCHIP, these matching funds are capped nationwide and by state but, to encourage states to participate in SCHIP, the matching rate is more favorable to states under SCHIP than under Medicaid. While the matching rates for both programs rely on a formula based on states' relative per capita income, each state's SCHIP matching rate is about 30% more favorable than its Medicaid matching rate. On average, the federal matching rate is 57% in Medicaid and 70% under SCHIP.

The enhanced SCHIP matching rate is not available for states to cover parents except through a waiver. As was true for children, few states have expanded coverage for parents with Medicaid's regular matching rate even though the federal minimum coverage standard for parents is much lower under Medicaid than it is for children. Reflecting this, as of 2006, the median Medicaid/SCHIP eligibility level for parents was only 65% of poverty compared to 200% of poverty for children.[14]

The SCHIP waivers enabled all eleven waiver states to build upon their Medicaid coverage for parents with the benefit of enhanced federal matching funds. However, beyond this common element, each of the states have unique circumstances that help shed light on why they sought their SCHIP waiver, how their SCHIP coverage of parents compares to their efforts with respect to children, and what the impact of the waiver may have been on children's coverage. In general, the states fall into one of three groups, which reflect the rationales of their waivers (Table 2).

Table 2:
Categories of SCHIP Parent Waivers

	States	Original Approval
Early Leaders in Children's Coverage	Minnesota	06/13/01
	Rhode Island	01/18/01
Comprehensive Family Coverage Initiatives	Arizona	12/12/01
	Illinois	09/12/02
	New Jersey	01/18/01
	Wisconsin	01/18/01
Expansions with Limited Eligibility/Benefits	Arkansas	03/03/06
	Idaho	11/04/04
	Nevada	11/02/06
	New Mexico	08/23/02
	Oregon	10/15/02

Early Leaders in Children's Coverage. The two states in this group, Minnesota and Rhode Island, had expanded coverage for children through Medicaid before SCHIP was enacted. Under the rules established by Congress for SCHIP, these states were allotted SCHIP funds but they had little ability to use these funds to cover children, since they had already expanded eligibility for children through Medicaid. In general, the SCHIP law provides that states can use their SCHIP funds only for children who were not eligible for Medicaid as of March 1997, a few months before enactment of the law.[15] These early leaders in children's coverage were permitted waivers to enable them access to their SCHIP funds for family coverage.

Comprehensive Family Coverage Initiatives. A second group of states—Arizona, Illinois, New Jersey, and Wisconsin—sought waivers to cover parents with SCHIP funds as part of their efforts to emphasize family, rather than child-only, coverage. These states articulated that one of their primary goals in seeking a waiver was to offer coverage to families and to increase coverage rates and improve care for children. For example, in its waiver concept paper, Illinois stated that covering more parents would benefit children by helping the state to reach the remaining group of eligible children not enrolled in SCHIP, providing better access to medical care for families, and improving the health status of children and parents.[16] Similarly, Wisconsin noted that its state policymakers believe that family-based coverage is more effective than child-only coverage because it makes coverage more attractive and it is less complex for all family members to enroll in a single plan.[17]

Expansions with Limited Eligibility/Benefits. The remaining five states—Arkansas, Idaho, Nevada, New Mexico, and Oregon—pursued their SCHIP-funded parent coverage waivers with a primary goal of reducing adult uninsured rates by increasing private coverage and, in some cases, capturing employer contributions. (Three of these states—Idaho, New Mexico, and Oregon—also received approval to cover childless adults with SCHIP funds under their waivers, a practice the Congress prohibited for any future waivers under the Deficit Reduction Act of 2005.) These expansions are limited because parent eligibility generally is restricted by other criteria in addition to income and because they provide more limited benefits than Medicaid or SCHIP. These waivers closely follow the 2001 HIFA waiver guidelines, which encouraged states to pursue initiatives that relied on private coverage options.

ELIGIBILITY, ENROLLMENT, AND BENEFITS UNDER SCHIP PARENT WAIVERS

Table 3 (next page) provides an overview of eligibility, enrollment, and benefits for parents under the SCHIP waivers as well as the upper income limit for children's Medicaid and SCHIP coverage in these states. The sections below present key findings based on this information.

Eligibility

In every state, children are covered (through Medicaid or SCHIP) to the same or a higher eligibility level as SCHIP waiver parents. Eight of the eleven states cover children in families with incomes up to at least 200% of poverty. Four of these states (including the two "Early Leader" states) cover children in families with incomes above 200% of poverty. Parent waiver coverage does not exceed 200% of poverty in any of the states. New Jersey has the lowest income ceiling for parents, at 115% of poverty, although it once covered parents at higher income levels and it plans to reinstate parent eligibility to 133% of poverty in September 2007.

Six of the eleven states use SCHIP funds to cover very low-income parents (below 50% of poverty). For example, SCHIP-funded parent coverage begins at 19% of poverty ($263 per month for a family of three in 2006) in Arkansas and at 35% and 36% of poverty ($484 and $498 per month for a family of three in 2006) in New Jersey and Illinois, respectively. SCHIP-funded parent eligibility begins as somewhat higher income levels in Arizona, Rhode Island, Minnesota, and Wisconsin. In general, these differences reflect differences in the upper income eligibility levels for parents in each state's Medicaid program prior to the waiver.[18] As noted above, the SCHIP-funded coverage generally "sits on top" of the states' Medicaid coverage for parents.

Four states provide coverage only to certain subgroups of uninsured parents in the eligible income range. In these states, eligibility is restricted to parents in the state-designated income range who have access to private coverage, whose employer helps to purchase coverage on their behalf, or who contribute the employer's as well as the employee's designated share of costs. In some cases, the initiatives are further limited to adults who work in small firms. For example, eligibility in Idaho and Nevada is limited to parents in the income-eligible range who are employed by small businesses (2-50 employees).

Table 3:
SCHIP Parent Waiver Coverage and Children's Medicaid/SCHIP Eligibility Limits

	Children's Medicaid/ SCHIP Limit (% FPL)	SCHIP Parent Waivers				
		Eligibility (% FPL)	Restricted to Subgroups?	Enrollment as of 12/31/06	Ever-Enrolled FFY 2006	Benefits
Early Leaders in Children's Coverage						
Minnesota	275%[1]	100-200%	No	18,649	34,313	Medicaid/SCHIP
Rhode Island	250%	100-185%	No	12,077	20,771	Medicaid/SCHIP
Comprehensive Family Coverage Initiatives						
Arizona	200%	101-200%	No	14,269	24,769	Medicaid/SCHIP
Illinois	200%	36-185%	No	129,994	209,622	Medicaid/SCHIP
New Jersey	350%	35-115%	No	79,523	88,401	Medicaid/SCHIP
Wisconsin[2]	185%	100-185%	No	38,994	70,227	Medicaid/SCHIP
Expansions with Limited Eligibility/Benefits						
Arkansas	200%	19-200%	Yes	n/a	n/a	Limited
Idaho	185%	35-185%	Yes	164	277	Limited
Nevada	200%	86-200%	Yes	n/a	n/a	Limited
New Mexico	235%	37-200%	Yes	2,260	2,756	Limited
Oregon	185%	0-185%[3]	No[4]	4,513	7,306	Limited
Enrollment Totals				**300,443**	**458,442**	

[1] Infants are covered up to 280% FPL.
[2] Children and parents are eligible up to 185% FPL, but they may remain enrolled with income up to 200% FPL.
[3] Under a Medicaid waiver, Oregon uses Medicaid funds to cover parents up to 100% FPL who receive direct coverage through its Medicaid program, The Oregon Health Plan, although enrollment has been closed for these parents since July 2004. Parents between 0-185% FPL in the state's premium assistance program are generally covered with SCHIP funds.
[4] Income-eligible parents are eligible for a subsidy for the purchase of group or individual private coverage. However, enrollment in individual coverage is sometimes closed; during these periods, eligibility is restricted to parents with access to group coverage.
Notes: These eligibility limits do not reflect income disregards. Arkansas and Nevada were implemented after December 2006 and, thus, do not have any enrollment to report.
Source: State reported data, March-April 2007.

Enrollment

As of December 31, 2006, a total of about 300,000 parents were enrolled under SCHIP family coverage waivers. This represents the number of parents enrolled at that point-in-time. There were roughly 460,000 parents "ever-enrolled" at some point during the 2006 Federal Fiscal Year (October 2005-September 2006). These numbers are lower than other reports of adult enrollment under SCHIP, which include pregnant women and childless adults.[19]

There is significant variation in the size of parent enrollment across the states. Parent enrollment ranges from 164 in Idaho to over 100,000 in Illinois, with two states (Arkansas and Nevada) not reporting any enrollment because they implemented their waivers after December 2006. The largest enrollments were in the "Early Leader" and "Family Coverage" states. This reflects the broader scope of their eligibility and the fact that that these states are the longest standing of the eleven waiver initiatives (and, therefore, have had the longest period of time to build enrollment). The more limited waiver expansions include some that were just recently implemented and, thus, have little or no enrollment to report. Further, the additional eligibility restrictions beyond income (discussed above) curb enrollment in these states.

For every state with substantial SCHIP parent coverage, parent enrollment represents just a fraction of children's enrollment through SCHIP and Medicaid. When considering SCHIP parent coverage relative to states' efforts to cover children, it is informative to examine children's enrollment within the broader context of both Medicaid and SCHIP.[20] In the six "Early Leader" and "Family Coverage" states (those with the highest SCHIP parent enrollment levels), as of December 31, 2006, about 294,000 parents were covered with SCHIP funds versus roughly 3.3 million Medicaid and SCHIP children (Table 4).

Table 4:
Enrollment of SCHIP Parents and Medicaid and SCHIP Children in Selected States as of December 31, 2006

	Parents Under SCHIP	Children		
		Medicaid	SCHIP	Total Children
Early Leaders in Children's Coverage				
Minnesota	18,649	304,197	30	304,227
Rhode Island	12,077	Not reported	12,212	76,533
Comprehensive Family Coverage Initiatives				
Arizona	14,269	496,564	59,250	555,814
Illinois	129,994	1,266,349	141,222	1,407,571
New Jersey	79,523	444,323	124,523	568,846
Wisconsin	38,994	340,996	29,649	370,645
TOTAL	**293,506**			**3,283,636**

Source: State reported data, March-April 2007; Total children for Rhode Island from "2007 Rhode Island KIDS COUNT Factbook" and communications with state official.

Consideration of both Medicaid- and SCHIP-covered children is relevant because of the different designs of each state's Medicaid and SCHIP eligibility rules for children and parents. Some of the waiver states cover a relatively small number of children through SCHIP since they had

already significantly expanded children's coverage through Medicaid before SCHIP was adopted. For example:

- Wisconsin uses SCHIP funds to cover all parents with incomes between 100-185% of poverty, but it uses SCHIP funds only for children age six and older in this income range. Children under six (generally the group with the highest Medicaid and SCHIP participation rates) are covered with Medicaid funds (rather than SCHIP funds) because Wisconsin had already covered these children through Medicaid before SCHIP was enacted.

- Similarly, Minnesota covers parents between 100-200% poverty under its SCHIP waiver, but the only children it covers with SCHIP funds are infants between 276-280% of poverty. It covers children with family incomes up to 275% of poverty through Medicaid.

Consideration of Medicaid-enrolled children is also important because, in a number of states, the children of SCHIP parents are covered through Medicaid rather than SCHIP. In these states, the income level of SCHIP-funded parent coverage starts at a level well below where SCHIP eligibility for children begins. For example:

- New Jersey covers parents between 35-115% of poverty under its SCHIP waiver. All children in this income range (as well as some children above this income range) are covered through Medicaid rather than SCHIP.

- Similarly, Illinois covers parents between 36-185% of poverty under its SCHIP waiver. Many of the children of these parents (younger children below 133% of poverty and older children below 100% of poverty) are covered through Medicaid, not SCHIP.

Benefits

The two "Early Leader" states and the four "Family Coverage" states provide comprehensive Medicaid or SCHIP benefits to parents. Four of these states also operate premium assistance programs in which they subsidize the purchase of employer-based coverage for some of the parents covered through the waiver. The parents in these premium assistance programs still have access to full Medicaid or SCHIP benefits and cost sharing protections, either as a "wraparound" to the employer-based insurance or, in the case of Illinois, by having the option to enroll in the direct coverage component at any time.

The five states with more limited expansions provide a limited premium assistance or benefit package. Idaho, Nevada, and Oregon provide premium assistance in which they subsidize the purchase of private coverage through an employer or the individual market. These states do not provide wraparound coverage for parents for any benefits not covered by the private plans or any of the plans' cost sharing requirements. Arkansas and New Mexico created new limited benefit plans under their waivers that employees can buy-into (both states also require employer contributions, although New Mexico allows employees to buy the employer share).

SPENDING UNDER SCHIP PARENT WAIVERS

Total federal spending for parent coverage under SCHIP waivers was about $428 million for Federal Fiscal Year 2006 based on the state-reported data (Table 5). This represents just a small fraction of total federal SCHIP spending for the year, which was $5.5 billion.[21] There is great variation across the waiver states in levels of spending for parent coverage, which reflects differences in their enrollment levels as well as differences in the scope of coverage provided.

Table 5:
2006 Federal Spending for SCHIP Parents

	FFY2006 Federal Spending (millions)
Arizona	$31.5
Arkansas	n/a
Idaho	$0.2*
Illinois	$115.6
Minnesota	$53.6
Nevada	n/a
New Jersey	$117.2
New Mexico	$6.6
Oregon	$11.8
Rhode Island	$31.2
Wisconsin	$60.5
TOTAL	**$428.2**

Note: Arkansas and Nevada were implemented after this period.
* Idaho based on FFY2005 spending estimates from the Congressional Research Services (CRS) and includes spending for childless adults.
Source: State-submitted data and CRS spending estimates.

IMPACT OF SCHIP PARENT WAIVER COVERAGE

Clearly, the most direct benefits of the SCHIP parent waivers are to increase coverage and access to care for parents newly eligible under the waivers. However, with respect to these waivers, a key issue to consider is whether they have helped promote the objectives of the SCHIP program by increasing coverage and improving care for low-income children. This section summarizes the research literature and findings from the waiver states on how parent coverage impacts coverage and care for children as well as the impacts for the parents themselves.

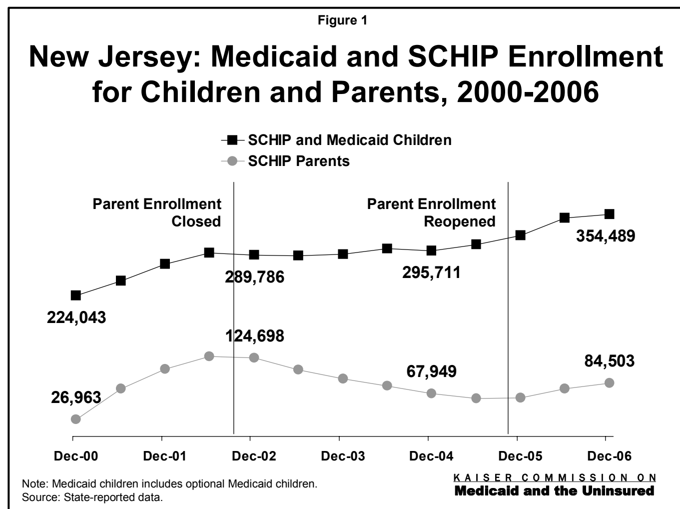
Impact on Children

A substantial amount of research has found that covering parents in programs such as Medicaid and SCHIP leads to increases in enrollment and retention of children in Medicaid and SCHIP[22] and decreases in uninsured rates for children.[23] Research also shows that covering parents leads to improvements in children's access to and use of care, as children of insured parents are more likely to see a provider and receive well-child care than those whose parents lack coverage.[24]

Evaluation findings and available enrollment data from the waiver states also suggest that parent coverage leads to increased enrollment of children and that children's enrollment patterns closely follow the trends in parent enrollment. In examining the relationship of SCHIP parent coverage and children's coverage, it is important to examine enrollment changes among both Medicaid and SCHIP children, because, as previously noted, many of the parents covered through the SCHIP waivers have children that are eligible for Medicaid. It is also important to note that the changes in enrollment over time for children likely reflect a number of factors beyond parent eligibility, including changes in eligibility or enrollment processes over the period (such as eligibility increases or simplifications in enrollment or renewal procedures), outreach efforts, and overall economic conditions. However, even recognizing the many factors that contribute to changes in enrollment, the strong correlation between enrollment of children and parents is evident.

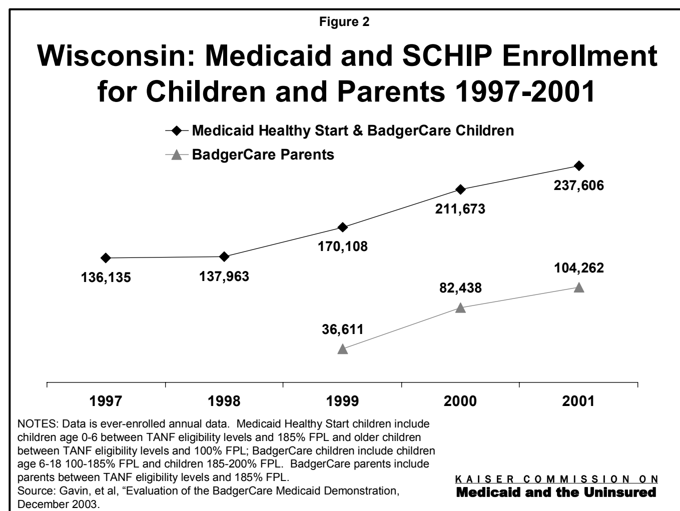
New Jersey's waiver evaluation found that, based on projections of historical enrollment data through the waiver period, there was additional enrollment of Medicaid and SCHIP children as a result of enrolling parents in FamilyCare, its SCHIP waiver program.[25] It also concluded that having one parent enrolled in its waiver program increased the likelihood that a child would remain enrolled in the program.[26]

Further, New Jersey's Medicaid and SCHIP enrollment data illustrate the strong correlation between enrollment of parents and children (Figure 1). After the state implemented its parent expansion in 2000, it experienced very quick enrollment of parents and, at the same time, enrollment of Medicaid and SCHIP children began increasing. The state closed the parent expansion in September 2002, and, when parent enrollment began to fall, children's enrollment leveled off. When the state reopened the parent expansion in September 2005, enrollment of both parents and children once again began to climb.

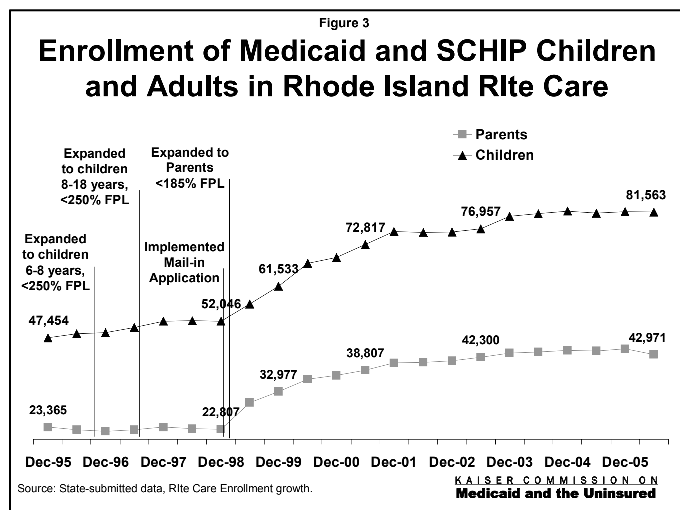


Similarly, Wisconsin has noted that its "approach of providing family coverage in BadgerCare [its SCHIP-funded Medicaid expansion] has been extremely successful in meeting the key SCHIP objective of enrolling eligible children," and that "by simplifying eligibility for the entire family, families are encouraged to seek health care coverage, resulting in more children enrolled in Medicaid and BadgerCare."[27] The state found that, "along with children in BadgerCare, Wisconsin has significantly increased Medicaid enrollment of low-income children…with the implementation of BadgerCare."[28] Like New Jersey, Wisconsin also found that the lengths of enrollment for children increased after BadgerCare implementation.[29]

Enrollment data from the evaluation of the Wisconsin waiver illustrate the connection between parent and child enrollment. Through BadgerCare, the state expanded coverage to parents (initially with Medicaid funds) and older children in 1999. Following implementation of BadgerCare, enrollment of children and parents increased in both BadgerCare as well as among children eligible for the state's Medicaid Healthy Start program. The enrollment gain among children in the Medicaid Healthy Start program is significant because many of the children of BadgerCare parents were eligible for Medicaid Healthy Start and most were eligible prior to the BadgerCare parent expansion. As the state notes in its evaluation, the enrollment gains among children in Medicaid Healthy Start occurred at the same time enrollment in other categories of Medicaid children and pregnant women was declining.[30] The evaluation attributes the increase in Healthy Start children's enrollment to the parent expansion, as well as to a small change in children's eligibility, enhanced outreach, and enrollment simplification that occurred during this period. The evaluation goes on to conclude that the uninsured rate in the state dropped significantly following implementation of its family coverage initiative and that, "Medicaid/BadgerCare is credited with keeping insurance coverage high in Wisconsin, despite rising employment."[31]



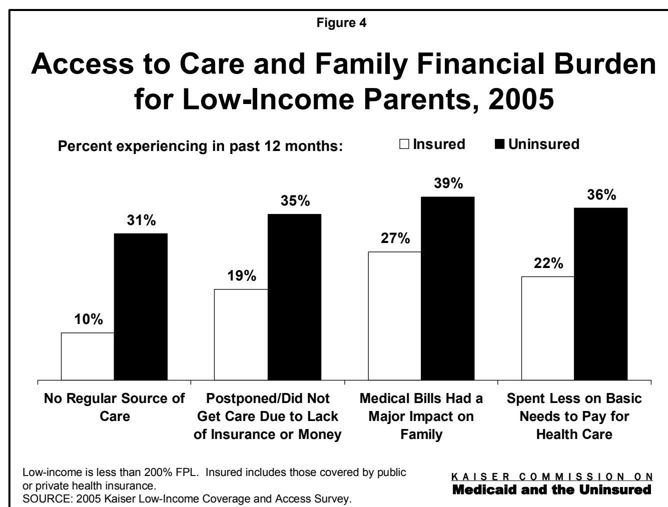
Enrollment patterns for children and parents in Rhode Island's RIte Care program further show how children's enrollment follows patterns of parent enrollment. The data show that prior to the state's first expansion to parents in 1998, children's enrollment remained fairly flat, even with expansions in children's eligibility (Figure 3). Once the parent expansion (which was initially Medicaid-funded) was implemented in 1998, enrollment of both children and parents quickly grew. This growth likely reflects a number of factors, including the parent eligibility expansion as well as eligibility simplifications and outreach efforts the state undertook during this period and changing overall economic conditions.



Impact on Parents

Beyond the positive benefits for children, the SCHIP parent waivers have also increased coverage and improved access to care for low-income parents. While the nationwide enrollment number for parents under the waivers is relatively small (at about 300,000 as of December 31,

2006), the eligibility increases provided an important coverage option for low-income parents who have very limited access to private coverage. In six of the eleven states, the parents gaining coverage included very low-income parents below 50% of poverty (or $691 per month for a family of three in 2006). Reflecting the significant need for and interest in coverage among low-income parents, the New Jersey and Wisconsin evaluations found that parent enrollment quickly exceeded expectations and projections, and a survey of parents enrolled in the Wisconsin waiver program found that the most frequently cited reason for enrolling in the program was that they could not get or afford other coverage.[32]



Research suggests that these gains in coverage make a significant difference in assuring parents' access to necessary and appropriate care. For example, uninsured low-income parents are more likely than their insured counterparts to lack a usual source of care, to have postponed or not gotten care due to cost, and to have had their families' finances affected by medical costs (Figure 4).

Consistent with this research, Rhode Island notes that its RIte Care program, which covers parents and children, has not only "demonstrably increased the number of low- and moderate-income Rhode Islanders who are insured, but the program has facilitated the abilities of enrollees to obtain services and changed patterns of care."[33] For example, every parent or child enrolled in RIte Care has a primary care provider who serves as their medical home.[34] Further, the state found decreased emergency department visits and hospital utilization since implementing the program.[35] Similarly, Wisconsin has found that parents enrolled in its BadgerCare program were more likely to have at least one physician visit in the past year and a usual source of care than uninsured adults.[36] Further, parents enrolled in the program were less likely than eligible but unenrolled parents to report postponing or delaying needed care and more likely to report confidence in their ability to obtain needed care.[37]

CONCLUSION

In sum, over the past decade, SCHIP parent waivers have been approved based on findings that they promote children's coverage and as part of efforts to reduce the number of uninsured. The data in this report show that, nationwide, SCHIP parent enrollment is relatively small, but the coverage provided through the waivers helps fill a major coverage gap for low-income parents. The states' experiences also illustrate the close relationship between parent and child coverage and access to care and the importance of family coverage for both parents and their children.

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ENDNOTES

[1] "Health Coverage for Low-Income Parents," Kaiser Commission on Medicaid and the Uninsured, February 2007, http://www.kff.org/uninsured/7616.cfm.
[2] Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of March 2006 CPS data.
[3] Colorado also has an approved SCHIP waiver that allows it to implement an Employer Sponsored Insurance (ESI) component that will provide children with family incomes up to and including 200 percent of FPL with the option of receiving premium assistance through their parent's employer. The state will subsidize premium assistance through a monthly per child subsidy. In addition, parents can incidentally be covered if the per child subsidy is adequate to cover the entire family premium.
[4] Section 2107 (e)(2)(A) of Title XXI of the Social Security Act (Title XXI creates SCHIP), which grants the Secretary waiver authority in SCHIP, refers back to section 1115 of the Act.
[5] Section 1115 of the Social Security Act.
[6] State Health Official Letter, July 31, 2000, http://www.cms.hhs.gov/smdl/downloads/sho073100.pdf.
[7] Title XXI, Section 2105(c)(3)
[8] State Health Official Letter, July 31,2000, Question #2. The guidelines noted that to show they were effectively covering children, states would need to meet at least three of the following five criteria in SCHIP and Medicaid: (1) the state used a joint application and common application procedure for SCHIP and Medicaid for children; (2) it had no asset test for children's coverage; (3) it had adopted the "continuous eligibility" option; (4) renewals could be done by mail and, in states with separate SCHIP programs, the renewal procedures were coordinated with Medicaid to assure no gap in coverage when a child's eligibility changes; and (5) the state allowed presumptive eligibility for children.
[9] State Health Director Letter, July 31, 2000, Question #4.
[10] CMS, HIFA Guidelines, http://www.cms.hhs.gov/HIFA/02_Guidelines; C.Mann, *The New Medicaid and CHIP Waiver Initiatives,* Kaiser Commission for Medicaid and the Uninsured, February 2002; http://www.kff.org/medicaid/4028-index.cfm .
[11]Centers for Medicare and Medicaid Services, HIFA Overview http://www.cms.hhs.gov/HIFA/01_Overview.asp#TopOfPage and Guidelines, http://www.cms.hhs.gov/HIFA/02_Guidelines.asp#TopOfPage.
[12] Section 6102 of the Deficit Reduction Act of 2005, amending section 2107 of Title XXI of the Social Security Act.
[13] Cohen Ross, Cox, and Marks, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and SCHIP in 2006," Kaiser Commission on Medicaid and the Uninsured, January 2007.
[14] Ibid.
[15] Title XXI, Section 2110(b).
[16] KidCare Parent Coverage Waiver Concept Paper, Illinois Department of Public Aid, November 2001.
[17] Gavin, et al, "Evaluation of the BadgerCare Medicaid Demonstration, Prepared by RTI International and MayaTech Corporation for the Centers on Medicare and Medicaid Services, December 2003.
[18] For the early leader states that had expanded coverage for parents prior to the waivers through Medicaid, the waivers only permitted SCHIP funds to be used for parents with incomes above 100% of the federal poverty line.
[19] The GAO estimates that about 640,000 adults were covered under SCHIP waivers in FFY2005, Allen. K, Government Accountability Office, "Children's Health Insurance, States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization," Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives, March 2007, GAO-07-558T.
[20] For some states, given the income eligibility levels for parents and children, it also would be useful to compare parent and child enrollment within specific income ranges. The data are not available, however, to undertake this analysis.
[21] Budget of the US Government, Fiscal Year 2008, Office of Management and Budget, February 2007.
[22] Committee on the Consequences of Uninsurance, Institute of Medicine, "Health Insurance is a Family Matter," Washington, DC, 2002; Ku and Broaddus, "The Importance of Family-based Insurance Expansions: New Research Findings about State Health Reforms, CBPP, September 2000; Dubay and Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid," Health Services Research, 38(5): 1283-1301, 2003; Wolfe and Scrivner, "The Devil May be in the Details: How the Characteristics of SCHIP programs Affect Take-up," Journal of Policy Analysis and Management, 24(3): 499-522, 2005; Guendelman, et al, "The

Effects of Child-only Insurance Coverage and Family Coverage on Health Care Access and Use: Recent Findings Among Low-Income Children in California," Health Services Research, 41(1): 125-47, Feb. 2006; Sommers, "Insuring children or insuring families: Do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP," Journal of Health Economics, 2006.
[23] Ku and Broaddus, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities, October 2006; Dubay and Kenney, "Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children," Kaiser Commission on Medicaid and the Uninsured, October 2001; Aizer and Grogger, "Parental Medicaid Expansions and Health Insurance Coverage," NBER Working Paper 9907, August 2003.
[24] Ku and Broaddus, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities, October 2006; Davidoff, et al, "The Effects of parents' Insurance Coverage on Access to Care for Low-Income Children," Inquiry, 40-254-268, Fall, 2003; and Gifford, Weech-Maldonado, and Farley-Short, "Low-income Children's Preventive Service Use: Implications of Parents' Medicaid Status," Health Care Financing Review, 26(4)"81-94, Summer 2005.
[25] Mercer Government Human Services Consulting, "NJ FamilyCare Section 1115 Demonstration Project Evaluation Report," Department of Human Services, State of New Jersey, forthcoming.
[26] Ibid.
[27] BadgerCare Waiver Amendment Request, March 10, 2000, Department of Health and Family Services, State of Wisconsin.
[28] Ibid.
[29] Gavin, op cit.
[30] Ibid.
[31] Ibid.
[32] Mercer, op cit. and Gavin, op cit.
[33] "RIte CARE/RIte SHARE Annual Report: Program Year Ending July 31, 2006," Center for Child and Family Health, Department of Human Services, Rhode Island, November 2006.
[34] Ibid.
[35] Ibid.
[36] Gavin, op cit.
[37] Ibid.

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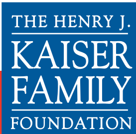

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