THE KAISER COMMISSION ON
Medicaid and the Uninsured

Revised August 29, 2007

SCHIP REAUTHORIZATION: KEY QUESTIONS IN THE DEBATE
A DESCRIPTION OF NEW ADMINISTRATIVE GUIDANCE AND THE HOUSE AND SENATE PROPOSALS

The State Children's Health Insurance Program (SCHIP) was enacted with bi-partisan support a decade ago as part of the Balanced Budget Act of 1997 (BBA). Together with Medicaid, SCHIP has helped to 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, but about 9 million children remain uninsured.

Both the House and the Senate passed legislation to reauthorize the SCHIP program, which is scheduled to expire on September 30, 2007. Congress will work to reconcile the differences between the House and Senate bills, but the President has threatened to veto either of the current SCHIP reauthorization bills, favoring a smaller SCHIP program in terms of coverage and financing. The Administration also just released new guidance to states on August 17th that would limit states' ability to expand SCHIP coverage to children in families with incomes above 250 percent of the poverty line.

This brief highlights some key questions underlying the debate over SCHIP reauthorization and provides a brief description of the new guidance issued by the Administration on August 17th and the bills passed by the House (HR 3162) and Senate (S 976) that must be reconciled to send to the President.

1. Who is covered now by Medicaid and SCHIP?

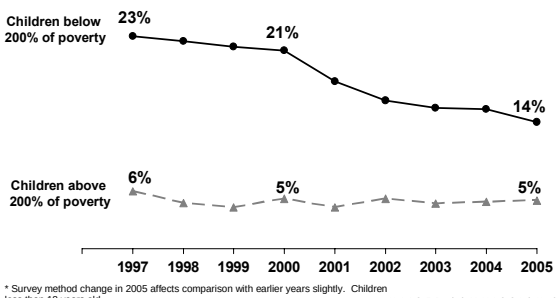
Medicaid and SCHIP together cover more than 30 million low-income children. Federal law requires states to cover infants and children under six with family incomes up to 133 percent of the federal poverty level and children under age 19 with family incomes up to 100 percent of the federal poverty level under Medicaid. Many states opted to use the flexibility in Medicaid to expand coverage to children beyond these minimum levels. Medicaid also covers about 14 million low-income parents, and 14 million elderly and people with disabilities. Federal law prohibits federal matching funds to be used to cover non-disabled adults without dependent children through Medicaid without a waiver.

SCHIP was designed to build 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 or about $41,300 for a family of four in 2007.

Currently, 20 states cover children in families with incomes up to 200 percent of poverty and 23 states cover children with family incomes above 200 percent of poverty (17 states set eligibility above 250 percent of poverty). In 2006, 91 percent of children covered by the program have incomes that are at or below 200 percent of the federal poverty level.[i] Over the last decade, Medicaid and SCHIP together have helped to reduce the rate of low-income uninsured children by about one-third. Increased Medicaid coverage accounted for nearly 60 percent of the decrease in rates of uninsurance for low-income children.[ii] (Figure 1)

Figure 1

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



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

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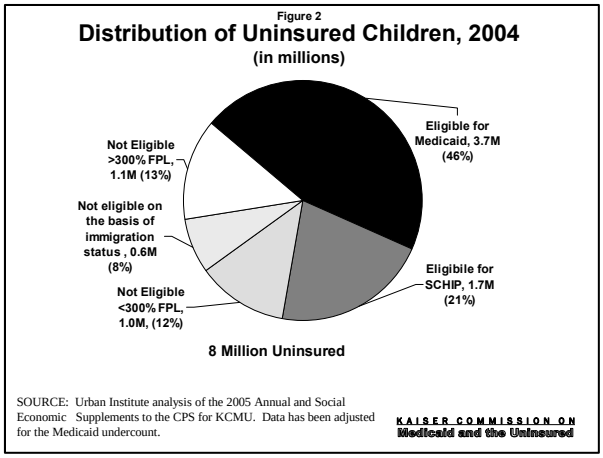
Coverage of groups beyond children under SCHIP is limited. The original SCHIP legislation permitted the Secretary of HHS to allow "Section 1115 Demonstration" waivers for alternative uses of SCHIP funds. Through waivers eleven states use SCHIP funds to cover parents, four states cover childless adults and 11 states use SCHIP funds to cover pregnant women through the option to define a fetus as an unborn child. In 2005, approximately 600,000 adults, compared to over 6 million children, were covered by SCHIP. The Deficit Reduction Act (DRA) enacted in February 2006 prohibits any new SCHIP waivers to cover childless adults.

Legal immigrants in the country for less than five years are not covered under Medicaid and SCHIP even if they meet income eligibility requirements and undocumented immigrants are only eligible for emergency care under Medicaid.

2. How many children are uninsured?

New Census data shows that there were approximately 9 million children under 18 without health insurance in 2006 (a 600,000 increase over 2005). The percent of children without health coverage also increased in 2006 representing the second consecutive year of annual increase since enactment of SCHIP in 1997.

Many researchers recognize that the raw census data under-estimates those covered by Medicaid. Looking at census data from 2004, peer-reviewed literature suggests that after adjusting for the Medicaid under-count, there were about 8 million children without insurance at a point in time during (compared to 9 million in the raw data). Of the 8 million uninsured children, about two-thirds are estimated to be eligible but not enrolled in Medicaid and SCHIP. (Figure 2)[iii]

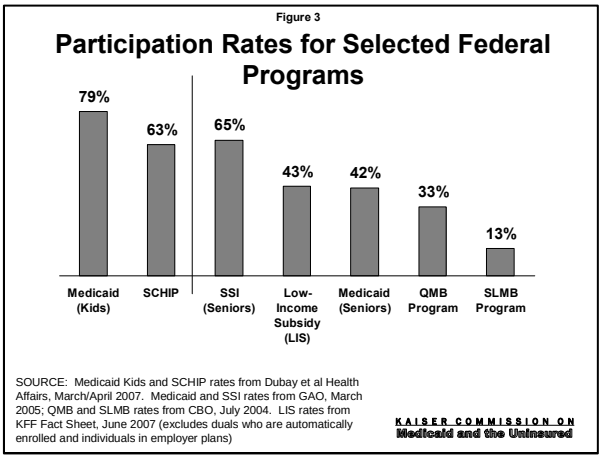


The Administration released estimates in June for 2003-2004 showing 4.9 million uninsured children. These figures are much lower than the 8 million estimate because they represent children who are uninsured for the entire year and because of the methodology used to adjust for the Medicaid undercount in the raw CPS data. This methodology overstates Medicaid enrollment (resulting in participation rates over 100 percent in some states) and results in an undercount of the number of children remaining uninsured. Insurance coverage is not static and there may be more children without insurance over the course of the year than uninsured for the entire year who would be affected by proposed legislation. The Congressional Budget Office (CBO) uses the Census Bureau numbers as point-in-time, not full year uninsured estimates in determining the costs and coverage implications of proposed legislation.[ivv]

3. What are the Medicaid and SCHIP participation rates?

Medicaid and SCHIP are popular programs with high participation rates. On average, 3 out of 4 who are eligible for Medicaid and SCHIP currently participate. Participation is generally higher for Medicaid because SCHIP covers children with slightly higher income levels, so some of those eligible may not be aware that they might qualify for public coverage (especially if they are in working families) and others might have access to private health coverage. Efforts to increase outreach and simplify the application process have been key elements in helping to achieve high participation rates. However, research shows while large numbers of people have heard of the Medicaid and SCHIP programs, a significantly smaller number of people are aware that a child can participate in these programs without receiving welfare so more public education is necessary.[vi]

In guidance released on August 17th, the Administration would limit states' ability to expand coverage to children with family incomes above 250 percent of the poverty line. States would have to make assurances that they had enrolled at least 95 percent of the children in the state below 200 percent of poverty who are eligible for Medicaid or SCHIP as a condition for expansion. Achieving this level of participation would be very challenging in voluntary program. Participation in other voluntary programs including SSI and Medicaid for seniors, the low-income subsidy benefit for Medicare Part D, and the QMB/SLMB programs are lower than Medicaid for children and SCHIP.
Participation in Medicare Part B is about 93 percent; although, eligibility is automatic and individuals must "opt-out" if they do not wish to participate. (Figure 3)



In addition to 95 percent participation being a high rate to achieve, it would also be difficult to measure participation rates in the absence of clear definitions and a reliable data source for state by state measurements. The differences in uninsured counts are indicative of potential measurement problems.

4. Where do Medicaid and SCHIP enrollees get their care?

Most children enrolled in Medicaid and SCHIP are enrolled in private managed care plans. About 74 percent of all children on Medicaid and 77 percent of children in SCHIP are enrolled in some type of managed care plans.[vii] States

contract with managed care plans run by private companies to provide care for these children. Often families have a choice of plans. Only 18 of the 224 plans that were in Medicaid in 2004, were public plans operated by counties, the rest are private firms like Blue Cross Blue Shield, WellPoint, UnitedHealth, Amerigroup, and Centene.[viii] A smaller group of children receive care in the fee-for-service delivery system. Even in these delivery systems, beneficiaries may choose to receive care from any number of private providers that participate in their state's Medicaid or SCHIP program.

The government role in Medicaid and SCHIP is to help finance care for low-income individuals and contract with private providers and health plans to deliver care. Because Medicaid and SCHIP enrollees receive care primarily through private managed care plans or from private providers, their insurance coverage is much more similar to private insurance coverage than "government run" programs like the Veterans Administration (VA) where the government pays for and provides care. Additionally, like employer sponsored coverage, enrollees may be required to pay premiums or cost sharing in Medicaid or SCHIP.

5. How can more uninsured children be covered through Medicaid and SCHIP?

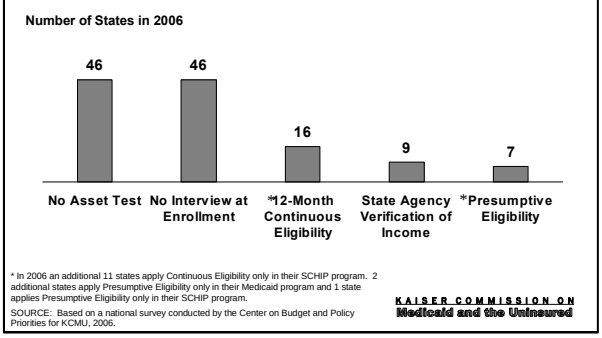
A decade of experience with SCHIP demonstrates that expanding eligibility levels, outreach and eligibility simplification in combination with adequate state and federal financing are the key ingredients to expanding coverage for children. Prior to the implementation of SCHIP, only 7 states had expanded coverage up to 200 percent of the federal poverty level.[ix] States embraced the new SCHIP program and worked quickly to implement programs with eligibility levels that extended coverage beyond Medicaid levels to try to reach more uninsured children.

With outreach embodied into the SCHIP law, state and national campaigns sought to educate people about public programs and help to encourage enrollment in both SCHIP and Medicaid. To help families enroll, many states made efforts to streamline and simplify enrollment. States started to use a joint application, eliminated the asset test and the face-to-face application interview, implemented 12-month continuous eligibility, and allowed individuals to self-declare income when applying for both Medicaid and SCHIP. Some states are also using technology and data sharing across public programs to help facilitate enrollment. The citizenship documentation requirements included in the Deficit Reduction Act for Medicaid have complicated efforts by states to simplify enrollment procedures. (Figure 4)

Illinois was one of the early states to move forward with universal coverage for children. In their experience implementing the AllKids program, they have found that the simple message that "all kids" are eligible has been a powerful outreach campaign. The majority of children enrolling in AllKids were previously eligible under the state's Medicaid and SCHIP programs but not enrolled.[x]

Figure 4

Streamlining the Enrollment Process for Medicaid and SCHIP is Also Critical



* In 2006 an additional 11 states apply Continuous Eligibility only in their SCHIP program. 2 additional states apply Presumptive Eligibility only in their Medicaid program and 1 state applies Presumptive Eligibility only in their SCHIP program.

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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Research shows that in addition to outreach and simplified enrollment, covering parents in Medicaid and SCHIP leads to increases in enrollment and retention of children in Medicaid and SCHIP and helps to decrease uninsurance rates for children. In July 2006, former CMS director Dr. Mark McClellan testified that "extending coverage to parents and caretakers may also increase the likelihood that their children remain enrolled in SCHIP. For example, in New Jersey, which covers parents through a section 1115 demonstration, the State found that having one parent enrolled increased the likelihood that a child remains enrolled."[xi] Covering parents also contributes to improvements in children's access to and use of care.[xii]

Adequate financing and fiscal incentives are central to boost state efforts to increase coverage. When SCHIP was implemented, states had federal financing available, an enhanced matching rate as an incentive for states to expand coverage and funds dedicated for outreach. As programs matured, enrollment grew and health costs continued to rise, more states began to spend more than their current year federal allotments. States relied on carry-over funds from prior years to fill the financing gaps. During the fiscal downturn from 2001 to 2004, many states implemented policies that dampened enrollment and funds for outreach dried up. In FY 2007, 14 states faced a federal funding shortfall and Congress allocated supplemental funds to help these states maintain their programs. The amount of funding available in SCHIP reauthorization will determine how far states can go to reach more uninsured children.

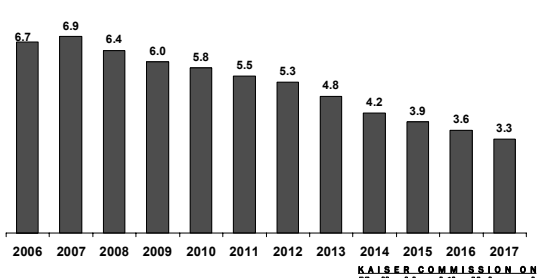
6. What would it cost to maintain and expand coverage through Medicaid and SCHIP?

Current SCHIP financing is $5 billion annually. While the program needs to be reauthorized for federal funds to be available after October 1, 2007, the CBO assumes that this level of funding would be continued in its "baseline". CBO assumes that the SCHIP baseline will be $25 billion over the

next five years, but that these funding levels are not adequate to maintain current SCHIP programs. To maintain or expand SCHIP coverage, Congress would need to allocate new funds (above the baseline levels) for SCHIP. An estimated $14 billion, in addition to the $25 billion in the baseline over the next five years, would be necessary just to maintain current eligibility levels for SCHIP[xiii]. (Figure 5)

Figure 5

SCHIP Enrollment Projections for Children if Federal Financing is Held Constant at $5 Billion Annually



SOURCE: CBO March 2001 Baseline: SCHIP Fact Sheet, February 23, 2007

The costs of expanding coverage through Medicaid and SCHIP are a function of the medical costs of care in addition to the costs of the policies that would help increase enrollment (such as fiscal incentives to states or outreach grants) and other administrative costs. Medical costs refer to the per capita costs multiplied by the estimated number of children who would be covered. These per capita costs reflect estimates of either the costs of using medical services in a fee-for-service health delivery system or the capitation payment for services in a managed care arrangement which is usually the case for children enrolled in SCHIP.

These estimates take into account a variety of factors including the relative cost of additional coverage (currently eligible children that are not enrolled may be healthier and therefore less costly); how families would respond to paying premiums if they are imposed by states, and the number of individuals that will substitute private coverage for public coverage (which is typically modest for low-income families, but may increase as incomes go up).

The costs of new coverage are shared by the states and the federal government and in some states enrollees also pay for a portion of the care through premium or cost sharing payments. Given the current match rate for Medicaid and the enhanced match rate for SCHIP, the states pay a larger share of the costs to cover an individual through Medicaid. The federal government pays 57 percent of the costs for Medicaid and about 70 percent of the costs for SCHIP.

Because Medicaid is an entitlement program, projected increases in costs are based on enrollment and state spending and the federal financing is not capped. However, because of the lower match, states have less incentive to find and enroll lower income children eligible for Medicaid. Federal SCHIP funding is capped, so no federal financing is available once a state has drawn down its allocation of federal matching funds. States may have less incentive to enroll more children in SCHIP once they are reaching their capped financing levels.

7. If public coverage is expanded, would some families substitute public coverage for private coverage?

The extent to which individuals drop private coverage to enroll in public coverage is one of the central debates around SCHIP reauthorization. This substitution effect is often referred to as "crowd out". It is impossible to perfectly target new policies to cover the uninsured without also reaching some individuals who currently have private insurance coverage. The question is how efficiently can the program be targeted to uninsured children.

A Congressionally mandated evaluation of SCHIP in ten states showed that in the six months prior to enrolling in SCHIP, most children (43 percent) were uninsured for all six months. Some children had private coverage (29 percent) in the six months prior to enrolling in SCHIP, but in most cases (13 percent) this private coverage was lost as a result of a job loss or change, employer change in benefits or a change in family structure and another 8 percent lost private coverage because they felt it was not affordable.[xiv]

Extensive research on this issue shows that substitution is very low for people with lower incomes. For example, for individuals with incomes below 200 percent of the poverty level private coverage is often not available or not affordable. Crowd-out estimates associated with efforts to enroll children who are currently eligible for Medicaid or SCHIP are low, about 14 percent or 24 percent respectively, because private insurance coverage is often not available. As eligibility levels are expanded up the income scale where private coverage is more available, the possibility for crowd-out increases. At 300 percent of the poverty level crowd-out could be as high as 50 percent. Expanding coverage to higher income levels often has the effect of increasing participation among lower-income groups already eligible for coverage.

An economist who has authored much of the research on crowd-out stated in March that, "public insurance expansions like SCHIP remain the most cost-effective means of expanding health insurance coverage…the public sector provides much more insurance coverage at a much lower cost than these [tax credits] alternatives. Tax subsidies mostly operate to buy out the base of insured without providing much new coverage."[xv]

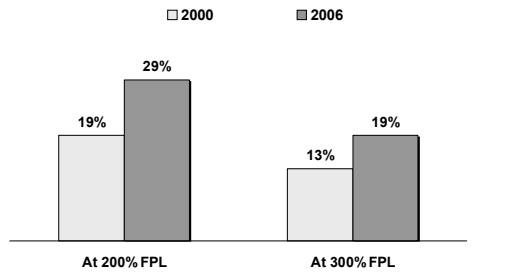
Under federal law, children must be uninsured to be eligible for SCHIP coverage. States have designed policies to comply with federal law and to deter people from dropping

private coverage and to help minimize the substitution effect by imposing waiting periods or by charging premiums and cost sharing amounts (similar to what they might face with private coverage) to make the program more consistent with employer-based coverage options. In 2006, 35 states had some waiting period (18 states were at 3 months, 16 were at 6 months and only Alaska had a waiting period of one year). The new guidance issued by the Administration would require states to establish a one year period of uninsurance for children with incomes above 250 percent of poverty.

While states do have policies to deter individuals from dropping private coverage that they may have, more generally private coverage has become less available for families because more employers are less likely to offer coverage (especially small firms or those firms that employ a large number of low-wage workers) or because premiums are unaffordable. Average family premiums were about $11,480 annually in 2006. This represents a 78 percent increase in premiums from 2000 while the federal poverty rate increased by only 17 percent during the same period. In 2000 average family premiums represented 19% of income for a family of 4 at 200 percent FPL. In 2006, average family health insurance premiums comprised 19 percent of family income at 300 percent of poverty. (Figure 6)

Figure 6

Average Family Premiums as a Share of Income at 200% FPL and 300% FPL



SOURCE: KCMU Estimates based on HRET survey and HHS Poverty Guidelines for a Family of 4

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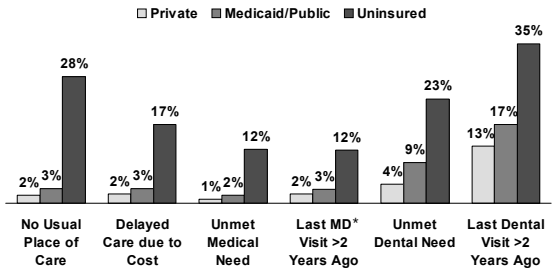
In addition to higher out of pocket expenses, some individuals are finding that their private insurance policies are not adequate to meet their health care needs. Due to all of these factors, many individuals have been left out of the private insurance market. Without Medicaid and SCHIP coverage, these individuals would most likely be uninsured.

8. Does coverage matter?

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.[xvi] Medicaid and SCHIP coverage have also helped to narrow ethnic and racial disparities in access to care, improve health care quality, result in improved health outcomes and improve school performance.[xvii] (Figure 7)

Figure 7

Health Coverage Promotes Improved Access to Care for Children



* 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, 2005.

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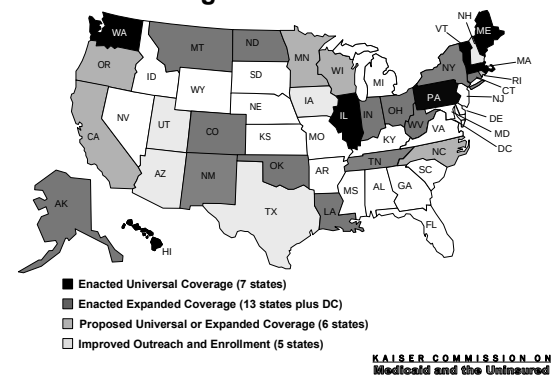
9. How will state health reform efforts be affected by SCHIP reauthorization?

As of June 2007, 31 states plus the District of Columbia had enacted or announced coverage initiatives for children. Seven states have enacted proposals to provide universal health coverage for children and another 6 states have proposals to do so. Other states are moving forward to expand coverage to children by increasing eligibility levels or through improved outreach and enrollment efforts recognizing that many of the uninsured are currently eligible for Medicaid and SCHIP. (Figure 8)

Figure 8

State Coverage Initiatives for Children



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Three states, Massachusetts, Maine and Vermont have passed legislation to implement universal coverage for their state residents. Several other states including Illinois, California and Pennsylvania have proposals for universal coverage. All of these plans include some type of public program expansion to cover low-income individuals. All of these plans also rely heavily on federal financing from Medicaid and SCHIP. Therefore, the amount of funding

available as a result of SCHIP reauthorization will have significant implications for state reform efforts. The new guidance issued by the Administration could hamper state efforts to expand coverage.

10. What will happen if SCHIP is not reauthorized by September 30, 2007?

Both the Senate and House passed legislation to reauthorize SCHIP. Congress will need to reach agreement on the policy options as well as the funding levels and funding offsets to be able to send a single bill to the President to sign into law by September 30, 2007; however the President has threatened to veto either the House or the Senate versions. The Administration also just released new guidance to states on August 17th that would limit states' ability to expand SCHIP coverage to children in families with incomes above 250 percent of the poverty line which stands in conflict with Congressional efforts to expand the program to address the increasing number of uninsured children in middle income families.

New Census data shows a continued increase in the numbers and rate of uninsured children driven by continued declines in employer sponsored coverage. In the face of declining employer sponsored coverage, SCHIP will not be able to support current program levels or expand to cover more uninsured children without additional federal funding. If SCHIP is not reauthorized by the end of the fiscal year, the program will expire leaving states without federal funds to support coverage for the over 6 million children currently covered by the program and putting these children at risk of being uninsured.

[i] Peterson and Herz, "Estimates of SCHIP Child Enrollees Up to 200% of Poverty Above 200% of Poverty and of SCHIP Adult Enrollees." Congressional Research Service, March 13, 2007

[ii] Dubay, Guyer, Mann and Odeh. "Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward." Health Affiars, March /April 2007.

[iii] Urban Institute analysis of the 2005 Annual and Social Economic Supplements to the CPS for KCMU. Data has been adjusted for the Medicaid undercount. Poverty levels reflect income adjusted for income disregards used in determining eligibility for public coverage. Approximately 118,000 of the 5.4 million eligible uninsured children are legal non-citizens who have resided in the country for less than five years and are eligible for state-funded public coverage. 76,000 are covered in Medicaid and SCHIP with state only funds and the remaining 42,000 are income-eligible for coverage, but not eligible on the basis of immigration status.

[iv] Congressional Budget Office, Memo to Health Staff, March 13, 2007 and "How Many People Lack Health Insurance and for How Long?" May 2003.

[v] Dubay, "Making Sense of Recent Estiamtes of Eligible but Uninsured Children." KCMU, August 2007.

[vi] Kenney. Presentation for the Alliance for Health Reform. February 9, 2007.

[vii] SCHIP data from SEDS (Statistical Enrollment Data System) for 2005 and Medicaid data from MSIS cube data for 2004. This data include PCCM arrangements.

[viii] Felt-Lisk, "Trends in Plans Serving Medicaid" Paper Forthcoming from KCMU.

[ix] National Governor's Association, MCH Update. September 1998. http://www.nga.org/Files/pdf/MCHUPDATE0898.pdf

[x] Coughlin. "A Race to the Top: Illinois's AllKids Initiative. KCMU Report Forthcoming

[xi] Testimony of Mark B. McClellan, MD, Ph.D. Administrator, Centers for Medicare & Medicaid Services Before the Senate Finance Subcommittee on Healthcare Hearing on State Children's Health Insurance Program July 25, 2006

[xii] Artiga and Mann, "Family Coverage Under SCHIP Waivers," KCMU, May 2007.

[xiii] CBO assumed that increases in SCHIP funding would offset some projected Medicaid spending, so net federal costs over the period would be $8.3 billion.

[xiv] Wooldridge, J. et al. "Congressionally-Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress." Report conducted by Mathematica Policy Research and the Urban Institute for the Office of the Assistant Secretary of Planning and Evaluation at the U.S. Department of Health and Human Services, October 26, 2005.

[xv] Letter from Jonathan Gruber to Representative John Dingell, March 1, 2007. http://energycommerce.house.gov/Press_110/110-ltr.022807.Gruber_ltr_to_Dingell.pdf

[xvi] Genevieve Kenney and Debbie Chang. "The State Children's Health Insurance Program: Successes, Shortcomings and Challenges". *Health Affairs.* Volume 23, Number 5 (2004)

[xvii] KCMU, "Impacts of Medicaid and SCHIP on Low-Income Children's Health," May 2007

New Guidance on SCHIP Issue by CMS on August 17, 2007

On August 17, 2007 the Centers for Medicare and Medicaid Services (CMS) issued new guidance in the form of a letter to State Health Officials that limits states' ability to expand SCHIP coverage to children with family incomes above 250 percent of the federal poverty level unless certain conditions are met. (http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf) This type of guidance serves as official policy guidance and has the force of law, although unlike regulations, a letter to State Health Officials is not open for public comments prior to implementation. According to CMS, these letters have been used "to provide States with guidance and clarification on current information pertaining to Medicaid policy and Medicaid data issues. The intent of these letters is not to establish policy, but to ensure consistency and better serve the States."

The new guidance requires that states adopt five strategies to prevent substitution of public coverage for private coverage if states opt to expand eligibility above an effective level of 250 percent of poverty: ensure that cost sharing under SCHIP is comparable to private coverage; establish a minimum of a one year period of uninsurance before a child could be eligible for coverage, monitor and verify health insurance status at the time of application (including information regarding coverage for a child through a non-custodial parent) and prevent employers from changing dependent coverage policies that would favor a shift to public coverage. Prior to this guidance, states had more flexibility around procedures for preventing crowd-out and often adopted one of the above five measures. Many states already have waiting periods, but most are 3 or 6 months.

In addition to new requirements to prevent substitution, states seeking to expand coverage to children above 250 percent of poverty will be required to provide assurances that: the state has enrolled at least 95 percent of the children below 200 percent of poverty who are eligible for SCHIP or Medicaid and that the number of children in the target population insured through private employers has not decreased by more than two percent over the prior five year period, and that the state is current with all reporting requirements in SCHIP and Medicaid (including monthly reporting on crowd-out requirements). The guidance says that states must come into compliance within 12 months or CMS may pursue corrective action.

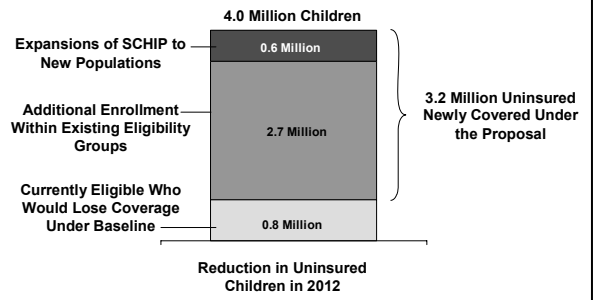
Children's Health Insurance Program (CHIP) Reauthorization Act of 2007, S. 1893

On August 3, 2007 the Senate adopted the Children's Health Insurance Program Reauthorization Act of 2007 (S. 1893/HR 976). The Senate bill includes the following major provisions:

Coverage. The Senate bill is expected to expand coverage to an estimated 6.1 million children in SCHIP and Medicaid in 2012. The majority of those enrolled (66 percent or 4.0 million children) would have otherwise been uninsured. Of the 4.0 million children who otherwise would have been uninsured, the bill would maintain coverage for .8 million who would lose coverage under baseline levels of funding and expand coverage to another 3.2 million. Of the 3.2 million, 2.7 (over 80 percent) represent children who are currently eligible and not enrolled and the remaining .6 million are expected enroll to as a result of state efforts to expand to new populations. (Figure 9)

Figure 9

Distribution of the Reduction in Uninsured Children in the Senate CHIP Reauthorization Proposal



SOURCE: CBO's Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under the Children's Health Insurance Program Reauthorization Act of 2007. July 26, 2007

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The Senate bill would allow states to expand coverage up 300 percent of poverty; states that expand coverage beyond these levels in the future would receive the lower Medicaid match rate for these children. The bill would establish new options to cover pregnant women through CHIP, but would limit other coverage for adults. The Act would prohibit new waivers for parent coverage and allow states that have waivers to continue coverage for parents for two years. After two years, the bill would limit funding for states that already cover parents by creating a set-aside for parent coverage that would be available to states at the Medicaid match or an enhanced match if states meet performance benchmarks on children's coverage. The bill would terminate coverage for childless adults in CHIP and allow states to transition this coverage to Medicaid within two years.

Financing. The bill would increase funding for children's coverage by about $35 billion over baseline levels of $25 billion over the next five years using a 61-cent per-pack increase in cigarette taxes and other tobacco tax increases to finance the new spending. The bill would replace the current allocation formula with one that relies on state's actual and projected spending and allows states 2 years (instead of 3) to spend their allotments. The bill creates a contingency fund for states that face shortfalls, experience disasters or sustained high rates of unemployment.

Enrollment and Outreach. The bill creates fiscal incentives for states to enroll eligible children in Medicaid and SCHIP by paying a bonus (that ranges from $75 per child to $625 per child) based on how far actual enrollment exceeds established baseline levels. The bill also provides outreach grant funding of $100 million per year. The bill includes $49 million to allow up to 10 states to implement "express lane" enrollment demonstrations and provides an enhanced match for translation and interpretation services. Outreach expenditures would not be subject to the states ten percent administration spending cap.

Benefits. The bill requires that there be parity between mental health services and medical and surgical services for states covering these services. The proposal also includes $200 million in grants to help improve access to dental care.

Quality. The bill requires HHS to develop child quality measures and would fund demonstration programs to improve quality, combat obesity and encourage the development of electronic health records for Medicaid and SCHIP.

Citizenship Documentation. The bill would extend the DRA citizenship documentation requirements to SCHIP, but would allow states new options to comply with these requirements by using Social Security Numbers instead of requiring original birth certificate or passports.

Premium Assistance. The bill allows states to offer subsidies to qualified, cost-effective employer-sponsored coverage, broadens how states use the cost-effectiveness test, makes it easier to share information between public and private plans and establishes a demonstration program to allow certain employers to buy-in to a pool that offers SCHIP benchmark coverage.

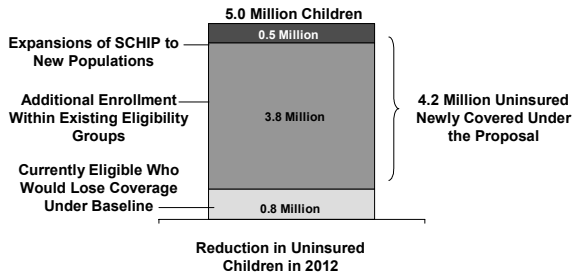
Children's Health and Medicare Protection Act (CHAMP Act) HR 3162

On August 1, 2007 the House approved the Children's Health and Medicare Protection Act (CHAMP). The CHAMP Act includes the following major Medicaid and SCHIP provisions:

Coverage. The CHAMP Act is expected to expand coverage to an estimated 7.5 million children in SCHIP and Medicaid in 2012. The majority of those enrolled (67 percent or 5.0 million children) would have otherwise been uninsured. Of the 5.0 million children who otherwise would have been uninsured, the bill would maintain coverage for .8 million who would lose coverage under baseline levels of funding and expand coverage to another 4.2 million. Of the 4.2 million, 3.8 (or 90 percent) represent children who are currently eligible and not enrolled and the remaining .5 million are expected to enroll as a result of state efforts to expand to new populations. (Figure 10)

Figure 10

Distribution of the Reduction in Uninsured Children in the Children's Health and Medicare Protection Act



SOURCE: CBO Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under the HR 3162, the Children's Health and Medicare Protection Act of 2007. August 1, 2007

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The House bill maintains flexibility for states to apply for waivers to cover parents and to cover children with incomes above 200 percent of the federal poverty level if states have enrollment and outreach efforts for children. The bill also adds new options for states to cover pregnant women through SCHIP and options to cover legal immigrant children and pregnant women and children up to age 21 through Medicaid or SCHIP.

Financing. The bill would increase funding for children's coverage by about $47 billion over baseline levels of $25 billion over the next five years primarily by using an increase of 45 cents per pack of cigarettes (compared to 61 cents per pack under the Senate Finance proposal) and reductions in payments for Medicare Advantage Plans. A much smaller share of financing would come from other Medicare provider rate cuts and an increase in the Medicaid drug rebate. New spending of $50 billion over the next five years is the amount that was set aside in the budget resolution passed by Congress in May (more than the $35 billion included in the Senate proposal and considerably more than the $4.8 billion included in the President's budget proposal.) The proposal also would replace the current allocation formula with one that relies primarily on state's projected spending, allows states 2 years (instead of 3) to spend their allotments, and re-bases the allotments every two years. Funds would be available for states that experience a shortfall in financing due to increased SCHIP enrollment based on a states average per capita costs of covering a child in SCHIP.

Enrollment and Outreach. The bill includes bonus payments for states that enroll children above baseline levels and adopt four out of seven eligibility simplification efforts (12-month continuous eligibility, elimination or automatic verification of assets, presumptive eligibility, automatic renewal, use of joint applications for Medicaid and SCHIP, elimination of an in-person interview or express lane eligibility determinations). The bonus payment would vary based on a states' average costs of covering a child in Medicaid and SCHIP and how far enrollment exceeds baseline levels. The bill would also require states to provide 12-month continuous eligibility in separate SCHIP programs and would increase the match rate for translation and interpretive services for families that do not speak English.

Benefits. The bill requires states to cover dental care, requires that there be parity in access to mental health and physical health care services, guarantees access to Federally Qualified Clinics and rural health clinics with Medicaid payment rules and limits the ability to approve Secretary-approved benchmark coverage under SCHIP. For Medicaid, the bill would allow states to offer coverage for family planning services without a waiver and would put a one year moratorium on the issuance of regulations that would limit payments for school-based administrative services, transportation or rehabilitation services. The bill prohibits the Secretary from approving new health opportunity account demonstrations that were authorized under the DRA.

Quality. The bill requires HHS to develop child quality measures and would establish the Children's Access, Payment and Equality Commission to monitor access and provider payment rates for Medicaid and SCHIP.

Citizenship Documentation. The bill allows for new options for individuals, newborns and tribal members to meet the citizenship documentation requirements imposed as part of the DRA. The bill would also allow states the option to return to pre-DRA requirements to document citizenship. The bill does not apply these requirements in SCHIP.

Premium Assistance. The bill would establish a demonstration program for up to 10 states to purchase family coverage through an employer buy-in program.

SIDE-BY-SIDE OF THE SENATE AND HOUSE SCHIP REATHORIZATION BILLS

	Children's Health Insurance Program (CHIP) Reauthorization Act of 2007, S. 1893	Children's Health and Medicare Protection Act (CHAMP), HR 3162
Enrollment Changes	• 4.0 million otherwise uninsured • 6.1 million enrollment increase	• 5.0 million otherwise uninsured • 7.5 million enrollment increase
Coverage Options	• State option to cover children up to 300% FPL (above 300% FPL reimbursed at Medicaid match) • State option to cover pregnant women • No new parent waivers, establishes a set-aside fund for parents reimbursed at Medicaid match rate after 2 years • Transitions coverage for childless adults to Medicaid in 2 years	• No upper income limit for children (current law) • State option to cover older children (21) and pregnant women under SCHIP; legal immigrant children and pregnant women under Medicaid or SCHIP • Waivers for parents allowed if states have outreach and enrollment efforts for children • No required transition of current childless adult waivers
New Spending	• Increase allotments by $35 billion over 5 years over baseline	• Estimated $47 billion new spending over 5 years over baseline
Allotments	• Distribution based on a combination of states' actual spending, projections and allotments increased by population growth and per capita growth in national health expenditures • Allows states 2 years to spend allotments	• Allotments and distribution based primarily on states' spending projections increased by population growth and per capita growth in national health expenditures • Allows states 2 years to spend allotments; re-base the allotments every 2 years
Outreach and Enrollment Incentives	• Bonuses for enrollment that exceeds baseline levels • $100 million per year in grant funding • $49 million for up to 10 states to implement "express lane" enrollment demonstrations • Contingency fund for states that face shortfalls, experience disasters, or sustained high unemployment rates	• Bonus payments for enrollment of currently eligible children above target levels in Medicaid and SCHIP and adopt 4 out of 7 eligibility simplification efforts • New option for Express Lane eligibility • 75% match for translation / interpretive services • Funds available for states with shortfalls in financing due to increased SCHIP enrollment above baseline levels
Benefits	• Requires parity between mental health and medical and surgical services for states • $200 million in grants to improve access to dental coverage	• Requires states to cover dental care requires that there be parity in access to mental health and physical health care services under SCHIP • Guarantees access to FQHCs and RHCs with Medicaid payment rules • Limits Secretary-approved benchmark coverage under SCHIP.
Quality / Access	• Requires HHS to develop child quality measures • Funds demonstration programs to improve quality and encourage the development of electronic health records for Medicaid and SCHIP.	• Requires HHS to develop child quality measures • Establishes the Children's Access, Payment and Equality Commission to monitor access to care and provider payment rates for Medicaid and SCHIP.
Citizenship Documentation	• Extend the DRA citizenship documentation requirements to SCHIP, but would allow states new options to comply with these requirements by using Social Security Numbers instead of requiring original birth certificate or passports	• Allows for new options for individuals, newborns and tribal members to meet the citizenship documentation requirements imposed as part of the DRA. • Allow states the option to return to pre-DRA requirements to document citizenship
Other	• Allows states to offer subsidies to qualified, cost-effective employer-sponsored coverage, broadens how states use the cost-effectiveness test, makes it easier to share information between public and private plans and establishes a demonstration program to allow certain employers to buy-in to a pool that offers SCHIP benchmark coverage.	• Establishes a demonstration program for up to 10 states to purchase family coverage through an employer buy-in program • Allow states to offer coverage for family planning services without a waiver in Medicaid • Imposes a 1 year moratorium on regulations to limit payments for school-based administration, transportation or rehabilitation services • Prohibits approval of new DRA health opportunity account demonstrations
Offsets for New Spending on Children's Health	• Financed by a 61 cent increase in the per pack federal tobacco tax	• Financed primarily through a 45 cent increase in the per pack federal tobacco tax and reductions to Medicare Advantage Plans • Small amounts from other Medicare provider cuts and Medicaid prescription drug rebate

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Medicaid and the Uninsured

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