THE KAISER COMMISSION ON
Medicaid and the Uninsured

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CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007 (CHIPRA)

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. Although coverage gains helped to increase access to health services for millions of children, about 9 million children remain uninsured.

The Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA) to extend the SCHIP program was passed with bi-partisan support in the Congress and vetoed by the President on October 3, 2007. To prevent the program from expiring on September 30, 2007, Congress passed a Continuing Resolution that would extend funding at current levels through November 16, 2007, but these levels are not adequate to fund states to maintain coverage for those children currently enrolled. This brief provides an overview of SCHIP and of key provisions in CHIPRA.

OVERVIEW OF SCHIP

Who is Covered by SCHIP Today?

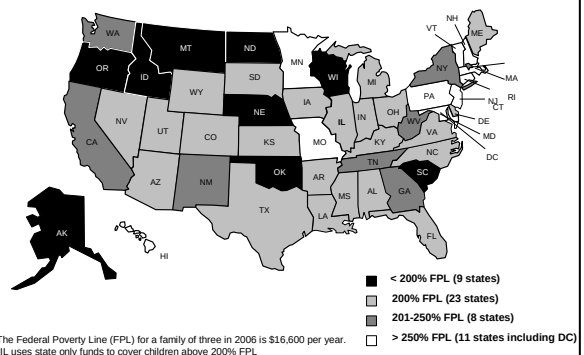
Medicaid and SCHIP cover more than 30 million low-income children. In 2006, 91 percent of children who were covered by SCHIP had incomes at or below 200 percent of the federal poverty level.[i] SCHIP was designed to build on Medicaid to provide insurance coverage to uninsured children who were not eligible for Medicaid and could not cannot afford to purchase private coverage. States were given flexibility to set eligibility levels.

Currently, 23 states cover children in families with incomes at 200 percent of poverty and 19 states cover children with family incomes above 200 percent of poverty (11 states set eligibility above 250 percent of poverty). (Figure 1) Additional states have plans approved or pending to increase eligibility levels. The poverty standard that states use to set eligibility levels is a national number that does not adjust for differences in purchasing power in different parts of the country for families with the same income.

Coverage of groups beyond children under SCHIP is limited. Through demonstration waivers, 11 states use SCHIP funds to cover parents, 4 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 of 2005 (DRA) 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. Undocumented immigrants are only eligible for emergency care under Medicaid.

Figure 1

Children's Eligibility for Medicaid/SCHIP, July 2007



*The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
**IL uses state only funds to cover children above 200% FPL
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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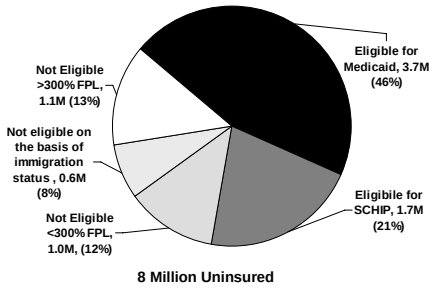
How Many Children Are Uninsured?

The most recent Census data shows that there were approximately 9.4 million children without health insurance in 2006 (a 710,000 increase over 2005). The percent of children without health coverage increased for the second consecutive year after years of decreases following the enactment of SCHIP in 1997. Approximately two-thirds of uninsured children are eligible for Medicaid or SCHIP, but not enrolled.

Figure 2

Distribution of Uninsured Children, 2004
(in millions)



SOURCE: Urban Institute analysis of the 2005 Annual and Social Economic Supplements to the CPS for KCMU. Data has been adjusted for the Medicaid undercount.

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Is SCHIP a "Government-Run" Program?

SCHIP is jointly financed by states and the federal government. The federal government matches state spending on eligible program beneficiaries at an enhanced match rate (compared to Medicaid). However, under SCHIP funds are capped, nationwide, and by state so federal funds match state spending up to the allotment.

States contract with managed care plans and providers to delivery care to beneficiaries. About three out of four children enrolled in Medicaid and SCHIP are enrolled in private managed care plans. States contract with managed care plans run by private companies to provide care for these children and often families have a choice of plans. Only 18 of the 224 plans participating in Medicaid in 2004 were public plans operated by counties, the rest are private firms.

Some children receive care in the fee-for-service delivery system where beneficiaries chose from any number of private providers that participate in their state's Medicaid or SCHIP programs. This is similar to private insurance coverage, not government programs like the Veterans Administration (VA) where the government pays for and provides care through a delivery system operated by government. Additionally, like private coverage, enrollees may be required to pay premiums or cost sharing in Medicaid or SCHIP.

Does Public Coverage "Crowd-Out" Private Coverage?

The extent to which individuals drop or chose not to purchase private coverage to enroll in public coverage is one of the central debates around SCHIP reauthorization. It is impossible to perfectly target new policies to cover the uninsured without also reaching some individuals who currently have private insurance. A Congressionally mandated evaluation showed that in the six months prior to enrolling in SCHIP only 29 percent of children had private coverage but in half of these cases private coverage was lost involuntarily due to job loss or change, employer change in benefits or a change in family structure. Another 8 percent lost private coverage because they felt it was not affordable.

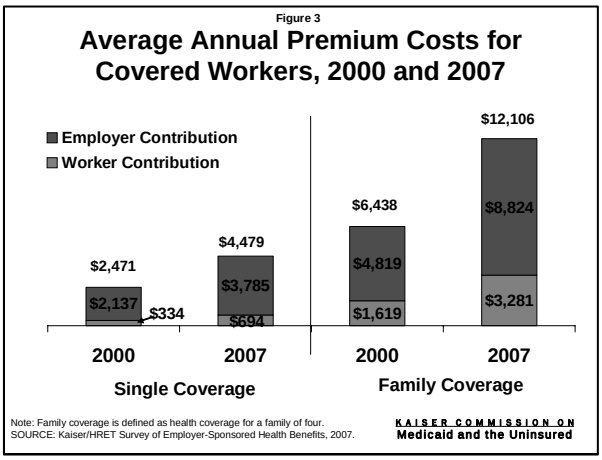
Extensive research on this issue shows that substitution is very low for people with lower incomes because private coverage is often not available or not affordable. Substitution or crowd-out estimates associated with efforts to enroll children who are currently eligible for Medicaid or SCHIP are low, about 14 percent or 24 percent respectively. As eligibility levels are expanded up the income scale where private coverage is more available, the possibility for crowd-out increases.

Analysis by economist Jonathan Gruber, author of much of the research on crowd-out, shows that public insurance expansions like SCHIP remain the most cost-effective means of expanding health insurance coverage compared to tax credit proposals where 77 percent of the benefits would accrue to individuals with insurance.[ii]

Private coverage has become increasingly unaffordable for low and moderate income families. Family premiums for employer-based health insurance coverage increased by 78 percent from 2001 to 2007 while worker wages increased by only 19 percent. An average premium for a family is now over $12,000 and if purchased directly would consume over a quarter of income for a family of four at 200 percent of the poverty level. (Figure 3) The increase in the cost of health insurance premiums falls heaviest on low and middle income families.

Figure 3

Average Annual Premium Costs for Covered Workers, 2000 and 2007



Note: Family coverage is defined as health coverage for a family of four.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007.

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How Does the New CMS Guidance Affect SCHIP?

New guidance released by the Administration in August requires that states expanding coverage to children beyond 250 percent of poverty adopt five strategies to prevent substitution of public coverage for private coverage including a one year period of uninsurance before a child could be eligible for coverage. These states are also required to provide assurances that they have 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. States would have one year to come into compliance with this guidance.

Prior to this guidance, states were required to implement procedures to limit crowd-out, but had more flexibility around the specific strategies that they used. Many states already have waiting periods of 3 or 6 months and/or impose some type of premiums or cost sharing.

OVERVIEW OF CHIPRA

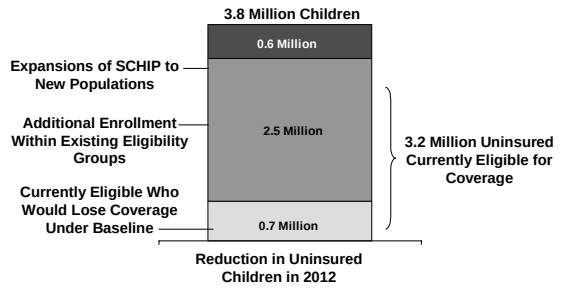
The Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA) to extend the SCHIP program was passed in the Congress and vetoed by the President. The bill was a compromise between the House and Senate versions for reauthorization of the program, but more closely resembles the Senate passed version. CHIPRA would rename the program "CHIP".

Who Would be Covered Under CHIPRA?

Children. CBO estimates that CHIPRA would provide coverage to 5.8 million children in SCHIP and Medicaid in 2012. The majority of those enrolled (66 percent or 3.8 million children) would have otherwise been uninsured. Of these 3.8 million children, the bill would maintain coverage for .7 million who would lose coverage under baseline levels of funding and expand coverage to another 2.5 million who are currently eligible but not enrolled. Thus, 3.2 million (over 80 percent) are currently eligible for Medicaid or SCHIP. The remaining .6 million are expected enroll to as a result of state efforts to expand to new populations. Analysis by the Urban Institute shows that 70 percent of the children who would be covered under the Senate bill (the basis for CHIPRA) would have incomes below 200 percent of poverty.[iii] (Figure 4)

Figure 4

Distribution of the Reduction in Uninsured Children in the Children's Health Insurance Program Reauthorization Act of 2007



SOURCE: CBO Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under HR 976, CHIPRA. Sept. 24, 2007

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Under CHIPRA, states maintain flexibility to set eligibility levels for children, but the enhanced matching rate is restricted for states that expand beyond 300 percent of poverty in the future. Two states would be grandfathered to be eligible for enhanced matching funds at the higher income levels. New Jersey currently sets eligibility at 350 percent of poverty or $72,149 and New York has passed state legislation to expand eligibility to 400 percent of poverty or $82,456 in 2006). After 2010, CHIPRA would impose new rules based on "best-practices" around crowd-out for higher income children.

Pregnant Women and Adults. The bill would establish new options to cover pregnant women, but would limit other coverage for adults and allow for a transition for states that had broader coverage in place. CHIPRA would prohibit new waivers for parent coverage and allow states that have waivers to continue coverage for parents for two years. For the 11 states that currently cover parents, the bill would limit funding 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) after two years. The bill would terminate coverage for childless adults and allow states to transition this coverage to Medicaid within two years.

Other Groups. Unlike the House SCHIP reauthorization bill, CHIPRA would not allow states the option to expand coverage to legal immigrant children or pregnant women in the country for less than five years. CHIPRA would also not allow states the option to cover undocumented immigrants and children of state employees so these groups would not be eligible for coverage.

Citizenship Documentation. The DRA citizenship documentation requirements for Medicaid would now be required for children in the reauthorized program, but CHIPRA would allow states new options to comply with these requirements by using Social Security Numbers instead of requiring original birth certificate or passports.

How Would CHIPRA Work to Improve Coverage of Low-Income Children?

CHIPRA creates fiscal incentives for states to enroll eligible children in Medicaid and SCHIP by paying a bonus per child that is based on several factors including how far actual enrollment exceeds target levels. To be eligible for the bonus payments, states must implement four of seven eligibility simplification efforts including continuous eligibility in Medicaid and SCHIP, elimination of the assets test, elimination of the in-person interview, joint application for SCHIP and Medicaid, presumptive eligibility determinations, and a new option to use "Express Lane" eligibility. The bill also provides $100 million in outreach grant funding. Ten percent of the outreach grants will be dedicated to targeting Native American children and the remaining funds will be available for state and local governments or other groups including safety-net providers, community based organizations or schools. CHIPRA would also provide an enhanced match for translation and interpretation services.

Does CHIPRA Have Provisions to Limit Crowd-Out and Expand Private Coverage?

CHIPRA would continue the requirement that children must be uninsured to enroll in SCHIP. The Act would require GAO and IOM to produce studies on how to measure public and private coverage and best-practices for states to use in addressing crowd-out. States expanding coverage beyond 300 percent of poverty must submit a plan describing how

they will address crowd-out and in 2010 states could not receive federal match for coverage of children with incomes above 300 percent of poverty unless they meet a target for coverage of children below 200 percent of poverty. These provisions would replace current crowd-out requirements that were included in guidance released by CMS in August.

CHIPRA has provisions to promote premium assistance programs by using a new cost effectiveness test and by allowing for premium assistance subsidies to qualifying employer plans. CHIPRA also requires employers to share information about benefit packages so states can more easily assess if plans are cost effective. States are also required to provide outreach and education to families and employers that may qualify for premium assistance.

What Changes Would CHIPRA Make to Benefits, Data and Quality?

The bill would require CHIP plans to include dental coverage and would require mental health parity to medical and surgical benefits if a state offers mental health or substance abuse services. CHIPRA would also apply the Medicaid payment rates for Federally Qualified Health Centers and Rural Health Clinics to SCHIP.

The bill includes $225 million over the next five years for child health quality initiatives including the development of quality measures and demonstration programs to improve quality, combat obesity and encourage the development of electronic health records for Medicaid and SCHIP. The Act requires states to submit an annual report to HHS including information on eligibility, enrollment and retention. CHIPRA includes $20 million for the Census Bureau to improve state specific estimates of children. The Act also requires a federal evaluation of the program in 2010.

How Would CHIPRA Be Financed and How Would Funds be Allocated to the States?

CHIP would continue as a capped program with enhanced matching rates. CHIPRA 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 Act would replace the current allocation formula with one that relies on state's actual and projected spending increased by factors for inflation and child population growth. CHIPRA would allow states 2 years (instead of 3) to spend their allotments. The bill creates a contingency fund (capped at 20 percent of the annual national allotment) available for states that face federal financing shortfalls for SCHIP due to increased enrollment of low-income children.

What is the Outlook for CHIPRA and Children's Coverage?

Congress passed and the President vetoed CHIPRA, bi-partisan legislation that would cover 3.8 million children who otherwise would be uninsured and increase spending for coverage by about $35 billion over the next five years. This bill resembles the Senate SCHIP reauthorization bill that was not as broad as the House version which would have increased funding for children's coverage by nearly $50 billion reaching 5 million uninsured children. The President's SCHIP proposal would only increase funding by $5 billion over the next five years, a level that the CBO says is not adequate to maintain coverage for current SCHIP enrollees.

The SCHIP reauthorization debate unfolds as new Census data shows a continued increase in the numbers of uninsured children driven by continued declines in employer sponsored coverage. The risk of working in a firm that does not offer insurance is very high for low-wage and even moderate income families—more than one-third of low-income families are not offered insurance through their employer or their spouse's employer. Although the availability of employer-based coverage increases at higher income levels, affordability remains a problem, especially for moderate income families between 200 and 400 percent of poverty. The increase in health insurance premiums has outstripped wage increases and has escalated more rapidly than the federal poverty level.

Even at higher income levels, public coverage seems to be filling in gaps in private coverage rather than drawing children away from their family's employer coverage. From 2005 to 2006, the number of uninsured children from families between 200 and 400 percent of the federal poverty level increased by 340,000 -- nearly half the total increase in uninsured children. For this middle income group, the increase was due to a drop in employer-coverage with no increase in public coverage to offset the employer drop. Thus, the drop in employer coverage for children in that income band appears to be driven by factors other than switching to public coverage.

The outcome of the SCHIP reauthorization debate remains a question as states struggle to administer their programs with unknown levels of federal support. Without additional federal financing, it will be difficult for states to move forward to address the growing number of uninsured children and some of the 6 million children currently covered could be at risk of joining the ranks of the uninsured.

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[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] 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

[iii] Kenney, Cook and Pelletier, "SCHIP Reauthorization: How Will Low-Income Kids Benefit Under House and Senate Bills?" Urban Institute, September 2007.

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