kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

Financing Health Coverage: The State Children's Health Insurance Program Experience

By Cindy Mann, JD and Robin Rudowitz

I. Executive Summary

Medicaid is expected to be in the forefront of federal policy debates as policymakers consider ways to address the federal budget deficit. The State Children's Health Insurance Program (SCHIP), which was created in 1997 and has close ties to Medicaid, has sometimes been cited as a model for Medicaid reform. Like Medicaid, SCHIP is jointly financed by states and the federal government, but unlike Medicaid, federal funds under SCHIP are capped, nationwide and state-by-state.

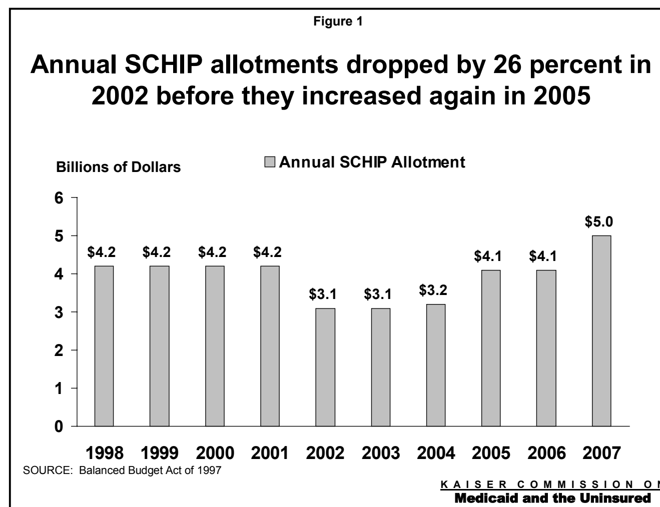
Overall, the SCHIP program has enjoyed widespread support and has been a success helping to reduce the number of uninsured children. SCHIP's financing system has several positive features: capped funding has allowed the federal government to limit and predict its outlays; the enhanced federal matching rate has provided incentives to states to expand coverage for children; and the state allotments created a public expectation, particularly in the early years of the program, that the federal dollars available in a state should be spent for coverage (rather than passed along to another state).

A review of the past six years of SCHIP funding and spending, however, shows that its capped financing system has also created significant challenges for states, inequities among states, and projected federal funding shortfalls. Over its relatively short life, SCHIP has been subject to numerous legislative changes to address some of these financing problems, but these changes have sometimes given rise to new problems and made it difficult for states to plan and predict their federal funding levels. While SCHIP's financing problems were somewhat masked by excess funding and a strong economy in the early years, the problems are now more apparent and are projected to result in declines in coverage for low-income children.

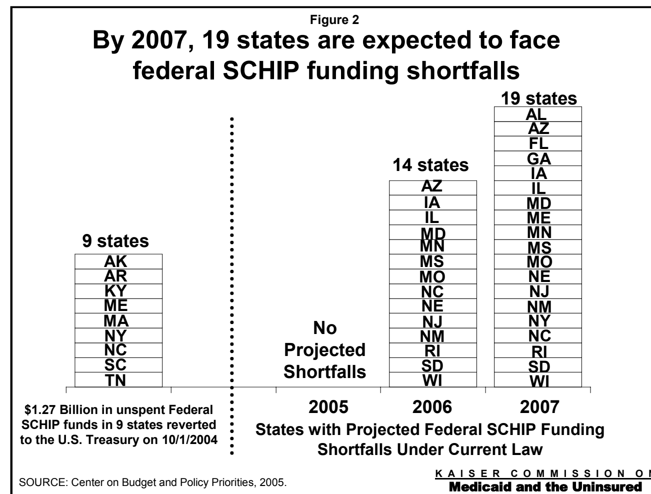
Stepping back from the details of SCHIP allotments, redistributions and reversions, it is possible to identify three basic sets of issues associated with SCHIP's funding structure:

- **Efforts to control and make federal spending more predictable came at the expense a funding structure that responds to program needs.** In any program jointly funded by the federal government and the states, there is tension between the federal government's interest in setting predictable levels of spending and the states' need for federal funding that is adequate and responsive to program costs. In SCHIP, federal funding was set 10 years in advance, giving the federal government predictability but at the expense of funding that responds to

unanticipated costs. SCHIP funding did not adjust, for example, to account for the downturn in the economy or the decline in employer-based insurance that increased children's need for publicly-funded coverage. The federal government's focus on deficit reduction at the time SCHIP was enacted exacerbated this tension. SCHIP was adopted as part of the Balanced Budget Act of 1997 ("BBA"), and the 10-year federal funding levels for SCHIP had to accommodate the federal deficit reduction goals of that broader legislation. This gave rise to the "SCHIP dip" – a 26 percent drop in federal funding for the program beginning in 2002 just when state programs were reaching maturity. **(Figure 1)**



- **Inequities and problems targeting funds are unavoidable when distributing capped federal funding to states through a pre-set formula.** Formulas for distributing funds to states to finance coverage will inevitably create inequities and misallocations because of the inherent difficulty devising a formula that responds to states' different and changing needs in a timely way. From the beginning, issues with data and problems identifying the target population (differentiating within the SCHIP formula between the children eligible for Medicaid versus those who were eligible for SCHIP) generated problems in state SCHIP allocations. Perhaps most fundamental, is that the formula for distributing the basic SCHIP allotments does not recognize variation in program costs based on factors such as scope of benefits, coverage levels, or participation rates. States with little use for SCHIP funds due to restrictions set by SCHIP program rules and even states that closed their SCHIP enrollment have received full allotments comparable in size to the allotments provided to states with robust enrollment and higher spending. Over time, some states wound up with more SCHIP funds than they were able to spend while other states needed additional funds to keep up with program costs and enrollment growth. (**Figure 2)**



- **Attempts to fix distributional problems can provide some help, but also create new problems such as making the funding system more complex and hard to manage.** Some formula problems are susceptible to solutions, but the SCHIP experience shows that the solutions are often too little or too late, or they create new problems. Since the SCHIP program was implemented, there have been several attempts to fix various problems with the formula. These "fixes" have not added any new federal money for the program, however, so formula adjustments create relative "winners" and "losers" among states. This has led to compromises that keep funds from flowing most efficiently to the states with the greatest need and to policies that allow funds earmarked for children to be diverted to other populations. Frequent changes in the rules for redistributing unspent SCHIP funds also has added new layers of complexity and made it difficult for states to plan and predict program funding.

Enactment of SCHIP sought to balance two interests: providing new coverage for uninsured children and limiting total federal outlays. This issue brief outlines some of the challenges that have arisen as a result of the balance struck in the SCHIP legislation. It offers valuable lessons to consider when the program is up for reauthorization in 2007, but also with respect to efforts to redesign aspects of the Medicaid program. The current focus on federal deficit reduction is reminiscent of the context that set the stage for the misalignment between overall SCHIP federal funding levels and spending and enrollment trends. Whatever these pressures may be, capped funding creates its own risks. SCHIP's experience illustrates that even in a relatively small program with relatively predictable costs, it is difficult to accurately project the needs for federal funding both over time and across states due to data constraints, unknown policy developments, and dynamic economic conditions.

If these financing issues have created challenges for SCHIP, a program that covers a relatively small, healthy and low-cost population, the potential for misalignment of funds, funding shortfalls, and disruptions to care would be far greater for Medicaid, a program

that costs 45 times more and covers a much larger and more diverse set of beneficiaries , including children with chronic illness, women with breast and cervical cancer, elderly people in nursing homes, and people with AIDS and HIV. Lessons from the SCHIP program show that caps on federal Medicaid spending and the formulas to distribute the capped funds could have severe and unintended consequences for the 52 million people served by Medicaid and for the states and providers that participate in the program.

II. Introduction

Rising health care costs, growing enrollment following the downturn in the economy, and pressures flowing from the aging population have put considerable stress on state Medicaid programs, prompting some to call for Medicaid reform. At the same time, a renewed focus on federal deficit reduction has led some federal policymakers to call for federal Medicaid funding reductions.[1] Currently the federal government shares all Medicaid costs with states, but changes in Medicaid's financing system are likely to be debated as a way to achieve federal savings. Over the years, proposals have been advanced that would impose federal funding caps of one kind or another. In some cases, the elimination or loosening of federal program rules has been offered to states as the quid pro quo for capping federal Medicaid payments.[2]

As the debate unfolds, it is instructive to consider how other health coverage programs have fared under capped federal funding. The State Children's Health Insurance Program (SCHIP), which was created in 1997 and has close ties to Medicaid, has sometimes been cited as a model for Medicaid reform. Like Medicaid, SCHIP is jointly financed by states and the federal government, but unlike Medicaid, federal funds under SCHIP are capped, nationwide, and state-by-state. This issue brief examines SCHIP's financing structure and the lessons learned from the past seven years of implementation.

III. Background

Enacted through the Balanced Budget Act of 1997 (P.L. 105-33), as Title XXI of the Social Security Act, SCHIP has been one of the more popular programs adopted by Congress in recent years, enjoying bipartisan support among federal and state policymakers. Its accomplishments are considerable. SCHIP has helped close the insurance gap for children, both by extending fiscal incentives that encouraged and enabled states to expand coverage and by triggering aggressive efforts to enroll children eligible for both SCHIP and Medicaid.

Despite many signs of success, however, SCHIP's financing structure has been fraught with problems necessitating frequent revisions in the law and ongoing debate about how to address these problems. Financing issues have caused inequities and uncertainties across states as well as projections that in some states children could lose coverage over the next few years as a result of federal funding shortfalls.[3]

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[1] Robert Pear. January 9, 2005. "Applying Brakes to Benefits Gets Wide G.O.P. Backing," *The New York Times*; Sarah Lueck. December 3, 2004. "U.S. Health Plans Catch Fiscal Hawks' Eye; Amid Deficit and Social Security Plans, Medicare and Medicaid Present Juicy Topics," *Wall Street Journal*; p. A4.

[2] The most recent proposal to cap federal payments to states was included in President Bush's FY 2003 Budget. See, *Bush Administration Block Grant Proposal,* Kaiser Commission on Medicaid and the Uninsured, May 2003.

[3] The White House Office of Management and Budget first projected these shortfalls and the loss of coverage in analyses released in the Administration's FY 2002 budget. *Fiscal Year 2003 Budget of the United States Government*, Analytical Perspectives, Office of Management and Budget.
Recently, the Office of Actuary at CMS issued a memo showing gradual decline in SCHIP enrollment after

A. SCHIP's Basic Structure

SCHIP was established to make health care coverage available to low-income uninsured children whose family incomes are above state Medicaid income eligibility standards. Like most pieces of major federal legislation, SCHIP was a product of political compromise. Some had advocated for a capped funding program with very few federal rules while others promoted an approach that would more directly build on Medicaid. The compromise offered states capped federal funds that they could use either to expand Medicaid or to finance coverage under a separate child health program. States could also adopt a combination of these two approaches.[4]

Under the law, states that use their federal SCHIP funds to expand Medicaid receive enhanced federal matching payments (enhanced relative to the regular Medicaid matching rate) up to the state's allotment of SCHIP funds. (If a state with a SCHIP-funded Medicaid expansion spends all of its SCHIP funds it can revert to regular Medicaid financing and receive regular federal Medicaid matching payments for its expansion group.) Coverage rules (e.g., benefits and cost sharing) under a SCHIP-financed Medicaid expansion are subject to the standard federal and state Medicaid rules.

States that use their SCHIP funds to finance coverage through a separate (non-Medicaid) program also receive enhanced federal matching payments up to the state's SCHIP allotment, although these programs cannot rely on Medicaid matching funds if their SCHIP funds are exhausted. Separate SCHIP programs are not governed by Medicaid program standards. The SCHIP rules allow states considerably more leeway regarding benefits and cost sharing. For example, while Medicaid requires states to provide children with dental, vision and mental health services, states that use their SCHIP funds in separate SCHIP programs may, but need not, cover these services. Separate SCHIP programs also create no federal entitlement or guarantee of coverage for eligible children. These programs may close enrollment to eligible children, operate waiting lists and institute waiting periods for children that are moving from private to public coverage without changing eligibility levels. Under Medicaid, states that have expanded beyond mandatory coverage levels could reduce coverage by restricting eligibility levels.

Every state has established an SCHIP program. Currently, 18 states use their SCHIP funds only to operate a separate SCHIP program, 11 states plus the District of Columbia use their SCHIP funds only in Medicaid, and 21 states rely on a combination approach (that is, they use SCHIP funds to expand Medicaid and to cover a group of higher income

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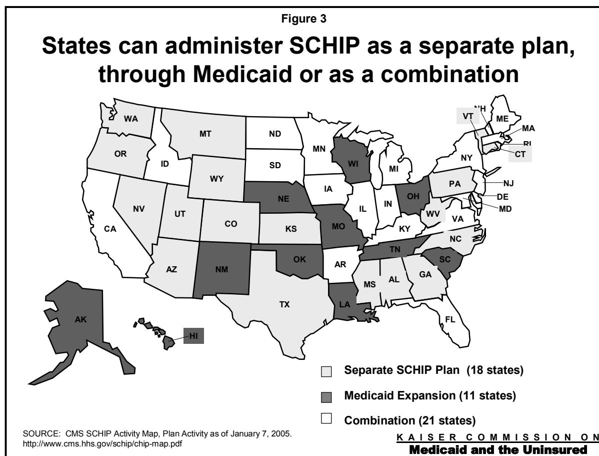
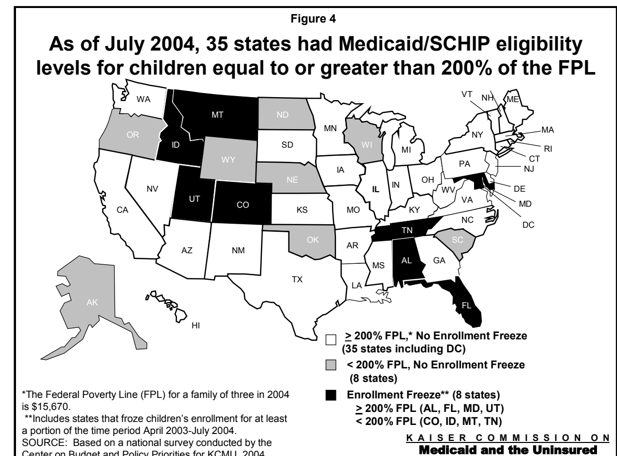
2005 assuming current-law allocation formula. Memo from John Klemm, Office of the Actuary, U.S. Department of Health and Human Services, October 4, 2004. The Center on Budget and Policy Priorities, which has developed a model that tracks and projects SCHIP spending based on state-reported data, estimates that unless further legislation is enacted, 19 states will have insufficient federal funding for their SCHIP programs between FY 2005 and 2007. (Estimates from January 2005)

[4] Cindy Mann, Diane Rowland, and Rachel Garfield. "Historical Overview of Children's Health Coverage." The Future of Children. Volume 13, Number 1.

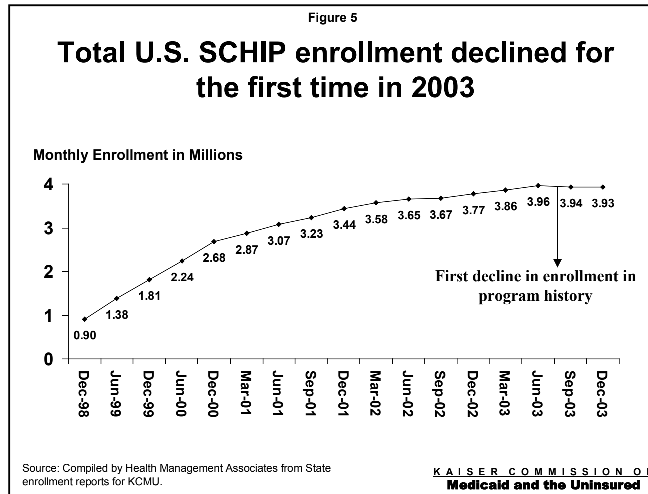
children in a separate program).[5] (**Figure 3)** The income eligibility levels for the SCHIP and Medicaid programs that have been implemented across the nation are shown in **Figure 4**.





Coverage financed through SCHIP began in January of 1998. After the initial start up period, states ramped up their programs and undertook a variety of steps to promote enrollment. As a result, the number of children gaining coverage grew steadily during the first four years of the program. In the second six months of 2003, total enrollment declined for the first time, although many states continue to see enrollment gains. Between June 2003 and December 2003, SCHIP enrollment grew in 37 states and declined in 11 other states and the District of Columbia. Some of the slowdown in enrollment was a reflection of the maturation of the program (the programs were ending the accelerated growth associated with program start-up), but in some states it resulted from policy changes designed to reduce state spending. Texas, which adopted several changes to slowdown enrollment, accounted for more than half (52 percent) of the nationwide decline in enrollment.[6] **(Figure 5)**

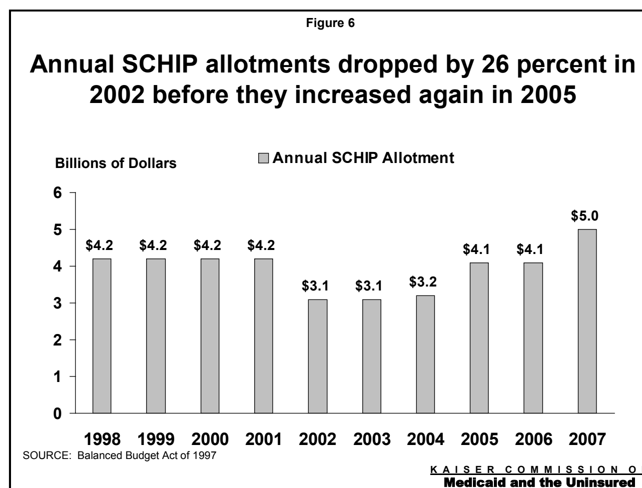
[5] Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/schip/chip-map.pdf.
[6] Vernon Smith, David Rousseau and Molly O'Malley, "SCHIP Program Enrollment: December 2003 Update." Kaiser Commission on Medicaid and the Uninsured, July 2004. KCMU collects and reports enrollment for a "point in time". CMS collects and reports SCHIP enrollment data showing the number of children "ever enrolled" in SCHIP during the year. Since this counts the number of children passing in and out of the program at any time during the year, it will show higher enrollment than the "point in time" data reported by states in the Kaiser survey. The most recent "ever enrolled" data is for fiscal year 2003, and it shows that 5,784,259 children were enrolled in a SCHIP-funded program at some point during that year. (See, revised SCHIP FY2003 Enrollment report, August, 2004, http://www.cms.hhs.gov/schip/enrollment/schip03r.pdf.) CMS does collect "point in time" data which it reports on a quarterly basis. The most recent data are for the third quarter of FY 2004, which show that 3,476,722 children enrolled; however, six states did not report their data. (See, FY2004 Third Quarter – Program Enrollment by Last Date in Quarter—Total SCHIP, http://www.cms.hhs.gov/schip/enrollment/2004pit3qt.pdf.)



B. SCHIP Financing

Federal SCHIP law establishes overall SCHIP funding levels and the formula and rules for distributing SCHIP funds to states. The key components of the financing structure are described below.

Aggregate annual caps on federal funds were established in the legislation that created the program in 1997. SCHIP's capped federal funding levels were set for ten years in the 1997 legislation that created the program: $4.2 billion was available for each of the first four years and then overall funding dropped by 26 percent to $3.1 billion in 2002, continuing through 2004. In 2005, funding begins to gradually rise back to pre-2002 levels. (**Figure 6)** These rather erratic and somewhat counterintuitive year-by-year funding levels were set based on broader federal budget constraints, not on any projection of the annual need for or the cost of children's health insurance coverage. SCHIP was created in the same broad legislation that was aimed at eliminating the federal deficit by the year 2002, and the annual SCHIP funding levels were largely driven by the demands of the broader federal deficit reduction goals.



Federal funds are allocated to states based on a formula set in the law. The federal funds allocated to SCHIP each year are divided and allocated to states based on a formula set in the statute. Each state receives federal SCHIP matching payments up to their capped allocation. (They may also have carryover or redistributed funds to spend, as discussed below.) Like Medicaid, states have to spend some of their own funds in order to qualify for federal SCHIP payments, but SCHIP offers states a more favorable federal matching rate than the regular Medicaid program. SCHIP matching rates range from a low of 65 percent to a high of 85 percent, compared to 50 percent to 77 percent under the regular Medicaid "FMAP."[7]

The formula for setting each state's share of the capped federal funds was intended to target funds to states with the greatest needs. For the initial two years (1998 and 1999), state allotments were determined largely by each state's share of the nation's low-income uninsured children.[8] To prevent the formula from discouraging enrollment efforts that would have the effect of lowering the number of uninsured children in a state (and, therefore, lowering that state's capped allotment), the original legislation built in a gradual change in the formula for distributing funds to states. A blended measure was to be phased in beginning in 2000 which considers each state's share of low-income children in addition to their share of uninsured low-income children.

The Balanced Budget Refinement Act (BBRA) of 1999 accelerated the phase-in of this blended measure largely in response to concerns over data problems associated with the state-level estimates of the number of low-income uninsured children. The 1999 SCHIP amendments also established "floors" and "ceilings" to protect states from more extreme year-to-year fluctuations in funding allocations.[9] For example, a state's allotment cannot drop or increase by more than 10 percent from year to year or no more than a 30 percent cumulative reduction. State allotments could also not increase more than 45 percent on a cumulative basis.

SCHIP law has a provision to "redistribute" unspent state allotments to states that have spent their entire allotment. The original law gave the Secretary of Health and Human Services authority to redistribute funds from states that did not spend their full allotment within three years to other states that did spend their entire allotment. The issue of how long states have to spend their allotments and the system for redistributing unexpended funds are the aspects of the law that have been the subject of considerable legislative activity since the original legislation. The short but somewhat convoluted history defies a simple description, but the key points are noted below:

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[7] The "enhanced FMAP" basically gives states a 30 percent discount as compared to Medicaid; it is equal to the Medicaid FMAP + 30% * (100 – Medicaid FMAP).
[8] The legislation identifies "low-income" children as those having incomes below 200 percent of the federal poverty line.
[9] A health cost adjuster is also included in the formula, but it does not have a significant impact on state allocations. For a detailed explanation of the allotment formula, see Federal Register Notice / Volume 67, No. 190 / Tuesday October 1, 2002. pp. 61632 – 61638.
http://www.cms.hhs.gov/schip/regulations/allotments/challot2003.pdf

- The original legislation allows states three years to spend their allotments and directs that any unexpended funds would then be redistributed to states that had fully spent their allotments. For example, under the original law, states could use their FY 1998 allotments in fiscal years 1998, 1999 and 2000. At the end of 2000, unspent allotments were to be redistributed to states that had fully spent their FY 1998 allotments. States would then have one year to spend the redistributed funds and any redistributed funds not spent at the end of that year were to revert to the U.S. Treasury (i.e., they would no longer be available for coverage under the program). This aspect of the formula was designed to help shift funds from states not using their allocated funds to cover children to those that were using all available resources.

- This original design has been revised twice to affect the spending and distribution of the FY 1998, 1999, 2000 and 2001 allotments and is again subject to debate and pending legislation. The law was amended to allow states that did not fully expend their early allotments within the three-year period to retain some of those funds; it established formulas to determine the distribution of the expiring funds that were not retained; and it extended the time states had to spend some of their redistributed or retained funds. These changes also prevented some funds from reverting to the U.S. Treasury.

- Even with these changes, debate over SCHIP funding continues. Legislation was introduced in the 108th Congress that would have prevented $1.3 billion in unspent SCHIP funds from reverting to the Treasury in October 2004 and reworked the redistribution formula.[10] This legislation did not pass and these funds did revert to the Treasury although debate over whether to restore these funds continues. In addition, on January 19, 2005, the Centers for Medicare and Medicaid Services (CMS) issued a notice proposing a new formula for redistributing FY 2002 unexpended allotments.[11]

States were originally required to use SCHIP funds for new coverage expansions. In order to ensure that the limited federal funds available for SCHIP were spent only for new coverage, the SCHIP law directed that the funds could only be used for coverage expansions adopted after June 1997. This provision has been subject to considerable controversy because states that had already expanded coverage for children under Medicaid were not eligible for enhanced matching payments for those children. States with similar coverage expansions have very different opportunities to access SCHIP funds depending on when they adopted their expansions. Legislative changes enacted in 2003, provided some modest, temporary assistance to some of the states affected by this situation.[12]

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[10] S. 2759 in the Senate introduced by Senators Jay Rockefeller (D-WV) and Lincoln Chafee (R-RI) and HR 4936 in the House introduced by Representatives John Dingell (D-MI) and Joe Barton (R-TX) in the 108th Congress.

[11] Vol 70 Fed. Reg No 12, p. 3036, January 19, 2005

[12] The amendments allowed states that expanded coverage up to at least 185 percent of the poverty line prior to SCHIP to use up to 20 percent of their SCHIP funds to finance coverage for children with incomes

Waivers and new rules allowed states to use SCHIP funds to cover populations not targeted in the legislation. Another development in SCHIP financing was with respect to waivers. The original legislation permitted the Secretary of HHS to allow "Section 1115" waivers to the same extent as permitted under Medicaid. Section 1115 permits the Secretary to "waive" certain program rules to allow research and demonstration projects that "further the objectives of the (program)." In July, 2000, CMS issued SCHIP waiver guidelines permitting states to use SCHIP funds, under certain circumstances, to cover pregnant women and parents. States had to demonstrate that they were already covering children up to 200 percent of the poverty line and had taken steps to promote children's enrollment.[13] The Bush Administration extended this policy to also allow states to use SCHIP funds, through waivers, to cover childless adults.[14] A new use of SCHIP funds was authorized by regulation. In September, 2002, HHS issued new rules allowing states to spend SCHIP funds to cover unborn children.[15]

A brief summary of the SCHIP financing legislation is included in Appendix A. **(Figure 7)**

Figure 7

There have been numerous legislative changes to SCHIP financing in the program's short history

Year	Legislative Change
1997	BBA: SCHIP enacted. Annual federal appropriations of nearly $40 billion set for 10 years; state allocation formula set based on need and costs; allows states 3 years to spend each years allotments and then gives Secretary of HHS authority to redistribute unspent funds
1999	BBRA: Accelerated phase-in of formula to distribute funds to states based on share of low-income children; sets hold-harmless provisions to minimize fluctuation in allotments
2000	BIPA: Established new rules for redistribution/retention of unspent funds from 1998 and 1999
2003	PL 108-74: Further extended the availability of 1998 and 1000 funds; allowed for states to use a portion of SCHIP funds for pre-SCHIP expansion
2004	Legislative efforts made to redirect unspent SCHIP funds. Efforts were unsuccessful and $1.3 billion in SCHIP funds were returned to the treasury
2007	SCHIP is up for reauthorization

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above 150 percent of the poverty line. This exception to certain SCHIP funds and did not change the ongoing rules for accessing SCHIP dollars.

[13] Source: CMS Letter to State Officials, Clarification Regarding Definition of "Optional Targeted Low-Income Children", July 10, 2000. Available online: http://www.cms.hhs.gov/schip/sho-letters/ch71000.asp

[14] Centers for Medicare and Medicaid Services. "Guidelines for States Interested in Applying for a HIFA Demonstration." Available online: http://www.cms.hhs.gov/hifa/hifagde.asp

[15] Vol. 67 Fed Register No. 191, pages 61955–61974, October 2, 2002. In addition, the 2000 legislative amendments allowed states to use an additional portion of their retained 1998 allotments for outreach.

IV. SCHIP Financing Issues

SCHIP financing has been successful in limiting federal outlays and providing incentives for states to expand coverage for children through the enhanced match rate. It also became clear that, at least in the early phase of the program, the state allotments set a public expectation that states should spend the funds available to them for coverage rather than pass them along to another state, and this also helped to bolster enrollment efforts. Some states were attracted to the SCHIP financing structure because while it capped federal funding it did allow states to limit their financial exposure by capping enrollment. A review of the past six years of SCHIP funding and spending, however, shows that its capped financing system created significant challenges for states as well as inequities among states. Funding constraints have led the CMS actuary to project funding coverage losses for children in some states.

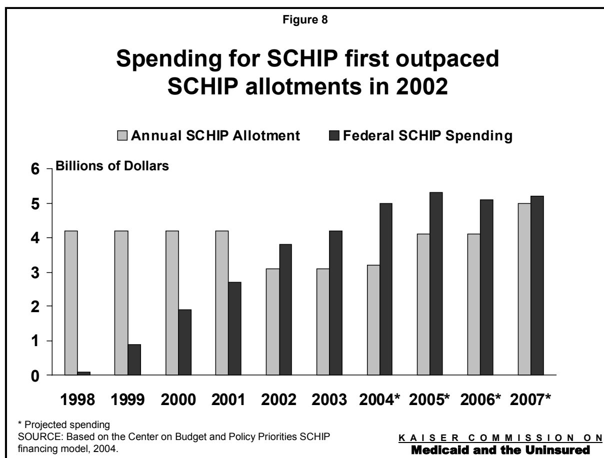
The issues relating to SCHIP's capped financing and its formula for distributing funds are considered below. There are three basic sets of issues: (A) the mismatch between program needs and available funding that came about as a result of the tension between the federal government's interest in setting and capping federal funding levels and the need for adequate program funding; (B) the difficulties associated with devising a formula for distributing capped federal funding to states; and (C) the complications that arise when new policies are developed to address funding formula problems.

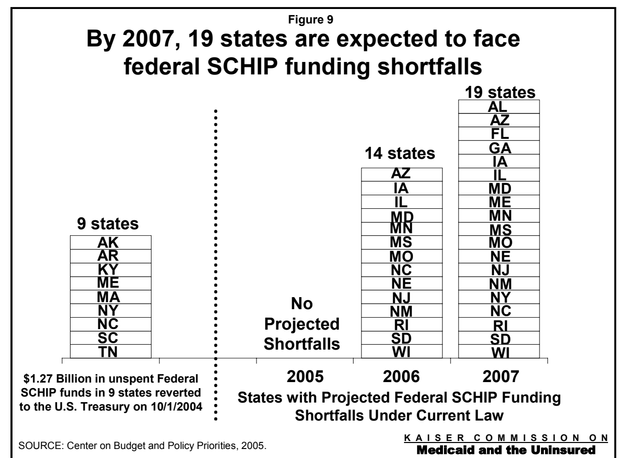
A. Tensions between Program Needs and the Federal Interest in Limiting and Predicting Federal Spending.

Problems can arise when deficit reduction targets, rather than program needs, drive federal spending allocations. SCHIP was created as part of a much broader legislation that made changes to a wide range of federal programs with the goal of balancing the federal budget by federal fiscal year 2002. SCHIP was something of an aberration in that legislation- it was one of the few components that called for increased federal spending. Because the main focus of the broader bill was to eliminate the deficit by 2002, all spending increases and reductions resulting from the different components of the legislation had to be reconciled to make the overall numbers fit within that larger goal. Aggregate year-by-year federal funding levels for SCHIP were set in this context.

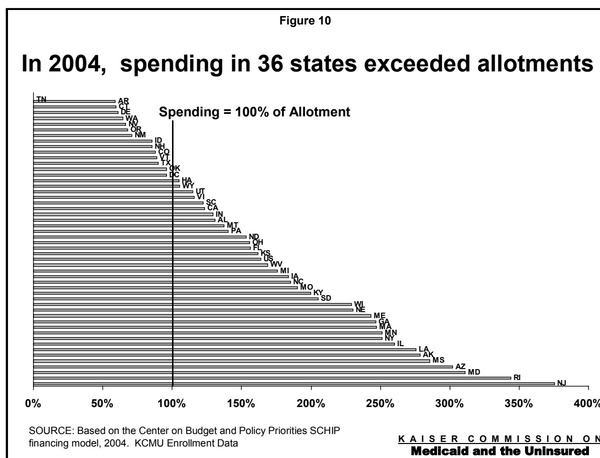
As a result, in FY2002, just as state SCHIP programs began to see enrollment grow rapidly, the overall level of funding for the program dropped by more than one quarter. The result was a mismatch between the states' need for funding and the level of available federal funds. (**Figure 8)**. Although the immediate impact of this mismatch was mitigated by the carryover of unexpended allotments from the initial start up years of the program, several states expect federal funding shortfalls in 2006 and 2007.[16] **(Figure 9)**

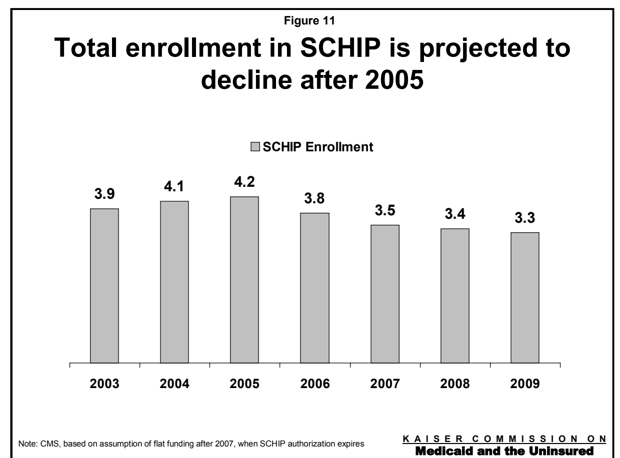
[16] According to projections based on state-reported data, 14 states may face federal funding shortfalls in 2006 and 19 states may have shortfalls in 2007. Center on Budget and Policy Priorities, January 2005.





Three of the states (ME, MA and NY) expecting shortfalls in 2007 actually had unspent funds that reverted to the treasury in the early years of the program. From 2000 to 2004, the peak years for SCHIP spending and enrollment nationwide, despite steadily growing enrollment, almost every state (except Nevada where the allotment increased by .5 percent over the period) experienced an average annual decline in its allotment level. In 2004, 36 states were spending more than 100 percent of their annual allotments. (**Figure 10**) As a result of these funding problems that have worsened over time, the CMS actuary projects a decline in enrollment after 2005. (These projected declines assume that federal SCHIP funding remains constant after 2007 when the program is up for reauthorization.) **(Figure 11)**





Federal funding levels set well in advance are unresponsive to intervening events. By setting overall SCHIP funding levels 10 years in advance, the federal government has been able to predict and control its financial exposure for SCHIP coverage. But that certainty at the federal level has come at the expense of program funding that is sensitive to intervening events. The year-by-year funding levels for SCHIP set in 1997, understandably did not predict the economic downturn experienced between 2001 and

2003. In the early years, SCHIP programs benefited from a strong economy and excess funds, but when the economy goes into a downturn, people lose their jobs, their incomes, and their health insurance. SCHIP is not specifically designed to be a counter-cyclical program, in that individuals do not have an entitlement to coverage and states can close enrollment when need rises, but most SCHIP programs did in fact respond to the downturn. At least part of the growth in enrollment between 2000 and 2003 was likely the result of higher levels of need among the target population. Overall program funding, however, did not adjust to account for higher levels of need. Going forward, SCHIP enrollment is projected to decline due to limited funding despite increases in the low-income population, continued weak economy and erosions in private health insurance.

B. Issues associated with distributing capped federal funding to states through a pre-set formula

The SCHIP distribution formula was intended to target federal funds to states with the most need. However, it became apparent early on in the program that the formula did not efficiently and effectively distribute these funds. The mismatch between state needs and the actual allocation of dollars was the result of many different factors.

Inadequate data made it difficult to accurately target SCHIP funds across states. A threshold problem with the formula was that it was impossible to accurately calculate each state's relative share of low-income uninsured children who would be eligible for SCHIP. The data available for estimating the number of low-income uninsured children in each state was not designed for, nor well suited to the task. The best available data was used -- the data collected through the U.S. Census Bureau's Current Population Survey (CPS) -- but with limited sample sizes for most states, the state-level data are somewhat unreliable. Three years of data are averaged for each state to help address the sample size problem, but this has meant that the data lags considerably. Allotments for 2005, for example, are based on CPS data for 2000, 2001 and 2002. Many states questioned the validity of the CPS data applied to their state and several undertook their own, more extensive, surveys for use as their benchmark for evaluating progress.[17]

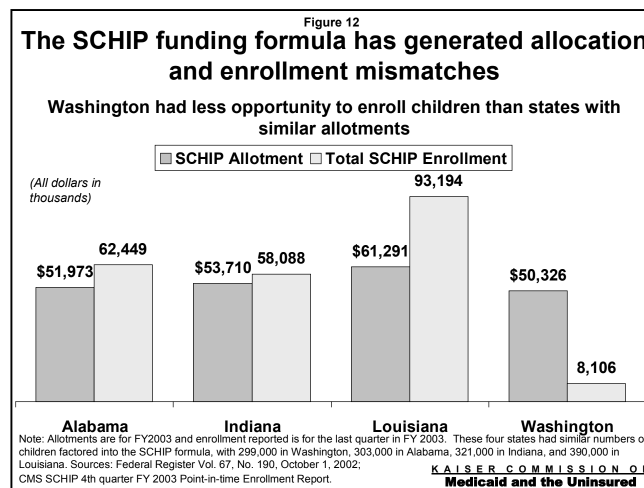
The SCHIP allocation formula did not adequately account for the "target population" or those children eligible for new SCHIP expansions. Another basic problem with the SCHIP allocation formula was that different states with the same share of uninsured children have very different needs for SCHIP funding, depending on factors relating to its Medicaid program that were not accounted for in the formula.[18] The original law prohibited states from using SCHIP funds for children already covered by a state's Medicaid program.

Consider two states that have the same percentage of low-income uninsured children. One state might have expanded its Medicaid program for children prior to enactment of

[17] See, for example, the 1998 SCHIP evaluation reports prepared by New Hampshire, New Jersey and Oklahoma. All reports can be accessed at http://www.cms.hhs.gov/schip/evaluations/1998.
[18] Frank Ullman, Brian Bruen, and John Holahan. "The State Children's Health Insurance Program: A Look at the Numbers." Assessing the New Federalism, The Urban Institute. March 1998

SCHIP but had not done much to promote enrollment of those Medicaid eligible children. Some portion of the low-income uninsured children in that state would be eligible for Medicaid, not SCHIP. By contrast, in the second state, which either had not expanded eligibility for Medicaid or which had been more successful enrolling eligible children in Medicaid, most of the low-income uninsured children would be eligible for SCHIP. The CPS data on uninsured low-income children --- and, therefore, the SCHIP formula for distributing funds---does not distinguish between these two states. Thus, they would receive similar allotments despite potentially vastly different levels of need for SCHIP federal funds. The blended measure, which factors in all low-income children, exacerbates this problem.

States are treated differently depending on when they had expanded coverage. As noted above, because SCHIP funds were capped, federal policymakers were particularly concerned that the funds be used to finance *new* coverage. They structured the SCHIP law so that states could not use SCHIP funds to refinance coverage expansions adopted before SCHIP. This did ensure that the funds were available for new expansions, but it also created inequities across states. States like Vermont, Minnesota and Washington had adopted coverage expansions in Medicaid before 1997. Because of the timing of their expansions, they were not able to access much of their SCHIP funds for the coverage they offered to low-income children in their state. **(Figure 12)** These types of inequities often come up when capped funds are distributed to states because formulas often build off of past patterns and practices.



Allotment levels do not vary based on program costs or other factors that affect program spending. Perhaps the most fundamental problem in capped funding programs is that state allocations are not calibrated to reflect underlying health care costs, economic conditions, changes in employers sponsored coverage or the scope of a state's efforts to cover children and the ongoing, actual cost of that coverage. Different states have very different SCHIP program costs depending on how broad their eligibility rules may be, the scope of the benefits provided under the program, the premiums and cost sharing imposed on families, and the rates paid to providers. In addition, much has been learned over the past several years on ways to promote participation rates among eligible

children; some states have been particularly aggressive in their efforts to promote enrollment among eligible children while other states have taken steps to curb enrollment, including the imposition of closed enrollment periods.[19] None of these factors, however, have any direct bearing on the formula for setting states' basic allocations.[20] The allotment levels for the states with SCHIP enrollment freezes have not been affected in any way by the decisions in those states to stop enrolling children into their SCHIP programs.[21]

Actual spending levels do affect whether a state receives redistributed funds, but those funds comprise an increasingly small share of overall SCHIP funding. Even with redistribution, some states will still face funding shortfalls. Finally, the timing and amount of any redistributed funds are so unpredictable that states may refrain from making program decisions based on the availability of these supplemental funds, especially going forward as redistributed funds become smaller. In 1999, for example, North Carolina temporarily stopped enrolling children in its SCHIP program because it projected a long-term shortfall in federal funds; in making this calculation it did not factor in the potential for reallocated funds since the state had no basis for predicting any certain level of funding from that source.[22]

Allocations can create pools of unspent funds that can in turn generate proposals and policies to divert those funds to other purposes. Formulas can allocate more funds to some states than are needed, at least for some period of time. This has been the case in SCHIP, where 28 states had excess SCHIP funds in each of the four occasions when SCHIP allocations expired (for the 1998, 1999, 2000 and 2001 allotments). When funds not needed for children's coverage accumulate in some states, pressure builds in that state to use those funds for other purposes and occasionally proposals surface at the federal level to divert those funds to other programs.[23] One response to the accumulation of funds in some states has been the use of section 1115 waivers allowing states to use SCHIP funds to cover other populations. In December 2003, 268,000 adults were

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[19] Cindy Mann, David Rousseau, Rachel Garfield, and Molly O'Malley, "Reaching Uninsured Children through Medicaid: If You Build it Right, They Will Come." Kaiser Commission on Medicaid and the Uninsured, June 2002. Cohen-Ross D, Cox L. "Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children." Kaiser Commission on Medicaid and the Uninsured, December 2003. Cohen-Ross D. "Update on the Florida SCHIP Enrollment Freeze." Kaiser Commission on Medicaid and the Uninsured, July 2004. Cohen-Ross D, Cox L. "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families." Kaiser Commission on Medicaid and the Uninsured, October 2004.

[20] As noted above, the allotment formula does include a small factor to adjust for differences in state healt costs, measured by health wages.

[21] To the extent that the allocations still depend in part on a state's relative share of low-income uninsured children, states that have aggressively enrolled eligible children in SCHIP may receive a lower allotment than a state that has done much less and therefore has a higher share of uninsured children.

[22] Edwin Park and Matt Broaddus. "OMB Estimates Indicate that 400,000 Children Would Lose Health Insurance Due to Reductions in SCHIP Funding." Center on Budget and Policy Priorities, November, 2001.

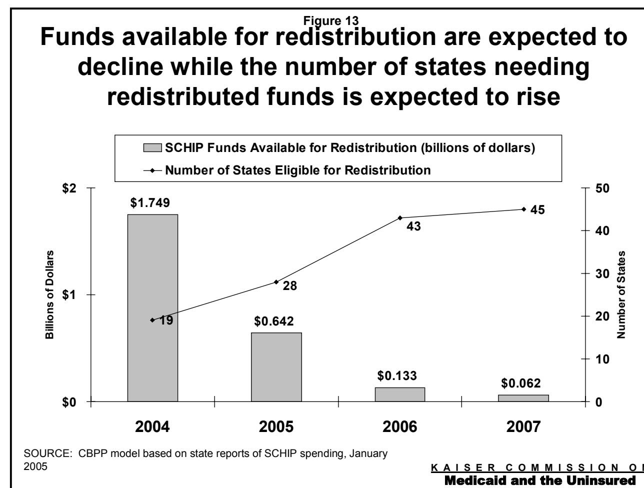
[23] *Issues Related to Unspent S-Chip Money,* Kaiser Commission on Medicaid and the Uninsured, November 2001.

covered with SCHIP funds in seven states.[24] The coverage of childless adults has raised the most controversy; the General Accountability Office has issued two reports critical of the federal agency's approval of these waivers as diverting SCHIP funds for purposes not authorized by the SCHIP law.[25]

C. Attempts to fix distributional problems can provide some help, but also can create new problems

Whenever a particular problem arises in a funding formula it is possible to consider ways to address that problem. Often, however, the fix is often either "too little" or "too late" to be of much help or it creates or exacerbates other problems with the formula. Under a capped federal program, a "fix" for one state or group of states comes only at the expense of funding for other states.

Despite good intentions, formula "fixes" often do not solve distributional problems. The original SCHIP law anticipated that unevenness of the state allotments would be addressed by the redistribution of "unspent" funds from states not using their allocated funds to other states that were using all available resources. There have been several developments with respect to the redistribution process and formula, however that shows the weakness of this "fail safe." First, and perhaps most significant, is that the amount of funds available for redistribution is now quite low. Due to higher levels of spending at the state level, and the overall drop in federal funding only $643 million dollars will be available for redistribution sometime in 2005 and some 28 states are projected to be in line to share those redistributed funds. By 2007, 45 states are expected to be eligible for redistribution with only $62 million available for redistribution. **(Figure 13)**



[24] Vernon Smith, David Rousseau and Molly O'Malley, "SCHIP Program Enrollment: December 2003 Update." Kaiser Commission on Medicaid and the Uninsured, July 2004. CMS's Revised FY 2003 Annual Enrollment Report shows that close to one half million adults had been enrolled at some point during fiscal year 2003 through waivers implemented in eight states. http://www.cms.hhs.gov/schip/enrollment/schip03r.pdf

[25] General Accounting Office: "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waivers Projects Raise Concern." July 2002 and "SCHIP: HHS Continues to Approve Waivers that are Inconsistent with Program Goals". January 2004.

Another problem is that the level and even the timing of the redistribution are unpredictable for states, making it difficult for states to rely on those funds as they make their program and budget plans. For example, the FY1998 funds were supposed to be redistributed in 2001, but intervening law changes delayed redistribution until 2002 and only a portion of the unspent funds were actually redistributed. The unpredictability partly results from the fact that when adjustments to the redistribution formula were made, political compromises have accompanied those adjustments, undermining efforts to more aggressively move funds from low-spending states to high-spending states. While some states needed more funds, other states routinely had unneeded funds that they retained for several years. Over the past six years, 28 states had unspent SCHIP funds on each of the four occasions when SCHIP allocations expired.

"Fixes" can make a formula even more arbitrary. Concerns over using data on low-income uninsured children prompted the Congress to include another factor in calculating state SCHIP allotments and to accelerate the reliance on this factor beginning in 2000. The formula is now determined both on the state's share of low-income uninsured children and on its share of the overall number of low-income children. While this adjustment addressed some concerns, it added an additional layer of arbitrariness to the distribution of SCHIP funds. States with roughly the same number of low-income children might receive the same SCHIP allotment even if their need for SCHIP funds varies significantly because of the scope and cost of their program, or differences in the availability of employer-sponsored coverage.[26]

"Fixes" come at the expense of other states. In the context of a program with overall capped funding, any "fix" for one state or a group of states inevitably comes at the expense of other states. In 2001, 11 states that had not been able to use much of their SCHIP funds because their coverage expansions were adopted before 1997 gained temporary access to their allotments through a revision in federal law. That fix came at the expense of other states. [27]

Frequent "fixes" can make funding levels unpredictable for states. The basic SCHIP financing rules have been changed by Congress multiple times in the past six years, and in between those changes the Department of HHS has issued various rules and notices relating to program financing. These changes have often helped address some of the problems that occur in the financing of the program but they also create difficulties for states trying to predict their funding and plan their program operations. The recent action taken to redistribute fiscal year 2002 funds underscores the problem. More than three months into the fiscal year, CMS issued a notice setting forth the formula (not one that had been used before) for redistributing $643 million in SCHIP funds to 28 states. The notice dispensed with the generally-required 30-day advance comment period and 30-day

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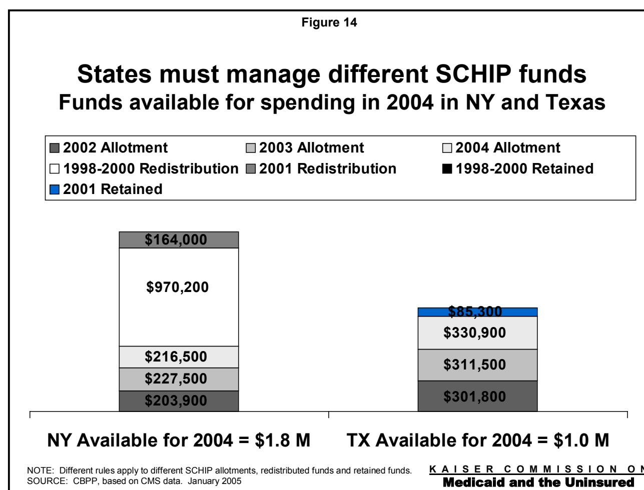
[26] John Holahan. "Variations Among States in Health Insurance Coverage and Medicaid Expenditures: How Much is Too Much?" Urban Institute. June 2002.
[27] Although the SCHIP waivers were not necessarily allowed as a "fix" to the distribution problems, the broad availability of waivers in the context of a program with a fixed amount of federal funds inevitably reduce the capped pool of funds available to other states.

delay in effective date in order to release these funds without further delay. The distribution, however, is "provisional" subject to a final adjustment in response to comments the agency receives.[28] States will not know the level of their redistributed funds until at least half-way through the fiscal year. This is despite the fact that states only have until the end of this fiscal year to spend these funds.

Various "fixes" can make funding formulas more complicated and difficult for states to manage. In any given year, a state is likely to be managing several different "pots" of SCHIP funds—an allocation for the current fiscal year, possibly allocations from the prior two fiscal years, and possibly retained or redistributed funds. Each source of funds carries their own rules with respect to when the funds can be spent, and some funds have different rules with respect to how those funds can be spent. Keeping track of these different funding pots and related rules can be a challenge for states. **(Figure 14)**



V. Conclusions

SCHIP's financing challenges offer valuable lessons to consider when the program is up for reauthorization in 2007, but also with respect to efforts to redesign aspects of the Medicaid program. Many of the lessons learned from the SCHIP experience have a direct bearing to the Medicaid debate. Perhaps most striking is the deficit-reduction focus that set the stage for the misalignment between federal SCHIP annual funding levels and state spending needs is relevant again at the federal level. If Medicaid's structure is changed from one in which federal payments automatically respond to program costs to one with federal funding caps of one kind or another, the federal government will gain more control over its federal spending. That control, however, will come at the expense of federal funding levels that respond to changes in program needs and costs.

SCHIP's financing system raises challenges, but no more so than other capped programs with formulas for distributing funds. Perhaps the most important lesson from SCHIP is

[28] Vol 70 Fed Reg No 12, page 3044, January 19, 2005

that even the most well-meaning efforts will inevitably be hindered when financing is governed by caps and formulas rather than actual costs and need. SCHIP has functioned reasonably well so far and will hopefully continue to weather the storms caused by its financing structure. This may be attributed to excess funding and a robust economy in the early years of the program. However, it is difficult to imagine states, providers, and beneficiaries being able to manage effectively if a program with responsibilities as broad as Medicaid's were subject to such strains.

Medicaid covers populations that include people with complex medical needs and unpredictable medical costs– children with chronic illness, women with breast and cervical cancer, elderly people in nursing homes, and people with AIDS and HIV--and its role in providing coverage and in the overall health care system dwarfs that of SCHIP. Total spending in SCHIP amounts to about two percent of Medicaid spending **(Figure 15).** With a much broader and more diverse set of beneficiary groups, Medicaid costs are sensitive to more factors than those that might affect SCHIP costs, and the potential for inequities across states is also much greater given the differences among states with respect to spending levels, growth rates, population mix, and health costs. The consequences of national and state-by-state funding mismatches and funding shortfalls combined with the unpredictability of federal funding levels and the difficulties managing the capped funds for a program that serves over 50 million people and accounts for more than 17 percent of the nation's health care expenditures could be much more severe.

Figure 15

Medicaid serves a larger and more diverse group of individuals than SCHIP

	Medicaid	S-CHIP
Groups Covered	• Low-income children (from 0% to 300% of FPL in the state with the highest eligibility standard) • Low-income parents and pregnant women • Low-income children and adults with disabilities/ •Low-income Elderly (65 years of age +) • Women with Breast and Cervical Cancer • Children in foster care • Children and adults with incomes above limits but with high medical expenses (eg., elderly who "spend down" to Medicaid levels because of nursing home costs)	• Children with incomes above Medicaid standards •Some parents and other adults through waivers
Number of Enrollees	52 million total, including 25 million children 8 million children and adults with disabilities 5 million elderly 14 other adults including pregnant women	6 million children
Costs	$276 billion federal and state	$6 billion federal and state

NOTE: Number of enrollees count those "ever on" on the program for the full year, 2003 Data

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Appendix A

SCHIP Legislative History

Balanced Budget Act, 1997 (BBA). SCHIP was enacted through the Balanced Budget Act of 1997 (BBA), and provided states nearly $40 billion dollars in federal funds over ten years for health coverage of low-income children. The BBA established the program's structure and set annual federal appropriations levels for the program through FY2007. The BBA also established a formula for distributing each year's total appropriation across the states and territories based on a measurement of need and a measure of state costs. Under the law, states had to spend each year's allotment within three years or the funds would return to the Federal Treasury. For example, a state needed to spend its FY1997 allotment by the end of FY1999. The law gave the Secretary of Health and Human Services authority to redistribute funds from those states failing to spend funds within the three years of ability to those able to spend funds within the required time period.

Balanced Budget Refinement Act, 1999 (BBRA). The Balanced Budget Refinement Act (BBRA) or 1999 accelerated the phase-in of the blended formula for distributing funds to states (i.e., adding a factor relating to a state's share of the nation's low-income children) due to the large sampling error associated with the state estimates for the number of low-income uninsured children. It also established"hold-harmless" provisions so that states were protected from extreme year-to-year fluctuation in funding allocations. Finally, the BBRA increased the SCHIP allotments for the territories and included funding to for the Census Bureau to improve data on the number of uninsured children and for the U.S. Department of Health and Human Services to perform evaluations of state SCHIP initiatives.

Benefits Improvement and Protection Act, 2000 (BIPA). Just before the first redistribution of the 1998 allocations was to take place, in December 2000, the Benefits Improvement and Protection Act (BIPA) established new rules for the redistribution of unspent FY1998 and FY1999 SCHIP funds and extended the availability of these funds. Under the BIPA formula, states were allowed to retain most (65 percent) of their unspent 1998 funds and almost half of their unspent 1999 funds. Some 35 percent of unspent FY1998 funds were redistributed to the 12 states that had expended their 1998 funds and 58 percent of unspent FY1999 funds were redistributed to the 13 states that had fully expended their 1999 funds. States had until the end of FY 2002 to spend the redistributed and retained FY1998 and FY1999 funds. The law also allowed states to use a portion of their retained funds for outreach (without counting toward the general limit on non-coverage expenditures).

SCHIP Program Allotments Extension, PL 108-74, 2003. Despite the legislative adjustments made through BIPA, nearly $1.3 billion in unspent FY1998 and FY1999 federal SCHIP funds was at risk for returning to the Federal Treasury. In August 2003, HR 2854 (PL 108-74) was enacted to further extended the availability of fiscal years

1998 and 1999 funds, allowing states to retain these funds through the end of FY2004. PL 108-74 also allowed states to retain 50 percent of the states' FY2000 and FY2001 SCHIP allotments left unspent after three years. Further, availability of these funds was extended through FY2004 for FY2000 funds and through FY2005 for FY2001 funds. These amendments also permitted certain states that had expanded coverage for children up to at least 185 percent of the poverty line prior to SCHIP to use up to 20 percent of certain SCHIP funds for some of the pre-SCHIP expansion. (A technical amendment to this provision was enacted in PL-108-127, enacted in November, 2003.)

Legislative Efforts in 2004. While legislative adjustments have extended the life of SCHIP funds and redirected unspent funds to states with greater SCHIP expenditures, roughly $1.3 billion of FY1998-FY2000 SCHIP funds were left unspent at the end of FY2004. These unspent funds were returned to the Federal Treasury as of October 1, 2004. Legislation has not been filed in the 109th Congress to restore these funds to the program.

SCHIP redistribution formula. In the absence of further legislation, the 2002 SCHIP allotments which states had three years to spend (FY2002, 2003, 2004) were no longer available as of October 1, 2004, subject to redistribution. A formula for redistributing these funds was proposed through a notice issued on January 19, 2005. The funds were provisionally released to 28 states subject to adjustment once the final formula is determined (after a 30-day comment period). (Federal Register/Vol. 70, No.12, January 19, 2005/3036-3044.)

SCHIP reauthorization. The BBA created SCHIP for a ten-year period; in 2007, the SCHIP program will be up for reauthorization.

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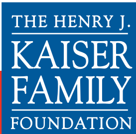

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.