



Issue Brief:
SCHIP Reauthorization
National Association of State Budget Officers

January 30, 2007

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Background

The State Children's Health Insurance Program (SCHIP) was established in 1997 under Title XXI of the Social Security Act as a matching grant to provide health insurance for low-income children who do not qualify for Medicaid, but whose families are not able to afford private coverage. The current period of authorization for SCHIP ends on September 30, 2007, although many states are anticipating a funding shortfall to begin as early as May. This issue brief examines SCHIP funding problems facing states, funding and other issues that are expected to be at the forefront of the fast-approaching reauthorization debate, and current actions in the states aimed at expanding the SCHIP program.

Structure and Accomplishments of the Program

While the federal government stipulates that SCHIP programs must be directed at targeted low-income children, states are free to a large extent to design their own programs and determine their income eligibility requirements. Currently, forty states and the District of Columbia have set their maximum income levels at or above 200 percent of the Federal Poverty Line (FPL), while 10 have set their income thresholds below 200 percent of FPL¹. States can choose one of the following options for administering the SCHIP program: expand eligibility for benefits under the state's Medicaid program, create a separate SCHIP program, or use a combination of the two programs to provide children with coverage. In general, separate SCHIP programs have greater flexibility in terms of benefit design, cost sharing, and enrollment limits, while Medicaid expansions are subject to the state's Medicaid program rules. Currently, eighteen states operate a separate SCHIP program, 11 states and the District of Columbia operate an expanded Medicaid program, and 21 states use a combination of the two. Six million children are currently enrolled in SCHIP, and together with Medicaid, SCHIP contributed to a reduction in the percentage of uninsured children from 14 percent in 1997 to 11 percent in 2005, despite falling rates of employer-sponsored coverage over the same time period. SCHIP has also had positive spillover effects on Medicaid enrollment in many states. Although the SCHIP program has a spending cap, unlike Medicaid, it uses an enhanced federal match rate, whereby the federal government pays 65 to 85 percent of state SCHIP initiatives, a much higher percentage than that of Medicaid. Despite these tremendous accomplishments, 8.3 million children still lack health insurance, an estimated 6 to 7 million of whom are eligible for SCHIP but are not enrolled in the program.

¹ The following states set their maximum income thresholds below 200 percent of FPL: Alaska, Idaho, Montana, Nebraska, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Wisconsin.

Funding Shortfalls and Reauthorization

At the end of the 109th Congressional session in December, seventeen states were facing an aggregate \$920 million shortfall of federal SCHIP funds in fiscal 2007. Prior to adjourning, Congress partially addressed this problem by approving a stop-gap measure that allows for the redistribution of \$271 million in unspent fiscal 2004 and 2005 SCHIP funds to states with shortfalls. Even with this measure in place, many states are expected to run out of funding in early May. On January 25, Senators Edward M. Kennedy of Massachusetts, John D. Rockefeller of West Virginia, and Olympia Snowe of Maine introduced a bill to fill in the expected fiscal 2007 shortfall in fourteen states. Senate Finance Committee leaders announced on January 26 that they will hold a hearing on February 1 on beginning a separate legislative effort to reauthorize the entire SCHIP program. In addition to funding issues, the reauthorization debate is expected to be dominated by discussions of the funding formula, enrollment eligibility requirements, and benefit coverage.

Funding. The most pressing issue that will arise in reauthorization discussions is the aggregate level of federal funding for the continuation of SCHIP. Since SCHIP is a mandatory program with an annual funding cap, there is no automatic mechanism to adjust for increases in health care costs from one year to the next. Therefore, under the baseline, the annual funding level will remain at fiscal 2007 levels through fiscal 2012, without factoring in Congressional Budget Office's projected increases in the cost to states of providing health care. These estimates indicate that an additional \$12 billion in federal funds will be needed between fiscal 2008 and 2012 in order to eliminate future funding shortfalls, assuming that annual funding for 2008 through 2012 remains at the current \$5 billion. Without additional funding, it is estimated the 36 states will run out of federal funding by 2012, putting coverage of 1.5 million children into question. For the first time in seven years, the number of children without health insurance increased in 2006 to 11.2 percent, up from 10.8 percent in 2005, indicating that state SCHIP programs are no longer able to keep up with funding demands in the face of the erosion of employer-sponsored health insurance. Reauthorization discussions will likely center around the aggregate level of federal funding made available for the next reauthorization period, how future shortfalls will affect uninsured rates, and whether to establish a mechanism for increasing funding levels each year based on health care costs.

Funding Formula. Another reauthorization issue involves the funding formula used to allocate federal funds to the states. In an in-depth survey of several state Medicaid directors conducted by the National Academy for State Health Policy (NASPH), the four most commonly cited issues with the funding formula involve the data source, the cost factor, the allocation formula, and the redistribution process.

- *Data Source:* Some directors reported that the data source used to determine funding allocation, the Current Population Survey (CPS), is not accurate and fails to reflect states' progress made in covering uninsured children. Using alternative data sources may be a strategy suggested by states in the reauthorization of SCHIP.
- *Cost Factor:* The cost factor, which is included in the funding formula to account for variations across states of the costs of providing health care, is determined by the three year average of wages per employee in the health services industry. This adversely affects states with higher poverty levels that may actually need a larger share of funding than wealthier states because poorer states tend to employ more part time workers and those with lower earning potential.
- *Allocation Formula:* SCHIP funds are allocated based on the cost factor as well as the population of low-income children and that of low-income *uninsured* children in the states. Even if the number of uninsured children in a state increases, a larger allocation is only received when the state's rate of increase in uninsured children from one year to the next is higher than the national average. Therefore, as the number of needy children rises nationally, available funding per child declines regardless of a state's particular funding needs.
- *Redistribution Process:* A major source of contention is the redistribution process for unspent SCHIP funds. States are given a three year window to spend their federal allocation, after which

time remaining funds are collected and distributed to states experiencing shortfalls. States are given a year to spend these funds, after which time funds revert back to the US Treasury. (In 2004, \$1.1 billion was reverted back to the Treasury). State Medicaid directors have expressed concern that the one year time period in which they must spend redistributed funds is insufficient time for states to produce and spend matching funds, because they must plan for, appropriate, and spend enough state dollars to receive the federal match. Timing is also an issue because of when state legislatures meet to make budget decisions

Enrollment Eligibility and Benefit Issues. Although funding issues are the most pressing concerns for states in the upcoming SCHIP reauthorization, problems surrounding benefit coverage and enrollment eligibility are also expected to receive attention during reauthorization. This is reflected not only through responses from the NASHP surveys, but also in publications by the Kaiser Commission on Medicaid and the Uninsured² as well as the Georgetown University Health Policy Institute's Center for Children and Families³.

One such problem is a statute restricting states from offering partial benefit coverage. Currently, SCHIP covers "targeted low-income children", which is defined as children in families below 200 percent of the federal poverty level who lack creditable health coverage. According to many Medicaid directors as well as advocacy groups, some health coverage deemed 'creditable' by the federal SCHIP statute fails to cover essential services and is inadequate for children with special needs or chronic illnesses⁴. Essentially, states operating separate SCHIP programs rather than Medicaid expansion programs are required to direct SCHIP funding solely to children without any coverage, barring states from offering partial benefit (sometimes called 'wrap-around') coverage to children with creditable but inadequate coverage. This often results in states not being able to offer children additional coverage for essential services such as vision care, dental care, and mental health services. State Medicaid directors, while cognizant of the broad flexibility given to states to design their own separate SCHIP programs, believe that this statute barring states from covering partial benefit services prohibits states from having the maximum positive impact on children's health. Most SCHIP directors surveyed believe that states operating separate SCHIP programs should be allowed, but not required, to provide additional services to children who have inadequate coverage. Options for changing the SCHIP statute to allow for such wrap-around coverage include amending the definition of "targeted low-income children" to allow states to use SCHIP funds to cover partial benefit packages for children with creditable, but less than comprehensive, coverage or allowing states to offer a partial benefit package as a health services initiative as defined in the Social Services Act. The Bush administration's recently-revealed Health Care Initiative includes the Affordable Choices Initiative, which would require states to define the parameters of a basic health care coverage policy. Although this measure is aimed at determining subsidy levels for uninsured people, it might give states an opportunity to re-define comprehensive coverage to include these additional services.

In terms of SCHIP enrollment flexibility, current policies prohibit Medicaid-eligible children from being enrolled in SCHIP and through a pre-screening process, automatically enroll eligible children in Medicaid. This practice often results in children from the same family being enrolled in different programs. Depending on the ages of children in a family and the family's income level, some children may be eligible for Medicaid, whereas older children may not qualify for Medicaid and will therefore be enrolled in SCHIP. The administrative burdens of having children from the same family in different

² "A Decade of SCHIP Experience and Issues for Reauthorization," The Kaiser Commission on Medicaid and the Uninsured, *The Henry J. Kaiser Family Foundation*, January 2007.

³ "Too Close to Turn Back: Covering America's Children: Building on the Success of Children's Coverage Through SCHIP and Medicaid," *Georgetown University Health Policy Institute Center for Children and Families*, December 2006.

⁴ Bergman, David, "Perspectives on Reauthorization: SCHIP Directors Weigh In," *National Academy for State Health Policy*, June 2005.

programs are significant to states as well as to the families who enroll in these programs. Some flexibility in these cases would ease these burdens and allow children within a single family to be served by the same program.

SCHIP Expansion Proposals

Several states are focused not only on maintaining current coverage levels but also on expanding SCHIP coverage beyond current levels. Recently, states such as Pennsylvania, Illinois, Tennessee, and Oregon have either passed or proposed legislation to cover all kids, and other states appear to be following suit:

- Arizona: Governor Janet Napolitano recently announced in the State of the State address plans to expand KidsCare by \$6 million next year alone. The expansion would extend health insurance to families up to 300 percent FPL and would also increase outreach efforts to reach Arizona children who are eligible for the program but are not enrolled. Currently, Arizona's KidsCare program is available for families up to 200 percent FPL.
- Illinois: In November 2005 Governor Rod Blagojevich signed the Covering All Kids Health Insurance Act, making insurance coverage available for Illinois children in families with income levels above 200 percent of the federal poverty line. Costs to the families are determined by a sliding scale, and the program is funded through enrollee premiums and cost sharing methods. Illinois continues to seek federal financial participation in the program;
- Oregon: Governor Ted Kulongoski proposed his plan to cover all children through an expansion of the Oregon Health Plan; Wisconsin Governor Jim Doyle proposed extending the state's Medicaid program to all uninsured children; and Washington Governor Christine Gregoire and New Mexico Governor Bill Richardson have also proposed insuring all children, but have yet to introduce specific plans on how to do so.
- Pennsylvania: In July 2006 Governor Edward Rendell announced the Cover All Kids Program, allowing children younger than 18 to receive health care coverage, regardless of their families' income levels;
- Tennessee: In 2006, Tennessee passed the Cover Kids Act to create a stand-alone SCHIP program for children in families with incomes up to 250 percent of the federal poverty line, which also allows children in higher income families to buy into the program;

Recently, a sixteen-member coalition of insurers, hospitals, physicians, drug companies, business interests, and consumer groups proposed an expansion of federal SCHIP funding by \$45 billion. The group, known as the "Health Care Coalition for the Uninsured", stated that the expansion in funding would cover almost all of the 9 million uninsured children in the country, but failed to include a funding plan for the large expansion. This will be problematic if the proposal ever reaches the implementation stage, largely because of the PAYGO rules Democrats in Congress have pledged to follow which require that new spending be offset by spending cuts or tax increases.

Conclusions

This brief presents only a glimpse of the myriad issues that will dominate the SCHIP reauthorization debate during the current Congressional session and are already being examined by interest groups, state legislators, governors, and the media. Funding levels will undoubtedly dominate the debate, as states struggle to serve all eligible families and avoid lapses or declines in coverage. Other issues are expected to be at the forefront of the discussion as well, such as the funding formula, partial benefit coverage, and enrollment flexibility. Meanwhile, many states are introducing plans to expand SCHIP programs beyond current income thresholds, and private interest groups are proposing expansions at the federal level.

As reauthorization takes center stage in Congress and as additional states take it upon themselves to expand children's health coverage, NASBO will keep you updated. For additional information about SCHIP reauthorization, please contact Jordan Head at (202) 460-1246 or email her at jhead@nasbo.org.