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Pennsylvania Medicaid Policy Center

The Reauthorization of The State Children's Health Insurance Program (SCHIP): Implications For Pennsylvania

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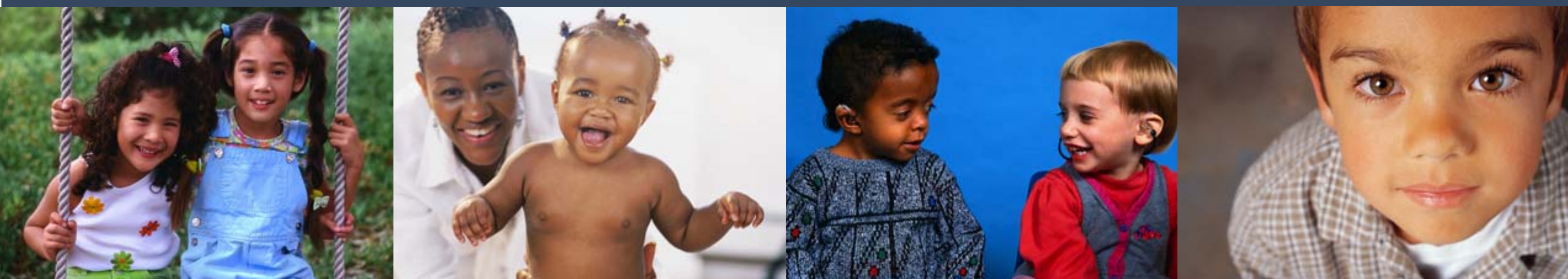

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Executive Summary

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP), one of the most significant health-system reform initiatives for children since the Medicaid expansions throughout the 1980s and 1990s. The SCHIP legislation allocated $40 billion to the states over a 10-year period, in order to provide health insurance to children who would otherwise be uninsured. The legislation presented states with two incentives to enroll children in SCHIP: (1) The federal matching rate for SCHIP was higher than it was for Medicaid. (For Pennsylvania in 2007 the match rates were 68.07 percent and 53.39 percent, respectively.) (2) States were afforded considerable flexibility in the way that they designed the programs. Prior to the implementation of SCHIP, Pennsylvania had established the Children's Health Insurance Program—a program that served as a prototype for SCHIP. Pennsylvania's SCHIP program is called CHIP.

Pennsylvania's CHIP program is designed to provide health insurance to children who would otherwise be uninsured. When it was established in 1998, CHIP covered all children up to the age of 19in families whose incomes exceeded Medicaid eligibility levels but were not higher than 200 percent of the Federal Poverty Level (FPL). In March 2007, Pennsylvania significantly expanded CHIP to cover children in families with incomes above 200 percent of the FPL. Table 1 below describes current eligibility levels. The section marked "Free" represents the initial program, and the sections labeled "Low Cost" and "At Cost" represent the expanded program.

Table 1: Eligibility Level and Cost Sharing PA CHIP

ELIGIBILITY LEVEL	Free			Low Cost			At Cost
% of Poverty Household Size	(Ages 0–1)	(Ages 1–5)	(Ages 6–18)	(Ages 0–18)	(Ages 0–18)	(Ages 0–18)	(Ages 0–18)
	Annual Income			Annual Income			Annual Income
% of Poverty	185%–200%	133%–200%	100%–200%	200%–225%	225%–275%	275%–300%	Over 300%
Household Size 4	$38,203 to 41,300	$27,465 to 41,300	$20,650 to 41,300	$41,301 to 51,625	$51,626 to 56,788	$56,789 to 61,950	$61,951 to No Limit

In Pennsylvania the number of children enrolled in CHIP increased from a monthly average of 70,000 in 1998 to 148,000 in 2006. As of March 2007, 154,994 children were enrolled in CHIP.

National studies have shown that SCHIP has had many positive effects on children. It has: led to a decrease in the number of children who are uninsured, increased access to care, led to a decrease in the amount of unmet need and delayed care, increased the proportion of children who have a regular source of care, and increased the use of preventive care. It has also eased general family worry about medical bills and parental concern that children's activities would lead to injury and high medical bills. As one parent wrote to the CHIP staff, "I am very happy that we are a CHIP family. CHIP gives me peace of mind to know that my son can play."

When SCHIP was enacted, Congress authorized a fixed amount of federal funding over a 10-year period. Each year, some of these funds were allotted to the states. The states could only draw down funds to match actual expenditures on services. Initially, the allotments to the states were much higher than the federal expenditures on the services, and the states were allowed to carry over unexpended funds. However, as time passed, federal annual expenditures began to exceed the annual federal allotments to the states. In Pennsylvania for FY (Fiscal Year) 2006, the federal allotment was $134 million while the federal expenditures on the program were $164 million. Pennsylvania used reserves to cover both the extent to which the federal expenditures exceeded the 2006 allotment and to help fund the cost of the recent expansion.

SCHIP has enjoyed considerable bipartisan support and is up for reauthorization this year. Although there appears to be no question that it will be reauthorized, many issues remain undecided, especially questions regarding total funding levels and state flexibility with respect to coverage. The ultimate framework will have an important influence on the nature of the decisions that states, including Pennsylvania, will make with respect to extending health insurance to the population.

The Reauthorization of the State Children's Health Insurance Program (SCHIP): Implications for Pennsylvania

Introduction

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP), one of the most significant health-system reform initiatives for children since the Medicaid expansions throughout the 1980s and 1990s. The SCHIP legislation allocated $40 billion to the states over a 10-year period, in order to provide health insurance to children who would otherwise be uninsured. In March 2007, 154,994 children were covered under the program in Pennsylvania.

SCHIP has enjoyed considerable bipartisan support and is being considered for reauthorization this year. Although there appears to be no question that it will be reauthorized, many details of the form and direction the program will take remain undecided, especially questions regarding total funding levels and state flexibility to cover both children and certain adults. At this point in time, there are significant differences in opinion among the president, governors, members of Congress, and advocates about what desirable SCHIP policy looks like. The ultimate framework will have an important influence on the nature of the decisions that states, including Pennsylvania, will make with respect to extending health insurance.

In this report, we provide the background behind the original SCHIP legislation and some of the basic decisions that were made in developing its framework. We describe the interrelationships between Medicaid and SCHIP and examine the basic funding structure for the program. Next, we examine some of the decisions that Pennsylvania has made in designing its program, and we compare its decisions with those of other states. We then present data on the number of children covered (both in the state and nationally) and examine the program's impact on children's access to healthcare. With this framework in mind, we turn to the types of decisions that will be made in the reauthorization and the implications of some of these decisions for Pennsylvania.

An Overview of SCHIP

BACKGROUND

During the 1990s, following the demise of efforts to enact universal health insurance and in light of the increase in the number of children without health insurance, both state and federal health-policy makers broadened their efforts to extend health insurance to children. This expansion effort was reflected at the federal level by the phase-in of Medicaid child health-coverage reforms enacted in 1989. These reforms mandated coverage of infants in families with incomes at or below 185 percent of the Federal Poverty Level (FPL); young children up to age 6 with family incomes at or below 133 percent of the FPL; and children ages 6–18 with family incomes at or below 100 percent of the FPL.

The expansion effort was also reflected in the passage of SCHIP. This legislation was spearheaded by Senators Orrin Hatch (R-UT) and Edward Kennedy (D-MA). At the time of its passage, SCHIP was praised by President Clinton for its importance in broadening the federal commitment to child health financing.

SCHIP's Structure and Interaction with Medicaid

Codified as Title XXI of the Social Security Act, SCHIP is a state grant-in-aid program that entitles states with approved plans to federal allotments (grants) toward health coverage of "targeted low-income children." While the states were entitled to these federal dollars, SCHIP did not contain an individual entitlement to services. (Under Medicaid, all children who meet the program's eligibility standards must be covered; whereas under SCHIP, the states could impose waiting lists if the designated funds could not pay for all of the children who met the eligibility standards.) States can operate their SCHIP programs as a Medicaid expansion, a separate program, or a combination of the two. States that operate their programs as a Medicaid expansion must follow all Medicaid requirements. States that operate their programs separately from Medicaid have greater flexibility in terms of enrollment, eligibility standards, benefits, and cost-sharing. Pennsylvania operates its CHIP as a program separate from Medicaid.

Eligibility: A "targeted low-income child" is an individual who satisfies the following two conditions:

(1) The child's family income must be above the Medicaid eligibility level and below 200 percent of the FPL, or 50 percentage points above the state's Medicaid eligibility level (whichever is greater).

(2) The child must not be eligible for Medicaid or covered under any form of health insurance.

Thus, a "targeted low-income child" is an uninsured child who is expressly found ineligible for Medicaid. As a practical matter, this requirement necessitates a combined SCHIP/Medicaid determination, and the states must provide a mechanism for enrollment into Medicaid if appropriate. States could expand coverage under SCHIP beyond federally authorized limits by securing demonstration waivers under Section 1115 of the Social Security Act or from a State Plan Amendment approved by the Centers for Medicare and Medicaid Services (CMS), the federal arm of the United States Department of Health and Human Services that administers SCHIP. Operating under such waivers, a state could expand coverage to parents or pregnant women, or increase eligibility standards for children above the income levels specified in condition (1) above. Until 2006, when Congress passed legislation forbidding such a practice, states could also receive waivers to extend coverage to childless adults.

It should be noted that prior to the enactment of SCHIP, states had the ability to expand their Medicaid programs to cover "targeted low-income children."[1] However, most states only covered the children that they were mandated to cover under Medicaid. SCHIP contained two types of incentives to encourage the states to extend coverage to these children. First, the federal match against state expenditures under SCHIP was set about 15 percentage points higher for SCHIP than for regular Medicaid. In Pennsylvania today, the federal Medicaid match is 54.39 percent while the enhanced SCHIP match is 68.07 percent.[i] (Thus, out of every $100 spent on SCHIP services, Pennsylvania pays $31.93 and the federal government pays $68.07.) Second, states were given more flexibility to design their SCHIP programs than they were to design their Medicaid programs. Unlike Medicaid, SCHIP is not an entitlement program for individual children, and there are no clearly defined benefits and prohibitions against cost-sharing. Therefore, states that operate SCHIP as a separate program have the ability to design benefits and coverage rules, use premiums and cost-sharing, and establish fixed limits on enrollment with waiting lists.[ii]

In establishing eligibility for SCHIP, the states had to show that the program would not "crowd out" private insurance. As a result, states that operate SCHIP as a separate program must implement procedures to ensure that coverage provided under SCHIP does not substitute for private-group health-plan coverage. These procedures may include a waiting period (or "go-bare" period), which may be waived or reduced for approved reasons such as a parent's loss of job-based health-insurance coverage or movement between government-sponsored programs.

Funding Mechanism: When the program was enacted, Congress authorized $40 billion of federal funding to be allocated to the states over a 10-year period. The federal government uses a formula to allocate the funds across the states in the form of annual payments or allotments.[iii] States have three years to spend their allotments before the funds are partly redistributed to other states under a special federal formula. Regardless of the size of the state allotment, a state can draw down its allotment only when it actually spends money on covered services for enrolled children.

The Design of the Pennsylvania SCHIP Program Today

In this section, we describe the major decisions that Pennsylvania has made in creating its SCHIP program, known as the Children's Health Insurance Program (CHIP). We also show how Pennsylvania's

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i States that operate SCHIP as a Medicaid expansion receive this enhanced match for children whose coverage is paid for through their annual SCHIP allotment.

ii Under the Deficit Reduction Act of 2006, states were given more flexibility in the design of their Medicaid programs.

iii This complex formula is used to ensure that aggressive SCHIP expansion in one state does not consume funds needed by other states. The formula also ensures that states that actively pursue program expansions can re-claim and use federal allotments that go unexpended in the states that received them.

decisions on its CHIP structure compare with those of other states.

Structure: As noted above, prior to the creation of the national SCHIP program, Pennsylvania had created CHIP, which served as a prototype for the federal program. CHIP is explicitly recognized in the federal law as an approved state program. To-day, Pennsylvania and 18 other states operate wholly separate child health programs, 11 states have Medicaid expansion programs, and 21 states have a combination of programs.[2] (The types of SCHIP programs implemented in each state are shown in Appendix B.)

Eligibility: In 1998, Pennsylvania set the upper income-eligibility level for CHIP at 200 percent of the FPL for all children through the age of 18. CHIP, therefore, covered all children in families with incomes above the Medicaid eligibility levels (which were set at the mandated minimum levels) and no higher than 200 percent of the FPL. CHIP did not impose either premiums or cost-sharing.[iv] In Table 1 below, the 1998 CHIP program is described under the "Free" column. The lower income level under each age represents the income level at which coverage under CHIP starts. Thus, children aged 0–1 were covered under the Medicaid program if their family incomes fell beneath 185 percent of the FPL, and they were covered under CHIP if their family income fell between 185 percent and 200 percent of the FPL.

In March 2007, following the passage of Pennsylvania's Cover All Kids legislation and CMS approval of an amended state plan reflecting the new law, Pennsylvania expanded the CHIP program. Under the expanded program, CHIP covers all eligible children from families with incomes between 200 percent and up to and including 300 percent of the FPL. The columns labeled "Low Cost" in Table 1 show the characteristics of the expansion.[v] The CHIP program did not change for children from families with incomes up to 200 percent of the FPL. However, families with children who are covered under the expanded program do face cost-sharing in the form of copayments and premiums.[vi] For example, families with incomes between 200 percent and 224 percent of the FPL must pay a monthly premium of $38 a month for each enrolled child. In addition, they must pay $5 for each doctor's visit and $6 for a generic prescription. (There is no cost-sharing for preventive and diagnostic dental services, vision services, well-baby and well-child care, and for emergency care that results in a hospital admission.) Families with incomes greater than 300 percent of the FPL can enroll their children into CHIP by paying a premium that is equal to the average per-child cost of the program. The "At Cost" column indicates the premiums and cost-sharing these families would have to pay to enroll their children into CHIP.

Table 1: Eligibility Level and Cost-sharing: PA CHIP

ELIGIBILITY LEVEL	Free			Low Cost			At Cost
% of Poverty Household Size	(Ages 0–1)	(Ages 1–5)	(Ages 6–18)	(Ages 0–18)	(Ages 0–18)	(Ages 0–18)	(Ages 0–18)
	Annual Income			Annual Income			Annual Income
% of Poverty	185%–200%	133%–200%	100%–200%	200%–225%	225%–275%	275%–300%	Over 300%
Household Size 4	$38,203 to 41,300	$27,465 to 41,300	$20,650 to 41,300	$41,301 to 51,625	$51,626 to 56,788	$56,789 to 61,950	$61,951 to No Limit
	↓	↓	↓	↓	↓	↓	↓
COST							
	Average Premium			Average Premium			Average Premium
Average monthly premium, per child	$0	$0	$0	$38	$53	$60	$150
Co-payments per child, per visit:							
Doctor Visit	$0	$0	$0	$5 (except for well-child visits)			$15
Brand Name Prescriptions	$0	$0	$0	$9	$9	$9	$18
Generic Prescriptions	$0	$0	$0	$6	$6	$6	$10
Specialist Visits	$0	$0	$0	$10	$10	$10	$25
ER Visits**	$0	$0	$0	$25	$25	$25	$50

*** Emergency-room visit fee is waived if the child is admitted for a hospital stay.*

Source: www.chipcoverspakids.com/upload/admin/File/2007_PREMIUMS.pdf. Accessed March 24, 2007. There is considerable variation across states with respect to income thresholds and cost-sharing provisions. With respect to income thresholds, 17 states, including Pennsylvania, established income thresholds above 200 percent of the FPL in 2007,[3] 24 states had income thresholds at 200 percent of the FPL, and 9 states had income

iv Pennsylvania also had a subsidized program that covered children in families with incomes no greater than 235 percent of the FPL; this program, which did not receive any federal matching funds, charged a premium.

v The FPL varies with family size (see the Glossary).

vi Cost-sharing is limited to 5 percent of income for children in families with incomes between 200 and 300 percent of the FPL. There is no limit on cost-sharing for children in families with incomes over 300 percent of the FPL.

thresholds below 200 percent of the FPL.[vii] With respect to premiums, 31 programs charged premiums and 26 programs had cost-sharing.[4] Pennsylvania has not used the federal Section 1115 demonstration-waiver process to expand coverage to adults. In 2007, 11 states had expanded coverage to parents, 5 states had expanded coverage to pregnant women, and 4 states had expanded coverage to childless adults.[5] (See Appendix C.)

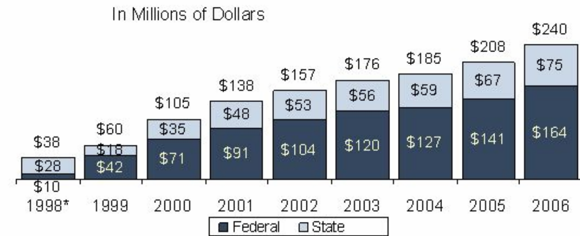
Benefits: Pennsylvania's CHIP benefit package is comprehensive. It covers routine health examinations, immunizations, prescription drugs, emergency care, maternity care, mental-health benefits, up to 90 days of hospitalization per year, durable medical equipment, substance-abuse treatment, partial hospitalization for mental health services, rehabilitation therapies, home healthcare, and dental, vision, and hearing services.

In 2007, Pennsylvania made a number of modifications to its benefit package in order to strengthen coverage for children with serious and chronic conditions and disabilities. The state clarified, for example, that there could be no maximums for chemotherapy, dialysis, respiratory therapy, and radiation therapy. The state also increased the number of therapy visits for speech, occupational, and physical therapy from 60 combined visits to 60 visits for each type of service annually.

Children who are enrolled in CHIP receive these services through coverage furnished by one of 9 managed-care plans that contract with the Commonwealth.[viii] As with Medicaid, these plans operate under comprehensive service agreements that set forth the coverage, access, provider network, performance quality, patient safeguards, and accountability standards that plans are expected to meet.

Funding: In FY 2006, expenditures on CHIP in Pennsylvania were $240 million dollars, of which $75 million were state expenditures and $164 million were federal funds. Figure 1 shows total annual expenditures on CHIP, as well as the state and federal share, from its inception as a federally subsidized program in 1998, through 2006.

Figure 1: PA CHIP Expenditures for Federal Fiscal Years 1998–2006

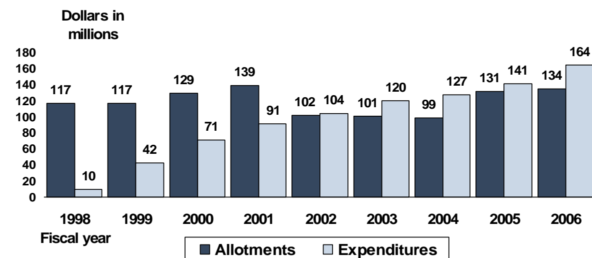


**Note: Federal approval of the Pennsylvania state plan was not received until May 1998. Therefore, federal matching did not begin until that time.*

Source: PA Insurance Department

Figure 2 provides information on the federal allotments to and federal expenditures on CHIP in Pennsylvania from 1998 to 2006. For many years Pennsylvania spent less than its annual allotment, however, in recent years it has spent slightly more than its annual allotment. As of October 1, 2006, Pennsylvania had about $165 million in unspent CHIP allotment funds. Pennsylvania is using those funds both to cover the difference between its current allotment and federal expenditures, as well as to support the federal cost of the CHIP expansion.

Figure 2: PA CHIP Allotments and Federal Expenditures, Fiscal Years 1998–2007



Note: Federal approval of the Pennsylvania state plan was not received until May 1998. Therefore, federal matching did not begin until that time.

Source: PA Insurance Department

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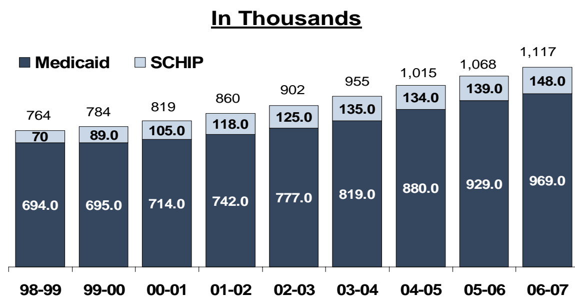
vii In recent years the states have been changing their income thresholds, and it is possible that some of these 9 states have raised their income thresholds. This number was reported by Kathryn G. Allen Director, Health Care, General Accountability Office, in her testimony before the Subcommittee on Health, Energy and Commerce, House of Representatives on February 15, 2007.

viii These plans are: Aetna, Americhoice, Capital Blue Cross, First Priority Health (Blue Cross of North Eastern PA), Highmark BC/BS (Western PA), Highmark Blue Shield (Central PA), Keystone Health Plan East (Independence Blue Cross), Unison Kids, and UPMC for Kids.

Enrollment: As of March 2007, Pennsylvania reported that 154,994 children were enrolled in CHIP while 964,040 children were enrolled in the Medicaid program. In 2005, the last year for which data on the number of children in Pennsylvania is available, about 38 percent of children were covered under either Medicaid or CHIP. Figure 3 shows that between 1998 and December 2006, enrollment in Pennsylvania SCHIP more than doubled. Over this same time period, the number of children enrolled in Medicaid increased by approximately one-third. The increase in the number of children enrolled in these programs is due in part to the economic downturn in 2001 and 2002.

Figure 3: Pennsylvania Medicaid Children & CHIP Enrollees by Fiscal Year, July 1998—December 2006



Note: 12 month average based on data from July through June of the next year. 2006-2007 data range from July 2006 through December 2006.

Source: Commonwealth of Pennsylvania, Department of Public Welfare. (2006). Medical Assistance Eligibility Statistics, (PA DPW).

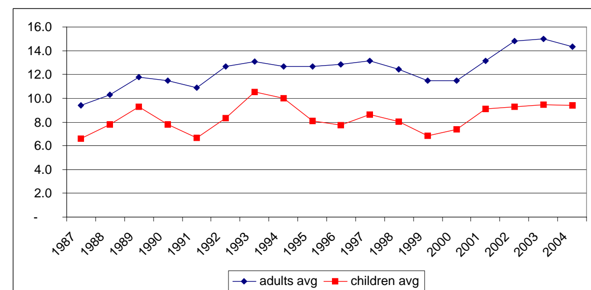
All told, SCHIP programs nationally reported that in 2005 (the last year for which data are available) more than 6 million individuals were enrolled in the program and that at any point in time, an average of 4 million people were enrolled. Nearly 650,000 adults were included in the total enrollment numbers.[6] SCHIP, in combination with Medicaid, provides health care coverage for a substantial and growing number of children. In 2004, these two programs covered about 34 million children in the United States.

The Impact of SCHIP on Children

The Impact of SCHIP on the Number of Uninsured Children: SCHIP has led to a decrease in the number of uninsured children, not only because of its expanded income standards on coverage of near-poor children, but also because states' active outreach efforts resulted in enrollment of very low-income children who were eligible for Medicaid. While there is no question that the SCHIP program led to a decrease in the number of low-income children who were uninsured, it is difficult to get an actual estimate of that number because it is impossible to know how many children would be uninsured in the absence of the program.

Figure 4 describes the percent of children and adults who were uninsured in Pennsylvania from 1987–2004. These data are based on self-report data in an annual survey conducted by the Census Bureau.[ix] Between 1987 and 1998 the percent of children who were uninsured moved with the percent of adults who were uninsured. However, this relationship changes after the implementation of CHIP. In particular, from 2001 to 2004 when the proportion of adults without health insurance was increasing, the percent of children who were uninsured was basically unchanged.[x]

Figure 4: Percent adults and children uninsured: PA 1987—2004



Source: Calculated from data from the Current Population Survey.

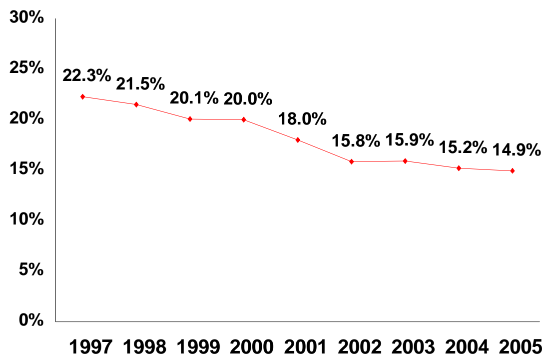
ix Given the small size of the Census state samples, we calculated running two-year averages to determine the percent of people without health insurance. To calculate the percent of children who were uninsured in 1997, we took the average of the percent of children who were uninsured in both 1997 and 1998; to determine the percent that were uninsured in 1998, we took the average of 1998 and 1999.

x It should be pointed out that Census estimates of the number of uninsured children in Pennsylvania are very different from that found by surveys conducted by the state. For instance, the Census Bureau reports that 8.3 percent of children in Pennsylvania were uninsured in 2005 while the Commonwealth estimates that only 4 percent of children were uninsured in 2006.

www.census.gov/hhes/www/hlthins/historic/hihistt5.html

Figure 5 shows that between 1997 and 2005 the proportion of low-income children in the United States who were uninsured declined from 22.8 percent to 15.6 percent. (Nationally, over this time period, the percent of nonelderly without health insurance increased from 16.9 percent to 17.9 percent.[7]) It is very likely that much of the decrease in the number of uninsured low-income children over this time period can be attributed to the combined effects of SCHIP and Medicaid. Although some argue that the expansion of public health insurance has in fact "crowded out" private coverage, others argue that the children reached by Medicaid and SCHIP live in families that have little access to private insurance to begin with.[8]

Figure 5: Percent of US Low-Income Children Without Health Insurance: 1997–2005



Source: Georgetown Center for Children and Families, L. Dubay analysis based on data from the National Health Interview Survey.

Beginning in 2004, the NHIS changed its methodology for counting the uninsured.

This results in the data for 2004 and later years not being directly comparable to the data for 1997-2003.

In spite of Medicaid and CHIP, there are still many uninsured children in Pennsylvania. In 2006, the Commonwealth of Pennsylvania estimated that there were 133,589 uninsured children[9]. Of those, 68 percent were eligible for either Medicaid or CHIP, 8 percent were eligible for the then-subsidized CHIP program, and 19 percent were not eligible for any public program. (The children who were eligible for the subsidized CHIP program and some of the children who were not eligible for any public program would be eligible for the expanded CHIP program.) Pennsylvania is not unique in having a number of uninsured but eligible children. Dubay, Holohan, and Cook have estimated that among uninsured children nationally, 74 percent are eligible for either Medicaid or SCHIP.[10]

The Health of Children Eligible for SCHIP: Children enrolled in SCHIP experience many of the same acute and chronic health conditions (such as developmental disabilities or asthma) as children who are enrolled in Medicaid.[11] The similarity between the two groups reflects the fact that they are all low-income children. Compared to children with private insurance, children enrolled in Medicaid/SCHIP are more likely to report being in less–than-excellent health (30 percent vs. 12 percent); have asthma (17 percent vs. 12 percent); be overweight (34 percent vs. 24 percent for children ages 6–11 years); have learning disabilities (11 percent vs. 6 percent); and need medications regularly (16 percent vs. 13 percent).[12]

Impact of SCHIP on Access to Care and on Health Needs: Lack of health insurance is associated with delayed and unmet healthcare needs, increased use of emergency rooms, lack of a medical home, and less preventive care. In general, when individuals gain health insurance, they also gain access to healthcare and use that care in more appropriate ways.[13]

One of the first studies that examined the impact of extending health insurance to children beyond the Medicaid requirements was conducted by Lave and colleagues.[14] They studied the impact of the initial CHIP program on children in Western Pennsylvania. After enrollment in the program, access to healthcare services improved. At 12 months after enrollment, 99 percent of the children had a regular source of medical care, and 85 percent had a regular dentist—an increase from 89 percent and 60 percent respectively at baseline. The proportion of children reporting any unmet need or delayed care in the past 6 months decreased from 57 percent at baseline to 16 percent at 12 months. The proportion of children seeing a physician increased from 59 percent to 64 percent, while the proportion visiting an emergency department decreased from 22 percent to 17 percent. The researchers also found that many

parents had limited their children's activities for fear that they would be injured; after enrollment in CHIP the parents relaxed these restrictions. The parents also reported that having health insurance reduced the amount of family stress, enabled children to get the care that they needed, and eased family burdens. These sentiments are noted on the CHIP Web site today. One parent wrote, "I am very happy that we are a CHIP family. CHIP gives me peace of mind to know my son can play." [15]

Similar findings have been reached in other evaluations of SCHIP programs. Studies of separately administered SCHIP programs have also found that SCHIP is associated with improved receipt of continuous care,[16] better quality of care,[17] a greater use of preventive care,[18] and a reduction in racial and ethnic healthcare disparities.[19] SCHIP has also been associated with improved outcomes for children with chronic conditions. For example, a New York study of asthmatic children found that they had fewer asthma attacks and hospitalizations after enrollment in SCHIP.[20]

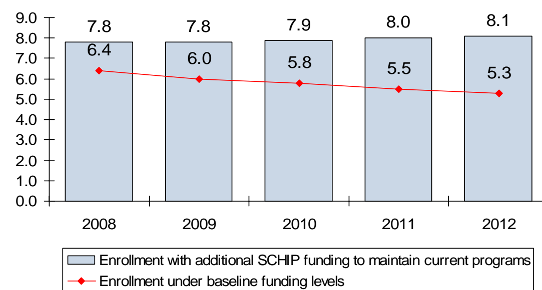
Issues and Challenges in SCHIP Reauthorization: Implications for Pennsylvania

As SCHIP is being reauthorized, it is important to note that SCHIP programs vary considerably across the states. Although in most states SCHIP covers only children and children from families with incomes up to 200 percent of the FPL, some states have expanded their income eligibility and have also received waivers to cover adults (see Appendix C). A number of states have had "shortfalls"; that is, they do not have enough federal funds to match state expenditures. In the last few years, the federal government has authorized additional funding to cover some of the shortfall. Therefore, much of the debate over the reauthorization is focused on the size of the program and who it should cover. More specifically, we address three key interrelated issues of debate in the reauthorization below.

The Size of the Federal Financial Commitment: The Congressional Budget Office (CBO) defines the SCHIP baseline budget as the budget that would be in place if the federal allotments to the states were maintained at their current level of $5 billion a year or $25 billion over the next five years (2008–2013). The CBO estimates that to maintain current programs over the next five years—with no expansion—the federal allotment would have to increase by $13.4 billion over current funding levels.[21] It is likely that CBO has underestimated the increase in federal funding since several states, including Pennsylvania, have recently expanded their programs, and it is unlikely that the costs of maintaining these programs is included in the estimates above.

Figure 6 shows estimated SCHIP enrollment under two scenarios: Maintaining funding at current "baseline levels or funding that keeps current service levels. CBO estimates that, compared a funding level that maintained current service levels, about 1.4 million fewer individuals would be enrolled under baseline funding in 2008, whereas 2.8 million fewer individuals would be enrolled in 2012. .

Figure 6: Estimated SCHIP Enrollment* Under "Baseline Funding" vs. Funding that Maintains Current Services



Point of reference: Total number of individuals (in millions) who could be covered at any time during the year.

Source: Congressional Budget Office. Fact Sheet for March Baseline: State Children's Health Insurance Program, February 23, 2007.

During the upcoming reauthorization debate, there will be significant debate about the appropriate level of federal funding. Many proposals for funding are already under consideration. For example, the president proposes to freeze SCHIP funding at the current baseline; that is, to fund SCHIP at $5 billion annually over the FY 2008–2013 time period. The National Governors Association has put out a policy statement arguing that the federal government should fill current fiscal shortfalls before reauthorization, and that "the federal funding levels should be increased to account for increased medical costs and population growth, as well as to ensure that all eligible populations, determined by each state, are

able to have access to affordable healthcare under SCHIP."[22]

Coverage of Children: A number of proposals have been put forth as part of the reauthorization process as to which children should be eligible for SCHIP. For example, the president, in addition to his proposal to freeze funding, proposes to reduce allowable SCHIP financial eligibility levels from their current level of 50 percentage points over state Medicaid eligibility standards to a flat 200 percent of the FPL. This proposal would affect states whose Medicaid eligibility standards for children are currently above or already at 200 percent of the FPL. (In 2005 that would have affected 14 states. It would currently affect many more, including Pennsylvania.) The affected states are provided in Appendix C. The National Governors' Association would cover all children the states want to enroll. Children's advocates such as the March of Dimes, the American Academy of Pediatrics, the National Association of Children's Hospitals and Related Institutions, and the Children's Defense Fund have advocated for "full finding" for SCHIP, that is a federal allotment that reflects the actual level of need in any given state as reflected by the lack of health insurance among children in a state.

Coverage of Adults: There is some controversy as to whether the states should be able to redistribute SCHIP funds to cover adults.[xi] As of January 2007, the Government Accountability Office (GAO) had identified 13 states that were using a portion of their SCHIP allotments to cover adults, operating under the authority of federal demonstration waivers[23] (See also Appendix C.) In some states (Arizona, Minnesota, Wisconsin, and Michigan) more adults are covered under the program than children. The president has indicated in his proposal that he would encourage expanded use of federal-demonstration authority to permit states to use their allotments to cover adults. (He proposes that other federal funding such as Medicaid Disproportionate Share Hospital (DSH) payments as well as Medicare DSH funding, be used by the states to expand coverage.[xii]). Pennsylvania currently does not cover any adults under CHIP.

These three issues—the size of the federal commitment, the income eligibility levels at which children should be covered, and whether the states can use any SCHIP funds to cover adults—are all interrelated. The decisions made by the federal government will influence the development of the formula that will be used to distribute the decided-upon federal funds among the states.

Another key issue is the source of funding for the SCHIP Program. If Congress were to fund SCHIP at levels that allow "full funding" at existing state eligibility standards, it needs to find the additional funds. In view of the current budget process, this will be challenging process.

Conclusion

The State Children's Health Insurance Program, which was established under the Balanced Budget Act of 1997, is to be reauthorized this year. This program, which was designed to cover children who would otherwise be uninsured, has been successful—it has increased insurance coverage among children. It has: increased access to care, led to a decrease in the amount of unmet needs and delayed care, and increased the proportion of children who have a regular source of care. In March of 2007, Pennsylvania expanded its SCHIP program to reach more uninsured children. Although some of the cost of this expansion will be borne by the Commonwealth and by the children's families through the use of premiums and cost-sharing, much of the cost is buffered by the use unexpended CHIP funds from prior years. However, the extent to which Pennsylvania will have access to federal funds to cover this large a program over time depends on the decisions that the federal government makes in reauthorizing the program.

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xi Some of the states have expanded Medicaid eligibility for children and used the freed-up federal funds to enroll some adults under SCHIP. One advantage of doing this is that federal government covers the cost of vaccines for children. States have also extended coverage to adults in part because research has demonstrated that covering parents has important health effects on children (eligible children are much more likely to enroll in state subsidized programs and to use health care services more appropriately)

xii While the use of Medicaid DSH funds to pay for insurance expansions for adults has been allowed for years under Section 1115 demonstrations, giving states access to Medicare DSH funds as well would represent significant new policy. Currently, the Medicare DSH payment is incorporated into the hospital payments rates. This recommendation would redirect these funds.

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Appendix A

State Options for Designing their Separate SCHIP Programs

Separate programs have four options for coverage, including:

(1) A "benchmark" package: This package reflects commercial insurance-industry standards and is defined as being essentially equal to either the Federal Employee Health Benefit Plan (FEHBP) Blue Cross/Blue Shield preferred provider option service benefit plan; a health benefit plan that is "offered and generally available" to state employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.[24]

(2) Benchmark-equivalent coverage: In this instance, the state must provide coverage with an aggregate actuarial value equal to at least one of the benchmark plans. States must cover inpatient and outpatient hospital services, physician surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations.

(3) Existing state-comprehensive coverage: In the states where existing state-based comprehensive coverage existed prior to the enactment of SCHIP (i.e. New York, Pennsylvania, and Florida), the existing health benefits were deemed to meet the coverage requirements of the SCHIP program.

(4) Secretary-approved coverage: This may include coverage that is the same as the state's Medicaid program; comprehensive coverage for children offered by the state under a Medicaid demonstration project approved by the Secretary; coverage that includes the full Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit or that the state has extended to the entire Medicaid population in the state; coverage that includes benchmark coverage plus any additional coverage; coverage that is the same as the coverage provided by New York, Pennsylvania, or Florida; or coverage that is purchased by the state that is essentially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison.

Appendix B

Design of SCHIP Programs, 2006

State SCHIP Design Choices as of July 2006[1]		
Separate Health Program	Medicaid Expansion	Combination of Programs
Alabama	Alaska	Arkansas
Arizona	District of Columbia	California
Colorado	Hawaii	Delaware
Connecticut	Louisiana	Florida
Georgia	Missouri	Idaho
Kansas	Nebraska	Illinois
Mississippi	New Mexico	Indiana
Montana	Ohio	Iowa
Nevada	Oklahoma	Kentucky
New York	South Carolina	Maine
Oregon	Wisconsin	Maryland
Pennsylvania		Massachusetts
Texas		Michigan
Utah		Minnesota
Vermont		New Hampshire
Washington		New Jersey
West Virginia		North Carolina
Wyoming		North Dakota
		Rhode Island
		South Dakota
		Virginia

1. Tennessee should implement a SCHIP Program in 2007.

Source: Kathryn G. Allen. Director Health Care, Government Accountability Office. "Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization." Testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives. February 15, 2007

Appendix C

States with Coverage of Children above 200 percent of the FPL and Adult Populations

State	Children	Adults		
	Income thresholds above 200% of FPL	Pregnant Women	Parents	Childless Adults[1]
Arizona			Yes	
Arkansas			Yes*	
California	250%			
Colorado		Yes		
Connecticut	300%			
Georgia	235%			
Hawaii	300%			
Idaho			Yes*	Yes*
Illinois			Yes	Yes*
Maryland	300%			
Massachusetts	300%			
Minnesota	275%		Yes	
Missouri	300%			
Nevada		Yes	Yes*	
New Hampshire	300%			
New Jersey	350%	Yes	Yes	
New Mexico	235%		Yes*	Yes*
New York	250%			
Oregon			Yes*	Yes*
Pennsylvania**	300%			
Rhode Island	250%	Yes	Yes	
Vermont	300%			
Virginia		Yes		
Washington	250%			
West Virginia	220%			
Wisconsin			Yes	
TOTAL	17	5	11	4

1. The federal government would not grant waivers to cover this population after 2001.

**Enrollment for adults in these states is limited.*

*** The source document only includes waivers granted up to January 1, 2007. Pennsylvania expanded coverage was approved in March 2007.*

Source: J. Guyer, C. Mann, M. Odeh. "States Affected by Proposals to Reduce SCHIP Coverage Options." Georgetown University, Center for Children and Families. Washington, DC, February 7, 2007.

Glossary

Centers for Medicare and Medicaid Services (CMS)

The federal agency within the United States Department of Health and Human Services that runs Medicare. CMS works with the states to run the Medicaid program and the State Children's Health Insurance Program (SCHIP).

Cost-sharing

The generic term that includes copayments, coinsurance, deductibles, and out-of-pocket payments for balanced billing on unassigned claims. Excludes monthly premiums for Supplementary Medical Insurance coverage, voluntary Hospital Insurance (HI) coverage, and supplemental insurance.

> Copayments: A specified dollar amount, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency-room visit, or the filling of a prescription.
> Coinsurance: A percentage share of medical bills which a beneficiary must pay.
> Deductibles: Specified amounts of spending which an individual or a family must incur before insurance begins to make payments.

Covered services

Services and supplies for which Medicare, Medicaid, or SCHIP will reimburse.

Deficit Reduction Act of 2006 (DRA 2006)

On February 8, 2006 the president signed the Deficit Reduction Act (DRA). The DRA calls for decreasing Medicaid expenditures by enacting new strategies. It allows states to adjust premiums and cost-sharing rates within certain eligibility groups and for certain services. The DRA also allows states to supplement the existing mandatory benefit packages with "benchmark" packages. However, some mandatory services were retained, and mandatory benefit packages for certain eligibility categories (pregnant women, parents, individuals with disabilities or special medical needs, dual eligibles, and people with long-term care needs) were also retained. The DRA also instituted changes in asset transfer penalties, instituted a longer look-back period, and added home equity into the asset equation. This legislation decreases reimbursement for prescription medication and allows states to impose increased cost-sharing for prescription medication. In addition, all beneficiaries are required to show documentation of U.S. citizenship to avail Medicaid services.

Disproportionate Share Hospitals (DSHs)

Hospitals that serve a disproportionately large volume of low-income persons. Hospitals that meet DSH criteria may receive supplemental payments for Medicaid.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

A screening, diagnostic, and treatment program under Medicaid with a specific focus on recipients under age 21, which reviews any physical or mental problems and the associated medical requirements to address these problems.

Eligibility

Meeting the requirements for coverage under Medicare, Medicaid, or SCHIP. In Medicaid data, the term eligible is often used to refer to individuals who qualify and have actually enrolled in the program.

Federal Medical Assistance Percentage (FMAP)

The percentage of Medicaid benefit payments reimbursed by the federal government. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per-capita income, and (by law) may range from a minimum of 50 percent to a maximum of 83 percent.

Federal Poverty Level (FPL)

Low-income guidelines established annually by the federal government. Public assistance programs, including Medicaid and SCHIP, often define income limits in relation to the FPL.

2007 Poverty Guidelines for the 48 Contiguous States and the District of Columbia are as follows:

Persons in family	Guideline
1	$10,210
2	$13,690
3	$17,170
4	$20,650
5	$24,130
6	$27,610
7	$31,090
8	$34,570

For families with more than 8 persons, add $3,480 for each additional person.

Fiscal Year (FY)

The 12-month period under which the federal government operates. Until 1976, the FY extended from July 1 of each year to June 30 of the following year. Beginning in 1976, the FY was changed to October 1–September 30. (The 3-month period July–September 1976—the so-called transition quarter—does not belong to any FY.) FYs are labeled by the year in which they end, e.g., October 1, 2000–September 30, 2001 is called FY 2001.

Managed Care Organization

Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. These include entities such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) plans. In the Medicaid world, other organizations may set up programs to provide Medicaid managed care. These organizations include Federally Qualified Health Centers (FQHCs), integrated delivery systems, and public health clinics.

Medicaid

The joint federal/state program, enacted in 1965 as Title XIX of the Social Security Act, that pays for medical care on behalf of certain groups of low-income individuals.

Medical Assistance

The Medicaid program in Pennsylvania.

Premium

A monthly fee that may be paid by Medicare, Medicaid, and SCHIP enrollees. Aged individuals who are not eligible for automatic Hospital Insurance (HI) enrollment may pay a monthly premium to obtain HI coverage. Supplemental Medical Insurance (SMI) enrollees pay a monthly premium that is updated annually to reflect changes in program costs.

State Children's Health Insurance Program (SCHIP)

Free or low-cost health insurance that is available in each state for uninsured children under age 19. SCHIP provides health insurance for uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage.

Waiver

An exception to the usual requirements of Medicare or the usual requirements of Medicaid granted to a state by CMS, authorized through the following sections of the Social Security Act or Social Security Amendments:

> 1115 of the Social Security Act: Allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, systemwide changes are possible under this provision.
>
> 1915(b) of the Social Security Act: Allows states to waive freedom of choice. States may require that beneficiaries enroll in HMOs or other managed-care programs, or select a physician to serve as their primary-care case manager.
>
> 1915(c) of the Social Security Act: Allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify for services in an ICF/MR, nursing facility, institution for mental disease, or inpatient hospital.
>
> 1929 of the Social Security Act: Allows states to provide a broad range of home and community-based services to functionally disabled individuals as an optional state plan benefit. In all states except Texas, the option can serve only people age 65 or over.

References

[1] Rosenbaum, S., A. Markus, and C. Sonosky. "Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP." *Journal of Health and Biomedical Law*, Vol 1. (2005): 1–45.

[2] Statement of Kathryn Allan, Director, Health Care. GAO. "Children's Health Insurance: State's SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization." Testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives. Washington, DC. February 15, 2007.

[3] Guyer, J., C. Mann, and M. Odeh. "States Affected by Proposal to Reduce Coverage Options." Georgetown University Health Policy Institute: Center for Children and Families. Washington DC. February 2007.

[4] Kaye, N., C. Pernice, and A. Cullen. "Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs." National Academy of State Health Policy. September 2006, Page 67.

[5] Ibid.

[6] Statement of Kathryn Allan, Op. cit., 2.

[7] Fronstein, P. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey." Issue Brief 298. Employee Benefit Research Institute. Washington, DC. October 2006.

[8] Davidson, G., Lynn Blewett, and K. Thiede Call. "Public Program Crowd-Out of Private Coverage: What Are the Issues?" The Synthesis Project. The Robert Wood Johnson Foundation. June 2004.

[9] http://www.budget.state.pa.us/budget/lib/budget/2006-2007/presentation/2006_07_budget_slides_color.pdf. Accessed May 1, 2007

[10] Dubay, G., J. Hollohan, and J. Cook. "Analyses of the 2004 CPS Data as Reported in L. Ku, M. Lin, and M. Broaddus." *Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP*. 2007 Edition. Center on Budget and Policy Priorities. Washington, DC. January 2007.

[11] Brach, Cindy, Eugene Lewit, Karen Van Landeghem, et. al. "Who's Enrolled in the State Children's Health Insurance Program (SCHIP)? An Overview of Findings from the Child Health Insurance Research Initiative." *Pediatrics,* 112:499-507 (2003);

Andrew Dick, Cindy Brach, Andrew Allison, et. al. "SCHIP's Impact in Three States: How Do the Most Vulnerable Children Fare?" *Health Affairs,* 23:563-70 (2004).

[12] L. Ku, Lin M., and Broaddus M., edition. Center for Budget and Policy Priorities. Washington, DC. January 2007.

[13] There is extensive literature on this topic. Much of it is summarized in the following books written by the Institute of Medicine. See:.

Committee on the Consequences of Uninsurance. Board on Health Services. Institute of Medicine. *Coverage Matters: Insurance and Health Care.* National Academy Press Washington, DC. (2001) and *Care Without Coverage: Too Little, Too Late.* Committee on the Consequences of Uninsurance. Board on Health Services. Institute of Medicine. *Coverage Matters: Insurance and Health Care.* National Academy Press. Washington, DC. (2002)

[14] Lave, J.R., C.R. Keane, C.J. Lin, E.M. Ricci, G. Amerbaxch, and C.P. LaVallee. "The Impact of a Children's Health Insurance Program on Newly Enrolled Children." *JAMA.* (1998). 279(22): 1820–1825.

[15] http://www.chipcoverspakids.com/interior.php?subPage=AboutTestimonials. Accessed March 3, 2007.

[16] Szilagyi, Peter G., Andrew Dick, Jonathan Klein, et. al. "Improved Access and Quality of Care After Enrollment in the New York State Children's Health Insurance Program." (2004) *Pediatrics,* 113(5) e395–e405.

[17] Ibid; Kempe, Allison, Brenda Beaty, Lori Crane, et. al. "Changes in Access Utilization and Quality of Care After Enrollment Into a State Child Health Insurance Plan." (2005) *Pediatrics*, 115(2):364–371.

[18] "The Impact of the Iowa SCHIP Program." op. cit.; "Effects of State Health Insurance." op. cit.

[19] Shone, Laura, Andy Dick, Jonathan Klein, et. al.,. "Reduction in Racial and Ethnic Disparities After

Enrollment in the State Children's Health Insurance Program." (2002) *Pediatrics.* 115: 697–705

[20] Szilagyi, P., et al. "Improved Asthma Care After Enrollment in the State Children's Health Insurance Program in New York." (February 2006.) *Pediatrics,* 117(2): 486–496.

[21] Congressional Budget Office. "Fact Sheet for CBOs March 2007 Baseline: State Children's Health Insurance." February 23,2007

[22] "National Governors Association. Policy Position. HHS-09. The State Children's Health Insurance Program (SCHIP)" 04/09/2007 www.nga.org/portal/site/nga/menuitem, Accessed April 15, 2007.

[23] Testimony of Kathryn Allen, op. cit., 2.

[24] 42 U.S.C. §397cc(b)(1)–(3)

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