

Examining a Major Policy Shift: New Federal Limits on Medicaid Coverage for Children

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While Congress was debating the reauthorization of the State Children's Health Insurance Program (SCHIP) in 2007, the Centers for Medicare and Medicaid Services (CMS) issued a directive and other decisions that limit states' ability to cover children in low-income families. First, in what has become a well-publicized and controversial action, CMS sent a letter to state health officials on August 17, 2007, effectively capping SCHIP eligibility at 250 percent of the federal poverty level (\$44,000 per year for a family of three).¹ Also, in a second set of less-publicized but critically important decisions, CMS prohibited some states from increasing Medicaid eligibility for low-income children who are eligible currently for SCHIP, stating that this population must first be covered using

SCHIP funds if such funds are available.

This lesser-known set of decisions has serious implications for states striving to expand health coverage for children. It limits significantly the availability of federal financing for child health insurance; locks in wide disparities in children's coverage between states; and, given the lack of transparency in CMS's decision-making, leaves state Medicaid and SCHIP programs in an uncertain and unpredictable posture. These decisions also have broader implications for Medicaid policy, undermining long-standing state flexibility to provide eligibility for children at incomes above mandatory levels if they choose.

This *State Health Policy Briefing* explores these recent decisions involving transferring the financing of coverage for low-income children from SCHIP to Medicaid and their implications for states. Specifically, the *Briefing* provides:

- An overview of CMS's recent decisions that contradict long-standing Medicaid policy providing state flexibility to expand Medicaid for children;
- The policy consequences of CMS's decision in terms of limiting a state's ability to expand children's coverage.
- A review of language in the twice-vetoed Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA), which would grant states needed flexibility.

NATIONAL ACADEMY for STATE HEALTH POLICY

State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

"Examining a Major Policy Shift: New Federal Limits on Medicaid Coverage for Children," State Health Policy Briefing, Vol. 2, Issue 4 (Portland, ME: National Academy for State Health Policy) April 2008.

Expansions of Medicaid Eligibility to Low-Income Children Denied

CMS has denied recently a number of states' requests to expand Medicaid eligibility for children who were eligible previously for SCHIP. Within the past two years, Louisiana, Montana, and North Carolina have requested permission

from CMS to amend their Medicaid programs to increase eligibility for children. Louisiana's and Montana's requests were denied, while North Carolina's request was granted after an earlier denial. CMS has indicated that coverage for these children must first be financed with capped SCHIP funds at the enhanced federal match rate until a state's annual SCHIP allotment has been exhausted.

CMS's interpretation is based on provisions within the Medicaid statute, as amended by SCHIP legislation, that limit states' use of enhanced matching funds for "optional targeted low-income children."² CMS believes this provision prohibits states from increasing Medicaid eligibility levels to cover these children under Medicaid instead of SCHIP. Pursuant to the new CMS interpretation, beneficiaries in the "optional targeted low-income children" category must be covered with SCHIP funds at the enhanced SCHIP matching rate. Once a state has spent its SCHIP funds, it can cover "optional targeted low-income children" under Medicaid at the lower Medicaid matching rate. This interpretation has the potential to affect the majority of states which operate separate SCHIP programs for all or some enrollees.³

In its communications with North Carolina, CMS wrote:⁴

North Carolina's claiming of reimbursement at the regular Medicaid FMAP was incorrect for expenditures for children in the Medicaid expansion program based on provisions of the Social Security Act (Act):

- *The population of children in the Medicaid Expansion group is within the definition of "optional targeted low income children" at 1905(u)2(B);*
- *The Federal matching rate for expenditures for such children under the Medicaid program is the enhanced SCHIP matching rate, under section 1905(b) of the Act, to the extent that there is available SCHIP allotment; and*
- *The Secretary is required to make payment of such Federal matching from the State's SCHIP allotment, per section 2105(a) (1) (A)*

These statutory provisions do not accord states the option to elect a different Federal matching rate for Medicaid Expansion children. SCHIP allotments must be exhausted before Federal matching funds can be requested for expenditures for Medicaid expansion children at the regular FMAP rate. Currently, CMS considers North Carolina to be out of compliance with the Social Security Act because the State has been claiming FMAP at the regular Medicaid FMAP rate for expenditures made on behalf of Medicaid Expansion children even though the state has available SCHIP allotment funds.

This interpretation appears to reverse long-standing federal statutory authority that allows states to determine income levels above the Medicaid mandatory levels for chil-

dren. As discussed below, under long-standing federal law, states can use several strategies, including income deductions and disregards, to finance coverage for children above mandatory Medicaid income levels for children. It also contradicts federal policies designed to prevent the *erosion* and not the *expansion* of Medicaid for children.

HISTORICALLY, STATES HAVE MAINTAINED FLEXIBILITY TO COVER LOW-INCOME CHILDREN IN MEDICAID AND SCHIP

Since Medicaid was created in 1965, the federal government and the states have worked together to provide health coverage for low-income children in need. Support for this goal was key to enactment of SCHIP in 1997. As of 2005, about 28 million low-income children were enrolled in Medicaid and almost 6 million were enrolled in SCHIP, but a further 9.4 million children remained uninsured. More than two-thirds of these uninsured children lived in families with a household income below 200 percent of the federal poverty level, making them likely eligible for Medicaid or SCHIP.⁵

Medicaid and SCHIP have different federal funding structures. Medicaid is an entitlement program, which means that states must enroll any individual who meets the eligibility requirements and that federal and state matching funding must be available to help a state pay for the benefits and services provided. SCHIP is a block grant program that gives states the flexibility to cover uninsured children in families with incomes above Medicaid eligibility levels within specific federal rules, including the ability to cap the program. The original 10-year authorization of SCHIP provided \$40 billion over 10 years in federal support and provided participating states an enhanced federal matching rate higher than for Medicaid to encourage states to create SCHIP programs.

Under Medicaid, states are required to provide eligibility to children under 6 years of age with family incomes at or below 133 percent of the federal poverty level and to children ages 6 to 19 with family incomes at or below 100 percent of the federal poverty level.⁶ States also have the option to cover infants and pregnant women with family incomes at or

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below 185 percent of the federal poverty level.⁷

States can also use several strategies – such as using optional Medicaid categories, income deductions and disregards, and §1115 waivers as described below – to expand eligibility in both Medicaid and SCHIP to reach lower- and higher-income children who do not have coverage. All 50 states have employed at least one of these strategies to cover more children under Medicaid.⁸

Optional categories

In addition to creating mandatory coverage categories based upon family income, Medicaid also allows states the option to extend coverage through optional coverage categories. The optional categories for children include: infants and pregnant women with family incomes at or below 185 percent of the federal poverty level (as mentioned above), medically needy children, and certain children with disabilities.⁹ The Kaiser Commission on Medicaid and the Uninsured has estimated that 20 percent of children enrolled in Medicaid receive their coverage through an optional eligibility group.¹⁰

Income deductions and disregards

States also have federal statutory authority to define and deduct certain categories of family income or disregard an amount of income when determining eligibility in Medicaid for some mandatory and optional Medicaid eligibility groups. States may add new types of income deductions as well as increase the amount of existing disregards.¹¹ For example, a state can adjust family income by deducting child care costs rendered necessary by parental employment. Or, for example, a state can disregard income between 133 and 200 percent of the federal poverty level for children ages 10-16. There is no statutory limit on these disregards. As of January 2008, 46 states (including DC) applied at least one of the following disregards or deductions when determining eligibility for children's Medicaid: earnings disregards, deduction for child care expenses, and deduction for child support received and paid.¹²

§ 1115 waiver authority

Under §1115 of the Social Security Act, the Secretary of Health and Human Services is authorized to waive many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to “promoting the objectives” of the federal Medicaid program while continuing to receive federal Medicaid matching funds. Many states have used waivers as a mechanism to expand coverage to children, parents, and childless adults. However, with §1115

waivers, states must meet budget neutrality requirements, meaning that the waiver cannot result in a higher level of federal spending than would have been the case under a state's Medicaid program. Under some recent §1115 waivers, federal Medicaid funds have been capped.

CMS'S RECENT INTERPRETATION APPEARS TO MIS-READ CONGRESSIONAL INTENT

Leading up to SCHIP's enactment, policy makers were concerned that some states would try to claim the enhanced SCHIP match rate for covering children already enrolled in Medicaid. Congress included a Medicaid “maintenance of effort” (MOE) requirement as part of SCHIP's passage in 1997 to prohibit states from limiting Medicaid eligibility for children and effectively transferring children from *Medicaid* to *SCHIP*.¹³ In keeping with this spirit, the preamble to the final SCHIP regulations suggests that the SCHIP rules were not intended to limit states' use of *Medicaid FMAP* to cover children, but instead were intended to limit the use of *enhanced FMAP under SCHIP* for children a state had covered before SCHIP's passage.¹⁴

While the MOE provisions achieved the Congressional policy goal of preventing states from ‘gaming’ the system, states that had increased their Medicaid eligibility levels for children before SCHIP was enacted felt burdened by these requirements since they could not receive the enhanced SCHIP match for higher income children that many other states were able to enroll in SCHIP programs. In 2000, Congress amended SCHIP's MOE requirements to allow a limited exception for 11 “qualifying states” that had expanded their Medicaid eligibility level for children to at least 185 percent of the federal poverty level prior to the enactment of SCHIP. These “qualifying states” must maintain their Medicaid eligibility levels for children, but were permitted to spend up to 20 percent of their SCHIP allotment to receive the enhanced SCHIP match for children under the age of 19 in families with incomes above 150 percent of the federal poverty level and who were being covered in the state's Medicaid program.¹⁵

CMS is now relying on provisions that were intended to prevent states from moving children from Medicaid to SCHIP to argue that states cannot move children from SCHIP to Medicaid. Given the clear MOE provisions, and the legislative fix to clarify the use of SCHIP funds for “qualifying states,” if Congress had wanted there to be limits on the use of Medicaid funds for children, they would have amended the statute.

CMS's Actions Have Frustrated States' Efforts to Expand Health Coverage for Children

CMS's decisions to prohibit states from increasing Medicaid eligibility for low-income children who are eligible currently for SCHIP has serious implications for states striving to expand health coverage for low-income children. CMS's actions significantly limit the availability of federal financing for child health insurance; exacerbate existing disparities among states; and, given the lack of transparency in CMS's decision making, leave states with an uncertain and unpredictable climate in which to run their Medicaid and SCHIP programs.

CMS'S ACTIONS LIMIT THE FEDERAL FUNDS AVAILABLE FOR STATES TO COVER CHILDREN

CMS's recent interpretation limits states' ability to finance child health insurance. Even though "optional targeted low-income children" are eligible currently for coverage financed by SCHIP in these states, moving this population to Medicaid would have enabled a number of states to cover additional children due to the structure of the two programs. Each child who meets Medicaid's eligibility requirements can enroll and federal matching funds will be available to reimburse states for qualifying benefits and services provided. There is no federally mandated cap on the number of eligible Medicaid beneficiaries a state can enroll. By contrast, SCHIP is funded through a federal block grant. Once annual SCHIP allotments and prior carryover funds have been spent by a state with a free-standing separate SCHIP program, no further federal assistance is available until the next fiscal year's allotment.

Consequently, children who meet SCHIP eligibility guidelines may be unable to enroll and obtain coverage if funds are exhausted. This structural difference between the two programs creates an incentive for states wishing to expand coverage for uninsured children to cover as many eligible children as possible under Medicaid.¹⁶ State SCHIP allotments then remain available to finance coverage for children not eligible for Medicaid.¹⁷

For example, prior to 2007, Louisiana operated a Medicaid expansion SCHIP program (LaCHIP) that covered children under age 19 with family incomes up to 200 percent of the federal poverty level. Louisiana receives regular Medicaid

FMAP for children ages 0 to 5 in families with income up to 133 percent of the federal poverty level, and children ages 6 to 18 in families with income up to 100 percent of the federal poverty level, and enhanced SCHIP FMAP for children above these levels up to 200 percent of the federal poverty level.

In 2007, CMS approved the creation of a separate Louisiana SCHIP program to provide medical services to unborn children through preventive care for women whose infants would become eligible after birth. Later in 2007, the Louisiana legislature passed Act 407, a bipartisan effort that authorized the expansion of LaCHIP eligibility from 200 percent to 300 percent of the federal poverty level. Although LaCHIP is a Medicaid-expansion program for coverage up to 200 percent of the federal poverty level, the population in the 200 to 300 percent of federal poverty level would have been covered under a separate SCHIP program model.

When Louisiana sought permission from CMS to implement the expansion, however, the state encountered several obstacles. First, citing new requirements outlined in its August 17 letter, CMS required Louisiana to demonstrate that the LaCHIP expansion would not result in the crowd out of private insurance.¹⁸ Second, CMS prohibited the use of Medicaid funds to cover children currently eligible for SCHIP

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(children below 200 percent of the federal poverty level) unless Louisiana first exhausted its SCHIP allotment. Increasing Medicaid eligibility would have freed up additional SCHIP funding for the state to cover the 200 to 300 percent of the federal poverty level population.

Unable to meet these new requirements, Louisiana was forced to decrease its eligibility expansion request from 300 to 250 percent of the federal poverty level. During the approval process, CMS also insisted that Louisiana must exhaust its SCHIP allotment first, which would have necessitated the use of state funds to cover the costs of those enrolled in the separate SCHIP program for children between 200 and 250 percent of the federal poverty level.

In February 2008, Louisiana received approval from CMS to increase its SCHIP eligibility from 200 to 250 percent of the federal poverty level. Imposing the requirements of the August 17 directive, CMS required eligibility to be

based on gross income, not net income. Therefore, Louisiana will not be able to deduct child care or other expenses from family income to bring the net income to under 250 percent of the federal poverty level.¹⁹ CMS still is holding to its decision to prevent an increase in Medicaid eligibility to finance the increased coverage. But, with extra SCHIP funding provided under the temporary extension of the SCHIP program,²⁰ Louisiana currently has funding to finance the coverage expansion with SCHIP allotments.

CMS'S INTERPRETATION EXACERBATES EXISTING DISPARITIES AMONG STATES

CMS's interpretation also locks in existing disparities among states in eligibility levels for children's coverage. While nine states currently cover children at 300 percent of the federal poverty level or higher with Medicaid and SCHIP, 29 states remain at 200 percent of the federal poverty level or below. Under CMS's policy, states that already cover children at higher eligibility levels will likely be able to continue to do so. However, states striving to move forward and cover more children by increasing Medicaid eligibility levels will be locked in.

For example, in Montana, Medicaid funds the coverage for children ages 0 to 5 in families with income up to 133 percent of the federal poverty level and children ages 6 to 18 in families with income up to 100 percent of the poverty level. SCHIP funds coverage for these children from the Medicaid limit up to 175 percent of the federal poverty level. Montana's legislature passed a bill in 2007 that sought to increase Medicaid eligibility for children ages 6 to 18 in families with income from 100 to 133 percent of the federal poverty level.²¹ This change would have created a uniform Medicaid eligibility threshold for all Montana children under age 18 at 133 percent of the federal poverty level. The revised standard also would have enabled an estimated 4,889 children to shift from SCHIP to Medicaid, thereby allowing Montana's SCHIP program to increase eligibility levels

Existing disparities among states in eligibility levels for children's coverage...are locked in.

and enroll additional children.²² However, CMS stated that Montana would need to use its SCHIP allotment to fund this Medicaid expansion in addition to funding the state's SCHIP program. As a result, Montana did not implement the Medicaid expansion for children ages 6 to 18 and the eligibility level remains capped at 100 percent of the federal poverty

level for this group. Montana is on the lower end of the scale for Medicaid eligibility for children, and CMS's decision thwarts the state's ability to make progress in covering more children.

CMS'S ACTIONS CREATE AN UNCERTAIN AND UNPREDICTABLE CLIMATE FOR STATE PLANS

Federal agencies generally promulgate regulations, or at least rely on publicly available guidance to communicate clarifications and changes to federal policy. However, CMS has not issued any public guidance or notice regarding these actions. Instead, CMS is issuing decisions on a state-by-state basis. A previous NASHP report showed that CMS's use of Dear State Medicaid Letters to communicate policy declined from 218 letters in 1996 to 2000 to only 90 letters from 2001 to 2005.²³ As a result, states have little information about CMS's process, the consistency of CMS's policy, or whether plan requests will be approved.

During the debate over SCHIP reauthorization, a key state concern was that funding be provided for periods that are long enough in duration to allow states to plan for the future of their programs. In order to make progress on state coverage goals, states need to be able to depend on a stable funding source and have clear, consistently applied rules upon which they can depend.²⁴ The interpretation that states must exhaust SCHIP funds before enrolling certain children in Medicaid is another frustrating road block for states' long-term planning and policy development.

In January 2006, North Carolina implemented a plan to transfer coverage of children ages 1 to 5 in families with income from 133 to 200 percent of the federal poverty level and children under the age of 1 in families with income from 185 to 200 percent of the federal poverty level from the enhanced SCHIP FMAP to the regular Medicaid FMAP. The state received informal CMS approval for this change *before* CMS reversed its position and communicated in writing a new interpretation of the statute.²⁵ When CMS temporarily withdrew its approval, North Carolina faced the task of financing benefits for existing SCHIP enrollees *and* these children²⁶ enrolled in Medicaid using only its SCHIP allotment. North Carolina was not in a fiscal position to take on such a financial burden, which would have resulted in a shortfall of \$18.25 million.²⁷ The state ultimately was able to persuade CMS to permit the expansion.

CMS changed its position on the North Carolina expansion twice – first approving the state's request; then reversing the decision more than a year later; then reversing itself again about two months later – without explanation, leaving policy in this area unsettled. While North Carolina was al-

lowed ultimately to move forward with its expansion, other states in similar circumstances have been denied. These states must now guess as to whether the changes to their

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Medicaid eligibility levels for children will ever be approved.

Language in SCHIP Reauthorization Legislation Could Have Resolved This Problem

The most recent version of the Children’s Health Insurance Program Reauthorization Act of 2007 (CHIPRA) would have restored to states some of the flexibility currently being limited by CMS, but the legislation failed to become law.²⁸ The bill contained clarifying language that would have fixed many of the problems states are facing as they attempt to cover “optional targeted low-income children” under Medicaid. The legislation would have overridden CMS’s current interpretation and allowed states to extend Medicaid coverage to “optional targeted low-income children” without first exhausting their SCHIP allotments.²⁹ CHIPRA also would have authorized states to choose whether to cover “optional targeted low-income children” under Medicaid or SCHIP.³⁰

Finally, CHIPRA would have modified and extended the provisions allowing the 11 “qualifying states” to use unspent SCHIP allotments to cover the difference in federal reimbursement for children who were already enrolled in Medicaid when SCHIP was enacted.³¹ Under the provision included in CHIPRA, qualifying states would be able to spend up to their full SCHIP allotment for the difference between the Medicaid and SCHIP match rates for children with family incomes above 133 percent of poverty covered under the state Medicaid program.

CHIPRA would have allowed states to use both Medicaid and SCHIP programs’ full fiscal potential, rather than conditioning Medicaid expansion on exhaustion of SCHIP funds. States would have garnered greater ability to extend health care benefits to poor and near-poor children by offer-

ing Medicaid benefits to targeted low-income children, while preserving state SCHIP allotments. States would then have been able to expand SCHIP eligibility to uninsured children with moderate family incomes.

Conclusion

Without input from states and other key stakeholders or new legislative authority to rely on, CMS has made a set of decisions that will make it increasingly difficult for states to use Medicaid funds to cover low-income children whose coverage is financed currently by SCHIP. These decisions have limited the availability of federal financing for child health insurance; locked in wide disparities in children’s coverage levels between states; and left states with an unpredictable climate in which to run critical health care programs.

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Acknowledgements

The authors wish to thank Peter Currie, a third-year law student in the Georgetown Law School Harrison Institute Clinic, for his research assistance. Thank you also to Andy Schneider, Sara Rosenbaum, Jackie Forba, Marjorie Morris, and Ruth Kennedy for their very helpful comments and Shelly Gehshan, Catherine Hess, Alice Weiss, and Alan Weil at the National Academy for State Health Policy for their thoughtful feedback.

Support for this *Briefing* was provided by the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation

Notes

- 1 CMS. *Dear State Health Official letter* SHO #07-001, August 17, 2007. Retrieved 1 February 2008. <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>.
- 2 CMS's rationale is stated in a letter to North Carolina. Letter from Kathleen Farrell, Director, Division of State Children's Health Insurance, to Carmen Hooker Odom, Secretary, North Carolina Department of Health and Human Services, (May 15, 2007). "Optional targeted low-income children" are defined as having a family income at or below 200% of the federal poverty level; and exceed the Medicaid applicable income level for the age of the child, but not by more than 50 percentage points. See 42 CFR 435.4, 42 CFR 535.229, 42 U.S.C. 1902(a)(10)(A)(ii)(XIV), and 42 U.S.C. 1905(u)(2)(B).
- 3 For states continuing a Medicaid-expansion program only, CMS's decisions might have less of an impact. Medicaid-expansion programs already must cover eligible children in Medicaid when SCHIP funding is exhausted. As of 2005, 10 states and the District of Columbia exclusively used the Medicaid-expansion model. See: Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, ME: National Academy for State Health Policy, September 2006).
- 4 Letter from Kathleen Farrell, Director, Division of State Children's Health Insurance, to Carmen Hooker Odom, Secretary, North Carolina Department of Health and Human Services, (May 15, 2007).
- 5 Kaiser Commission on Medicaid and the Uninsured. *Health Coverage of Children: The Role of Medicaid and SCHIP* (Washington, DC: The Henry J. Kaiser Family Foundation; February, 2005). Retrieved 6 February 2008. <http://www.kff.org/uninsured/upload/7698.pdf>.
- 6 For a more detailed discussion of Medicaid and SCHIP eligibility, see Neva Kaye and Lynda Flowers, *How States Have Expanded Medicaid and SCHIP Eligibility* (Portland, ME: National Academy for State Health Policy, January 2002).
- 7 *Ibid.*
- 8 *Ibid.*
- 9 42 U.S.C. 1396a(a)(10)(A)(ii)(I)-(XIX) (2006). See also, Kaiser Commission on Medicaid and the Uninsured. *Medicaid's Optional Populations: Coverage and Benefits* (Washington, DC: The Henry J. Kaiser Family Foundation; February, 2005). Retrieved 6 February 2008. <http://www.kff.org/uninsured/upload/7698.pdf>, <http://www.health08.org/medicaid/upload/Medicaid-s-Optional-Populations-Coverage-and-Benefits-Issue-Brief.pdf>.
- 10 Based on estimates provided by the Urban Institute using data from fiscal years 1998 and 2001. Kaiser Commission on Medicaid and the Uninsured, *Ibid.*
- 11 Social Security Act §1902(r)(2). Retrieved 4 February 2008. http://www.ssa.gov/OP_Home/ssact/. See also, Leighton Ku, Frank Ullman and Ruth Almeida, *What Counts? Determining Medicaid and CHIP Eligibility for Children* (Washington, DC: Urban Institute, 1999). Retrieved 4 February 2008. <http://www.urban.org/publications/409076.html>.
- 12 Survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2008, forthcoming.
- 13 The MOE requirement prohibits states from enacting Medicaid eligibility standards more restrictive than those in force as of June 1, 1997, to prevent states from evading the requirement that children found to be eligible for Medicaid would be enrolled in that program—which had a lower federal match. 42 U.S.C. Sec. 1397ee(d). Retrieved 4 February 2008. <http://www.access.gpo.gov/uscode/uscmain.html>.
- 14 Preamble to State Child Health; Implementing Regulations for the State Children's Health Insurance Program, 66 Fed. Reg. 2489, 2647 (January 11, 2001).
- 15 These eleven states are: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. Regardless of the amount of unspent enhanced FMAP funds available, states cannot spend more than 20 percent of their total allotment for the Medicaid children above 150 percent of poverty.
- 16 SCHIP funding can be used to finance three types of programs: 1) an expansion of Medicaid; 2) a stand-alone SCHIP program; or 3) a combination of a Medicaid expansion and stand-alone SCHIP program. It is important to note that the federal government pays states an enhanced matching rate under SCHIP, which creates a countervailing incentive for states to utilize all available SCHIP funds before resorting to Medicaid. In Medicaid expansion programs, children would revert to regular Medicaid match rate when SCHIP funds become unavailable.
- 17 Many states have obtained §1115 waivers to cover adult parents with SCHIP funds. For these states, the portion of the SCHIP allotment already dedicated to parental coverage would not be available for expanded child coverage.
- 18 Crowd out is the substitution of public coverage for private insurance. See Lisa Dubay, *Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says* (Washington DC: Kaiser Family Foundation, 1999). Retrieved 1 February 2008. <http://www.kff.org/uninsured/1999112m-index.cfm>.
- 19 In its August 17 letter, CMS has attempted to require states with SCHIP gross income limit above 250 percent of the federal poverty level to comply with the new "crowd-out strategies," including: (1) linking SCHIP cost-sharing requirements to cost-sharing requirements under private plans, so that public insurance is not overly favored; (2) establishing a minimum one-year waiting period for eligible beneficiaries prior to receiving coverage; and (3) collecting of information about any coverage provided by a non-custodial parent. These requirements are designed to prevent families with private insurance from enrolling their children in SCHIP, but may also constitute an enrollment deterrent for uninsured children. See CMS. *Dear State Health Official letter* SHO #07-001, August 17, 2007. Retrieved 1 February 2008. <http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf>. Gross income means income with no deductions for child care or other expenses.
- 20 The legislation extended funding until March 2009 under the "Medicare, Medicaid, and SCHIP Extension Act of 2007": http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s2499es.txt.pdf.
- 21 Montana House Bill No. 577, 60th Legislature § 53-6-131(7) (2007). Retrieved 1 February 2008. <http://data.opi.state.mt.us/bills/mca/53/6/53-6-131.htm>. Notwithstanding any other provision of this chapter, medical assistance must be provided to infants and pregnant women whose family income does not exceed 133% of the federal poverty threshold, as provided in 42 U.S.C. 1396a(a)(10)(A)(ii)(IX) and 42 U.S.C. 1396a(l)(2)(A)(i), and whose family resources do not exceed standards that the department determines reasonable for purposes of the program.
- 22 Montana House Bill No. 577, fiscal note. Retrieved 4 February 2008.
- 23 Sonya Schwartz, Shelly Gehshan, Alan Weil and Alice Lam, *Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity* (Portland, ME: National Academy for State Health Policy, December 2007).

- 24 State legislators and other policy makers dislike uncertainty in funding, and may be less likely to make investments in the program. See John McInerney. *Potential Impacts of Delaying SCHIP Legislation* (Portland, ME: National Academy for State Health Policy, December 2007). Retrieved 1 February 2008. http://www.nashp.org/Files/Impacts_of_Delaying_SCHIP.pdf.
- 25 Letter from Kathleen Farrell, Director, Division of State Children's Health Insurance, to Carmen Hooker Odom, Secretary, North Carolina Department of Health and Human Services, (May 15, 2007).
- 26 North Carolina would have had to cover 1-5 year olds from 133 to 200 percent of the federal poverty level and children under age one from 185 to 200 percent of the federal poverty level with its SCHIP allotment.
- 27 Letter from Carmen Hooker Odom, Secretary of the North Carolina Department of Health and Human Services, to Dennis Smith, Director, Center for Medicaid and State Operations, CMS (June 5, 2007).
- 28 H.R. 3963, 110th Cong. § 115 (2007). Retrieved 4 February 2008. <http://thomas.loc.gov/cgi-bin/bdquery/z?d110:h.r.03963:>.
- 29 Ibid.
- 30 Ibid.
- 31 As referenced earlier in the paper, this remedy addresses an unintended consequence of SCHIP. Before a Congressional fix in 2000, states could only use enhanced federal SCHIP funds to provide coverage above Medicaid levels in effect on March 31, 1997. SCHIP funds could not be used to pay for children already eligible for Medicaid as of that date. Eleven states were unable to access a large portion of their SCHIP allotments because their Medicaid eligibility levels were significantly above the federal mandatory minimum levels for Medicaid when SCHIP was enacted on March 31, 1997. H.R. 3963, 110th Cong. § 107 (2007). Retrieved 4 February 2008. <http://thomas.loc.gov/cgi-bin/bdquery/z?d110:h.r.03963:>.