NATIONAL ACADEMY
for STATE HEALTH POLICY

Perspectives on Reauthorization
SCHIP Directors Weigh In

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June 2005

Prepared with support from the
David and Lucile Packard Foundation

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Prepared with support from The David and Lucile Packard Foundation

CHIP 25

ACKNOWLEDGMENTS

This brief could not have been written without the contributions of the ten state officials who served on the advisory group for this project. The members of the group helped to identify and frame the key issues discussed in this document. In addition, their comments on early drafts of the document proved invaluable. We would also like to thank the many SCHIP directors who participated in the conference calls that formed the basis of this brief. We hope we have captured their recommendations adequately.

In addition, we want to express our appreciation to The David and Lucile Packard Foundation for its ongoing support of NASHP's efforts to assist states in the implementation and refinement of their SCHIP programs. In particular, we are grateful to Gene Lewit, Senior Program Manager at the Packard Foundation, for his continued support.

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OVERVIEW

The Balanced Budget Act of 1997 included the authorization of Title XXI of the Social Security Act, otherwise known as the State Children's Health Insurance Program (SCHIP). In creating SCHIP, Congress sought to assist state efforts to initiate and expand the provision of health benefits coverage to uninsured, low-income children. By the end of 2004, seven years after the program was first authorized, some 4 million children were enrolled in SCHIP programs in all 50 states and the District of Columbia.[1]

SCHIP is financed by both the federal and state governments and is administered by the states. Within federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. The federal government provides a capped amount of funds to states on a matching basis for federal fiscal years 1998 through 2007. The matching rate for SCHIP is higher than the matching rate states receive for Medicaid.

At the federal level, SCHIP is overseen by the Department of Health and Human Services through the Center for Medicaid and State Operations (CMSO) within the Centers for Medicare & Medicaid Services (CMS). To be eligible for federal SCHIP funds, states must submit a child health plan to the Secretary of Health and Human Services, and that plan must be approved by the Secretary.

States can provide SCHIP coverage to low-income children by using one of three options. They can:

- create a separate child health program;
- expand eligibility for benefits under the state's Medicaid plan; or
- combine the two approaches.

Separate SCHIP programs and Medicaid expansion SCHIP programs are each defined by different rules and regulations. Generally, separate SCHIP programs have some flexibility around benefit design, cost sharing, and enrollment limits, while Medicaid expansion SCHIP programs must adhere to the same rules as Medicaid programs.

SCHIP's current period of authorization is scheduled to end after federal fiscal year 2007. As reauthorization nears, policymakers at both the state and federal levels have begun to

[1] By the end of 2004, 3,831,310 children were included in the national enrollment figure, a number that does not include enrollment data for Arkansas, Colorado, and Michigan, states that did not report to CMS via the Statistical Enrollment Data System (SEDS). Source: Centers for Medicare & Medicaid Services, FY 2004 Fourth Quarter–Program Enrollment on the Last Day of the Quarter. Retrieved 14 March 2005.
http://www.cms.hhs.gov/schip/enrollment/chenroll0404pit.pdf

focus on areas of concern within the program and to identify recommendations for reform and improvement.

To assist in that effort, the National Academy for State Health Policy convened an advisory group of ten state SCHIP directors in the summer of 2004 to identify and discuss their major concerns related to reauthorization. Members of the advisory group represented states of varying sizes, geographic location, and SCHIP program design. The group began by reviewing the final SCHIP regulations that were developed to govern the program and that were published in the Federal Register of January 11, 2001.[2] In addition, the group examined a summary of comments and responses to the SCHIP rules that were included in the Federal Register of November 8, 1999.[3]

Based upon this review and lengthy discussions about their own experiences managing SCHIP programs, the members of the advisory group identified four areas that they felt should be addressed during reauthorization in order to further advance the SCHIP program's goal of reducing the number of uninsured children in low-income families. The group focused on the following four areas:

- The funding formula,
- Partial benefit coverage,
- Enrollment flexibility, and
- Excluded populations.

After the advisory group identified these areas of concern, NASHP invited SCHIP directors in all 50 states and the District of Columbia to participate in discussions about these issues and how best to address them. Throughout the fall of 2004, NASHP hosted conference calls on each of the four topics, and more than 30 SCHIP officials participated in each of them. To assist the process, NASHP prepared background materials, facilitated the discussions, and wrote summaries of each call. These summaries were then reviewed by the advisory group and recommendations were finalized. The group's recommendations related to the funding formula affect both separate SCHIP programs and Medicaid expansions. Those related to the other three areas address issues specific to separate SCHIP programs.

This brief, a compilation of the call summaries, is meant to give voice to the perspectives and recommendations of those who manage the SCHIP programs in the states. Many state SCHIP officials have been involved in the program since it was established in 1997. The successes they have achieved, the obstacles they have faced, and the lessons they have learned in implementing SCHIP should be of significant interest and value to those at the national level who are in a position to effect changes in the program.

The ideas expressed in this brief are the consensus opinion of participating SCHIP directors and are not intended to reflect a ranked or exhaustive list of topics that should

[2] 66 Fed. Reg. 2490 (January 11, 2001).
[3] 64 Fed. Reg. 60882 (November 8, 1999).

be addressed. Although the National Academy for State Health Policy played a convening and compiling role in this effort, the opinions here are not necessarily those of the organization or its funders.

THE FUNDING FORMULA

Overview

When SCHIP was created, an early challenge concerned the method by which limited federal funds were to be apportioned to individual states. Ultimately, Congress adopted an allocation formula that considers each state's share of low-income children, share of low-income uninsured children, and the state's cost of providing health care services. Data for the first two elements are obtained from the March supplement to the Current Population Survey (CPS), while the final element comes from the Bureau of Labor Statistics. In addition, funds not spent by states within an allotted time are redistributed to other states based upon a complex formula.

States have identified four concerns with the funding formula as it is currently constructed:

- The data source,
- The state cost factor,
- The allocation formula, and
- The redistribution process.

The Data Source

The SCHIP funding formula is currently based on information obtained from the March supplement to the Current Population Survey (CPS), a monthly survey of 60,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. In addition to other information, the CPS obtains information on insurance coverage for children and the number of children from low-income families (those earning less than 200 percent of the federal poverty level or FPL). By using a three-year moving average of this information, the SCHIP allocation formula is designed to reduce annual fluctuations and provide more precise estimates.

States do not consider the CPS to provide an accurate estimate of the number of low-income children or of the number of uninsured low-income children. States' own estimates of the share of their population without health insurance tend to be lower than those of the CPS for a variety of methodological and measurement reasons. CPS estimates can also be unstable, particularly in smaller states with a smaller sample size. In October 2003, a report from the State Health Access Data Assistance Center indicated that between 1999 and 2002, states' SCHIP funding allocations fluctuated on average

22 percent per state, an average variance of about $18.5 million[4] and one that often made it difficult for states to develop reliable budgets for their SCHIP programs. If CPS estimates are systematically low or high across states there is no effect on the share of SCHIP dollars each state gets. Still, states worry that varying estimates of the number of uninsured children can make it difficult to determine how much progress each state is making in enrolling eligible children.

Having managed SCHIP programs for seven years, states generally have more information on the eligible population than they did when the program began. In particular, states have had to report enrollment data to CMS as part of annual SCHIP reporting requirements. Furthermore, from state-funded investigations and outreach activities, as well as through the use of HRSA-sponsored State Health Planning Grants and other state-based surveys, states now have a much clearer sense of the size of the SCHIP-eligible population than is available from the CPS data.

Although reliable alternatives to the CPS data exist for many states, this is not the case for all states. Since the funding formula requires a national data set, states are interested in identifying options for improving the reliability and stability of the estimates used in the SCHIP funding formula.

States were unable to reach a consensus on recommendations for alternatives to the CPS data, but they felt it was important to raise their concerns. They expressed the hope that SCHIP directors would be involved in efforts to resolve these issues.

Cost Factor

The cost factor is a measure of a state's health services wages relative to the national average and is obtained by taking a three-year average of the wages per employee in the health services industry (according to Bureau of Labor Statistics data). It is included in the funding formula in an attempt to account for state variations in the cost of providing health care. As a result, states that have a low average wage will have a slightly smaller allocation; those with a higher average wage will have a slightly larger allocation.

States believe that average wages are not a good way to estimate the cost of providing care. They contend that the cost factor adversely affects states with higher poverty rates because poor states tend to employ part-time workers and those with lower levels of educational attainment. States argue that while these factors result in a reduced federal allocation they do not serve to capture the true cost of providing care to low-income children.

[4] State Health Access Data Assistance Center, Issue Brief 7, *Yet Another Wild Card in State Budget Deliberations: Federal SCHIP Allocations to States* (Minneapolis, MN: University of Minnesota School of Public Health, October 2003).

In addition, large, predominantly rural, states have significantly higher transportation costs associated with serving each child. This cost is not reflected in the wage costs used in the formula.

States believe that average health care wages are a poor way to estimate the cost of providing care. However, they were unable to reach consensus on recommended actions for addressing this issue.

The Allocation Formula

Currently, SCHIP funds are allocated to a state based on the state cost factor and on the population of low-income children and low-income *uninsured* children.[5] For a number of reasons, this formula is of concern to many states.

The SCHIP Allocation Formula

States' SCHIP allocations are determined by the following formula:

Population base (**P**) **=** ½ the number of low-income children in the state **+** ½ the number of low-income, uninsured children in the state

Modified population base (MPB) **=** P **x** (.15 + (.85 **x** state cost factor))

State Allotment **=** (Modified population base / Sum of modified population base for every state) **x** Total annual federal allotment

Each state receives a share of the federal allotment based primarily on the state's share of low-income children and low-income uninsured children. Even if the *number* of these children in a state increases, the state will receive a larger allocation only if the state's rate of increase is faster than the national average. Thus, in a time of increasing need, a state receives no additional support. Stated differently, the funding available per child decreases when the number of needy children increases nationally.

[5] Title XXI of the Social Security Act defines a low-income child as one living in a family earning less than 200 percent of the federal poverty level.

In addition, the inclusion in the formula of the number of low-income uninsured children means that the more successful a state is in enrolling children in SCHIP, thereby changing them from uninsured to insured status, the smaller the state's funding allocation becomes. By contrast, states that are less successful in enrolling eligible children retain larger funding allocations.

States feel strongly that successfully enrolling children in SCHIP should not have a negative effect on a state's funding allocation.

The Redistribution Process

Currently, states have a three-year window in which to spend their initial federal allocation. Funds left over from states that did not fully expend their allocation are collected and distributed to those states that overspent their allocation. States then have a single year in which to spend their redistributed funds before the funds revert back to the federal treasury. In the fall of 2004, $1.1 billion in unspent SCHIP funds reverted back to the federal treasury.

The Secretary of Health and Human Services is charged by statute with determining an appropriate redistribution methodology. Although this has led to uncertainty in how remaining funds would be redistributed, the primary problem with the redistribution process is one of timing. With a single year in which to match redistributed funds, states do not have enough time to plan for, appropriate, and spend enough state dollars to utilize redistributed funds effectively. These problems are exacerbated by the timing of the announcement of redistributed funds and when state legislatures meet to make budget decisions, particularly for states that have legislatures that meet biannually.

States believe it would be prudent to extend the period during which redistributed funds can be spent. This would allow for better planning and more time in which state lawmakers can evaluate the best way to allocate the additional resources.

PARTIAL BENEFIT COVERAGE

Overview

The SCHIP statute bars states with separate SCHIP programs from covering insured children. This prohibition means that states with separate SCHIP programs cannot use SCHIP funds to augment (or "wrap around") privately obtained coverage for children whose coverage does not include benefits that they may need but which their families cannot afford.

SCHIP Statutory Requirement

The SCHIP statute identifies the population eligible for SCHIP as "targeted low-income children." The statute defines this term, in part, as children in families with incomes below 200 percent of the federal poverty level (FPL) who lack "creditable health coverage," a term that refers to insurance coverage for basic preventive and catastrophic services. Creditable health coverage has a complicated and very specific meaning which is related both to the Public Health Service Act (PHSA) and the Employee Retirement Income Security Act (ERISA).

This provision is consistent with the statutory goal of reducing the number of children without health insurance. It requires states to direct their SCHIP funding to providing coverage to children without any other source of coverage. Effectively, it prevents states from using SCHIP funds in a separate SCHIP program to wrap around coverage for those with any creditable coverage, no matter how inadequate it may be.

By contrast, children eligible for Medicaid and Medicaid SCHIP expansion programs can enroll in those programs regardless of their insurance status because the Medicaid statute does not include such a bar, and Medicaid has explicit provisions for how the program can wrap around other coverage.

SCHIP is intended to promote comprehensive well-child care that is comparable to care that is commonly available in a state. Accordingly, the statute requires that states with separate SCHIP programs must provide a benefit package that is either approved by the Secretary of Health and Human Services or pegged to a benchmark package. In those cases where the benchmark package covers what are referred to as "additional" benefits (e.g., prescription drugs, mental health services, vision services, hearing services), the approved SCHIP plan must provide an actuarially equivalent benefit equal to or greater than 75 percent of these "additional" services.[6] States that implement a Medicaid expansion SCHIP must offer the same benefits as the Medicaid program.

[6] Title XXI, Section 2103(a)(C).

However, many commercial plans—including those used as a benchmark benefit package—fail to cover some specific health services that are important to childhood development, such as those for eye care, dental care, and some mental health services.

SCHIP programs that provide this "additional" coverage invariably exist side-by-side with commercial programs that do not provide similarly comprehensive coverage. Consequently, low-income working families otherwise eligible for SCHIP who are enrolled in plans that do not cover these additional services have two choices: they must either pay for expenses out-of-pocket that could be covered if they were enrolled in SCHIP, or they can assume a great deal of risk by disenrolling from their employer-sponsored plan and enrolling in SCHIP. This may, however, result in a three- to six-month gap in coverage, due to many states' anti-crowd-out provisions. Thus, these families are penalized for obtaining employer-sponsored health care because they receive a benefit package that does not meet the needs of their children while other families that do not obtain employer-sponsored coverage receive a more comprehensive benefit package through SCHIP.

Under SCHIP, states have been granted broad flexibility to design their individual programs. Nonetheless, current SCHIP regulations mean that states with separate SCHIP programs are unable to address this particular issue. Permitting these states to cover these partial benefit services—without having to pursue a waiver—is consistent with the flexibility afforded states in other aspects of the program and could enable more low-income children to have comprehensive coverage.

To that end, SCHIP directors believe the prohibition against partial benefit packages should be lifted, permitting—but not requiring—states to provide additional services to children who have "inadequate" coverage through a partial benefit packages.

Options for Changing the Statute

SCHIP directors identified the following options for changing the existing SCHIP statute in order to allow for partial benefit coverage:

- Amend the definition of targeted low-income children to allow states to use SCHIP funds in separate SCHIP programs to cover a partial benefit package for children covered by less-than-comprehensive, but creditable, health coverage. This might also include a provision allowing states to determine when creditable health coverage does not meet a state standard for comprehensiveness.

- Amend §2103 of the Social Security Act to specifically allow a partial benefit package for children otherwise eligible for SCHIP who are covered by a group health plan that does not cover those services mentioned in §2103(c)(2) and (3).

- Allow states to offer a partial benefit package as a health services initiative, as defined in §2105 of the Social Security Act, but allow it as a category that is exempt from the 10 percent administrative services cap.[7]

States acknowledge that the primary goal of the SCHIP statue is to reduce the number of children without health insurance and that spending SCHIP funds on wrap-around coverage does not appear to directly address that goal. However, this narrow view of the program ignores two important facts. First, SCHIP has provisions to assure that children are covered with a comprehensive benefit package, and supplementing the benefits of children whose private coverage is inadequate is consistent with the overall SCHIP goal. Second, state efforts to supplement private coverage may make that coverage more affordable, thereby shoring up the base of private coverage on which SCHIP builds.

Given the broad flexibility states have to design SCHIP programs that are consistent with their own needs and values, a statutory change that permits coverage of a partial benefit package seems appropriate.

[7] States are currently permitted to spend up to 10 percent of their SCHIP funding on administrative services that are not directly related to providing health care coverage to children. However, the Title XXI statute permits states to engage in "health services initiatives" that are directed to low-income children broadly but that cannot reasonably differentiate between children enrolled in SCHIP and those not enrolled in SCHIP.

ENROLLMENT FLEXIBILITY

Overview

The SCHIP statute currently prohibits states from enrolling Medicaid eligible children in separate SCHIP programs. But states have identified a number of instances where allowing some Medicaid eligible children to enroll in SCHIP is preferred by the child and his or her family. Allowing states and families the flexibility to choose between Medicaid and SCHIP in certain cases would further the goal of increased health care coverage for low-income children.

SCHIP Statutory Requirement

SCHIP programs are required by §2102(b)(3) of the Social Security Act to screen applicants and, if found eligible, ensure their enrollment in Medicaid. According to the statute:

> *The plan shall include a description of procedures to be used to ensure—*
>
> *(A) through both intake and follow-up screening, that only targeted low-income children are furnished child health assistance under the State child health plan;*
> *(B) that children found through the screening to be eligible for medical assistance under the State Medicaid plan under Title XIX are enrolled for such assistance under such plan.*

As a result, children who are eligible for Medicaid cannot be enrolled in a separate SCHIP program.

Early comments on SCHIP regulations sought permission to allow some flexibility for Medicaid eligible individuals who prefer to participate in a separate SCHIP program even in cases where SCHIP has some cost-sharing requirements and, in some cases, fewer benefits. CMS responded to these comments by noting,

> *While we recognize that some families may decide to go without insurance rather than apply for Medicaid, we believe that it would be contrary to the statutory purposes to permit States to enroll children in a separate child health program who have been found potentially eligible for Medicaid through a screening process.* [8]

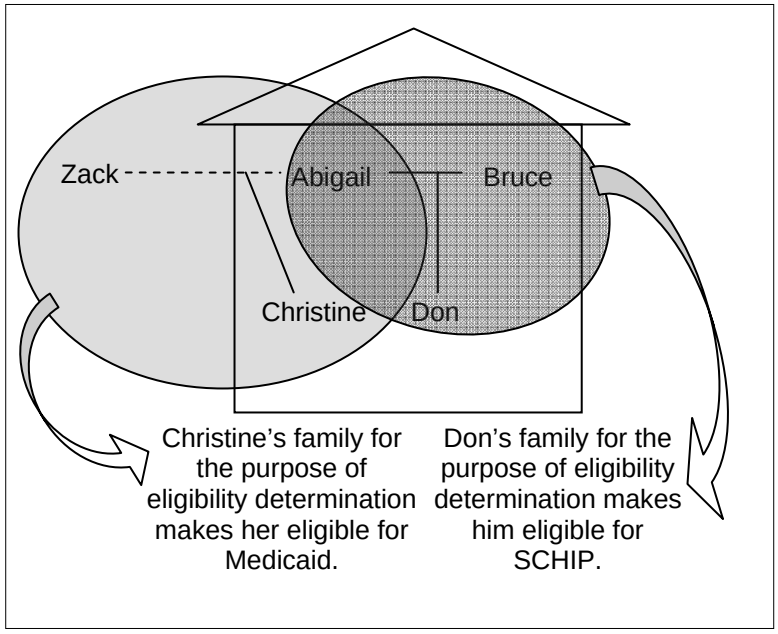
[8] Federal Register, Vol. 66, No. 8, p. 2546 (Jan. 11, 2001).

Arguments for Allowing Enrollment Flexibility

Keeping the family together

In many states, some members of the same family may be served by Medicaid while others are served by SCHIP. The specific program that each child in the family qualifies for is determined by family makeup, income, and the children's ages. States would like to serve members of the same family through a single program. Federal Medicaid eligibility requirements present a barrier to this objective.

Family makeup and income

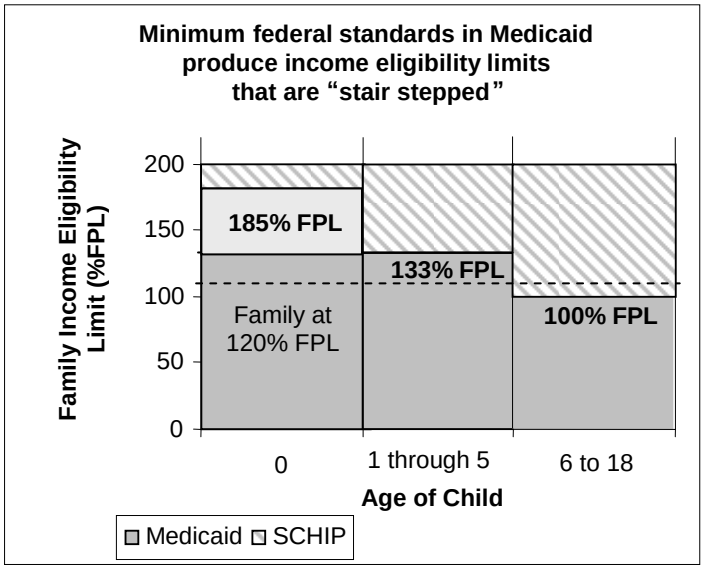


An example helps to illustrate the enrollment issue that can arise for children in blended families:

Abigail and Bruce are married and live in a state with a Medicaid program and a separate SCHIP program. They have two children who live with them: Christine and Don. Don is Abigail's and Bruce's son. Christine is Abigail's daughter from a previous marriage to Zack. For the purpose of eligibility determination, Christine's parents are Zack and Abigail. Even though she lives in a household that is SCHIP eligible, based on Abigail's and Bruce's income, Christine is only eligible to enroll in Medicaid because Zack's—not Bruce's—income helps determine her eligibility. As a result, the household is split: one child is eligible for Medicaid, the other for the separate SCHIP program.

Age and family income

Many states have adopted the minimum federal standards for Medicaid eligibility that are based on age and income.[9] For families with more than one child, this can result in children being enrolled in different programs. Take, for example, a family that earns 120 percent FPL and lives in a state that has adopted the federal minimum standards. The family's two-year old son would be enrolled in Medicaid, while its 10-year-old daughter would be ineligible for Medicaid and would be enrolled in SCHIP.



For families, the differences between the programs can become burdensome and could actually reduce the availability of health care services by requiring a household to comply with the rules of two different health care programs. As a result, states are seeking some enrollment flexibility in cases where children in one family are required to enroll in different programs.

Stigma

Despite states' best efforts to facilitate enrollment in both Medicaid and SCHIP, state officials report that stigma continues to serve as an obstacle to providing health coverage to children. States continue to encounter families who would prefer to do without health insurance rather than receive Medicaid which requires families to contribute little, if anything, to the cost of care. They report that Medicaid stigma is particularly acute in rural areas, where patients and physician office staff might know each other outside of the clinical setting. State experience suggests that this problem exists even in states that have fully integrated, seamless health care coverage programs for children (and do not use the name Medicaid) as well as in those states that continue to use the term Medicaid and have a separate name for their SCHIP programs.

[9] Federal Medicaid law establishes different minimum eligibility levels for different age groups of children and different family incomes. The current law requires states to provide Medicaid coverage to children up to age six who live in households with incomes up to 133 percent of the federal poverty level (FPL). States must also cover children age six through eighteen up to 100 percent FPL. In addition, if—by December 19, 1989—the state had exercised its option to cover children under age 1 (infants) up to and including 185 percent of FPL, the state is now required to maintain that level.

Pregnant teens

States believe that discretionary enrollment flexibility would also be beneficial for teenagers on SCHIP who become eligible for Medicaid due to a pregnancy. Most states have established Medicaid income eligibility levels for infants and pregnant mothers that are higher than those that are applied to teenagers. Consequently, many teenagers on SCHIP who become pregnant become eligible for Medicaid and are, therefore, barred from SCHIP. This change from one program to another can be disruptive to the continuity of care. In some states, separate SCHIP programs are already being used to cover non-Medicaid eligible pregnant women though waivers which permit coverage of unborn children. For other states, allowing pregnant teens to remain in SCHIP—and with the same provider—might be preferable to having them move to Medicaid.

For theses reasons, states are seeking flexibility that will enable them to: allow some Medicaid-eligible children to choose to enroll in SCHIP; allow households with children in both Medicaid and SCHIP to enroll in the same program; and permit teenagers who become eligible for Medicaid due to a pregnancy to remain in SCHIP

Options for Changing the Statute

One option is to amend §2102(b)(3) of the Social Security Act to permit Medicaid-eligible children to waive Medicaid eligibility and enroll in SCHIP. For example, this might include a provision that allows states to establish, with Secretary approval, a lower and upper corridor around the Medicaid income eligibility limit within which families can choose to enroll their children in either program.

Another option is to allow states to establish, with Secretary approval, certain categories of Medicaid-eligible children—based on household, pregnancy, and/or other characteristics—that are eligible to elect coverage through SCHIP.

It is important to note that states receive a higher federal matching rate for children who are enrolled in either a Medicaid expansion program or a separate SCHIP program than for children enrolled in Medicaid. State SCHIP directors propose, as part of these recommendations, that states that opt to allow certain children to choose SCHIP coverage over Medicaid receive the Medicaid match for those children. This provision would eliminate any financial incentive states might have to encourage families to choose SCHIP over Medicaid.

Excluded Populations

Overview

The current SCHIP statute prevents dependents of state employees from enrolling in separate SCHIP programs if the state contributes more than a nominal amount to family coverage. This has meant that dependents of state employees who are otherwise eligible for a separate SCHIP program are prevented from enrolling simply because a parent is employed by the state. States must screen SCHIP applicants for Medicaid eligibility, and the prohibition against coverage of state employees means that states with separate SCHIP programs must also screen for an applicant's employer, a requirement that results in an additional administrative burden for states. For those families who are employed by the state through TANF[10] and other welfare-to-work efforts, being made ineligible for SCHIP can hinder efforts towards self-sufficiency. Furthermore, many state employees in low-paying jobs find it unfair that they are subject to a different standard based solely on their employer.

SCHIP Statutory Requirement

Although the statute notes that the purpose of the legislation is to "enable States to initiate and expand child health assistance to uninsured, low-income children,"[11] two kinds of children are deemed ineligible for coverage by separate SCHIP programs:

- an inmate of a public institution or a patient in an institution for mental diseases, and
- a child who is a member of a family that is eligible for health benefits coverage under a state health benefits plan on the basis of a family member's employment with a public agency in the state.

Rules interpret this statute to mean that where states make more than a nominal contribution (defined as $10 per month) towards a state employee's family coverage, the children of that employee are ineligible for SCHIP coverage. There are only two states—Mississippi and North Carolina—that fall under this threshold and are therefore permitted to enroll dependents of state employees into SCHIP.

[10] Temporary Assistance for Needy Families (TANF), is a program that provides assistance to poor families with children and is the successor to Aid to Families with Dependent Children (AFDC). One aspect of some states' TANF programs is a welfare-to-work program that establishes supervised employment opportunities for recipients as a way of obtaining some of the job skills and experiences that will eliminate the need for public assistance.
[11] Social Security Act, Title XXI, §2101(a).

Presumably, the rationale for excluding otherwise eligible dependents of state employees was to discourage states from reducing or eliminating their support of family coverage for state employees, thereby allowing states to supplant state funds with federal funds.

Numbers affected

Most states believe they have done a good job of communicating to state employees that they are not eligible for SCHIP. As a result, states report relatively small numbers of children who were denied coverage because they were eligible for the state employee dependent benefit.

Nonetheless, Mississippi, a state that is permitted to enroll dependents of state employees, did report that of approximately 67,000 children enrolled in SCHIP, approximately 2,700, or 4 percent, were dependents of state employees. The state believes that if children of state employees were not eligible for SCHIP, it would present a significant obstacle to recruiting quality workers.

Equity

Perhaps the greatest concern for states is the inequity of denying SCHIP coverage—based solely on employer—to otherwise eligible children. Additionally, the prohibition against enrolling dependents of state employees is only required of separate SCHIP programs, not Medicaid expansion SCHIP programs.

Although the federal government was concerned about using federal SCHIP funds to pay for the state-funded health care of state employees, a similar exemption for federal employees was not enacted. As a result, federal employees in low-paying jobs are permitted to enroll in SCHIP, while state employees are not.

Administrative burden

Many of the states subject to this provision have found it difficult and complicated to identify those applicants who are eligible for state employee benefits. This issue is exacerbated in states where cities, counties, universities, and other quasi-autonomous governmental bodies buy in to the state employee benefit plan, rendering the dependents of employees of these entities ineligible for SCHIP. Tracking which groups are eligible for the state employee dependent coverage and which are not has proved difficult.

Many states also report that efforts to screen SCHIP applicants for eligibility for state benefits are further complicated by the use of private contractors and sub-contractors. State agencies are using private contractors to perform an increasing number of tasks, and the distinction between employees of private contractors and the state are becoming more difficult to discern. Simply asking a SCHIP applicant if they are employed by the state in

such cases will not yield accurate results. Furthermore, some states report that even though a paycheck comes, for example, from a state university, the employee will, in fact, be employed by a private contractor. Making an accurate determination for some applicants can be difficult, and must be done on an individual basis. As states continue to outsource tasks to private contractors, the resources states must devote to differentiating between private and public employees will continue to grow.

TANF and Welfare-to-Work

Many states report that they employ substantial numbers of individuals through TANF or other welfare-to-work programs. Because these individuals work for the state, their children are ineligible for SCHIP. And because they cannot afford the personal contribution required for their family to participate in the state health insurance plan, their efforts to become self-sufficient are compromised. Furthermore, the dependents of those who work in numerous low-paying positions—including clerks, teachers' aides, custodians, and other non-faculty positions in schools and universities—may also be ineligible for SCHIP.

For these reasons, SCHIP directors believe the statute should be amended to allow states to more easily enroll the qualified dependents of state employees into their SCHIP programs.

Options for Changing Statutes and Rules

States have identified three possible solutions to the problem of SCHIP-ineligible dependents of state employees. They are:

- **Define the nominal contribution a state can make to dependent coverage as higher than the current level of $10.** Some states report that the amount they contribute to dependent coverage is only marginally higher than this amount. In at least one case, the state's contribution is $11 per month. By increasing the amount of the nominal contribution cap, more states would be able to enroll more children in SCHIP.

- **Construct a maintenance of effort clause, much like the one that exists concerning Medicaid income eligibility limits.** Such a clause might require states to maintain the level of financial contribution toward the cost of coverage for dependents of state employees that was in existence prior to the creation of SCHIP (or some other date as established by Congress). In order to qualify for SCHIP funding, states are prohibited from establishing Medicaid eligibility standards that are more restrictive than those that were in place as of June 1, 1997. Establishing a similar "maintenance of effort" clause for state contributions to family coverage would serve two functions: it would prevent the erosion of state

coverage for dependents of employees, and it would allow additional low-income children to be covered by SCHIP.

- **Establish a hardship provision that allows dependents of state employees to qualify for SCHIP if the cost to purchase the state package is more than a certain percent of the family's income (e.g., 5 percent).** This provision would require states to evaluate on a case-by-case basis the income of state employees who apply to have their dependents enroll in SCHIP. This option shares the benefits of the previous one: it limits federal financial liability and serves as an obstacle to crowd out by preventing states from enrolling all eligible state employee dependents in SCHIP, and it allows children with the greatest financial need to enroll in SCHIP. States are currently permitted to exercise a similar hardship provision for insured children whose cost of coverage exceeds a certain percent of the family's income.

CONCLUSION

The State Children's Health Insurance Program and its enhanced matching rate have enabled states to expand coverage to millions of children, the largest expansion of children's health coverage since Medicaid was passed in 1965. Since SCHIP was created in 1997, states have taken full advantage of the flexibility built into the program to design programs that address their specific needs. As of April 2005, 12 states had implemented a Medicaid SCHIP expansion; 18 had opted to create a separate SCHIP program; and 21 had chosen both options.[12]

SCHIP's current period of authorization is scheduled to end after federal fiscal year 2007. As reauthorization nears, policymakers at both the state and federal levels have begun to focus on areas of concern within the program and to identify recommendations for reform and improvement. Throughout the reauthorization process, federal policymakers will no doubt receive recommendations for needed change from advocacy organizations, health care providers, governors, and many other key stakeholders. This issue brief contains recommendations reflecting the consensus opinion of SCHIP directors nationwide.

Discussions related to the funding formula and how it might be changed are important to the future of the program and will be central to the reauthorization process. The SCHIP directors involved in the discussions that shaped this brief focused on issues of equity and accuracy as they relate to individual components of the formula, and they also raised issues related to the redistribution of unspent funds. Any changes to the formula that result from the reauthorization process will have ramifications for both Medicaid expansion and separate SCHIP programs and, therefore, for all states.

States with separate SCHIP programs enjoy greater flexibility in program design than those that have chosen to implement Medicaid expansions. As a result, the separate SCHIP programs that operate in 39 states are different from Medicaid and from Medicaid SCHIP expansions, and these differences raise a number of issues related to reauthorization that are unique to the separate programs. The SCHIP directors that participated in the conversations that formed the basis of this brief focused on three key issues. States are requesting the additional flexibility to:

- Enroll dependents of state employees into separate SCHIP programs;
- Offer supplemental benefits to children who would be eligible for a separate SCHIP program if they did not already have health insurance; and
- Allow families to choose to enroll their children in a separate SCHIP program even if they are eligible for Medicaid.

[12] For a list of the states that have adopted each option, go to http://www.cms.hhs.gov/schip/chip-map.pdf. The Centers for Medicare & Medicaid Services. State Children's Health Insurance Program: Plan Activity as of April 7, 2005. Retrieved 22 April 2005.

In creating SCHIP, Congress sought to assist state efforts to initiate and expand the provision of child health insurance, primarily in the form of health benefits coverage to uninsured, low-income children. By the end of 2004, seven years after the program was first authorized, some 4 million children were enrolled in SCHIP programs in all 50 states and the District of Columbia.[13] The program has provided health coverage to millions of children who are not eligible for Medicaid but whose parents cannot afford private coverage.

This brief is designed to give voice to the perspectives and recommendations of those who manage the SCHIP programs in the states. Their successes, experiences, and insights should be of significant interest and value to those at the national level who are in a position to effect changes in the program.

[13] By the end of 2004, 3,831,310 children were included in the national enrollment figure, a number that does not include enrollment data for Arkansas, Colorado, and Michigan, states that did not report to CMS via the Statistical Enrollment Data System (SEDS). Source: Centers for Medicare & Medicaid Services, FY 2004 Fourth Quarter–Program Enrollment on the Last Day of the Quarter. Retrieved 14 March 2005.
http://www.cms.hhs.gov/schip/enrollment/chenroll0404pit.pdf