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State eligibility rules under separate state SCHIP programs--implications for children's access to health care

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SCHIP POLICY STUDIES PROJECT

Issue Brief

Policy Brief #4:
State Eligibility Rules under Separate State SCHIP Programs —Implications for Children's Access to Health Care

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Executive Summary

This Policy Brief is the fourth in a series of reports[1] issued by the George Washington University Center for Health Services Research and Policy that examine the design of separately-administered State Children's Health Insurance Programs (SCHIP) that is, programs that operate directly under the authority of the federal SCHIP statute rather than expansions of state Medicaid programs.[2] These Policy Briefs also consider the implications of states' design choices for children's access to health care.

The first three briefs in this series focused on three aspects of separate SCHIP programs: children's legal right to assistance under separate programs;[3] benefit and coverage design

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[1] Funding for this research comes from a cooperative agreement from the Health Resources and Services Administration (HRSA) [R40 MC00165-03] as part of the Children's Health Insurance Research Initiative (CHIRI), which is co-funded by the Agency for Healthcare Research and Quality (AHRQ), the David and Lucile Packard Foundation and HRSA.

[2] Title XXI of the Social Security Act, 42 U.S.C. §1397aa *et seq.*; 42 C.F.R. §457 *et seq.*

[3] Rosenbaum, S., and Smith, B. (2001) "State Design and the Right to Coverage" Policy Brief #1 Washington, D.C.: Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, www.gwhealthpolicy.org/chiri.htm.

choices under SCHIP plans;[4] and the design and structure of freestanding managed care contracts negotiated by SCHIP agencies.[5]

This issue brief focuses on how financial eligibility for SCHIP actually is calculated, that is, the formulas that states have developed to count children's family income for purposes of measuring eligibility. This topic is of central importance to overall program administration because of the federal legal prohibition against assistance to targeted low-income children who are in fact Medicaid-eligible. This prohibition on duplication of assistance was a crucial assumption in the enactment of SCHIP. It is also key to the conservation of limited SCHIP funding for targeted low-income children who are ineligible for either Medicaid or any other form of health insurance, particularly as unemployment rises and the number of lower income children without health insurance may be poised to increase.

Because Medicaid and SCHIP are both means-tested programs, financial eligibility turns in great part on a child's income eligibility. A basic tenet of Medicaid since its enactment (and one that is thus incorporated into SCHIP because of how the two statutes are linked) is that income eligibility is determined by how much *countable income* a child is considered to have, not on the family's gross income. Medicaid establishes federal standards for how income is evaluated and counted. SCHIP on the other hand leaves these standards to state discretion, imposing in their place what can be thought of as an "outcome" test, namely, that SCHIP funds be used for children who are not eligible for Medicaid.

Our review of the financial eligibility criteria reported by separate SCHIP programs in their state plans found that only 20 of the 34 states with separate SCHIP programs in effect in 2000 report using rules to count income that are sufficiently compatible to Medicaid rules on countable income so that a determination of SCHIP eligibility simultaneously could be reasonably interpreted as a finding of ineligibility for Medicaid. Of those 20 states, only 12 state SCHIP programs unequivocally pick up where Medicaid rules leave off in their valuation of countable income. In the remaining 14 states, the financial eligibility standards and methodologies for evaluating income (i.e., the rules for counting income) are either *more restrictive* than those used under Medicaid or else are sufficiently ambiguous so that it is impossible to know without a detailed audit if more restrictive criteria in fact are in use. In these states, despite the fact that the SCHIP income *eligibility standard* may be *nominally higher* for SCHIP than it is for Medicaid (e.g., 200 percent of the federal poverty level versus 150 percent of the federal poverty level), the formulas used to count income and thus calculate eligibility may be more restrictive than those used under Medicaid. As a result, a SCHIP child's *countable* income in these states actually may be lower than it is for a Medicaid-enrolled child. State income valuation rules appear to be more restrictive in several basic areas, in particular, in the availability of deductions against income, rules used to calculate family size, and the rules that

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[4] Rosenbaum, S., Markus, A., Sonosky, C., and Repasch, L. (2001) "State Benefit Design Choices under SCHIP – Implications for Pediatric Health Care" Policy Brief #2 Washington, D.C.: Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, www.gwhealthpolicy.org/chiri.htm.

[5] Rosenbaum, S., Shaw, K., and Sonosky, C. (2001) "Managed Care Purchasing under SCHIP—A Nationwide Analysis of Freestanding SCHIP Contracts" Policy Brief #3 Washington, D.C.: Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, www.gwhealthpolicy.org/chiri.htm.

determine exactly what household income will be counted toward a child when considering eligibility (i.e., income attribution).

These findings support several basic conclusions. First, the use of more restrictive standards under SCHIP, while not expressly prohibited, would appear to be inconsistent with the program's central purpose, namely, to assist certain low-income children whose family resources place them beyond the limits of their state's Medicaid program.

Second, using countable income rules that are more restrictive than those applicable in Medicaid means that in these states, SCHIP has a greater potential to allocate limited program resources to children who do not qualify for assistance because they are in fact eligible for Medicaid. This mis-allocation means that other low-income children who truly do not meet Medicaid standards may find that no assistance is available; indeed, states where SCHIP expenditures are projected to exceed their annual allotments are expected to consider queuing targeted low-income children for assistance because of funding shortages and some states, such as North Carolina, already have begun to do so.

Third, the use of more restrictive standards and methodologies under SCHIP also means that the resulting benefit packages available to enrolled children may be thinner in order to accommodate additional children and cost sharing may be higher. To the extent that more limited benefits and higher cost sharing have been predicated on these families' greater ability to afford out of pocket payments, the fact that the countable income standards actually are more restrictive would appear to undercut the basic logic underlying more limited benefits.

In states that use more restrictive SCHIP financial eligibility criteria, there would appear to be a need for an additional post-eligibility determination enrollment procedure designed to avert erroneous enrollment into SCHIP of children who in fact may be poorer than their Medicaid counterparts. Because the use of an additional post-eligibility determination enrollment procedure could further delay the receipt of necessary care, states using more restrictive standards may wish to revise their SCHIP standards and methodologies to make them compatible with Medicaid.

Introduction

This issue brief examines how financial eligibility for SCHIP is calculated, that is, the formulas that states have developed to count children's family income for purposes of measuring eligibility. While earlier studies have examined various aspects of the SCHIP eligibility issue, they have not specifically focused on the specific question considered here of how income is evaluated and counted.[6] The Brief opens with a background and overview on eligibility

[6] See, e.g.: GAO. (2001) Medicaid and SCHIP: States' Eligibility and Payment Policies Can Affect Children's Access to Care (GAO-01-883, September) Accessed www.gao.gov November 22, 2001; GAO. (2000) Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits (GAO/HEHS-00-86, April) Accessed at www.gao.gov; Kaiser Commission on Medicaid and the Uninsured. (2002) Enrolling Uninsured Low-Income Children in Medicaid and CHIP. Fact Sheet. Washington, D.C.: The Henry J. Kaiser Family Foundation; Pernice, C., Wysen, K., Riley, T., and Kaye, N. (2001) Charting SCHIP: Report of the Second National Survey of the State Children's Health Insurance Program. Portland, ME: National Academy

standards and methodologies, and reviews the basic differences in eligibility determination between Medicaid and SCHIP. Following a brief description of the methods used to carry out this study, this analysis presents findings regarding the eligibility standards and methodologies in SCHIP and discusses the implications of these findings for children's access to health care.

Background

The State Children's Health Insurance Program (SCHIP),[7] codified at Title XXI of the Social Security Act, entitles states to federal funding (known as allotments) to extend publicly subsidized insurance to certain "targeted low-income" children who are ineligible for Medicaid or another form of "creditable coverage." Unlike Medicaid (which is an open-ended legal entitlement in the case of both states and individuals), states' SCHIP allotments are subject to annual aggregate upper limits.[8] At the same time however, the SCHIP statute specifically classifies the benefits states confer on eligible children as a non-entitlement benefit[9] and provides states with extensive discretion over the design of their programs, including the eligibility standards they will set.

States have two basic options where SCHIP program design is concerned. A state can elect to use its entire federal SCHIP allotment to expand its Medicaid program, in which case it receives enhanced federal medical assistance payment for the services and benefits furnished to "expansion" children. Alternatively, a state can use its federal SCHIP allotment to establish and operate a separate SCHIP program that is administered directly under the authority of Title XXI rather than as a Medicaid expansion under Title XIX. As of FY 2001, 15 states and the District of Columbia, operated their SCHIP programs exclusively as a Medicaid expansion. The remaining 35 operated their programs either in whole or in part as a separate program

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for State Health Policy; O'Brien, M.J. *et al.* (2001) "State Experiences with Access Issues under Children's Health Insurance Expansions" Field Report New York, NY: The Commonwealth Fund; Perry, M., Kannel, S., Valdez, R.B., and Chang, C. (2000) Medicaid and Children Overcoming Barriers to Enrollment Findings from a National Survey. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured; Mann, C., Ross, D.C., and Cox, L. (2000) Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children Washington, D.C.: Center on Budget and Policy Priorities; Ross, D.C., and Cox, L. (2000) Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures-Findings from a 50-State Survey Washington, D.C.: Center on Budget and Policy Priorities. Prepared for the Kaiser Commission on Medicaid and the Uninsured; Ku, L., Ullman, F., and Almeida, R. (1999) "What Counts? Determining Medicaid and CHIP Eligibility for Children" Assessing the New Federalism Discussion Papers Washington, D.C.: The Urban Institute.

[7] 42 U.S.C. §1397aa *et seq.*; 42 C.F.R. §457 *et seq.*

[8] 42 U.S.C. §1397aa. See also Kaiser Commission on Medicaid and the Uninsured. (2001) "Issues Related to Unspent S-CHIP Money" Policy Brief Washington, D.C.: The Henry J. Kaiser Family Foundation; Guyer, J. (2001) "Trends in CHIP Expenditures: State-by-State Data" Policy Brief Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.

[9] 42 U.S.C. §1397bb(b)(4). Rosenbaum and Smith, *op. cit.* An earlier report issued by CHSRP found that 9 of the 34 states that operated separate SCHIP programs in 2000 appear to confer at least a limited state-law entitlement status to the benefits they furnish to eligible children.

subject to the requirements of Title XXI rather than the more stringent requirements of Title XIX.[10]

Table 1: State SCHIP Administration: Medicaid Expansion versus Separate SCHIP Programs

State	Medicaid Expansion	Separate SCHIP Program (in Whole or in Part)	Maximum Medicaid Income Eligibility Limit[0]/Upper SCHIP Income Eligibility Limit in Separate SCHIP Programs (% FPL)		No. of Children Served Under Separate SCHIP Program (FY 2000)
AL	✓	✓	133/133/100/100	200	37,587
AK	✓				
AZ		✓	140/133/100/50	200	60,803
AR	✓				
CA	✓	✓	200/133/100/100	250	428,641
CO		✓	133/133/100/43	185	34,889
CT	✓	✓	185/185/185/185	300	9,593
DE		✓	185/133/100/100	200	4,474
DC	✓				
FL	✓	✓	200/133/100/100	200	201,409
GA		✓	185/133/100/100	235	120,626
HI	✓				
ID	✓				
IL	✓	✓	200/133/133/133	185	17,659
IN	✓	✓	150/150/150/150	200	6,534[1]
IA	✓	✓	200/133/133/133	200	8,699
KS		✓	150/133/100/100	200	26,306
KY	✓	✓	185/150/150/150	200	14,477
LA	✓				
ME	✓	✓	200/150/150/150	200	8,828
MD[2]	✓	✓	200/200/200/200	300	N/A
MA	✓	✓	200/150/150/150	200 (400+)[3]	40,128
MI	✓	✓	185/150/150/150	200	21,231
MN	✓				
MS	✓	✓	185/133/100/100	200	8,295
MO	✓				
MT		✓	133/133/100/71	150	8,317
NE	✓				
NV		✓	133/133/100/89	200	15,946
NH	✓	✓	300/185/185/185	300	4,119
NJ	✓	✓	185/133/133/133	350	50,361
NM	✓				
NY	✓	✓	185/133/100/100	192[4]	764,147
NC		✓	185/133/100/100	200	103,567
ND	✓	✓	133/133/100/100	140	2,267
OH	✓				
OK	✓				
OR		✓	133/133/100/100	170	37,092
PA		✓	185/133/100/71	200 (235)[5]	119,710

[10] Centers for Medicare and Medicaid Services. *The State Children's Health Insurance Program Annual Enrollment Report—Federal Fiscal Year 2001: October 1, 2000-September 30, 2001* (US Department of Health and Human Services, Baltimore, MD, on-line), www.hcfa.gov. Accessed July 18, 2002.

State	Medicaid Expansion	Separate SCHIP Program (in Whole or in Part)	Maximum Medicaid Income Eligibility Limit[0]/Upper SCHIP Income Eligibility Limit in Separate SCHIP Programs (% FPL)		No. of Children Served Under Separate SCHIP Program (FY 2000)
RI	✓				
SC	✓				
SD	✓	✓	140/140/140/140	200	299
TN	✓				
TX	✓	✓	185/133/100/100	200	84,974
UT		✓	133/133/100/100	200	25,294
VT		✓	225/225/225/225	300	4,081
VA		✓	133/133/100/100	185	37,681
WA		✓	200/200/200/200	250	2,616
WV		✓	150/150/100/100	200	21,659
WI	✓				
WY		✓	133/133/100/67	133	2,547
Total	35	35			2,334,866

SOURCES: Centers for Medicare and Medicaid Services. (2000) State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Year (FFY) 2000. Accessed at www.hcfa.gov; Ross, D.C., and Cox, L. (2000) Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures-Findings from a 50-State Survey Washington, D.C.: Center on Budget and Policy Priorities. Prepared for the Kaiser Commission on Medicaid and the Uninsured.

Notes:

[0] Medicaid income eligibility guidelines for infants (0-1)/children (1-5)/children (6-16)/children (17-19).

[1] The Indiana State SCHIP Annual Report for FY 2000 states that "there were 6,534 children who obtained health insurance through Indiana's State-designed program at some point between January 1, 2000 (the beginning of the program) and September 30, 2000."

[2] Maryland received approval on November 7, 2000 for a state plan amendment to implement a separate child health program effective July 1, 2001.

[3] Massachusetts provides state-financed coverage to children with incomes above SCHIP levels. Eligibility is shown in parenthesis.

[4] New York has a net income standard of 192% of the FPL.

[5] Pennsylvania provides state-financed coverage to children with incomes above SCHIP levels. Eligibility is shown in parenthesis.

In designing their separate SCHIP programs, states have broad discretion over eligibility standards, as long as they do not make eligible for SCHIP any child who is eligible for Medicaid or another form of "creditable coverage."[11] States may select the standards and methodologies used to determine eligibility; because these standards and methodologies are critical to the determination of eligibility, they must be described in the approved state plan.[12]

[11] 42 U.S.C. §1397jj(b)(1)(C); 42 C.F.R. §457.310(b)(2).

[12] 42 U.S.C. §1397bb(a)(5) and (b)(1); 42 C.F.R. §457.305(a). In addition, the Centers for Medicare and Medicaid Services' instructions for completing the application template for the State Child Health Plan under Title XXI of the Social Security Act state that the plan must "identify the state's income standards, including the definition of household and family income, deductions, disregards, and methods for evaluating family income."

Table 2 compares the principal eligibility requirements for Medicaid and separate SCHIP programs. In several respects, SCHIP and Medicaid eligibility criteria are similar; in other respects they may differ significantly because of the latitude given to states administering separate SCHIP programs. This is particularly true in the case of income evaluation, as well as resources and resource evaluation.

Table 2
Principal Issues in Medicaid and SCHIP Eligibility:
A Comparison of Federal Medicaid and SCHIP Requirements

Standard	Medicaid	Separate SCHIP
Income eligibility levels	• States must cover infants and children ages 1-6 with family incomes up to 133% FPL, as well as children ages 6-18 with family incomes up to 100% FPL. • States may cover children of any income level, as defined by the state.	• States must limit coverage to targeted low-income children who are ineligible for Medicaid or other creditable coverage. States have the option of setting income eligibility levels (i) between the upper, state-defined Medicaid eligibility level for children and 200% FPL or (ii) 50 percentage points higher than the upper, state-defined Medicaid eligibility level if that level is set higher than 200% FPL. • States must cover lower income children before higher income children.
Methods for evaluation of family income	• States must calculate eligibility based on family size, using a federal definition of "family." • In determining family income, states may treat as "countable" only family income that has been adjusted in recognition of child support payments, work-related costs, and child care costs. In addition, countable family income levels must be adjusted for shelter costs. • States may attribute to children under 21 only income that is actually	• States have flexibility in defining the term "family," deciding which income will be counted, and attributing income to children under 21. • States are prohibited from furnishing separate SCHIP benefits to children who are eligible for Medicaid.

Standard	Medicaid	Separate SCHIP
	contributed with the exception of parents or spouses.	
Resources and resource evaluation	• States may eliminate the resource test. • States that elect to count resources must adhere to federal requirements regarding countable and excluded resources (e.g., homes, cars of certain value, work-related tools).	• States have flexibility over both resources and resource evaluation standards.
Retroactive coverage	• States must provide retroactive coverage for up to three months prior to enrollment.	• No similar requirement; states may provide retroactive coverage as an eligibility option.
Continuous eligibility	• State may provide continuous eligibility for up to 12 months. • States may not terminate coverage until they determine that the child is no longer eligible for all possible eligibility categories.	• Same. • No similar requirement.
Availability of other coverage as a condition of eligibility	• States cannot deny coverage to children who have other third party coverage (e.g., employer sponsored coverage); Medicaid becomes the payer of last resort.	• States cannot enroll children who have creditable coverage (e.g., employer coverage, Medicaid, or other coverage).
State residency and citizenship requirements	• States must cover residents, federally defined, including residents without a fixed address; federal definitions also apply with respect to individuals who are in a state for employment purposes, even if their domicile is elsewhere. • States must provide full coverage to otherwise eligible children who are	• States may define the term "resident." • Same rules for long term legal residents; no emergency assistance for recent residents.

Standard	Medicaid	Separate SCHIP
	citizens or who were legal residents as of August 22, 1996. Short term legal residents (in the U.S. for fewer than 5 years) entitled if otherwise qualified to emergency coverage only, similar to non-qualified aliens.	

SOURCE: GW CHSRP, 2001.

Medicaid and valuation of income: Since its enactment, Medicaid has required that in evaluating whether an individual qualifies for Medicaid, a state agency consider only "countable" income; in doing so, the statute and regulations also set forth broad rules for income valuation formulas. First, income eligibility must be adjusted for family size, and federal standards effectively define the term "family." Under federal Medicaid standards flowing from the program's continued link to AFDC standards in effect prior to the 1996 welfare reform act,[13] the concept of family traditionally has meant the child (applicant), the child's siblings, and the child's legally responsible relatives living in the household, as opposed to all relatives or individuals living in the household.

Second, in evaluating family income, states are required to recognize certain relatively modest deductions, including a $90 monthly work expense deduction, child care expenses of between $175 and $200 per month depending on the age of the child, and monthly child support payments up to $50. States may at their option adopt more generous methodologies for evaluating income and recognizing deductions.[14] Other state deductions may include other types of deductions such as expenditures for uncovered medical services.

Third, in attributing family income, states may not treat as automatically available to a child under 21 any household income other than the income of parents or a spouse (in the case of a minor married child) or income that is actually contributed to the family. This prohibition on income attribution other than in limited circumstances has received extensive judicial attention over the years. [15]

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[13] Despite the fact that AFDC was repealed in 1996, states must continue to cover all persons who would qualify for Medicaid based on their eligibility for pre-welfare reform AFDC benefits. 42 U.S.C. §1396u-1(b).
[14] Sec. 1931 of the Social Security Act; 42 U.S.C. §1396u-1.
[15] 42 U.S.C. §1396a(a)(17)(D). See *Herweg v. Ray*, 455 U.S. 265 (1982); *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981) (upholding spousal deeming). For early cases establishing the limits on Medicaid deeming, see *Molloy v. Eichler*, 860 F.2d 1179 (3d Cir. 1988); *Mitchell v. Lipscomb*, 851 F.2d 734 (3d Cir. 1988); *Georgia Dep't of Medicaid Assistance v. Bowen*, 846 F.2d 708 (11th Cir. 1988); *Olson v. Norman*, 830 F.2d 812, 811 (8th Cir. 1987); *Vance v. Hegstrom*, 793 F.2d 1018, 1023-26 (9th Cir. 1986); *Childress v. Bowen*, 833 F.2d 231 (10th Cir. 1987); *Reed v. Blinzinger*, 816 F.2d 296 (7th Cir. 1987); *Ward v. Wallace*, 652 F. Supp. 301 (M.D. Ala. 1987); *Sundburg v. Mansour*, 627 F. Supp. 616 (W.D. Mich. 1986), *aff'd,* 847 F.2d 1210 (6th Cir. 1988); *Gibson v. Puett*, 630 F. Supp. 542 (M.D. Tenn. 1985); see also *Skaliotis v. Rhode Island Dep't of Human Servs.*, C.A. No. 95-2438, 1996 R.I. Super. LEXIS 117 (R.I. Super. Apr. 18, 1996) (spousal deeming does not require case-by-case assessment of equity); *Rodolfo-Masera v. Rowe*, No. CV 92-505549S, 1993 WL 526575 (Conn. Super. Dec. 3, 1993) (holding that applicant

Within the context of the basic requirement that children not be enrolled in SCHIP if eligible for Medicaid or other creditable coverage, SCHIP leaves all of these choices – that is, the definition of "family," the adjustments that will be made to gross family income, and rules on the attribution of income– up to state programs. States must describe the methods they elect to use in their state plans.[16]

Comparing Medicaid eligibility rules against SCHIP: To gauge the impact of Medicaid income evaluation rules on eligibility, take for example the case of a 7 year old child who lives with two parents, a grandmother, and an uncle in a state that restricts Medicaid to children with family incomes at or below 100 percent of the federal poverty level. The parents together earn $800 per month. The grandmother, who receives Social Security benefits of $700 per month, of which she contributes $250 per month for food and groceries, sending another $200 to another daughter. The uncle, who is employed at odd jobs and contributes only irregularly because of child support obligations, makes about $600 per month.

Under Medicaid eligibility rules applicable to the child, the family would consist of three people (the child and her two parents). Total gross monthly family income would be $1050 (the parents' $800 plus the grandmother's contribution of $250). This gross income would then be adjusted to reflect shelter costs, plus deductions totaling approximately $355 for the cost of after school child care (up to $175 per month for a child older than 2), and the parents' allowable work costs (up to $90 per month per earner). The family's total income would be $695, below the Medicaid eligibility level for a 7-year-old child (i.e., $1,179 for a family of 3 with an income at the poverty level).

Now imagine that the state administers a separate SCHIP program that covers children between Medicaid eligibility and 150 percent of the federal poverty level that treats all household income as family income, does not adjust for child care or work expenses, and treats the assistance unit size as all related persons living in the same household. In this situation, the assistance unit rises to 5 persons (the child, her parents, the grandmother, and the uncle). The countable family income rises to $2000 (the parents' $800 plus the grandmother's Social Security plus the uncle's $600), bringing total monthly household income to 120 percent of the federal poverty level. This income is low enough for the child to qualify for separate SCHIP benefits; if the Medicaid methodology were in use, the child would qualify for Medicaid.

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should be allowed to prove that funds held jointly with son should not be deemed to spouse); *Bucchere v. Rowe*, 648 A.2d 173 (Conn. Super. Ct. 1994) (deeming income of pregnant applicant's father to her while she was living in father's household); *Haynes v. Missouri State Div. of Family Servs.*, 874 S.W.2d 457 (Mo. Ct. App. 1994) (finding pregnant child, not the unborn child, to be the applicant and deeming parent's income to her).

[16] The Centers for Medicare and Medicaid Services' instructions for completing the application template for the State Child Health Plan under Title XXI of the Social Security Act state that the plan must "identify the state's income standards, including the definition of household and family income, deductions, disregards, and methods for evaluating family income."

Methods

To carry out this study, we analyzed the state plans for Calendar year 2000 filed with the federal government by separate SCHIP programs in order to determine whether states parallel or depart from basic Medicaid eligibility principles. We examined state SCHIP plans to determine how states define the term "family" for purposes of income calculation against the poverty level, how income is calculated (gross versus net) and whether in evaluating income, states automatically attribute as available to a child (e.g., deem) household income other than the income of parents or spouses.

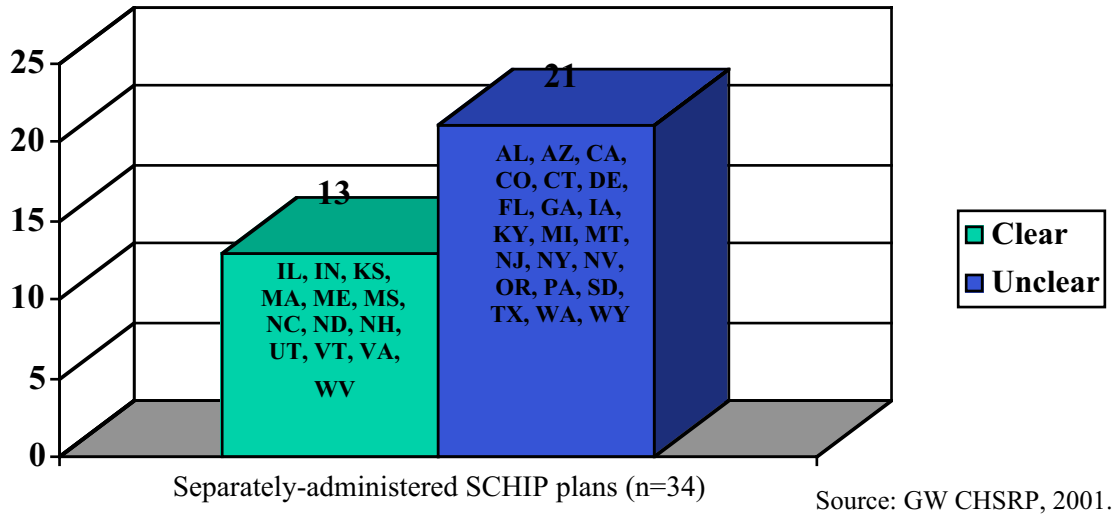
Results

The results are shown in the following figures and tables.

Figures 1 through 3 and Tables 3 through 7 summarize the findings from the reviews of 34 freestanding SCHIP plans in effect in 2000. Figure 1 and Tables 3 through 6 show that the majority of the states with freestanding SCHIP plans did not lay out clear rules in their plans that allowed us to determine whether they followed Medicaid financial eligibility rules or departed from them. More specifically:

- Only 13 states—Illinois, Indiana, Kansas, Massachusetts, Maine, Mississippi, North Carolina, North Dakota, New Hampshire, Utah, Vermont, Virginia and West Virginia—provided sufficient information in their plan on how they would adjust gross income, define family, and attribute income.
- The remaining 21 states were unclear in their plan on one standard, two standards or all three standards.

Figure 1. **States with separately-administered SCHIP programs that specify income adjustments, family definition, and attribution of income in their state plans (2000)**



Source: GW CHSRP, 2001.

Figure 2 and Table 6 show that, among the 21 states whose plans were ambiguous or lacked clarity, income attribution was the area where the majority of states did not specify which rules they would use, whereas income valuation was the area least frequently omitted. These charts also show that the majority of state plans lacking clarity were more often unclear on two of the three income standards rather than on only one or all three standards. More specifically:

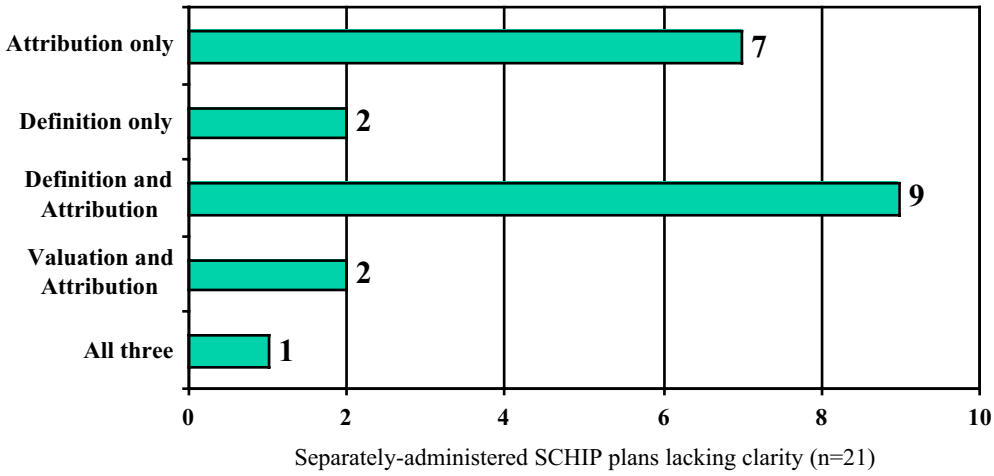
- How states would attribute income was unclear in 19 cases, whereas the definition of family and the evaluation of income were unclear in 12 and three cases, respectively.

- Nine states were unclear on one income standard: Alabama, Arizona, Colorado, Connecticut, Delaware, Montana, Wyoming failed to describe how they would attribute income; Florida and Michigan did not explicitly define the term "family."

- Eleven states were unclear on two income standards—either family definition and income attribution or income valuation and income attribution. Nine states (California, Iowa, Kentucky, New Jersey, New York, Nevada, Pennsylvania, South Dakota, and Texas) did not explain how they would define family nor did they show how they would attribute income, while the remaining two states (Georgia and Oregon) failed to specify how they would assess income and attribute it.

- The Washington State plan was silent on all three standards.

Figure 2. Separately-administered SCHIP plans lacking clarity, by area of income determination (i.e., income valuation, family definition, and income attribution), 2000



Source: GW CSHRP, 2001.

Figure 3 and Table 7 show the extent to which states choices regarding income eligibility resemble Medicaid, "tip" toward Medicaid, or depart from Medicaid. A state was categorized as resembling Medicaid when the three income standards described in its plan paralleled those of the Medicaid program. A "tipping" state was a state with two income standards paralleling Medicaid standards and principles. A state that paralleled Medicaid on one income standard or none "tipped" away from Medicaid. Figure 3 and Table 7 show the variation that exists among the 34 states with freestanding SCHIP plans in their reference to Medicaid standards and principles. Overall, state plans specified more frequently that the state would evaluate income according to Medicaid than whether it would define "family" according to Medicaid; they also provided a family definition that followed Medicaid specifications more often than a description of income attribution that followed Medicaid specifications. While the majority of states either resembled Medicaid or "tipped" toward Medicaid, a sizeable portion of the state plans were so ambiguous that it was impossible to determine, based on the plan, whether the state had adopted the Medicaid principles regarding financial eligibility or departed from them. The plan of only one state was classified as "tipping" away from Medicaid. More specifically:

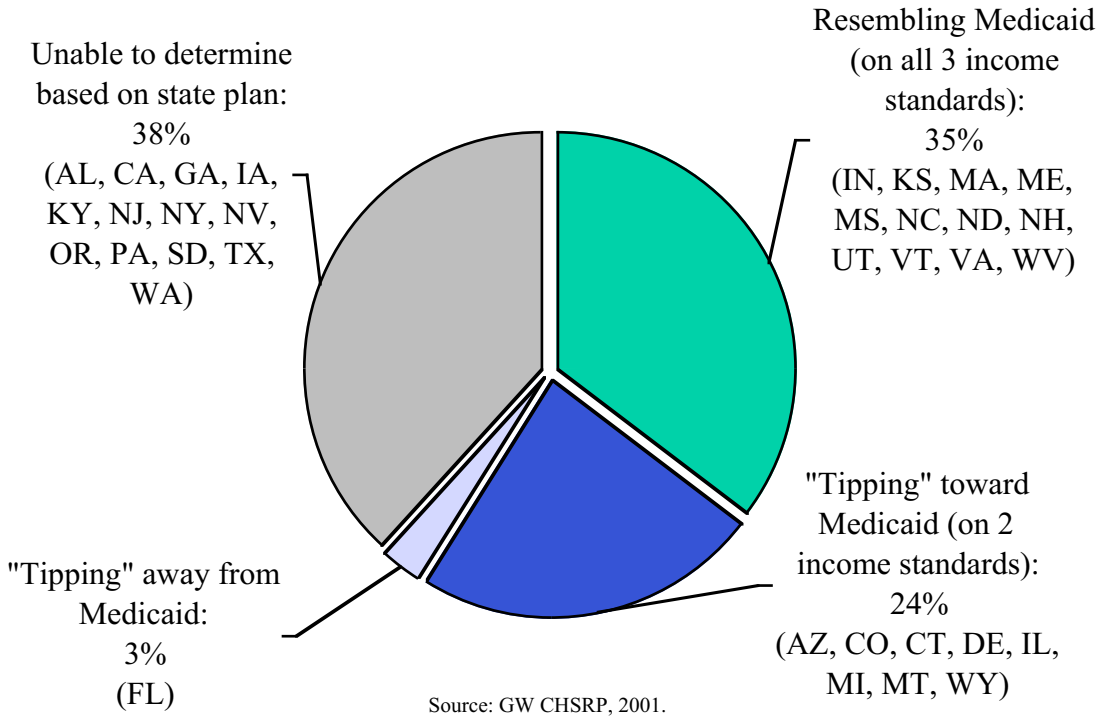
- The income standards and methodologies of 12 states resemble Medicaid in all three areas of income determination—income valuation, family definition, and income attribution. These states include: Indiana, Kansas, Massachusetts, Maine, Mississippi, North Carolina, North Dakota, New Hampshire, Utah, Vermont, Virginia, and West Virginia.

- The income standards and methodologies of eight states "tip" toward Medicaid in two of the three areas of income determination. While Michigan "tips" toward

Medicaid in the areas of income valuation and attribution, the remaining seven states—Arizona, Colorado, Connecticut, Delaware, Illinois, Montana, and Wyoming—"tip" toward Medicaid in the areas of income valuation and family definition.

- One state—Florida—"tips" away from Medicaid by opting for a gross income test and household income.
- In the case of 14 states (Alabama, California, Florida, Georgia, Iowa, Kentucky, New Jersey, New York, Nevada, Oregon, Pennsylvania, South Dakota, Texas, and Washington), the income standards and methodologies could not be determined based on the state plan.

Figure 3. Variation of separately-administered SCHIP plans in their reference to Medicaid income eligibility standards and principles (n=34), 2000



Source: GW CHSRP, 2001.

Table 3. Income Valuation: Does the SCHIP plan provide for income deductions/disregards?

State	Gross	Net	Types of deductions/disregards
AL	✓		
AZ		✓	As required by CMS, certain payments and grants as specified at 20 CFR Part 416, the Appendix to Subpart K, will be excluded when determining gross income, no other disregards
CA		✓	Medi-Cal income exemptions plus 50% FPL income disregard
CO		✓	Spenddowns for medical bills, day care, child support
CT		✓	65% FPL income disregard
DE		✓	$90 work-related, $175/$200 child care, $50 child support
FL	✓		
GA	✪	✪	✪
IA		✓	20% of income exempt
IL		✓	Employment-related costs, child care costs, earned income of children who are not minor parents exempt
IN		✓	Same income definition and income methodologies as Medicaid
KS		✓	Income deductions and disregards from Title XIX applicable to SCHIP
KY		✓	Income disregards applied
MA		✓	Income received by TAFDC, EAEDC or SSI recipient, sheltered workshop earnings, portion of federal veterans benefits identified as aid and attendance benefits, unreimbursed medical expenses, household benefits, or enhanced benefits, income in-kind, roomer and boarder income, and any other income excluded as provided by federal laws other than the Social Security Act (see 42 C.F.R. Part 416, Appendix to Subpart K) not counted
ME		✓	SCHIP eligibility process integrated with Medicaid eligibility process
MI		✓	No description of deductions
MS		✓	Determined in the same manner as Medicaid
MT		✓	$120 job-related, $200 dependent care
NC		✓	Deduction for child care and standard work expense consistent with Title XIX poverty-level group
ND		✓	Test closely follows current Medicaid policy for poverty level eligibility recipients
NH		✓	Same as poverty-level children with additional disregard of 65% FPL
NJ	✓	✓	133-200% FPL: No deductions or disregards 200-350% FPL: Disregards of 50-150% FPL
NY	✓	✓	Net household income <192% FPL with disregards for premiums and child care costs or gross equivalent of such income <192% FPL
NV	✓		
OR	✪	✪	✪
PA		✓	Since 2000, work expense deduction, day care expenses
SD		✓	Child support paid, actual child care expenses for employment-related day care up to $500 for the family, $50 child support, earned income of children <19
TX		✓	Offsets for expenses such as child care, work-related expenses, other deductions consistent with Medicaid standards
UT		✓	$1620 child income, child care assistance, reimbursement of expenses incurred by individual, needs-based veteran's pensions, educational income, reimbursement for Medicare premiums, death benefits, bona fide loans, payments for food, shelter, clothing, and other needs, income excluded from income under other statutes
VT		✓	Existing Medicaid income disregard rules apply to SCHIP
VA		✓	Child care and child support disregard
WA	✪	✪	✪
WV		✓	Same disregards as Title XIX
WY		✓	Child care assistance, reimbursement of expenses incurred by individual, needs-based veteran's pensions, educational income, reimbursement for Medicare premiums, death benefits, bona fide loans, payments for food, shelter, clothing, and other needs, income excluded from income under other statutes
Totals	5	28	

✪ = Not possible to tell based on the state's SCHIP plan

Source: GW Center for Health Services Research and Policy, 2001.

Table 4. Income Adjustment for Family Size: Does the SCHIP plan define the term "family" as per Medicaid?

State	Definition provided	Same definition as Medicaid but actual definition not provided in plan	No definition or reference to Medicaid definition
AL	✓		
AZ	✓		
CA			✓
CO	✓		
CT	✓		
DE	✓		
FL			✓
GA	✓		
IA			✓
IL	✓		
IN		✓	
KS		✓	
KY			✓
MA	✓		
ME		"Integrated with Medicaid"	
MI			✓
MS		✓	
MT	✓		
NC		✓	
ND	✓		
NH		✓	
NJ			✓
NY			✓
NV			✓
OR		✓	
PA			✓
SD			✓
TX			✓
UT	✓		
VT		✓	
VA		✓	
WA			✓
WV		✓	
WY	✓		
Subtotals	12	10[1]	
Totals		22[2]	12

NOTES:

[1] Maine is included based on the statement included in its plan that the SCHIP eligibility process will be integrated with the Medicaid eligibility process.

[2] For the purpose of this research, these two columns qualify as being clear about Medicaid, though the level of specificity clearly varied among states.

Source: GW Center for Health Services Research and Policy, 2001.

Table 5. Income Attribution: Does the SCHIP plan limit income attribution to income of parents and spouse or income that is actually contributed to the family?

State	Unclear	Parents and spouse only	Same methodology as Medicaid but no description provided in plan	Parents and spouse and other household members
AL	✓			
AZ [1]	✓			
CA	✓			
CO	✓			
CT	✓			
DE	✓			
FL				✓
GA	✓			
IA	✓			
IL				✓
IN			✓	
KS			✓	
KY	✓			
MA		✓		
ME			"Integrated with Medicaid"	
MI		✓		
MS			✓	
MT	✓			
NC			✓	
ND		✓		
NH			✓	
NJ	✓			
NY	✓			
NV	✓			
OR	✓			
PA	✓			
SD	✓			
TX	✓			
UT		✓		
VT			✓	
VA			✓	
WA	✓			
WV			✓	
WY	✓			
Subtotals		4	9[2]	
Totals	19	13[3]		2

NOIES:

[1] The Arizona SCHIP plan is only specific about income attribution of qualified aliens.

[2] Maine is included based on the statement included in its plan that that the SCHIP eligibility process will be integrated with the Medicaid eligibility process.

[3] For the purpose of this research, these two columns qualify as being clear about Medicaid, though the level of specificity clearly varied among states.

Source: GW Center for Health Services Research and Policy, 2001.

Table 6. States with separately-administered SCHIP plans that do not specify their income determination rules (2000)

State	Valuation	Definition	Attribution	Totals
AL			✓	1
AZ			✓	1
CA		✓	✓	2
CO			✓	1
CT			✓	1
DE			✓	1
FL		✓		1
GA	✓		✓	2
IA		✓	✓	2
IL				0
IN				0
KS				0
KY		✓	✓	2
MA				0
ME				0
MI		✓		1
MS				0
MT			✓	1
NC				0
ND				0
NH				0
NJ		✓	✓	2
NY		✓	✓	2
NV		✓	✓	2
OR	✓		✓	2
PA		✓	✓	2
SD		✓	✓	2
TX		✓	✓	2
UT				0
VT				0
VA				0
WA	✓	✓	✓	3
WV				0
WY			✓	1
TOTALS	3	12	19	

KEY:
✓= Plan is unclear
Source: GW Center for Health Services Research and Policy, 2001.

Table 7. States with separately-administered SCHIP plans that follow Medicaid income determination rules (2000)

State	Valuation	Definition	Attribution	Overall "tipping"
AL	N	✓	✪	✪
AZ	✓	✓	✪	✓
CA	✓	✪	✪	✪
CO	✓	✓	✪	✓
CT	✓	✓	✪	✓
DE	✓	✓	✪	✓
FL	N	✪	N	N
GA	✪	✓	✪	✪
IA	✓	✪	✪	✪
IL	✓	✓	N	✓
IN	✓	✓	✓	✓
KS	✓	✓	✓	✓
KY	✓	✪	✪	✪
MA	✓	✓	✓	✓
ME	✓	✓	✓	✓
MI	✓	✪	✓	✓
MS	✓	✓	✓	✓
MT	✓	✓	✪	✓
NC	✓	✓	✓	✓
ND	✓	✓	✓	✓
NH	✓	✓	✓	✓
NJ	✓, N	✪	✪	✪
NY	✓, N	✪	✪	✪
NV	N	✪	✪	✪
OR	✪	✓	✪	✪
PA	✓	✪	✪	✪
SD	✓	✪	✪	✪
TX	✓	✪	✪	✪
UT	✓	✓	✓	✓
VT	✓	✓	✓	✓
VA	✓	✓	✓	✓
WA	✪	✪	✪	✪
WV	✓	✓	✓	✓
WY	✓	✓	✪	✓
Totals	28	22	13	

KEY: ✓= Follows Medicaid; N = Does not follow Medicaid; ✪ =Not possible to tell based on the state's SCHIP plan

Source: GW Center for Health Services Research and Policy, 2001.

Conclusion

Eligibility standards, which determine access to publicly-financed health insurance programs such as Medicaid and SCHIP, are an important policy consideration because they can affect access to care for the populations targeted by these programs.

Numerous studies have underscored the importance of coverage to improve access to care, especially for children, by identifying lack of insurance as one significant barrier to obtaining basic primary and preventive care services that are crucial to a child's healthy development.[17] Compared to publicly-and privately-insured children, uninsured children are 70 percent more likely to forego needed medical care for common conditions (e.g., ear infections), and 30 percent less likely to receive medical attention when injured.[18] Compared to poor insured children, poor uninsured children are eight times more likely than privately-insured children and six times more likely than publicly-insured children to report the absence of a usual source of care, and more than twice more likely than poor insured children, whether publicly-or privately-insured, not to see a physician at least once a year.[19]

The majority of children in the U.S. obtain coverage as dependents through their parents' workplace. The Medicaid and SCHIP programs play an important role in providing coverage to low-income uninsured children whose parents do not have health insurance available at their workplace or cannot afford health insurance. Both programs are means-tested federal-state insurance programs that purchase medical coverage for low-income children. Medicaid covers children ages 0-6 up to 133 percent of the federal poverty level and children ages 6-19 up to 100 percent of the federal poverty level, with a state option to expand coverage beyond these groups either by raising the income eligibility limit for the program or by offering additional income disregards. SCHIP, on the other hand, targets low-income (i.e., below 200 percent of the federal poverty level) uninsured children who do not qualify for Medicaid. Medicaid and SCHIP cover one in four children and over 40 percent of all low-income children.[20]

Despite estimates showing that 84 to 96 percent of low-income uninsured children are now eligible for coverage under either Medicaid or SCHIP, a quarter remain uninsured.[21] Thus,

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[17] Newacheck, P., Hughes, D., and Stoddard, J. (1996) Children's Access to Primary Care: Differences by Race, Income, and Insurance Status. Pediatrics, 97(1): 26-32; Kaiser Commission on Medicaid and the Uninsured. (2001) The Uninsured and Their Access to Health Care. Fact Sheet. Washington, D.C.: The Henry J. Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured. (2001) Health Coverage for Low-Income Children. Fact Sheet. Washington, D.C.: The Henry J. Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured. (2001) Enrolling Uninsured Low-Income Children in Medicaid and CHIP. Fact Sheet. Washington, D.C.: The Henry J. Kaiser Family Foundation. Perry, M., *et al.*, *op. cit.*

[18] Kaiser Commission on Medicaid and the Uninsured. (2001) The Uninsured and Their Access to Health Care. Fact Sheet. Washington, D.C.: The Henry J. Kaiser Family Foundation.

[19] Kaiser Commission on Medicaid and the Uninsured. (2001) Health Coverage for Low-Income Children. Fact Sheet. Washington, D.C.: The Henry J. Kaiser Family Foundation.

[20] *Ibid.*

[21] Dubay, L., Haley, J., and Kenney, G. Children's Eligibility for Public Programs: National and State Estimates. Washington, D.C.: The Urban Institute. Forthcoming. Kaiser Commission on Medicaid and the

improving access to Medicaid and SCHIP is paramount to securing access to health services for these children. Both programs offer more or less equivalent coverage of preventive and primary care services, but Medicaid is more generous than SCHIP in terms of providing the comprehensive benefits needed by children with special health care needs. By setting eligibility standards generously and without discrimination, states will likely increase SCHIP and Medicaid coverage and thus access to care. In addition, in the case of states with separately-administered SCHIP programs, coordinating the eligibility standards of the two programs is especially important in order to establish a seamless system of care for low-income children.

This study found that the majority of state plans lacked clarity on the income standards and methodologies they would apply to determine eligibility under separately-administered SCHIP programs in violation of the SCHIP statute and regulations. It also found that state plans displayed some variety in their reference to Medicaid standards and principles, with the majority of states opting for income standards and methodologies that either resembled or "tipped" toward Medicaid.

These findings suggest that states, when given the flexibility to exercise discretion in designing health insurance programs for near-poor and low-income children, are likely to make design choices that have the effect of "tipping" their freestanding SCHIP program toward Medicaid. This willingness by states to retain Medicaid eligibility rules might be explained by the requirement under SCHIP that states enroll children who are found to be Medicaid-eligible in Medicaid first. In fact, it is commonly accepted that the freestanding SCHIP programs act as an outreach mechanism for the Medicaid program in order to enroll the millions of children who are eligible for Medicaid but not enrolled. In addition, by following Medicaid eligibility rules, states can facilitate the coordination of services for children whose family income fluctuates along the spectrum of income covered by the two programs.

These findings also suggest that some states will use the flexibility accorded by SCHIP law to depart from Medicaid principles. As a result, in these states, some SCHIP-enrolled children actually may be poorer than children enrolled in Medicaid. The use of more rather than less restrictive eligibility criteria in separate SCHIP programs also heightens the potential for erroneous enrollment of Medicaid eligible children in SCHIP programs. Moreover, these states may be less effective in decreasing the number of low-income, uninsured children who have no other health insurance alternative.

In states that have made a Medicaid-like choice, a greater number of children above the income eligibility limit will become eligible for SCHIP and thus gain access to the services they need. In those states, there will also be less potential for erroneous enrollment of Medicaid eligible children in SCHIP programs. Finally, in states that are ambiguous about their choice, implications for children's access to care remain unclear. If the majority turns out to actually use Medicaid standards, then pediatric access to care may improve. If the opposite is true,

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Uninsured. (2001) Health Coverage for Low-Income Children. Fact Sheet. Washington, D.C.: The Henry J. Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured. (2001) Enrolling Uninsured Low-Income Children in Medicaid and CHIP. Fact Sheet. Washington, D.C.: The Henry J. Kaiser Family Foundation

however, the effectiveness of SCHIP programs in achieving the statutory goal of decreasing the number of uninsured children may be hampered.

These findings support several basic conclusions. First, the use of more restrictive standards under SCHIP, while not expressly prohibited, would appear to be inconsistent with the program's central purpose, namely, to assist certain low-income children whose family resources place them beyond the limits of their state's Medicaid program.

Second, using countable income rules that are more restrictive than those applicable in Medicaid means that in these states, SCHIP has a greater potential to allocate limited program resources to children who do not qualify for assistance because they are in fact eligible for Medicaid. This mis-allocation means that other low-income children who truly do not meet Medicaid standards may find that no assistance is available; indeed, states where SCHIP expenditures are projected to exceed their annual allotments are expected to consider queuing targeted low-income children for assistance because of funding shortages and some states, such as North Carolina, already have begun to do so.[22]

Third, the use of more restrictive standards and methodologies under SCHIP also means that the resulting benefit packages available to enrolled children may be thinner in order to accommodate additional children and cost sharing may be higher. To the extent that more limited benefits and higher cost sharing have been predicated on these families' greater ability to afford out of pocket payments, the fact that the countable income standards actually are more restrictive would appear to undercut the basic logic underlying more limited benefits.

In states that use more restrictive SCHIP financial eligibility criteria, there would appear to be a need for an additional post-eligibility determination enrollment procedure designed to avert erroneous enrollment into SCHIP of children who in fact may be poorer than their Medicaid counterparts. Because the use of an additional post-eligibility determination enrollment procedure could further delay the receipt of necessary care, states using more restrictive standards may wish to revise their SCHIP standards and methodologies to make them compatible with Medicaid.

[22] Park, E., and Broaddus, M. (2001) OMB Estimates Indicate 400,000 Children Will Lose Health Insurance Due to Reductions in SCHIP Funding–Use by States of Unspent SCHIP Funds to Provide Health Insurance to Unemployed Workers Could Worsen Effects of Funding Reduction on Children Washington, D.C.: Center on Budget and Policy Priorities.