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# Introduction to the State Children's Health Insurance Program

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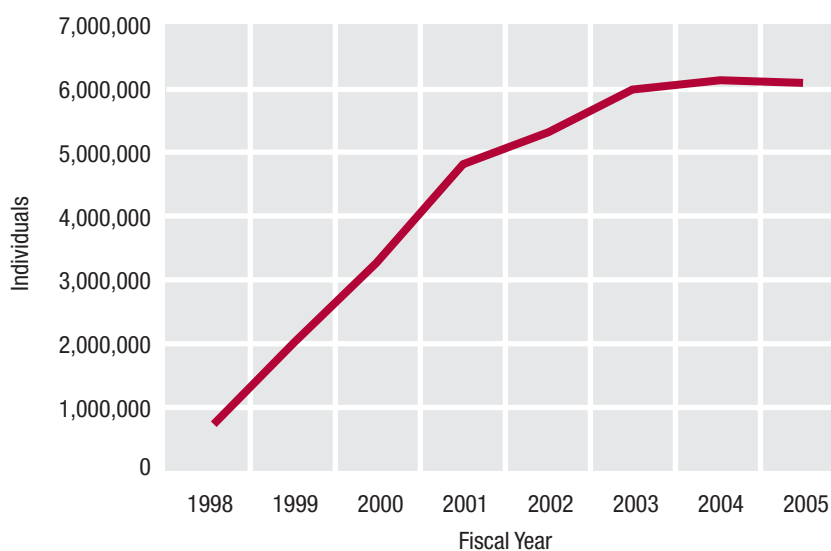
Number 2, March 2007

## Research Brief

SCHIP HAS HELPED TO REDUCE THE NUMBER OF UNINSURED CHILDREN IN THE U.S. AND AS OF FISCAL YEAR 2005, MORE THAN 6 MILLION CHILDREN HAVE BEEN ENROLLED IN THE PROGRAM.

The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 to provide health insurance coverage for uninsured, low-income children in families with incomes above Medicaid eligibility levels. Together, SCHIP and Medicaid have made a significant contribution to the decline in the percentage of uninsured children. From 1997 to 2005, the number of uninsured children has decreased by more than 2 million, reducing the proportion of uninsured children in America by 25 percent.<sup>1</sup> Today more than 6 million children have been enrolled in SCHIP as part of the largest expansion of health insurance coverage for children since Medicaid was implemented in the 1960s.<sup>2</sup>

### SCHIP Enrollment FY 1998–FY 2005<sup>3</sup>



All 50 states and the District of Columbia have implemented SCHIP. States had the option of using Medicaid, creating a separate program or using a combination of the two to expand coverage. During fiscal year (FY) 2005, 11 states used Medicaid expansions, 19 ran separate state programs, and 20 states used a combined approach.<sup>3</sup>

States also set the upper family income limit for eligibility. In July 2006, the income eligibility limits ranged from 140 percent of the federal poverty level (FPL) (North Dakota) to 350 percent FPL (New Jersey).<sup>4</sup> Twenty-five states and the District of Columbia set upper income eligibility limits at 200 percent FPL and another 13 states exceeded 200 percent FPL.<sup>4</sup> In addition, as of FY 2005, ten states covered adults, typically parents of Medicaid and SCHIP children (Arizona, Colorado, Idaho, Illinois, Michigan, Minnesota, New Jersey, Oregon, Rhode Island and Wisconsin).

## Benefits Provided by SCHIP

States using Medicaid to cover their SCHIP children must provide the same mandatory Medicaid benefits to SCHIP enrollees, as well as all optional services specified in their state Medicaid plans. For children in Medicaid, the benefits available through the Early and Periodic Screening, Diagnostic, and Treatment Program must be provided, which include well-child care, immunizations and medical care to treat illnesses and conditions.<sup>4</sup>

States that created separate programs had the option to choose: (1) a benchmark benefit package; (2) a benchmark equivalent package; (3) an existing state-based comprehensive coverage package; or (4) any benefits package that the Secretary of Health and Human Services approves. A benchmark benefit package includes: the standard Blue Cross/Blue Shield Standard Option Service Benefit Plan that is offered under the Federal Employees Health Benefit Plan, a health benefits plan that is offered to state employees or a benefits package that is offered by the health maintenance organization that has the largest, non-Medicaid enrollment in the state.<sup>5</sup>

## SCHIP Financing

Together, the federal and state governments finance SCHIP and states administer the program. Congress appropriated nearly \$40 billion for SCHIP for fiscal years 1998 to 2007, allocating between \$3.15 billion to \$5 billion per year to states to expand health insurance coverage to low-income children.<sup>5</sup> Because SCHIP is not an entitlement program like Medicaid, states can impose caps on the number of children they enroll, create waiting lists, cut eligibility, reduce benefits and stop enrollment. In one SCHIP evaluation of 13 states, three states had enforced caps on enrollment in 2003.<sup>6</sup> Specifically, Alabama capped enrollment in its SCHIP program and by March 2004, approximately 11,500 children were on the waiting list. Florida imposed a cap when 271,000 children enrolled in Healthy Kids and by January 2004, there were more than 100,000 children on the waiting list. Colorado imposed a cap when enrollment reached 53,000 children and the state did not keep a waiting list. In addition, several states made their enrollment procedures more difficult due to tight state budgets.<sup>6</sup>

To target the states with the greatest need for federal funds, Congress developed a funding formula that took into account two factors: the “child component,” which is the number of uninsured children below 200 percent FPL; and the state “health care cost factor,” which is used to control for cost differences among states in health care delivery.<sup>7</sup> State allotments for a fiscal year remain available for use by the state for three years. Any amount leftover after the three years becomes available for redistribution among states that have outspent their allotments.<sup>8</sup>

Medicaid matching rates range from 50 percent to 76 percent. SCHIP is also a federal matching program where states receive an “enhanced” federal match rate that ranges from 65 percent to 83 percent. The enhanced rate gives states an incentive to implement and enroll children in SCHIP.<sup>4</sup>

States with separate SCHIP programs are allowed to impose cost-sharing provisions, but costs cannot exceed 5 percent of a household’s total income in a year.<sup>6</sup> Preventive

services are exempt from cost-sharing.<sup>4</sup> Early in SCHIP, cost-sharing provisions were nominal (families spent approximately 1 percent of their income on premiums, enrollment fees, and copayments). Due to state budget crises, however, states are imposing increasingly larger fees. For example, Wisconsin raised its monthly premium from 3 percent of family income to 5 percent for families with incomes between 150 to 185 percent FPL. Alabama imposed new copayments and annual fees on children in families earning between 133 to 200 percent FPL. In Texas the \$15 per family annual fee was replaced with \$15 monthly premiums for families with incomes between 101 and 150 percent FPL, with larger premium increases for families with incomes above 150 percent FPL.<sup>6</sup>

### **Programming RWJF has Done to Support SCHIP Implementation**

In response to the creation of SCHIP, the Robert Wood Johnson Foundation began the *Covering Kids* initiative in 1997. The Foundation's goal was to enroll more eligible children in Medicaid and SCHIP through outreach, enrollment simplification, and health insurance coordination strategies. *Covering Kids* started with \$13 million in grants to 15 states, and eventually totaled \$47 million in grants to 50 states and the District of Columbia. A second program, *Covering Kids & Families* (CKF) was introduced in 2002 as a four-year, \$55 million expansion of *Covering Kids*. *Covering Kids & Families* worked to enroll eligible, uninsured children and adults in public programs.<sup>9</sup>

Since 2002, the Urban Institute, Health Management Associates and Mathematica Policy Research, Inc. have been conducting an evaluation assessing the impact of CKF in the areas of outreach, simplification and coordination, sustainability, access to care and economic barriers. In addition, the evaluators have undertaken several case studies of states that have overcome challenges in enrolling eligible children and lessons learned. The evaluation will continue until April 2008.<sup>10</sup>

### **The Future of SCHIP**

FY 2007 is the final year of SCHIP's ten-year authorization and SCHIP will have to be reauthorized in order to continue. SCHIP is a block grant with a fixed annual funding level that does not take into account increases in health care costs. As a result, the SCHIP funding that states receive is not keeping pace with the rising cost of health care. In addition, researchers at the State Health Access Data Assistance Center at the University of Minnesota found that due to the unstable funding formula, there was considerable variation in the proportion of SCHIP funds allocated to states over time. From 1999 to 2002, a state's share of SCHIP funding varied on average by 22 percent, making it very difficult for states to manage and administer SCHIP.<sup>7</sup>

While there were no state shortfalls in FY 2005, shortfalls totaling nearly \$100 million are projected in FY 2006 for four states.<sup>4</sup> For FY 2007, 18 states are projected to experience shortfalls totaling \$930 million.<sup>4</sup> Congress recently addressed the 2007 SCHIP shortfalls under H.R. 6164, in which no state would experience a shortfall before May 4, 2007. This is not a solution to the budget shortfalls, but this proposal gives Congress time to consider more comprehensive solutions through the SCHIP reauthorization process.<sup>11</sup> In order to cover the shortfalls, Congress will need to take legislative action and consider revising the funding formula to determine how the

allotments are distributed. Without additional funding, states facing shortfalls will have to increase their state funding or cut back their SCHIP programs by reducing eligibility, eliminating benefits or increasing cost-sharing. These changes could cause large numbers of low-income children to lose health care coverage.

- 1 U.S. Census Bureau (1997 data): <http://www.census.gov/hhes/www/hlthins/hlthin97/hlt97asc.html>; U.S. Census Bureau (2005 data): <http://www.census.gov/hhes/www/hlthins/hlthin05/hlt05asc.html>
- 2 Centers for Medicare and Medicaid Services: <http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/FY2005AnnualEnrollmentReport.pdf>, Centers for Medicare and Medicaid Services: <http://www.cms.hhs.gov/History/Downloads/CMSProgramKeyMilestones.pdf>
- 3 Centers for Medicare and Medicaid Services: <http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/FY2005AnnualEnrollmentReport.pdf>
- 4 Herz EJ and Peterson CL “State Children’s Health Insurance Program (SCHIP): A Brief Overview.” CRS Report for Congress, October 12, 2006.
- 5 Centers for Medicare and Medicaid Services: [http://www.cms.hhs.gov/MedicaidGenInfo/05\\_SCHIP%20Information.asp](http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp)
- 6 Hill I, Stockdale H and Courtot B. “Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis.” The Urban Institute Series A, No. A-65, June 2004.
- 7 Davern M, Blewett LA, Bershadsky B, et al. “State Variation in SCHIP Allocations: How Much Is There, What Are Its Sources, and Can It Be Reduced?” *Inquiry* 40: 184-197, Summer 2003.
- 8 Dubay L, Hill I and Kenney G. “Five Things Everyone Should Know about SCHIP.” The Urban Institute Series A, No. A-55, October 2002.
- 9 Ellis E, Gifford K and Longo J. “Covering Kids and Families Evaluation: Influence of Covering Kids and Families on Medicaid and SCHIP.” June 2005.
- 10 Robert Wood Johnson Foundation Web site: <http://www.rwjf.org/portfolios/features/featuredetail.jsp?featureID=1031&type=3&iaid=132&gsa=1>
- 11 First Focus: SCHIP Shortfall Reduction Package Summary (H.R. 6164): <http://www.firstfocus.net/InTheNews.aspx?id=4194>