



Forum Session Meeting Announcement

Friday, July 21, 2006

11:45am–12:15pm — Lunch
12:15–2:00pm — Discussion

The State Children's Health Insurance Program: Past, Present, and Future

A Discussion Featuring:

Jeanne M. Lambrew, PhD

Associate Professor

George Washington University

Jocelyn Guyer

Senior Program Director

Center for Children and Families

Georgetown University Health Policy Institute

Gayle Lees Sandlin

Director

ALL Kids Children's Health Insurance Program

Alabama Department of Public Health

With Comments from Key Congressional Staff

Location

Hyatt Regency on Capitol Hill

400 New Jersey Avenue, NW

Regency A

Registration Required

Space is limited. Please respond as soon as possible.

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The State Children's Health Insurance Program: Past, Present and Future

OVERVIEW

This Forum session will explore the history of the State Children's Health Insurance Program (SCHIP), including the policy and political context in which it was conceived. Speakers will offer federal and state perspectives of the program from the time of its inception as part of the bi-partisan Balanced Budget Act of 1997, its first years of implementation, attaining outreach and enrollment milestones, struggling through the state budget crises of the early 21st century, and looking to the future. Speakers will offer their insights into the program's achievements and challenges, with particular focus on the influence the much younger SCHIP has had on the more mature Medicaid program. Finally, the discussion will touch on some of the potential policy and financing issues that will likely emerge in the process of reauthorizing the program, the authority for which expires on September 30, 2007.

SESSION

During its relatively short existence, the State Children's Health Insurance Program (SCHIP) has served many important purposes: it has expanded access to health insurance coverage for children, helped underscore the importance of a consistent and comprehensive source of primary and preventive care, and improved the perception of publicly financed health programs. As reauthorization of this small but influential program approaches, federal policymakers have an opportunity to reflect on the history of SCHIP, consider its achievements and limitations, and think proactively about its future.

SCHIP was enacted as part of the Balanced Budget Act (BBA) of 1997 in a new Title XXI to the Social Security Act. The legislation authorized \$39 billion over 10 years in federal funding to states for the purpose of providing health insurance coverage to uninsured "targeted low-income children" (in general, those with incomes below 200 percent of the federal poverty level, which is \$33,200 for a family of three in 2006). The BBA authorized funding for the new SCHIP program through federal fiscal year 2007.

For a variety of reasons, the SCHIP program arrived at a time and under circumstances that made it ripe for success. The economy was doing exceedingly well, states and their governors were open to the idea of expanding health care coverage (especially for children), and there was a great deal of enthusiasm for the program. This confluence of events

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provided a unique opportunity for state, federal, and community cross-collaboration toward a common goal: extending health insurance coverage to as many of the estimated 11 million uninsured children in the nation as possible. Although many children remain uninsured today, SCHIP has been successful by all accounts and it has fulfilled expectations. It is estimated that the rate of uninsurance among low-income children decreased from nearly 23 percent in 1997 to 15 percent in 2003, despite a national economic downturn and an acute state fiscal crisis that resulted in many families losing access to employer-based health insurance coverage.¹

One key aspect of the SCHIP program that distinguishes it from Medicaid is that its program elements were designed to more closely reflect the characteristics of the commercial health insurance market. This was the result of the bi-partisan negotiations that took place as the legislation was developed. Some felt very strongly that states should not be limited to expanding coverage only through the traditional Medicaid program and should have an opportunity to design new and different coverage programs outside the parameters of Medicaid. As a result, SCHIP offers states the opportunity to receive “enhanced”² federal matching funds for expanding coverage to children either through Medicaid or through the creation of a completely separate SCHIP program.³ States that elect to create separate, or “stand-alone,” SCHIP programs, have several options in designing benefits packages and designating higher levels of cost sharing for higher income populations. The SCHIP legislation also included provisions intended to increase public-private partnerships through the development of premium assistance for the purchase of employer-sponsored insurance. Finally, SCHIP is distinctly different from Medicaid in that it is not an “entitlement.” Funding for the program is capped each year (see discussion of the financing structure, below), and states have the ability to more freely contract and expand the program based on fiscal circumstances.

SCHIP AND MEDICAID: BUILDING BLOCKS FOR COVERAGE

One of the peripheral influences of SCHIP has been its effect on both the internal workings and the external perception of the Medicaid program. The option of creating Medicaid-expansion SCHIP programs enabled states to bolster Medicaid coverage in significant ways and, in some cases, also allowed them to cover parents of children eligible for the SCHIP-funded coverage.

In addition, the outreach and enrollment efforts generated by the enthusiasm for SCHIP carried over to Medicaid in many states. States began to think about the Medicaid program in a new way, as a health coverage program rather than an income support program. The BBA included a provision that specifically severed what was previously an automatic—or categorical—tie to welfare that guaranteed health coverage

for individuals who were receiving Aid to Families with Dependent Children (AFDC) through Medicaid. This official “de-linking” from welfare was an initial step toward changing the public perception of the Medicaid program, but many other factors were in play as well.

Many community-based organizations were involved in state efforts to promote outreach and enrollment in health coverage programs, and these initiatives were translated to the national level with the advent of SCHIP. The legislation included a portion of funds to be dedicated to outreach, and philanthropic organizations like the Robert Wood Johnson Foundation bolstered the efforts by designating \$55 million over a four-year period to be provided in grants to states through the Covering Kids program.⁴ The grants financed media and marketing campaigns, as well as technical assistance to states to develop methods for simplifying and streamlining eligibility and enrollment processes that would make it easier for eligible children to be enrolled in Medicaid or SCHIP.

Upon reflection, it is these administrative simplification efforts that have made perhaps the most difference in families’ ability to access Medicaid and SCHIP. States redesigned program applications to make them less burdensome for families, only asking for information that was essential to determining SCHIP and/or Medicaid eligibility and removing nonessential verification requirements. Many applications have been reduced from 20 pages down to 3 or 4. In some cases, states even permit self-declaration of income (to be later confirmed by pay stubs or other documentation) to facilitate enrollment and access to care. In another popular strategy, states allow families to mail in the application, or even enroll by phone. Removing the old “face-to-face” interview process that required individuals to make a special trip to the welfare office—often having to take off from work or arrange for child care and to face significant waiting times and unfriendly receptions—was a major step toward removing the welfare stigma that permeated Medicaid in many states.

Once enrolled, many states stopped demanding that individuals go through eligibility redeterminations as frequently, most commonly moving to a 6- or 12-month renewal process. This change has dramatically improved program retention. And some states have utilized technological advances by allowing families to complete online applications and to complete pre-populated renewal forms that only require them to note changes in circumstances, sign, and return the form to the state in order to remain enrolled.

LOOKING TO THE FUTURE: REAUTHORIZATION APPROACHES

Over the past nine years, SCHIP has undeniably made a positive impact on children’s coverage. Although the overall number of low-income uninsured children in the nation has only declined by 30 percent since SCHIP was enacted, it is likely that if the program were not in existence, rates of

uninsurance among children would actually have increased. An Urban Institute analysis of Census Bureau data found that the overall number of uninsured grew in 2003 because of continuing declines in employer-sponsored insurance and changes in the distribution of income. However, for children, this decline in access to employer-sponsored coverage was more than offset by increases in enrollment in Medicaid and SCHIP, so the uninsured rate did not increase.⁵

As SCHIP reauthorization approaches, several policy and financing issues will likely be raised by states and the federal government in hopes of improving the effectiveness of the program. For example, many children are eligible for public programs but are still not enrolled; however, others do not qualify for SCHIP or Medicaid either because their family incomes are too high or because of other aspects of the program design. For example, the SCHIP statute explicitly excluded the children of state employees from eligibility for coverage. Many state employees' wages are below the eligibility thresholds for SCHIP, and therefore would otherwise qualify based on income.⁶ Another legislative issue that may emerge through the reauthorization process could facilitate the use of premium assistance in SCHIP. For example, the cost effectiveness test could be modified to be more like Medicaid and make it easier for more families to qualify for premium assistance.⁷

Another key issue for debate during reauthorization of SCHIP will be the program's financing structure. SCHIP funding is distributed to the states in the form of annual "allotments" that can be spent over a three-year period. At the end of three years, any remaining funds are redistributed to those states that have spent all of their individual allotments. States generally have one year to spend the redistributed funds. If any funds remain after the redistribution period expires, the statute requires those funds to be returned to the federal government. This statutory constraint has proven difficult for states, as there appeared to be too much money in the early years of the program and not enough funds as states' SCHIP programs have matured. A series of legislative fixes have provided temporary solutions, but the structural problem remains.

A second problem area with respect to SCHIP financing is the underlying data that are used to determine states' individual allotments. The current allocation formula considers each state's proportion of uninsured, low-income children, based on the estimates developed from the Current Population Survey (CPS). From the start, states have fundamentally objected to the use of the CPS as the primary data source, arguing that it overcounts the number of low-income and uninsured children. Critics have noted that the sample size is too small to provide accurate and stable estimates from year to year, and that the actual survey design does not include clearly worded questions about health insurance coverage. It is estimated that SCHIP allotments fluctuate, on average, by 22 percent per state each year, making it difficult to develop reliable budgets.⁸ For these and other reasons, some states either were not able to access their

full SCHIP allotments each year (due to the maintenance of effort requirement in the statute) or, conversely, have had costs that exceeded their annual federal allotments.⁹ The SCHIP allotment formula is an issue that will be revisited through the reauthorization process.

This Forum session will place SCHIP in the context of the policy and political climate of 1997 and provide an understanding of how the policy issues have played out over time. The discussion will offer one state's experience with implementing SCHIP and the role the program has played in expanding access to health coverage for children. In addition, research will be presented that will highlight the influence of SCHIP on the broader Medicaid program and consider the positive contributions that have been made in terms of re-characterizing Medicaid from a welfare program to a health coverage mechanism. Finally, speakers will consider the potential issues for reauthorization of the program that are likely to emerge over the next 12 months. Congressional staff will also be on hand to offer their insights into how the reauthorization process might unfold, depending in part on the outcome of the November 2006 elections.

KEY QUESTIONS

- What was the political and policy climate that existed during the debate around the Balanced Budget Act of 1997? How have the circumstances changed over the past decade that might influence how Congress approaches SCHIP reauthorization?
- Given that the BBA was a bi-partisan bill, what were the key compromises that resulted in the development of SCHIP?
- What factors were involved in designing the financing structure of the program? What is the "SCHIP Dip" and why was it created?
- What have been the states' experiences in implementing SCHIP? How are the options available under SCHIP different from Medicaid?
- From the state perspective, what have been the main successes of the program, and what key challenges remain?
- Have any of the recent modifications to the Current Population Survey alleviated and/or addressed the problems with the data that are used in determining SCHIP allotments?
- How has SCHIP positively influenced Medicaid? What lessons have SCHIP programs taken from Medicaid's long history in providing health care services to children?
- What will be the most important issues for consideration as the program approaches reauthorization in 2007?

SPEAKERS

Jeanne M. Lambrew, PhD, is an associate professor at George Washington University, where she teaches health policy analysis and conducts policy-relevant research. She will present the history and background of the development and implementation of SCHIP in the context of its inclusion in the Balanced Budget Act of 1997. Dr. Lambrew worked on health policy issues at the White House from 1997 through 2001, and she was the lead on drafting and implementing SCHIP legislation. In that role, she initially served as the senior health analyst at the National Economic Council and later became the program associate director for health at the Office of Management and Budget.

Jocelyn Guyer is a senior program director at the Georgetown Health Policy Institute's Center for Children and Families (CCF), where she conducts analyses of emerging issues relating to Medicaid, SCHIP, and the uninsured, including proposals to restructure the Medicaid program. She also examines family coverage issues and cost-sharing policies in Medicaid and SCHIP. Ms. Guyer will offer a preview to the results of a CCF analysis of the interaction between SCHIP and Medicaid and the progress of the two programs in advancing access to health insurance coverage for low-income children and families.

Gayle Lees Sandlin will share her experiences as a SCHIP director who has led the development, implementation, and ongoing operation of the Alabama Children's Health Insurance Program, known as ALL Kids, since the program was created in 1998. Alabama was the first state to receive federal approval of its program and has continued its commitment to children's coverage despite budget pressures over the years. Ms. Sandlin will also offer her perspectives on the key issues for states as SCHIP reauthorization approaches.

ENDNOTES

1. John Holahan and Arunabh Ghosh, "The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003," The Urban Institute, September 2004; available at www.urban.org/UploadedPDF/411089_HealthInsCoverage.pdf. See also Cindy Mann, Jocelyn Guyer, and Joan Alker, "A Success Story: Closing the Insurance Gap for America's Children Through Medicaid and SCHIP," Georgetown University Health Policy Institute, Center for Children and Families, Issue Brief, July 2005; available at <http://ccf.georgetown.edu/pdfs/success.pdf>.

2. The SCHIP statute offers states an enhanced federal matching rate for expanding coverage through the program. Like Medicaid, this enhanced matching percentage is based on each state's per capita income and is outlined in the statute. The SCHIP enhanced matching rate is generally 15 percentage points higher than the standard Medicaid matching rate. The percentages range from 65 percent in the wealthier states to 87 percent in the poorest state.

3. States also have the option to use a combination of both approaches. To date, 12 states are operating Medicaid-expansion programs exclusively, 18 states have developed separate SCHIP programs, and 21 states are using the combination approach. Many states started

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out with Medicaid expansion programs and, as they gained more experience, decided to add a separate SCHIP program that built on Medicaid.

4. The Robert Wood Johnson Foundation has provided a total of \$150 million in grants to states since 1997 through the program now known as Covering Kids and Families. For more information see <http://coveringkidsandfamilies.org/about/>.

5. Holahan and Ghosh, "The Economic Downturn."

6. For more information on SCHIP reauthorization issues, see David Bergman, "Perspectives on Reauthorization: SCHIP Directors Weigh In," National Academy for State Health Policy, June 2005; available at www.nashp.org/Files/CHIP25_final.pdf.

7. For more information about premium assistance in SCHIP and Medicaid, see Cynthia Shirk and Jennifer Ryan, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum, Issue Brief, forthcoming July 2006.

8. Bergman, "Perspectives on Reauthorization," 6.

9. Some states had enacted previous Medicaid expansions that inadvertently disqualified them from being able to receive enhanced matching funds through SCHIP. For example, because Minnesota had already expanded Medicaid through a section 1115 demonstration program, the state could only qualify to receive enhanced matching funds for expanding children's coverage beyond the existing Medicaid eligibility level of 275 percent of the federal poverty level (FPL). Consequently, the Minnesota state legislature only approved a SCHIP expansion up to 280 percent of the FPL. This issue was addressed in the Deficit Reduction Act of 2005, which provided a specific technical fix for the ten states that were most affected by the maintenance of effort requirement.



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