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CHIP AT 10: A DECADE OF COVERING CHILDREN

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BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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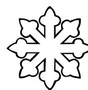

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CHIP AT 10: A DECADE OF COVERING CHILDREN

TUESDAY, JULY 25, 2006

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:37 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch, (chairman of the subcommittee) presiding.

Present: Senators Snowe, Rockefeller, Bingaman, Lincoln, and Wyden.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE

Senator HATCH. The Chairman will call this hearing to order.

We are happy to invite all of you, and happy to have you all here.

It is no coincidence that the inaugural hearing of the Subcommittee on Health Care is on the Children's Health Insurance, or CHIP, Program.

Next year, Congress will focus on how to reauthorize and finance the CHIP program. Therefore, our Ranking Minority Member Senator Rockefeller and I believe it is important for today's hearing to set the ground for that process by examining the history of the CHIP program and the successes that it has had over the past decade.

The Balanced Budget Act of 1997 (BBA 1997) created CHIP as title 21 of the Social Security Act. Today, all 50 States, the District of Columbia, and five territories have CHIP programs.

As is allowed by the law, 17 States use Medicaid expansions, 18 States use separate State programs, and 21 States use a combination approach of both their Medicaid program and the State program.

The CHIP program is financed through both the Federal and State Governments; it is overseen by the States. States receive an enhanced Federal match for the CHIP program. This Federal match is significantly higher than the Federal match that States receive through the Medicaid program.

The Medicaid Federal Medical Assistance Percentage, known as the FMAP, ranges between 50 and 76 percent in fiscal year 2006. The CHIP FMAP ranges from 65 percent to 83.2 percent.

Through BBA 1997, approximately $40 billion in Federal funding was appropriated for the CHIP program. Collectively, States have

spent $10.1 billion since it was first implemented through September 30, 2005.

I am extremely happy to report that 6.2 million children have their health insurance coverage through the CHIP program. As one of the original authors of the CHIP program, with my friend, Senator Kennedy, who is here to testify today, Senator Rockefeller, and the late Senator Chafee, we are all very pleased with the program's successes. We know it is an important program, and everybody who participates in it knows it.

When we drafted this legislation in 1997, our goal was to cover the several million children who had no insurance coverage. We have gone a long way in meeting that goal, but we are clearly not there yet. Coverage of these uninsured children should still be our top priority.

I know some may disagree with me, but in my opinion we should not consider expanding this program to other populations until we have covered all needy children who do not have health care coverage.

This fall, the Health Care Subcommittee will hold a second hearing to examine the more difficult issues facing Congress as it reauthorizes the CHIP program. These issues include the future financing of the program, who should be covered, and how to provide effective outreach to eligible children who are not currently covered.

The purpose of today's hearing is to focus on the successes of this very important program. Senator Rockefeller, I, and others on this committee appreciate the hard work that our staffs have put into today's hearing, and those who are testifying have put into today's hearing, and we look forward to working with all of the folks involved and the other Senators who have an interest in this issue.

Now, testifying before the subcommittee today is Senator Ted Kennedy, whose vision and drive were integral to the development of the CHIP program. Senator Kennedy was co-author with me of the Child bill, which, when melded with the Chafee-Rockefeller bill expanding Medicaid coverage for children, became CHIP.

On the second panel, we will hear from the Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan. He is accompanied by Dennis Smith, a Finance Committee alumnus who is now the Director of Medicaid and State Operations for CMS.

The last panel is made up of Ms. Evelyne Baumrucker and Mr. Chris Peterson, both of whom are Congressional Research Service specialists on the CHIP program. Ms. Baumrucker will provide a broad overview of the program, while Mr. Peterson will focus on the financing of the CHIP program.

I want to thank all of our witnesses for taking time out of their busy schedules to testify before the subcommittee today.

Senator Rockefeller is here, so we are going to take his statement at this time. He has to get seated first, though. He is the only one that has an ergonomic chair here, and I have just decided I want one of those, too. That really is a nice chair.

We are ready for you.

Senator KENNEDY. Let me get organized. I have some very nice things to say about you.

Senator HATCH. Oh, my goodness. Let us make sure you have time to organize then. [Laughter.] Shall we start with Senator Kennedy then?

Senator KENNEDY. I have to get over to that pension conference to look after Kohl. Do you want me to give an opening statement?

Senator ROCKEFELLER. Do you have a chair like this?

Senator KENNEDY. No. [Laughter.] Only the Rockefellers have that.

Senator ROCKEFELLER. You cannot afford it? [Laughter.]

Senator HATCH. All right. Would you care to make your statement at this time, Jay?

Senator ROCKEFELLER. No. I am going to defer to Senator Kennedy.

Senator HATCH. Then we will turn to Senator Kennedy. I just want to personally thank Senator Kennedy for his leadership on this program and for the privilege of working with him on it, and on so many other programs that we have worked together on. We are very honored to have you here, and we will look forward to taking whatever you want to say at this time.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM MASSACHUSETTS

Senator KENNEDY. Well, thank you very much, Chairman Hatch, and my good friend as well, Jay Rockefeller, and my other colleagues and friends on the Finance Committee. I will not take a long time.

But there are few pieces of legislation which my heart and soul is in as much as this particular legislation, and I want to thank you at the outset, Chairman Hatch, for your enormously skilled and courageous determination in achieving this legislation. Senator Hatch, as I think the members of this committee know, was the chairman of our Health and Human Resources Committee prior to the time he was chairman of the Judiciary Committee. It was during the time that he was the chairman of the Health and Human Resources Committee that I really—and all of us did—detected his very strong commitment in terms of children and their needs, and how best to address them.

So at the time a number of us were working, and working closely, to try to achieve a comprehensive approach to extend health care coverage to children, it was only natural that Senator Hatch would be in the leadership.

As we remember, during those negotiations he had a very basic and fundamental view that was different from mine. I thought we could expand what had been very successful, and that is the Medicaid program, and just extend it up the ladder in terms of eligibility.

Senator Hatch said, no, he wanted much greater involvement in the States, to let States make judgments and determinations, and that we ought to have a framework where the States could select the range of different services and the types of coverage for children, but that this ought to be a State function. We really worked during that period of time to effectively work out a grand compromise.

It would not have been the way that I would have drafted it, not the way Senator Hatch would have drafted it, but I think what we have seen over this period of time is that it has worked in all of our States, and worked very effectively.

Just very briefly, Mr. Chairman. I think the success from a health point of view is stated in my full statement. I think the Academy of Pediatrics says it so well: "Enrollment in the SCHIP is associated with improved access, continuity, and quality of care, and a reduction of racial/ethnic disparities. As pediatricians, we see what happens when children do not receive the necessary health care services, such as immunizations and well-child visits. Their overall health suffers and expensive emergency room visits increase." This is just an overwhelming, compelling endorsement in terms of the SCHIP program.

We also include in the statement the range of different organizations to really represent the best in terms of children's interests that are strongly in favor of the extension and the renewal of the SCHIP program.

If I could, Mr. Chairman, just take a moment or two in reviewing for the committee basically what we have in terms of all of the children. This is from the Center for Children and Families at Georgetown. Here we have 53 percent of all uninsured children who are eligible under Medicaid, or 4.4 million children, who do not receive Medicaid.

Now, 22 percent of uninsured children would be CHIP eligible, and you have 1.8 million of those children who, even though they are eligible, do not receive the coverage, and then 25 percent, 2.1 million children, who are not eligible in terms of income.

What this chart says very compellingly, Mr. Chairman, is that we have to have much greater outreach, much greater information. We have millions of children who are eligible for these programs but who are not taking advantage of them, and there is a much more aggressive program that could be out there.

I would be glad to work with your committee. We have ideas about using schools and other ways of trying to get just a reduction in the number of uninsured children. For those who are eligible today, this really is a very sad situation, one that we ought to consider.

Mr. Chairman, look at what has happened in terms of the health care coverage for children since we passed SCHIP. In 1997, 22 percent of children were uninsured. Look where we are now. We have basically reduced this to half, down to 13.5 percent.

Look at that dramatic line down since SCHIP has been in effect. We have made dramatic progress in terms of reaching all children. We still have, obviously, a ways to go. That is certainly my hope, my ideal.

But this is a remarkable success story in terms of coverage. We still have a ways to go, as the other chart demonstrated. We can get there. I think there are ways of doing it. Obviously, it is through information, it is going to be through resources.

But I dare say, Mr. Chairman, if we had another chart that shows what had happened to the general population in terms of the number of uninsured, you would see a similar line going up. We

have had 6 million Americans who have lost their health insurance over this period of time. So it is even more dramatic.

As we have seen a significant reduction in the total number of Americans who are insured, we have seen a dramatic reduction in the total number of children who are uninsured. That is, I think, a very important achievement. So we are making good progress. That quality, as I mentioned before, has been supported and has been acclaimed and been very important.

This is the real troublesome aspect, Mr. Chairman. The red line would be current services, and the blue line is the funding at the baseline services. You see that that shortfall, as we go out to 2012, is $12 billion.

We see that that is significant. Even to keep the current services that we are providing at this time, without the expansion, we are going to need that level of funding over a period of time.

I think that is best summed up by these two charts, Mr. Chairman. Look at the two charts together. This shows you what we have seen with the growth. After passage in 1997, we have seen growth from 1998, and 1999, to 2004, and the 4 million that are covered.

This chart shows you the millions of children who will lose coverage with the baseline CHIP funding. That shows you, under 2012, what the other chart showed you—basically 1.5 million children without current services. That is without any kind of an expansion.

Finally, Mr. Chairman, this chart here will show you, in the out years, going to 2012, the 36 States that will run out of CHIP funding in 2012. We have other charts here to show you the increasing number of States. This is by 2012, but there is an increasing number of States that are losing it. So it is really a question of resources, availability, and accessibility.

This is a program, Mr. Chairman, that is marked by success by all of the evaluations. You will remember, we had different amendments on the floor of the Senate to try to require eyeglasses, and we were unable to get that.

We had additional kinds of requirements to try to put in dental care, and we were unsuccessful. But what we have seen is that a number of the States, like my own State of Massachusetts, have included dental care and eyeglasses; other States have made judgments in expanded programs.

What we can say is that this has been enormously successful. It is a quality health care program. It is reaching the most vulnerable. It is reflected not only in giving the children a healthy start, it is helping children to read the blackboard so that they can learn better, it is making sure that they are healthier when they go to school so that they are going to have better attendance and they are going to have better results in terms of their own academic achievements and accomplishments.

Basically, this is to ensure that the youngest in our society are going to have the kind of healthy start that we all want for our children, and should be available to all America's children.

We will give to the committee some suggestions and ideas about how to deal with the financial gap later on, and we would also like to submit some suggestions and ideas about how to gain informa-

tion to get out to the respective States to illustrate some of those programs that have been the most creative and been most elaborative.

We have McDonald's, which has used its little paper plates with SCHIP. We have had a number of organizations in the private sector that have different examples of how they have done it with extraordinary success.

We have, still, a ways to go in that area, but the States are increasingly under pressure, so there is less reliance in terms of trying to expand the program. Unfortunately, there is increasing pressure to try to restrict it.

We hope, Mr. Chairman, that we can work closely with the committee to see that this program is maintained. Hopefully, we will find ways that it can be expanded, but certainly maintained, to reach children in our country.

Primarily, these are the children of workers. We know that it goes up to, depending on the States, with a family of three, $31,000, $32,000, $33,000. We are getting to individuals who are working, working hard, and just cannot afford those kind of premiums and are increasingly vulnerable in not having that coverage.

So we thank you very much, Mr. Chairman, and the committee for giving attention to this issue, and hopefully we will have an extension of the program.

Senator HATCH. Well, thank you, Senator Kennedy. We appreciate you taking time out of what we know is a really busy schedule to come and help us to understand your point of view. We appreciate it very much. We appreciate your leadership on this as well.

Senator KENNEDY. Thank you very much.

[The prepared statement of Senator Kennedy appears in the appendix.]

Senator HATCH. I think we're happy to let you go so that you can keep that busy schedule.

Senator KENNEDY. Thank you.

Senator HATCH. Take care. Thanks for taking time to be with us. We appreciate it.

Senator Rockefeller, we will turn to you.

Senator ROCKEFELLER. Well, first of all, before he leaves—well, he is leaving. I went back last night and I read through the whole Senate debate that we had back in 1997, and it is extraordinary, what strikes me.

Obviously, you were talking a lot, and John Chafee was talking a lot, Senator Hatch was talking a lot, I was talking a lot. A lot of people were talking a lot, and it was all focused on exactly what you were talking about. In fact, some of the words were the same, that there had been improvements, but we have so many kids to go.

There was this sense that the budget really matters, but when it comes, somehow, to children and health care, and then you referred to dental and vision and the problems that we are running into now with the Medicaid waiver and EPSDT, all of that, I mean, everything was discussed and there was passion, and it was bipartisan, and it was beautiful.

Anyway, when you leave I am going to say some very nice things about Senator Hatch. I had not planned on including you. [Laughter.]

Senator KENNEDY. All right. I will just have to live with it, Mr. Chairman. [Laughter.] Thank you.

Senator HATCH. Now that he has his chair, I think he is more livable, I will put it that way. [Laughter.]

Senator ROCKEFELLER. Am I on?

Senator HATCH. You are up.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. I really mean that. I would just say to Jeff and Ron and to Blanche, that it was an extraordinary debate. John Chafee and I came out very much against the idea. We were very much not for the idea of having it done individually by States.

We thought it should be done through the Medicaid program. You want to talk about getting information out there to people? Well, that is what Medicaid does. But the governors were absolutely adamant on that. The result was, it took quite a long time.

In West Virginia, it took 3 years for us to get started, because a governor would appoint a commission, then somebody else, then somebody would get fired and you would have to start all over again.

It took 3 years, really, before we got going. But we now have 92 percent covered. That is not something to relax on. We have to get to 97 percent because the rest are, statistically, a problem. But one of the things that I really want people to understand is that Senator Hatch was huge in that whole thing.

I remember, and only you and I in this room know—well, potentially in this room—and remember a table in the middle here.

Senator HATCH. That is right.

Senator ROCKEFELLER. And we were not making a lot of progress, and it was past 10 or 11 or something at night, so we decided that 20 of us, or whatever, were going to talk alone.

Senator Hatch got up—and I think it was midnight, because that is what my notes say. He stood up. There was no need for him to stand up; we were just sitting around one table. But he was lifted out of his chair to speak, to fight for $8 billion more, the necessity of the program.

I can remember Al D'Amato, who did not do a lot of talking about children, Frank Murkowski, and so many people were just talking. The bipartisanship was redolent. It passed. It passed. The Health Committee, the Finance Committee did not agree on everything. We worked it out and it passed.

I will read the following: "Mr. President, I thank both my Ranking Leader," et cetera, et cetera. I said, "My good friend Senator Kennedy from Massachusetts, having witnessed this process, Senator Hatch fought like a tiger, would not yield in very close quarters in order to get the additional $8 billion added on for children's health insurance, along with Senator Chafee and others."

Senator Moynihan said, on the floor of the Senate, "This is one of the finest moments of the 105th Congress. It could not have come about without the courage and the conviction of the Senator

from Utah. I would like to affirm everything he has said about support on both sides of the aisle. It would be nice to have a unanimous vote."

Orrin Hatch was just critical in all of that, and that needs to be said. Which then needs to be said that we cannot back up on this. We have a terrible budget crisis in the country, and I understand that. There are all kinds of things that maybe we cannot do, but we cannot not do what we need to do on this, which is to extend it and to make it possible for States.

West Virginia has been very interesting in this. We are not one of the States that was on his chart. We are not in need, financially. So our governor has taken it from 200 percent of poverty—150 percent of poverty where it started out, to 200—and now to 300.

But then he has had to rescind it because he is not sure if the Federal Government will pay the money back, which is a huge problem in all of this. A huge problem. Will the Federal Government make those States which are trying to do the right thing whole? So, 6 million kids. That is extraordinary.

It should be more, as the chart showed and as we all know. We did provide the States the flexibility. Many of them are using that very, very well. States should be allowed to continue their ability to expand benefits. I now feel that way strongly, as long as they have adequate funds to match the Federal contribution.

So, this was one of the best things that has ever happened in the Senate in the 21 years that I have been here, partly because of the way it was done, the lack of acrimony, the coming together. The Finance Committee and the Health, Education, and Labor Committee had a different way of doing it than we did, so it ended up making no difference whatsoever. We got it done. Children have health insurance. But a lot more have yet to get it, and that is our mission. Thank you.

Senator HATCH. Well, thank you, Senator Rockefeller. I remember it was really an interesting time, because the Democrats wanted CHIP, and so did the Republicans on the committee, except for two. And the Republicans wanted the Balanced Budget Act. This was the glue that brought the first balanced budget together in over 40 years.

I can remember standing at the dais when the bill came up for passage, and one of the leading Republicans came up to me and he said, "I hate this bill." Then he voted "aye." I was just tickled to death at that. I thought that was just wonderful.

Today, almost everybody claims it is their bill, and they should because it has been a very workable and good bill. I appreciate your awfully kind remarks, and Senator Kennedy's as well. It means a lot to me, coming from you.

Well, we are very privileged to have the Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan. Later, he will be joined by Dennis Smith, a former Finance Committee alumnus who is now the Director of Medicaid and State Operations for CMS.

I have really been pleased with your service out there. It is an almost impossible job, and you work really hard at it. So it is always a pleasure to see you, and we really look forward to hearing your testimony.

STATEMENT OF HON. MARK McCLELLAN, M.D., PhD, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC; ACCOMPANIED BY DENNIS SMITH, DIRECTOR OF MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Dr. MCCLELLAN. Thank you, Mr. Chairman and Senator Rockefeller, and all the distinguished members of the subcommittee. I very much appreciate the opportunity to discuss the successes and the importance of continuing the States' Children's Health Insurance Program.

I would like to give particular thanks to Chairman Hatch, to Senator Rockefeller, and to Senator Kennedy who just left us, for their leadership, as we have just been talking about, in establishing this very important program.

Next year marks the tenth anniversary of SCHIP. It is a program that has exceeded expectations in providing effective, innovative, and up-to-date coverage. Enrollment of children exceeds the original expectation that this program would cover 5 million children. There are now more than 6.1 million children, more than 6.7 million people overall, with coverage in fiscal year 2005.

The administration remains committed to building on their success by working with the States and all of you in the Congress to continue to serve children and families through SCHIP as effectively as possible.

SCHIP has succeeded because of its design. As we have just discussed, it was designed to give States the flexibility to find the best way to provide coverage within very broad and reasonable Federal guidelines. SCHIP gives States the ability to adjust the program's coverage to reflect the particular needs and economic circumstances of the populations serviced.

It gives States the ability to use new and creative approaches to provide affordable, mainstream health insurance coverage for children and families effectively.

For example, instead of setting up costly new benefit programs, some States have used SCHIP to help families pay for employer-provided coverage, with employers and the beneficiaries contributing to help keep costs down.

I want to highlight some specific areas where we want to work with you to build on these notable successes. First, we want to strengthen our efforts to identify and enroll the many eligible, but unenrolled, children.

While the coverage successes have been notable, there are still about 5.5 million children with family incomes below 200 percent of poverty who are not enrolled. As Senator Kennedy highlighted, over three-fourths of all unenrolled children in this country are eligible now for Medicaid and SCHIP, but are not enrolled.

The President proposed his Cover the Kids initiative to change that and build on the successful outreach models we have seen so far. This initiative would provide $1 billion in grants to States, tribes, schools, and faith-based and community organizations to increase enrollment in SCHIP and Medicaid.

Second, as the Finance Committee works to reauthorize SCHIP, the administration wants to work together to address the multi-

billion dollar imbalance in funding that results in some States having shortfalls while others have surpluses beyond their needs.

Since fiscal year 2002, spending of SCHIP funds in some States has exceeded their annual allotment of Federal funds. Shortfalls of Federal SCHIP funds have been avoided, in practice, by using left-over prior year balances and by redistributing funds from States with unspent funds to those that are facing the shortfalls.

At the end of fiscal year 2006, this fiscal year, we are projecting a total of $4.1 billion in existing unexpended allotments, and these amounts will be available for expenditure in fiscal year 2007 and beyond.

In addition, the $5 billion 2007 allotment will become available for fiscal year 2007 as well, so that makes a total of $9.1 billion available nationally to States in fiscal year 2007. The State projected expenditures in fiscal year 2007 are about $6.4 billion, far less than the total allotment of funds available to address their needs.

However, even though the available SCHIP funds will total more than $9 billion, the shortfall for certain States in 2007, if there is no reallotment, will still be about $906 million.

That is because most of the $4.1 billion in unexpended funds, carried over from this year and previous years, is unavailable for use in fiscal year 2007 by the States that may need it.

The only funds available for reallotment under current law are about $105 million in unexpended fiscal year 2004 allotments which remain at the end of fiscal year 2006.

As we work to reauthorize the SCHIP program, we also want to work with you to address this issue, so that SCHIP allotments are distributed in a manner that meets State needs more effectively.

We have an effective track record of assuring that available SCHIP funds are used when needed for coverage to prevent any consequences from shortfalls in specific States caused by the statutory allocation formula, combined with differences in how States have used the program.

Third, CMS is taking new steps to increase the quality of care in SCHIP programs and to ensure that SCHIP supports enhancing the overall quality and affordability of our health care system.

CMS, my agency, is working with the States to develop long-term performance measures for SCHIP. We are also collaborating with States to improve how performance measurement data is collected.

So, I am very pleased, again, by the opportunity to take stock of the SCHIP's successes and begin the process of working with you to reauthorize this landmark health care legislation. I would be happy to answer any questions you have.

As you mentioned, Mr. Chairman, Dennis Smith, our Director of the Center for Medicaid and State Operations, is here with me to help with any particular technical issues or further questions you may have.

[The prepared statement of Dr. McClellan appears in the appendix.]

Senator HATCH. Well, thank you. And at the request of Senator Rockefeller and myself, we would like to invite Dennis Smith to sit with you at the table in case any Senators would care to ask any technical questions. So, that would be good.

Dr. McClellan, I certainly appreciate your testimony, and taking time to testify before the committee today. Of course, the purpose of this hearing is to promote the successes of the CHIP program.

Many States are experiencing shortfalls, as you have mentioned, in their CHIP allotments, and the problem is growing, so we need to put more money into the CHIP program to solve this problem. Do we need to do that, or is the issue really how the money is allocated under current law? I would like to know that.

Also, is it not true that States that cap their CHIP enrollments are not included in the list of shortfall States? Why is this? Are States required to notify CMS when they take that type of action?

Dr. MCCLELLAN. Let me answer both in turn. First of all, as I mentioned in my opening statement, there are billions of dollars of funds in allocations that have not yet been used and are not projected to be used in the next year, the year after that, or the next several years of the program, so there are some real opportunities to keep meeting State shortfall needs with available funds that have not been used in all the States.

In 2007, I mentioned that there were about $9.1 billion that we are projecting to be available to meet a total of $6.4 billion in expected program funding, so that is billions of dollars in excess if we can keep taking steps like we have in the past to make sure that the allocations go where they are needed.

Now, you are right that some States have imposed limitations on enrollment. What we have seen more of in recent years, in recent months, is States not necessarily restricting the number of children who can participate in the program, but, rather, limiting sometimes the manner in which they participate.

For example, certain States have had problems with what is called adverse selection in the program, where people might buy into it just for 1 month when they or their children need particular medical services, drop it, then get back in again a few months later.

So some States—and I think Utah is a good example of this—have gone to more limited open enrollment periods, with the expectations that people can, and should, participate in the program for the whole coming year until the next enrollment period so that you avoid that kind of selection problem.

That promotes more continuity in health insurance coverage. While it is a restriction on when people can enroll in the program, it is not so much a cap on the number of children that can be served.

Again, because of the things that we have been able to do together with reallocating unspent funds, we have been able to make sure that all States are able to get the Federal funding they need to support their coverage.

Senator HATCH. Do you have a list of the States that cap CHIP enrollment, and would you provide that for us?

Dr. MCCLELLAN. We would be delighted to do that. For 2006, there are four States that would be projected to have a shortfall, but that is being addressed, as you know, with measures taken in the Deficit Reduction Act and the use of some of the expiring 3-year-old allotments from 2003.

Senator HATCH. Well, thank you.

I have a difficult question. I am deeply concerned about the fact that many children who are eligible for CHIP or Medicaid are not covered. Personally, I believe covering those children should be our number-one priority before we start covering others under the CHIP program.

So, Dr. McClellan, could you explain the administration's position on this issue? I know that the administration has granted waivers to some of the States in order to give them flexibility as far as providing health coverage to their residents.

I certainly understand that logic. However, when we have so many eligible children out there who are not covered, that also causes me a lot of concern. So, how many uninsured children are out there today and how many are eligible for CHIP and Medicaid, and what are we going to do about these problems?

Dr. MCCLELLAN. I think that is the number-one priority. I agree with you fully about that. Among the children who are still uninsured, the majority, 5.5 million of the 8 million or so children, are in families with incomes under 200 percent of poverty who are eligible for Medicaid or SCHIP in every case; many others at even higher income levels also are eligible for Medicaid or SCHIP in their State.

So the vast majority of children who do not have coverage today are eligible for our existing programs, particularly SCHIP, and that highlights the importance of effective outreach and education strategies. Now, I started working on this issue soon after you all had enabled legislation to get enacted.

When I was here working in the previous administration, I was at the Department of Treasury, and we set up a program there through local Tax Assistance Offices to provide help to lower-income families in finding out about the program when they came in for help with their taxes.

Since that time, we have seen example after example—Senator Kennedy mentioned this too—of creative approaches by State and local governments, by the private sector, by volunteer organizations to help with outreach. We need to do more to support those efforts.

There are, clearly, approaches that are effective. That is why the President has proposed in his budget fully $1 billion to promote outreach and education efforts in order to help people get enrolled. That absolutely should be our top priority.

Senator HATCH. Well, thank you. I have 2 minutes left, but I notice they did not start the clock on time.

I am going to turn to Senator Rockefeller.

Senator ROCKEFELLER. Dr. McClellan, let me just pick up on that. This is not what I was going to ask you. But explain to me why West Virginia is in the situation that it is. In other words, it is a State that has lots of money left over, and they want to go from 200 to 300 percent of poverty. People say that is outrageous, but when you do the numbers, it really is not. Anyway, an uncovered kid is an uncovered kid.

But they actually withdrew that. The legislature passed it, then pulled back from the 300 because they were afraid that the Federal Government would not reimburse.

Now, they are ready with their share and with a much more generous inclusion that would get us more toward 97 percent, Med-

icaid, CHIP, regular insurance, but they are afraid—our governor is very much in touch with Secretary Leavitt all the time—that the Federal Government is not going to reimburse their money. Is their fear in any way justified?

Dr. MCCLELLAN. Well, we have been in frequent contact with Governor Manchin and with other officials in the State. As I mentioned in my earlier statements, there is currently an excess of total funding for this program. Even if States like West Virginia did expansions to 300 percent of poverty, we have more than enough funds for the foreseeable future to pay for that.

I think it would help give the States more certainty if we could work together, as we often have in the past, on making sure the States know that if they are going to need additional funds, that they can draw down much of the unallocated funds that are available.

Senator ROCKEFELLER. But he may be worried, as I am, that the first call on that money will go to the States that do not have the money right now, that do not have an excess and cannot meet, let us say, 200 percent of poverty, much less 300 percent. Is he justified?

Dr. MCCLELLAN. We are looking, Senator, next year, even in 2007, at an excess, between the total funds potentially available and the spending projected for the program, of close to $3 billion.

Now, there are a lot of lower-income families and children in West Virginia without health insurance coverage now, but the kind of cost that West Virginia is projecting for their program is far less than the total allocation available to this program.

I think what we could do in the relatively short run to help provide your governor with more certainty is support the kinds of reallocation approaches that we have done in the past to make sure that no State faces a shortfall, with all the excess funding that is currently available.

Looking ahead to the longer term, this is why reauthorization of the program is so important. That is why the administration wants to work with you, Senator Hatch, and the Congress to make sure that this program continues effectively.

Senator ROCKEFELLER. One more question. The cost of health care has gone up, God knows what, in the last 10 years, which has, of course, its effect on coverage. What covered people then could not cover people now. Let us forget about dental, vision, EPSDT, and all the rest of it. Just, the cost has gone up. How much is that affected?

Dr. MCCLELLAN. How much has that affected the program? Well, some of that projection was expected when you authorized the program initially close to a decade ago. That is why the allotments grew over time, and we're now serving more people than had ever projected to be enrolled in SCHIP, and we are doing it within the current overall funding that the program received, that $40 billion in funding back in 1997.

The reason that we are doing that, I think, is SCHIP has been a pretty cost-effective way of delivering coverage. The average benefits, Senator, in the SCHIP program nationally cost only around $1,100 per person, and that is for several reasons.

Number one, the States had flexibility in designing the benefits to meet the needs of their population. Number two, the States had flexibility in finding ways to combine SCHIP support with other sources of financial support.

So, for example, many States have implemented programs that help people afford private health insurance through their job so that the employer can contribute as well.

Senator ROCKEFELLER. Can I slip in one more question? Do you think that Senator Chafee and I were wrong? And we were just beaten back by the governors. We, unfortunately, invited the governors to come in, and they did, and so we were beaten.

Again, my theory always was that they are out there already. People know about them. They are in every community. They are available. You do not have to worry about school lunches and all kinds of things like that to inform kids or their parents. But it has worked very well.

I am just curious as to whether you think that Senator Chafee and I were wrong about that. Could it have started earlier? Would it have made any difference—it is 10 years later—if we got 6.2, or whatever? Maybe that was sufficient. Maybe it is academic at this point.

Dr. MCCLELLAN. It is certainly not academic. This is very important to the lives of children in this country. But I am very glad you invited the governors in, and I hope you will invite them back for the reauthorization next time around.

I think what they will tell you—again, what they told you before—is that giving them opportunities to design this program in a way that is going to work best and most cost effectively in the State is going to help get more children covered.

Now, it may have taken a little bit more time as a result for some of these programs to get going, but we had the program established in every State within just a couple of years of enactment.

At this point, participation is good. We need to do more on getting eligible people enrolled. I think the governors can have some useful input on that process as well.

Senator ROCKEFELLER. I think you are right. I would not even be discussing 200 or 300 percent if we had had our way, right?

Dr. MCCLELLAN. Right.

Senator HATCH. We appreciate the work of Senator Bingaman as well. You are next, Senator Bingaman.

Senator BINGAMAN. Thank you very much, Mr. Chairman, for having the hearing.

Mr. Administrator, thank you for being here.

Let me, first, just say I agree with many of the previous statements, yours included, about the success that has been achieved under the SCHIP program. A couple of things I want to just mention very briefly before I ask questions. I hope that this effort to expand coverage to other children can be included in the reauthorization.

As I recall, we had this provision for covering kids, which Senator Frist introduced. I co-sponsored it with him. We worked with your staff in drafting that. We included it in the Senate-passed version of the Deficit Reduction Act. That was dropped in con-

ference. I assume you will support the inclusion of that in any reauthorization.

Dr. McCLELLAN. Absolutely. It is a key part of our budget, as you know. I want to thank you personally for your strong support and leadership on the outreach and education efforts, both in the legislation and in some of the creative things that the State of New Mexico has done.

Senator BINGAMAN. Well, great.

Let me also make mention of this bill that Senator Lugar has which I am also co-sponsoring entitled "The Children's Express Lane to Coverage Act."

This is intended to reduce the bureaucracy across a number of programs by allowing income eligibility determinations for other Federal programs to apply to Medicaid and SCHIP. That is something I also hope we could support as part of a reauthorization. I hope that would be consistent with your thinking.

Dr. McCLELLAN. We would be delighted to look into it with you.

Senator BINGAMAN. All right.

Let me just, now, move to an issue that was put into this legislation, this Deficit Reduction Act. That is, a provision was put in there that, in my view, is wrong-headed. It requires people enrolling in Medicaid to prove their citizenship, including at least 28 million children and 15 million adults.

Failure to prove citizenship by citizen children and their parents will result in the denial of health services financed with Federal Medicaid funds. This is particularly a problem, as I have understood it, for children in foster care and newborns.

On the foster care issue, I think the Basilon Center issued a statement on this indicating that it is particularly difficult for these children, given that their birth families may not cooperate for them to get the citizenship papers that they need to prove their citizenship.

If they are already enrolled in foster care, I would think that would be a pretty good indication that they are citizens and, therefore, should not be denied SCHIP coverage for lack of citizenship proof. Have you looked into that?

Dr. McCLELLAN. Senator, we spent a lot of time looking into the most effective way to implement this requirement which, as you note, is intended to make sure that the Medicaid benefits go to people who are entitled to receive them, but to do so in a way that does not impose undue burdens that prevent access for people who may need it.

That is why, in the regulation that we issued in early July, we laid out a whole set of alternative ways to standardize documentation for people to demonstrate their citizenship.

We had a lot of useful input from the States on that, including concerns related to foster children and some of the other groups that you have mentioned. For example, with input from the States, we included an ability for States to use their existing data systems, kind of like you mentioned for that Senator Lugar bill.

There are existing data systems that were already established to document citizenship and eligibility for the Medicaid benefits. That is something that a lot of States are using. With automated access to birth records or other records, they do not need to go to the birth

family in order to use it. We want to watch this closely. As you identify issues and problems, we want to work with you to address them.

Senator BINGAMAN. One other, related issue is, of course, newborn children. We all know, under our Constitution, that they are citizens. It seems a bit perverse to be requiring them to prove citizenship, or someone to prove that they are citizens, if they were just born in this country.

Let me ask, finally, about children who are dual eligibles under both Medicaid and Medicare. We wrote you a letter in February. I wrote to you and Secretary Leavitt and raised the problem of thousands of these children. These are largely children with end-stage renal disease or transplant patients, and they were moved from getting vaccines from children and Medicaid drug coverage to the Medicare Part D program.

You sent out a letter on this, or a notice—I guess it is called a memorandum—to all Part D sponsors. I read through it. Frankly, I did not see that it solved the problem.

It says, "We have been notified of circumstances where Part D sponsors are unaware of Part D eligibility for children," and then goes on to say that you have heard about reports and you want to remind plans about this group.

But it sort of punts the responsibility to solve the problem to these plans, and that was not what we had in mind. We thought this was something that CMS could solve.

Dr. MCCLELLAN. Our goal is to make sure that everyone who is eligible for Medicare and Medicaid gets the drug coverage they need. The program memorandum that you mentioned was a reminder to the plans that they have an obligation to provide access and necessary treatments.

When we hear about any beneficiary having difficulty getting needed medicines, we have an entire CMS-directed process to make sure there is timely action to resolve the issue.

The notice that you mentioned was a reminder to the plans that they need to comply with these coverage requirements. So if you know, or if there is any beneficiary here who is listening who is on Medicare and Medicaid particularly, or has a child with end-stage renal disease on Medicare and Medicaid, if they are having any difficulty getting the medicines they need, they need to let us know at 1–800–MEDICARE.

We also can handle these cases through our regional offices. I know you have worked with us on certain cases like that. We will resolve them to make sure they get the coverage they need. This was just a reminder to the plans that they have to provide that coverage.

Senator BINGAMAN. All right. So you interpret this memo as saying they have to provide that coverage.

Dr. MCCLELLAN. Right. And we also combine it with our oversight of the plans and our process for resolving any beneficiary complaint issues to make sure that they do.

Senator BINGAMAN. Thank you. My time is up.

Senator HATCH. Well, thank you, Senator.

Senator Wyden and Senator Lincoln, would you defer and allow me to call on Senator Snowe so she can go over and represent both of us at the unveiling of Senator Dole's portrait?

Senator LINCOLN. Sure.

Senator HATCH. I wish I could be there, but this is important.

Senator SNOWE. Thank you.

Senator HATCH. With your acquiescence, we would appreciate it.

Senator SNOWE. I will be very brief. Thank you, Mr. Chairman. I thank my colleagues as well. I want to thank you, Chairman Hatch, for your tireless advocacy on behalf of children, and being a true leader, along with Senator Kennedy, and I know Senator Rockefeller, on this issue and creating this funding program for poor children in America.

Hopefully, we can look to the future and ways in which we can do more in not only addressing the potential funding shortfalls that will exist in the future, but also with respect to expanding the program as well to accommodate all children.

I just wanted to follow up on some of the issues. You indicated that, potentially, there obviously is an unmet need. We know that there are 9 million children that are currently uninsured, 70 percent of whom would be eligible for the SCHIP program.

So given the fact that there will be less dollars available for reallocation and redistribution for States—the unspent fund and who could use it—I know in our State, if we were to enroll all the children who were currently eligible, there would not be sufficient funding.

So what are your views about, how do we address that for the future? Because, obviously, we are going to have a serious funding shortfall in future years, based on all the studies that have been developed. What would you recommend in not only attacking that problem, but also in the future and expanding it to more children?

Dr. MCCLELLAN. Well, we want to make sure that the SCHIP program continues to serve all the children who need benefits in the program effectively. That does mean, Senator, as part of the reauthorization process next year, we need to look closely at these financing mechanisms. I think we can address a lot of this problem, especially in the next few years, by finding more effective ways to allocate the dollars that are already in the program to where they are actually needed by States, including Maine.

As I mentioned earlier, with looking ahead to 2007, I know Maine does have some significant Federal financing needs for this program. But there is more than enough money, billions of dollars more than we are projecting is necessary, to meet those financing needs.

So that is, I think, the right step in the short term. This is obviously going to be part of the reauthorization process, where we want to work with you to get it right for the longer term.

Senator SNOWE. Do you think that there is sufficient funding currently to meet all the needs in America with respect to those who are in the program currently? What about all the other children who remain uninsured that could be eligible as well?

Dr. MCCLELLAN. The gap projected for 2007 between funds allocated to the program and expected spending in the program with

current projected enrollment, is close to $3 billion. That is almost 50 percent of the total program costs this year.

So even if we did succeed wildly, as I hope we will, in expanding the use of this program to people who are eligible, the program has a lot of extra funding in it right now that we need to allocate appropriately. We do need to keep working together, as we have in the last few years, to make sure those allocations go to where they are needed.

In the longer term, this is something that we need to discuss as part of the reauthorization process. But for looking ahead this year and in 2007, I think the most important issue for us to keep working together on, as we have in the past, is giving the dollars to the States that need them and to continue identifying and promoting effective education and outreach programs.

Senator SNOWE. Even with the growing cost of health care, will you be able to accommodate that differential? Because that is obviously adding to the cost of the overall program.

Dr. MCCLELLAN. Right, it is. But remember that a lot of the people who are eligible, but unenrolled in programs now, are eligible for Medicaid, not SCHIP. As you know, for the SCHIP enrollment process, States are required to do a screen for Medicaid first before they enroll them in SCHIP.

So if we succeed in enrolling most of these children, that is going to mean more people participating in Medicaid, but it is not going to directly affect the SCHIP dollar allocation. So that still gives us a very big cushion if we direct the dollars to the right place to accommodate all these children.

Senator SNOWE. According to a July 20, CRS report on the SCHIP program, they indicated that some States have occasionally experienced year-to-year declines in the number of children covered. Between 2003 and 2004, annual SCHIP enrollment in 12 States fell.

What would cause enrollments to fall in those States, and what happens to those families? Do they re-enroll at some point or are they enrolled in another program with employer coverage, or what?

Dr. MCCLELLAN. Senator, there are a number of factors that could contribute. Overall, what we have seen in the last few years is States expanding coverage and expanding benefits.

But certain States may have economic upturns, they may have other unique circumstances that cause the number to remain level. I do not think we have seen big declines in any States.

If you look at enrollment trends beyond just 1 year where fluctuations, for a lot of reasons, could affect the year-to-year trends, the overall pattern in the program has been steadily increasing participation up through 2005 and, as I said, expansion of benefits overall.

But we can watch that closely. If there are any particular States where you have questions, I would be happy to look into it for you.

Senator SNOWE. Thank you.

Thank you, Mr. Chairman. I thank my colleagues as well.

Senator HATCH. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. I just want to say to you and Senator Rockefeller, having watched the incredible dedica-

tion and commitment you both showed last time around, I want people to understand that this success did not happen by accident. You two put in an extraordinary amount of effort, and millions of kids and parents are the better for it.

Senator HATCH. Thank you, Senator.

Senator WYDEN. I just wanted to tell you both how much I appreciate your leadership.

Dr. McClellan, my two questions essentially involve how I am approaching health care today. I have come to feel that we ought to be taking steps to help people immediately. That is, for example, reauthorizing this SCHIP program to help children.

But we also ought to be thinking in terms of the broader challenge, which is to create a system that works for all Americans. Most of the world has figured it out. We have not. So I really want to look in a couple of areas, both with respect to what we do now and what we do for the future.

With respect to children, probably one of the first things I want to do now is to get parents more involved in health care for kids. All my colleagues have been asking why we have all of these kids who are eligible, yet we are not getting them signed up.

I would really like to try to come up with some fresh strategies for getting parents involved in the delivery of this program, and health care for kids generally.

I imagine we could look at a variety of approaches. We could even say that, for communities and States that had innovative ways to get parents more involved, we could give them a bit more help.

But tell me, if you would, from this point on, what can we do to get parents more involved in getting health care to children?

Dr. MCCLELLAN. Well, first of all, I want to thank you for focusing on this issue and for the discussions that we have had an opportunity to engage in about these bigger picture goals for our health care system, spending dollars more effectively, and keeping people healthier.

As you have mentioned to me in those discussions, getting people more involved in thinking about their health, thinking about the health care of their family, is an absolutely essential step to doing it. We have looked at a number of strategies that States have employed in order to get parents more involved in these decisions with their children.

For example, in New Mexico, outreach through school nurse programs has been effective in reaching parents, informing them about the program, particularly for kids who are having any kinds of health difficulties. I mentioned earlier the work that I had done back in the 1990s through Tax Offices, which, again, get parents involved as well.

One of the steps that seems to have really worked in SCHIP is having more of a family focus in coverage. In other words, if you just have coverage focusing on a child, it may be more difficult to engage the parent, engage the whole family, in getting into effective coverage.

That is one reason I think we have seen such success in the SCHIP expansions that have covered parents as well as kids, and the SCHIP expansions that have provided support for covering a

kid through a parent's employer coverage on top of the employer subsidy for that parent themselves.

So steps like that are absolutely the right way to go, and I look forward to some more opportunities, through this reauthorization process, to make sure that we are supporting family involvement, family responsibility, and family participation in effective, mainstream health insurance coverage.

Senator WYDEN. I think that that is, clearly, important. Obviously, if you make the link between parents and children, it helps. But I think we have to challenge the parents of this country. I think that they may not know exactly the toll that the lack of health care takes.

I would just encourage you and the administration to work with us to be a lot bolder than we have been. This is a moral blot on our country, that we have millions of eligible kids who are falling between the cracks.

You have Senator Hatch, Senator Rockefeller, these Senators doing a lot of work in trying to approach this on a Federal level, but it really comes down to communities, and families, in particular. So, I am going to follow up with you some more in this area.

It also touches on the second question I have, which is, given the scarcity of dollars, I would like to get a sense of what we get the most benefit for in terms of the SCHIP dollars.

When I look at the studies, by and large they tend to have people quoting the same people and they tend to be, if not dated, they tend to be ones that say, look, we know that vaccinations make sense, and the like.

I would really like to see, for purposes of this reauthorization, some fresh evidence that tells us what gets us the most for the dollar that we spend on kids. Do you have that? Is that under way?

Dr. MCCLELLAN. I would very much like to work with you on getting that together for next year's reauthorization. One of the areas where we have been focusing more lately—and if the Chair does not mind us spending a few extra seconds, I would like to ask Dennis Smith to talk a little bit about this—is looking at how families get their health care now.

In many cases, they are getting care, they are just getting it in an expensive and poorly coordinated way, because they wait until their child gets sick because they were not vaccinated, or they did not get ongoing preventive care and they go to the emergency room. Well, that is very costly and it does not promote good health and participation in school as much as we would like to see.

So I would like to ask Dennis Smith to maybe add a couple of words about the importance of getting good performance measures along these lines to help us with the reauthorization.

Mr. SMITH. Thank you very much. And again, one of the things that we have learned to focus on through the SCHIP experience is helping to get parents to understand the importance of insurance rather than just going to the emergency room for health care.

One of the most exciting things that is going on right now is in Massachusetts and their model waiver, in which they looked at the expenditures of people just going into the emergency room for their health care versus when they could actually change someone's be-

havior by giving them a card and saying, your appointment is next Tuesday, come back then.

Physician visits went up, hospital admissions went down, and Massachusetts is saving a lot of money because they have really gotten people to understand the importance of insurance itself.

We experienced that with SCHIP as well. Part of the slow uptake was helping people to understand the importance of getting enrolled in the program that they are eligible for.

Senator WYDEN. Well, my time is up. I think your last point is especially important, because there was progress made even before the new legislation went into effect. The new legislation is going to build on that as well by further integrating private insurance and these preventive benefits under Medicaid.

Mr. Chairman, I thank you and Senator Rockefeller, and look forward to working with both of you.

Senator HATCH. Well, we look forward to working with you, Senator Wyden.

Senator Lincoln, we appreciate having you here.

Senator LINCOLN. Thank you, Mr. Chairman. I, too, want to offer my thanks to you and to Senator Rockefeller for your years of dedication in this arena, and what it means to families across this country and to children, particularly to the future of our country.

As we know, children that are healthier are going to learn better, they are going to perform better. They are going to be healthier because they are going to eat better. I mean, all of the things come back to their overall health and the ability to be able to get that kind of health care that they need at critical stages in their lives.

I guess, as the mother of twin boys and having spent a good bit of time in the pediatrician's office these last 6 months, I know all too well, as we all do as parents, the importance of reliable health insurance coverage for children. We realize the blessing it is to us when we need it the most and it is actually there for us.

I just think, in situations like these where you really need it and it is there for you and you really understand how important it is and how blessed you are to have it, and then you think of all of those who do not, we realize how critical it is, not only to the health of my child, but also to our family's peace of mind and to other children across the country.

That peace of mind that we talk about is something that, for all of us as parents, we know and understand what it means to us. But it should belong not only to those families who can afford private health insurance, it should be a peace of mind that should also be available to working families who are struggling to make ends meet.

I think that is one of the reasons this program has made many of us so proud, is that it does enable, and it empowers, working families across this country who otherwise would not have the comfort and the peace of mind of knowing that, when they do need the doctor's visit or the health care for their children, it is going to be available to them.

So, it is certainly why I am a very staunch supporter of the State Children's Health Insurance Program. I am proud of my colleagues who have led the way, and look forward to working with them, and others, to ensure that we fund the reauthorization in a way that

is not only respectful of what we have already done, but encouraging in terms of the progress that we can make in enhancing and improving the program.

Between SCHIP and Medicaid, in my State, since 1997, those two programs have cut the number of children without health coverage by one-third. Yet, in excitement over that success, I realize that millions of children still remain uninsured. I hope that we will all work in a bipartisan way, as I know we have in the past, to ensure that the reauthorization occurs in a way that is really important.

I also feel, after looking at Senator Kennedy's charts, reinvigorated in my dedication to shoring up the funding shortfalls for this vital program and providing our children with the care that they need and, again, that peace of mind that I think families deserve.

Dr. McClellan, we appreciate you being here, and your work and attention to this issue. Just a couple of quick questions from me on things that are important.

As we look at shoring up that funding, I also hope that we would look and focus some attention on preventive efforts that I think can ultimately cut down on the growing health care costs to our Nation's children, and to our budget.

I know last week I met with a delightful young lady from Jonesboro, AR to discuss the wonderful effort she has made in her efforts to educate her high school colleagues on the effect of teen pregnancy and the effects it can have on the lives of not only the teenagers, but also the children.

Research has certainly shown us that children of teen mothers are more likely to be born prematurely and at a low birth weight, both of which can lead to a host of long-term health problems and a greater reliance on Federal programs, which we do not want to see happen, and we know that we can do a better job at that.

I think the National Campaign to Prevent Teen Pregnancy is currently compiling a report to better determine the extent to which teen pregnancies impact Federal programs such as SCHIP, and I hope that we will use some of those types of information as we move forward in building a stronger program.

There has been an overall improvement in terms of newborn screenings across the 50 States. Nearly one-quarter of 4 million babies born in the U.S. this year will not be screened, however, for the full panel of disorders recommended by the American College of Medical Genetics. Approximately 40,000 of the babies born in Arkansas each year are screened for less than a third of these disorders.

I think this situation is unacceptable and I hope that we can do better by our families there. I would just like to have your input in terms of considering the substantial health care costs that could be avoided by a stronger focus on preventive care.

Is it time that we implement a national newborn screening policy, which I think could be so important and such a cost-saving measure in terms of economics? What an incredible relief it could be to many families, where we could actually prevent some of the debilitating circumstances of diseases if we catch them quite early, or disabilities.

Dr. McCLELLAN. I absolutely agree with you that an emphasis on prevention needs to be a key part of the SCHIP reauthorization process. It goes along with what Senator Wyden said as well.

We have seen what a difference participation in SCHIP programs can make for newborn well-being. I also would highlight that, through SCHIP waivers, we have been able to expand coverage to many pregnant women as well.

Senator LINCOLN. Right.

Dr. McCLELLAN. And getting them into regular care is a good predictor of making sure that their kids are going to avoid those low birth weights and are going to get the needed screening tests and get connected with effective health care coverage when they are born.

So I think that fits in very well with the directions that we would like to see for the future.

Senator LINCOLN. Of course, those are all State mandates, really, in terms of the preventive care, the newborn screening policies.

To what extent do you think that CMS could educate beneficiaries, the parents of newborns, about the significance of preventive newborn screening?

Dr. McCLELLAN. I think it very much goes along with the direction that Dennis Smith laid out in terms of what we are seeing in State-effective steps in SCHIP today, towards more family involvement and more emphasis on prevention.

States do differ in required newborn screening. However, it is clear that getting newborns into effective coverage from the time they are born—and ideally from the time their mom is pregnant—is a good predictor of effective use of early prevention-oriented tests.

So that is a direct tie-in between what we would like to continue to build on in the SCHIP program and your points about the use of these newborn screening tests.

Senator LINCOLN. Well, it is just so remarkable, when you meet these children who have had the newborn screening, for a child that perhaps could not have heard, but through audiology newborn screening has been able to, whether it is implants, what have you, and really see a difference in their growth and in their health. So, I think that is important.

Mr. Chairman, my time is up. But may I ask a unanimous consent request, on behalf of my colleague, Senator Bingaman, to include in the record testimony of The American Academy of Pediatrics?

Senator HATCH. Without objection.

Senator LINCOLN. Thank you.

Thank you, Dr. McClellan.

Dr. McCLELLAN. Thank you.

[The prepared statement of The American Academy of Pediatrics appears in the appendix on page 59.]

Senator HATCH. Well, I want to thank both of you for being here. We really appreciate the testimony you have brought here, and the knowledge and practical experience that you have had with this program. It means a lot to us. So, thanks to both of you. We appreciate you being here.

Dr. McCLELLAN. Thank you.

Senator HATCH. Our last panel is made up of Ms. Evelyne Baumrucker and Mr. Chris Peterson. Both are Congressional Research Service specialists on the CHIP program.

Ms. Baumrucker will provide a broad overview of the program, while Mr. Peterson will focus on the financing of the CHIP program. This is both Ms. Baumrucker's and Mr. Peterson's first time testifying before a Congressional committee, so I promise that the subcommittee members will not be too difficult for you or too hard on you. [Laughter.]

I also want to say hello to my friend, Royal Schipp, whose daughter worked with me for a number of years before the Finance Committee Chairman stole her away from me. Although we have been really happy with her work on the Finance Committee.

Royal is the Director of the Domestic Social Policy Division of CRS, and we are very proud of you, Royal, and the long, long service that you have given around here. It means a lot to us up here on Capitol Hill because we rely rather extensively and heavily on the Congressional Research Service, and especially your division as well. We are glad to have you.

We will start with you, Ms. Baumrucker.

STATEMENT OF EVELYNE BAUMRUCKER, ANALYST, CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Ms. BAUMRUCKER. Good afternoon, Mr. Chairman, Mr. Rockefeller, and members of the committee. My name is Evelyne Baumrucker, and I am a Health Policy Analyst with the Congressional Research Service.

I am pleased to provide the committee with an overview of the State Children's Health Insurance Program, including a brief legislative history and discussion of program basics.

I will begin with a brief legislative history of the program, where I highlight some of the major themes that were influential in shaping the SCHIP program. Major themes include incremental expansion of the Medicaid program to pregnant women and children beginning in the mid-1980s, followed by consideration by the 104th Congress of comprehensive health care reform. When majority support could not be achieved for this proposal, some in Congress backed alternative measures to expand health insurance coverage solely for children. In 1995–1996, the 104th Congress considered proposals to dramatically restructure Medicaid by transforming it into a capped grant program. While President Clinton vetoed the legislation, it initiated the movement from costly and unpredictable mandatory spending on individual entitlements to capped Federal grant programs, culminating in the passage of Welfare Reform, which created the Temporary Assistance for Needy Families Federal capped grant to States. It is in this historical context that the 105th Congress enacted the Balanced Budget Act of 1997 that established the State Children's Health Insurance Program under a new title 21 of the Social Security Act.

SCHIP entitles States, with approved plans to predetermined capped Federal allotments, to offer health insurance to low-income, uninsured children either under an expansion of Medicaid, under a new, separate SCHIP program, or a combination of both approaches. SCHIP was crafted to maximize State flexibility in pro-

gram design and was intended to look like private health insurance coverage in terms of Federal rules regarding covered benefits, cost sharing, and so forth.

In fiscal year 2004, there were 6.2 million children enrolled in SCHIP. Of those, about a fourth were covered under Medicaid, with the remaining 4.4 million covered under separate SCHIP programs. In addition, 646,000 adults, mostly parents of SCHIP- and Medicaid-eligible children, were enrolled in SCHIP in eight States, primarily through section 1115 waivers under the Health Insurance Flexibility and Accountability Initiative.

Like Medicaid, SCHIP is a Federal/State matching program. But to encourage State participation, State dollars are matched with available Federal funds at a higher matching rate. On average, the Federal Government financed about 70 percent of all SCHIP costs, as compared to about 57 percent of all costs under Medicaid. The Congress appropriated approximately $40 billion in Federal funds over 10 years, beginning in 1998. Of that amount, approximately $4.6 billion in new Federal grants for SCHIP was available in fiscal year 2004. By contrast, Federal spending under the Medicaid program for comparable populations was 10 times that spent on SCHIP, or approximately $50 billion. Despite its relative size, SCHIP represents the largest Federal health care investment in children since the creation of Medicaid in 1965, and has served as an important model for the benefit and cost-sharing changes to the Medicaid program under the recently-enacted Deficit Reduction Act of 2005.

Since SCHIP was established, the number of uninsured children has declined nationwide, particularly among those who are near-poor. According to the Center for Disease Control's National Health Interview Survey, the percentage of uninsured children declined by 5 percent, from 13.9 percent in 1997, to 8.9 percent in 2005, and the percentage of near-poor uninsured children declined by 8.1 percent, from 22.8 percent to 14.7 percent over the same period.

Under broad Federal rules, States have the flexibility to define coverage and to require certain beneficiaries to share in the cost of some SCHIP services. For States that provide Medicaid coverage to SCHIP children, Medicaid benefit and cost-sharing rules prohibiting cost sharing for most children under the age of 18 will apply. In addition, States have the option to implement the new DRA Medicaid options for alternative benefits and cost sharing, and may choose to target SCHIP enrollees as a part of their State plan amendments. When States provide coverage to children through separate SCHIP programs, coverage and benefit options outlined in SCHIP and modeled after a set of employer plans will apply. Medicaid coverage for SCHIP children is considered an individual entitlement. No such individual entitlement exists for children covered under separate SCHIP programs.

With all of the flexibility available to States, SCHIP programs across States continue to evolve, as evidenced by the numerous changes States have made to their original State plans over time. States seek amendments to adjust their programs to meet the changing needs to, for example, make changes to income eligibility thresholds, define new co-payment standards, or to modify their benefit packages.

The SCHIP program was designed to allow States maximum flexibility to design their programs within the constraints of a capped Federal grant program. Within this context, the Congress may need to consider how to balance State variability with equity among States. As the Congress turns its focus to SCHIP in anticipation of the program's reauthorization in fiscal year 2007, discussions surrounding the SCHIP funding formula and redistribution issues will likely dominate. Limited Federal funding may require priority setting by Federal and State Governments.

I look forward to continuing to support the committee as you work through these, and other, SCHIP issues.

Senator HATCH. Well, thank you so much, Ms. Baumrucker.

[The prepared statement of Ms. Baumrucker appears in the appendix.]

Senator HATCH. Mr. Peterson, we will take your testimony.

STATEMENT OF CHRIS PETERSON, SPECIALIST, CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Mr. PETERSON. Thank you, Chairman Hatch, Senator Rockefeller.

I am here to talk about the Federal financing of SCHIP; in particular, to provide an overview of policy levers that could be used to affect the projected 2007 shortfalls, and the program's reauthorization.

But to illuminate some of those future issues, a quick look back is necessary, and I use this table to highlight certain patterns which have been talked about earlier.

Column B shows the Federal SCHIP allotments made to States and territories every year over the program's history. Now, original allotments have three key characteristics. First is their total amount, as you see here. These levels were originally set in BBA 1997 and have been altered only slightly since.

Senator HATCH. That is in billions of dollars, right?

Mr. PETERSON. Billions of dollars. Well, millions. Actually, $4.2 billion is 1998, for instance.

Senator HATCH. All right.

Mr. PETERSON. In essence, these numbers represent the size of the pie available to States.

The second key characteristic is what each State's share of that pie is. This is based on a formula in statute that has also been largely unaltered and takes into account each State's number of low-income children, uninsured low-income children, and States' average wages for health care employees. The third key characteristic is how long these funds are available, which has always been 3 years.

After 3 years, the unspent funds are available for redistribution to other States. As you can see in column C, in the first few years of redistribution, a lot of unspent money was at stake and Congress intervened to affect how those funds were distributed.

However, as these amounts dropped, Congress left the distribution up to the HHS Secretary. These funds now go entirely to States' projected initial shortfalls.

Looking ahead, less redistribution money means that States must place greater reliance on their own original allotments. Thus,

the determination of original allotments becomes increasingly critical to States.

Column D shows State spending of Federal SCHIP dollars, with amounts ever increasing since 1998. Based on State projected spending, 2006 appeared to be the first year in which numerous States faced shortfalls, totaling about $283 million.

Among the proposals that Congress considered, the one that made it into the final Deficit Reduction Act appropriated $283 million, which you see down in red, to address the 2006 shortfalls.

Based on State estimates from November of 2005, CRS projects this would leave a shortfall of approximately $3 million in four States. Based on the same State estimates, we project a shortfall of about $1 billion for 18 States in 2007.

In his testimony, Dr. McClellan used projections 6 months more recent, with slightly different projected shortfalls. I retained the earlier numbers, one, because it was the basis of the DRA distribution, and two, because it illustrates some fairly significant changes in State projections in a short amount of time.

This could be due to States altering their SCHIP programs, local economic factors, or the way States produced these projections. Regardless, a much larger appropriation would be required to eliminate the 2007 shortfall compared to what was needed for 2006.

The President's budget calls for the 2005 allotment's availability to be reduced from the standard 3 years to 2. CRS projects this would eliminate the projected shortfalls in 2007.

However, in the long run, assuming baseline allotment levels, more States face the prospect of chronic shortfalls, raising more fundamental questions about SCHIP, such as, how much responsibility does the Federal Government have to address shortfalls in this capped grant program?

Ten years ago when SCHIP was created, it could not be predicted what various States would do, let alone whether they would exhaust their Federal SCHIP funds years down the road.

Now, however, we have years of experience. That information could be useful for changing the program, if Congress thought it worthwhile. That information will also enable analysts like myself to make projections about which States might face what size shortfalls, based on criteria considered by Congress.

Financing is just one of the potential issues for SCHIP moving forward. Regarding potential shortfalls, which policy levers are used depends on the goals. If the goal is absolutely to prevent any State from experiencing shortfalls, Congress could, for example, allow States to draw Federal SCHIP funds on an uncapped basis, or, similar to DRA, simply appropriate the additional funds.

Moving forward in the current construct, however, the three major financial levers pertain to the original allotments—their total level, how each State's share is determined, and how long the States have access to the funds. These are difficult questions, and CRS looks forward to continuing its work with this subcommittee.

[The prepared statement of Mr. Peterson appears in the appendix.]

Senator HATCH. Well, thank you both very much. I know that it is always a little worrisome to testify before any Congressional committee, and this is your first time.

You have both done very, very well, and we are very appreciative to have both of you here. We are appreciative of your work as well, and that of all of you folks at CRS.

I also noted, Ms. Baumrucker, in your testimony and CRS reports, that you talked a lot about the difference between the Medicaid FMAP and the CHIP FMAP.

Could you go into that issue in just a little more detail for the committee? How does a State determine how many uninsured children reside in that particular State, especially since that is a particular component of how the CHIP FMAP is determined? What typically happens if States cannot match the Federal contribution?

Ms. BAUMRUCKER. The difference is the Medicaid FMAP is, on average, around 57 percent Federal share; in the SCHIP program, the Federal Government pays about 70 percent of the share. That share is based on the low-income uninsured children in the State, the State cost factor.

Mr. PETERSON. Are you are referring to the number of uninsured estimates in general?

Senator HATCH. Right.

Ms. BAUMRUCKER. Or the FMAP?

Senator HATCH. I just want to know how you go about it.

Ms. BAUMRUCKER. The match piece?

Senator HATCH. Yes. How does a State figure out how many uninsured children really reside there?

Mr. PETERSON. The number of uninsured children? The Current Population Survey is currently the only source of information of that on a national basis that provides uninsured estimates for all 50 States. Issues with that are, for small States, there is a lot of variability that is probably just a function of the State being small.

So there are other opportunities, perhaps. The American Community Survey, for example, has been offered as an alternative, but it currently does not include a question on the number of uninsured. So, for instance, the ACS interviews many more people, 3 million people, compared to 100,000 in the Current Population Survey. So, it is a great source of information, particularly for estimates of low-income kids, but at this point it does not yet include estimates for the number of uninsured.

Senator HATCH. Could you tell us, Mr. Peterson, who the children are who are not covered by CHIP or Medicaid? Either one of you can respond.

Mr. PETERSON. Well, some of that has been talked about before in terms of the total number. But from one set of estimates, they estimate that approximately 60 percent of uninsured kids are eligible for public coverage. There are a number of characteristics we could talk about.

I will just highlight one. Among kids who are eligible and uninsured, the estimates that I have from the Agency for Healthcare Research and Quality are that 82 percent of these kids are in families with income under $30,000.

It is interesting that, in contrast, among those who are uninsured and ineligible, 82 percent have income above $30,000. The point being, among those who are eligible and unenrolled, they tend to be very low-income kids.

Senator HATCH. Could you provide for the record for the committee, whether now or later, any information that you have on the 4 million children who are uninsured, but are not eligible for CHIP or Medicaid?

Mr. PETERSON. Sure.

Senator HATCH. All right. I would appreciate that.

[The information appears in the appendix on pages 163 and 169.]

Senator HATCH. Now, in your written statement, you mention that some States facing shortfalls can use Medicaid dollars when their Federal CHIP funds run out, but other States do not have that option.

Could you explain what is going on there?

Mr. PETERSON. Under current law, as Evelyne had mentioned, States can create their SCHIP programs either through a Medicaid expansion, or with a separate SCHIP program, or combination of both.

When States exhaust all of their SCHIP funds, for the portion that is Medicaid expansion, they can revert to Medicaid at that reduced FMAP, but they are at least getting some funds for that. If a State has only a separate program, then they have no fall-back, so they are responsible for 100 percent of those costs.

It is the case that in the 18 States that we project to face shortfalls in 2007, four of those have only a separate SCHIP program, meaning that once those SCHIP funds are exhausted they cannot receive additional Federal funds, but the other 14 would be able to draw down Medicaid funds, at least for some portion.

Senator HATCH. Ms. Baumrucker, why would States have chosen a Medicaid expansion program over a separate CHIP program, or vice versa, when they are in the process of deciding their CHIP programs?

Ms. BAUMRUCKER. At the start of SCHIP, a lot of States went with Medicaid expansion programs because they already had Medicaid programs up and running. So, that was an easy place for them to start to guarantee that they would be part of the SCHIP program and be able to draw down their allotment that was entitled to them.

However, when States choose a Medicaid expansion program, they are extending an individual entitlement to the children that they bring in through the Medicaid expansion program.

When a child comes in through Medicaid expansion, they are entitled to the benefits and the cost-sharing rules of that program. You cannot cap enrollment in a Medicaid expansion program, except if you use the 1115 waiver authority to cap coverage.

In a separate SCHIP program, however, States that would run out of their Federal allotments could cap their program enrollment or institute waiting lists, et cetera, in order to scale back on their programs and stay within their Federal allotments.

In addition, the benefit packages look more like private health insurance coverage in terms of the coverage that is offered, and in terms of the cost sharing for program participation.

So, States that were covering children at higher income levels look to that flexibility provided under the separate SCHIP program and title 21 for options that were available there.

Senator HATCH. Well, thank you. Thanks to you both.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. You notice, we have a vote just starting. But we have time for a couple of questions.

I mentioned earlier to Dr. McClellan, and I used the word "EPSDT." Now, it is interesting. I think John Chafee and I were thinking about that. Under Medicaid, you have to do EPSDT.

Ms. BAUMRUCKER. That is right.

Senator ROCKEFELLER. A State, if it takes initiative on its own in the CHIP program, does not have to do that. It does not have to do that.

Ms. BAUMRUCKER. That is right.

Senator ROCKEFELLER. That is serious business, not doing that. I mean, Senator Kennedy talked about vision and dental, and that is true. But EPSDT is the basic way you screen children, the basic way you sort of set where they are in terms of health care.

I want you to address that, but I want you to hold on a minute so I can ask my second question. Either of you can respond.

Also, do you not think that it makes sense, in any kind of a health care program—or does it make any sense at all—not to take into account health care inflation, which has been discussed here, or the number of people who will newly become eligible in the cost predictions? Yet, I believe it is true that CHIP does not take into account those real and likely possibilities in preparing its projections in terms of funding.

My own view is, we have to change somehow the way we fund CHIP or the rules by which we do it, if that is possible. We should want more States to step up and try to cover more children under CHIP, not to dry up the resources available to those States who are willing to do the right thing.

I also understand that nearly 1.5 million children will lose their coverage if we do not fix this financing flaw. I am interested in your answer to both questions, either of you, both of you.

Mr. PETERSON. On the financing side, those levels—and that was what I first talked about in that column B—were first set in BBA 1997. Of course, that was when SCHIP was created from scratch.

Senator ROCKEFELLER. Right.

Mr. PETERSON. So now, with reauthorization coming up, it seems like a perfect opportunity, if one thinks that is the way to go, to incorporate new information such as enrollment.

Senator ROCKEFELLER. It makes for better predictions, right? Better budget planning?

Mr. PETERSON. If one is trying to tie the allotments to actual spending, yes.

Senator ROCKEFELLER. Yes. Yes.

Mr. PETERSON. Yes. And the other thing is regarding——

Senator ROCKEFELLER. Is it not weird, strange, or wrong to have Medicaid do EPSDT and have CHIP not do it, when I think that most people think that CHIP probably does do it? That is, those that know what EPSDT is.

Ms. BAUMRUCKER. Right. EPSDT refers to a benefit under the Medicaid program that is called the Early Periodic Screening Diagnosis and Treatment Program, and it provides for screenings that

happen at periodic times in the child's life that would identify health care needs.

The EPSDT benefit guarantees coverage for services that would ameliorate the effects of the health defect that are identified through one of these health care screenings. It is true that this is offered under Medicaid, and it is an individual entitlement to children under the Medicaid program. This benefit is not a covered benefit under the SCHIP benefit package.

Senator ROCKEFELLER. That is how you find out if a kid is autistic, right?

Ms. BAUMRUCKER. That could be a potential place where that type of problem would be identified.

Senator ROCKEFELLER. Yes. All right. So that is on our plate.

Did you answer the second one?

Mr. PETERSON. Yes. I think you were talking about——

Senator ROCKEFELLER. Yes, you did. You did, fundamentally. You did.

What changes would you recommend be made if our goal was to serve, in fact, all children? In the case of West Virginia, 92 percent, up to 97 percent. We are getting up in that range, or we can think that way. We are always assuming that there are some we will never find, or circumstances change for them.

I understand that we believe that there are nearly 6 million children under age 19 who could be enrolled in CHIP or Medicaid, but for whatever reason are not.

Mr. PETERSON. Well, the flip side of that is, States have their own constraints. So on the Federal side, there is the limitation that this is a capped grant program. But then States also have their own financial issues. They have to pay 30 percent of those costs.

So for reauthorization, both of those pieces will need to be considered if one's goal is to expand as much as possible for children.

Senator ROCKEFELLER. All right. Let me just finish on EPSDT again.

I was governor for 8 years. We did not have this. I think EPSDT is a real benchmark, to me. It is just a huge thing. If I had been instructed by the Federal Government—which I never wanted to have happen, because governors are governors—that if we were going to get any help on this at all, that CHIP had to do EPSDT, no questions asked. It had to as a condition of getting any money. Is that unfair?

Ms. BAUMRUCKER. That is for you to decide. That would have to be a priority set based on a capped grant program. If that is something that is really a priority for the Senate, then that would be something that you would have to take under consideration and include in the benefit list as a mandate or as a "must cover."

Senator ROCKEFELLER. She sounds like an intelligent analyst. [Laughter.]

Ms. BAUMRUCKER. Yes.

Senator ROCKEFELLER. Knows all the facts but does not come up with a solution. All right. Thank you.

Senator HATCH. She is saying you have to come up with the solution.

Senator ROCKEFELLER. That is correct.

Senator HATCH. We are grateful for the testimony of both of you. This has been a good hearing. I feel like we are on our way to maybe fully understanding some of the more remarkable aspects about this bill and how it has worked, and what we need to do in the future. So, I want to thank you for being here.

With that, we will recess until further notice.

[Whereupon, at 4:13 p.m., the hearing was concluded.]

A P P E N D I X

Additional Material Submitted for the Record

State Children's Health Insurance Program (SCHIP)
Overview of Program Rules
Testimony Before the Senate Finance Health Subcommittee

July 25, 2006

Evelyne P. Baumrucker
Analyst in Social Legislation
Domestic Social Policy Division

Good morning Chairman Hatch, Senator Rockefeller, and Members of the Subcommittee on Health. My name is Evelyne P. Baumrucker and I am a health policy analyst at the Congressional Research Service. In an attempt to help set the stage for your policy discussions in anticipation of the FY2007 reauthorization of the State Children's Health Insurance Program (SCHIP), my testimony provides a brief legislative history of the period prior to the enactment of SCHIP. I will also provide an overview of the SCHIP program including (1) what SCHIP is; (2) who is eligible; (3) how the program is structured; (4) what benefits are covered; and (5) what the cost-sharing rules are. My colleague Chris Peterson, will follow with testimony regarding federal financing issues facing SCHIP.

Legislative History of SCHIP

I was asked by the Committee to provide a brief legislative history of the SCHIP program and to highlight some major themes that may have been influential in shaping the SCHIP program. The following is a summary of some of the major legislative activity (including Public Laws and key health care proposals) that may have impacted the design of SCHIP:

- ***Incremental expansion of Medicaid (1986-1991).*** Beginning in 1986, Congress mandated a number of incremental Medicaid expansions intended to broaden health care coverage of children. Both mandatory and optional coverage groups of children and pregnant women were added to the law. Eligibility was also extended to Medicare beneficiaries with annual incomes substantially higher than those of other Medicaid recipients, and Congress added requirements regarding benefits, reimbursement of providers, and new, more extensive standards for nursing home care.
- ***Comprehensive Health Care Reform (1993-1994).*** In reaction to increasing numbers of uninsured individuals and health care costs nationwide, the 104th Congress considered comprehensive reform proposals including President Clinton's Health Security Act (H.R. 1600, S. 1757). This bill would have guaranteed health insurance coverage to most Americans through a combination of mandated employer contributions and government subsidies. When it was apparent that majority support could not be achieved for this proposal, some in Congress backed alternative measures to expand access to health insurance solely for children.
- ***104th Congress' attempt to block grant Medicaid (1995-1996).*** Following the debate on comprehensive health reform, the 104th Congress considered proposals that would have dramatically restructured the Medicaid program by transforming it into a capped block grant program. This occurred in response to the increasing cost of the Medicaid program and concern among state Governors and the Congress that projected Medicaid program growth was unsustainable at both the federal and state levels.[1] Under this proposal, most current law federal eligibility and benefit requirements would have been eliminated and states would have been permitted to define the scope of their Medicaid programs through Medigrant plans submitted to the Centers for Medicare and Medicaid Services (CMS), (formerly the Health Care Financing Administration (HCFA)). While President Clinton vetoed the legislation, it set the stage for moving away from costly and unpredictable mandatory spending on individual entitlements to capped federal grant programs, culminating in the passage of the Personal Responsibility and Work Opportunity

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[1] As of January 1998, the Congressional Budget Office (CBO) projected Medicaid's annual average rate of growth to be 6.7% for the period between FY1998 and FY2003.

Reconciliation Act of 1996 (P.L. 105-33 or PRWORA) which created the Temporary Assistance for Needy Families (TANF) federal block grant to states.

- ***State Children's Health Insurance Program (SCHIP) created as a part of the Balanced Budget Act of 1997 (BBA97, P.L. 105-33).*** It is in this historical context that SCHIP was enacted. SCHIP entitles *states* with approved state SCHIP plans to pre-determined capped federal allotments to offer health insurance to low-income uninsured children (explained further below). SCHIP was crafted to maximize state flexibility in program design and was intended to look like private health insurance coverage in terms of federal rules regarding covered benefits, cost-sharing, and so forth. It provided an incremental vehicle that allows states to expand health care coverage over that available under the existing Medicaid program.

What Is SCHIP?

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program under a new Title XXI of the Social Security Act.[2] In general, this program builds on Medicaid by providing federal matching funds that allow states to provide health insurance coverage to certain uninsured low-income children either under Medicaid, under a separate SCHIP program, or a combination of both approaches.

FY2004 annual enrollment estimates as reported by the states show that there were 6.2 million children ever enrolled in the SCHIP program.[3] Of those, about 1/4 or 1.8 million targeted low-income children were covered under Medicaid with the remaining 4.4 million covered under separate SCHIP programs. In addition, 646,000 adults were ever enrolled in SCHIP (in eight states). These adults include mostly parents of SCHIP and Medicaid-eligible children. State variation in program enrollment ranged from just over 5,000 children in North Dakota to over 1.3 million in the state of California. (See **Appendix 1** for FY2004 SCHIP annual enrollment data and program types in the 50 states and the District of Columbia).

Title XXI entitles *states* to pre-determined capped federal allotments. In terms of federal funding, SCHIP is small compared to Medicaid. The Congress appropriated approximately $40 billion dollars in federal funds over 10 years. Of that amount approximately $4.6 billion in new federal grants for SCHIP was available in FY2004. By contrast, federal spending under the Medicaid program for non-disabled adults and children (i.e., populations comparable to those served under SCHIP) was approximately $50 billion. This represents ten times the amount of federal dollars spent on SCHIP. Despite its relative size, SCHIP represents the largest federal health care investment in children since the creation of Medicaid in 1965 and has served as an important model for the benefit and cost-sharing changes to the Medicaid program recently enacted under the Deficit Reduction Act of 2005 (DRA, or P.L. 109-171).

Like Medicaid, SCHIP is a federal-state matching program, but to encourage participation in SCHIP, state dollars are matched with available federal funds at an enhanced

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[2] For more information on the State Children's Health Insurance Program, see CRS Report RL30473, *State Children's Health Insurance Program(SCHIP): A Brief Overview,* updated August 20, 2006, by Elicia J. Herz and Chris L. Peterson.

[3] Ever enrolled refers to unduplicated enrollment counts.

rate. While the Medicaid federal medical assistance percentage (FMAP) ranges from 50% to 76.00% in FY2006, the enhanced SCHIP FMAP ranged from 65% to 83.2% across states.[4] Details regarding SCHIP financing are discussed in companion testimony by my colleague, Chris Peterson.

Within this financing structure, SCHIP was designed to provide states with considerable flexibility so that the program could, at state option, look more like private health insurance coverage. The statute outlines key program features including eligibility, benefit, and cost-sharing requirements, as well as federal funding and allotments to states.

Since SCHIP was established, the number of uninsured children has declined nationwide, particularly among those who are near poor. According to the Centers for Disease Control (CDC) National Health Interview Survey, the percentage of uninsured children declined from 13.9% in 1997 to 8.9% in 2005, and the percentage of near poor uninsured children (i.e., those in families with annual incomes between 100% and 200% of the federal poverty level (FPL))[5] from 22.8% in 1997 to 14.7% in 2005. In 2004, more than 1/4 of all children (29.9%) in the United States were covered by public health insurance plans.[6,7]

Who Is Eligible for SCHIP?

Financial Eligibility Standards

States have considerable flexibility to determine who has access to SCHIP coverage. In general, SCHIP defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997.

Federal law allows states to set the upper income eligibility limits for targeted low-income children up to 200% FPL. Alternatively, if the applicable Medicaid income level for children was at or above 200% FPL prior to SCHIP, the upper income limit may be raised an additional 50 percentage points above that level. For example, a state with a Medicaid income threshold of 200% at the start of SCHIP would be permitted to raise the state's income eligibility for SCHIP up to 250% FPL. As of October 2004, 39 states covered at least some groups of children in families with annual income at or above 200% of the federal

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[4] *Federal Register*, Federal Financial Participation in State Assistance Expenditures, FY 2006, Volume 69, Number 226. Notices. Pages 68370-68373, November 24, 2004.

[5] In 2006, the poverty guideline in the 48 contiguous states and the District of Columbia is $20,000 for a family of four. ("Annual Update of the HHS Poverty Guidelines," 71 *Federal Register* 3848, Jan. 24, 2006.)

[6] Centers for Disease Control and Prevention, *Health Insurance Coverage: Estimates from the National Health Interview Survey, 2005: Early Release of Health Insurance Estimates Based on Data from the 2005 National Health Interview Survey*, by Robin A Cohen, Ph.D., and Michael Martinez, M.P.H.; Division of Health Interview Statistics, National Center for Health Statistics, Released June 2006.

[7] For the purposes of the 2005 National Health Interview Survey, "public coverage" includes Medicaid, the State Children's Health Insurance Program (SCHIP), state-sponsored or other government-sponsored health plan, Medicare (disability), and military plans.

poverty level (FPL). To date, the upper income eligibility threshold under SCHIP has reached 350% FPL in one state (i.e., New Jersey).[8] (See **Appendix 1** for FY2004 SCHIP upper income eligibility thresholds in the 50 states and the District of Columbia.)

Because eligibility for SCHIP is means-tested, states conduct income and assets tests on applicants to determine whether they meet a state's income eligibility thresholds. States have flexibility to decide what counts as income and assets and whether to disregard (not count) income or apply other types of resource or assets tests.[9] For example, in a given state with an SCHIP upper income eligibility threshold of 200% FPL, some families with income above 200% FPL may be eligible due to the amount of annual income that is disregarded when determining SCHIP eligibility.

States may (or may not) choose to take advantage of this flexibility allowed under SCHIP. For example, Minnesota was already generous under Medicaid before the start of SCHIP. The state offered Medicaid coverage to children under age 18 in families with annual incomes up to 275% FPL. Under SCHIP, the state enacted a modest expansion of Medicaid to uninsured children under two years of age in families with annual income between 275% and 280% FPL. Later the state was granted CMS approval under the Section 1115 waiver authority (named for the section of the Social Security Act that defines the circumstances under which such waivers may be granted) to extend SCHIP coverage to parents and relative care takers of Medicaid and SCHIP-eligible children in families with annual incomes between 100% and 200% FPL. FY2004 state reported annual enrollment estimates show that Minnesota extended SCHIP coverage to approximately 4,784 children and 39,571 adults. By contrast, Rhode Island used SCHIP funds for a broader expansion (as compared to Minnesota's expansion) to extend coverage to uninsured children age 8 through 18 in families with annual income between 100% and 250% FPL. In addition, the state was granted CMS approval under the Section 1115 waiver authority to extend SCHIP coverage to parents of Medicaid or SCHIP-eligible children with income between 100 and 185% FPL, and pregnant women with income between 185-250% FPL. FY2004 state-reported annual enrollment estimates show that Rhode Island enrolled approximately 25,573 children and 23,327 adults.

Non-Financial Eligibility Standards

Title XXI allows states to use the following *non-financial standards* in determining SCHIP eligibility: age (e.g., subgroups under 19); geography (e.g., sub-state areas, as in the

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[8] The SCHIP upper income eligibility standards are taken from **Table 1** in *Beneath the Surface:Barriers Threaten to Slow Progress on Expanding Health Coverage of Families and Children*, by Donna Ross and Laura Cox, The Kaiser Commission on Medicaid and the Uninsured, Oct. 2004.

[9] Income disregards are specified dollar amounts subtracted from gross income to compute net income, which is then compared to the applicable income criterion. Such disregards may *increase* the *effective* income level above the stated standard. States may apply resource or asset tests in determining financial eligibility but are not required to do so. Individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage. States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, tax credits, etc.

case of California which has CMS approval for county-based SCHIP programs); residency; disability status (so long as any standard relating to that status does not restrict eligibility); access to, or coverage under, other health insurance (to establish whether such access/coverage precludes SCHIP eligibility); duration of SCHIP enrollment; and citizenship status. Specifically, certain qualified aliens who entered the United States on or after August 22, 1996 are eligible for SCHIP after five years.[10]

States *may not* use federal SCHIP funds to cover children eligible for regular Medicaid, children covered by a group health plan or other assistance, inmates of public institutions (e.g., inmates in detention facilities, or prisons), patients in an institution for mental disease, or children of state public employees. In addition, illegal immigrants are barred from SCHIP eligibility.

How Is SCHIP Structured?

Under SCHIP, states may cover targeted low-income children under their Medicaid programs (often referred to as SCHIP Medicaid expansion programs) and/or they can create separate SCHIP programs. In both cases the federal share of program costs comes out of the federal SCHIP appropriation. For states that provide Medicaid coverage to targeted low-income children, Medicaid rules typically apply. By contrast, when states provide coverage to children through separate SCHIP programs, Title XXI rules typically apply.

SCHIP Medicaid Expansion Programs

SCHIP Medicaid expansion programs provide Medicaid coverage to new groups of children either by establishing a new optional eligibility group and/or by liberalizing the financial rules for any of several existing Medicaid eligibility categories.[11] Medicaid coverage for these "targeted low-income children" is considered an *individual entitlement*, but unlike regular Medicaid coverage, it is paid for out of the SCHIP appropriation and matched at the SCHIP enhanced matching rate. States with Medicaid expansion programs that have exhausted their available federal SCHIP allotments may also finance coverage for such children by accessing federal Medicaid funds at the regular Medicaid FMAP rate. In addition, such states *cannot* cap enrollment in their Medicaid expansion programs, but are permitted to submit a state plan amendment (SPA) to CMS for approval to reduce or otherwise remove the Medicaid eligibility expansion.

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[10] Eligible qualified aliens include (1) those in the United States before August 22, 1996; (2) refugees, asylees, and certain Cuban, Haitian and Amerasian immigrants; (3) unmarried dependents of veterans and active duty military; and (4) those entering the United States after August 22, 1996 as lawful permanent residents with continuous residence for five years.

[11] Under Medicaid law, Section 1902(r)(2) authority may be used to liberalize income and resource methodologies for a number of groups, including, for example, poverty-related children (i.e., those under six in families with income up to 133% FPL and those between 6 and 18 in families with income up to 100% FPL). Family coverage is provided under Section 1931, which has its own provisions for liberalizing income and resource standards.

Separate SCHIP Programs

By contrast, Title XXI does not establish an *individual entitlement* to benefits for children covered under separate, non-Medicaid SCHIP programs. Instead, Title XXI entitles *states* with approved plans to pre-determined federal allotments. Unlike states with Medicaid expansion programs, states operating separate SCHIP programs that exhaust their available federal SCHIP allotments are permitted to submit a state plan amendment for CMS approval to institute program waiting lists and/or to cap their SCHIP program enrollment.

What Benefits Are Covered Under SCHIP?

SCHIP Medicaid Expansion Benefit Package

States that offer Medicaid coverage to targeted low-income children must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their state Medicaid plans. In addition, effective March 31, 2006, as an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act (DRA) gives states the option to enroll state-specified groups (i.e., that were established under Medicaid on or before February 8, 2006) in new benchmark and benchmark-equivalent benefit plans. These plans are nearly identical to the benefit packages offered through separate SCHIP programs (described below). However, states may choose to provide other wrap-around and additional benefits. For any child under age 19 in one of the major mandatory and optional Medicaid eligibility groups (including targeted low-income children under SCHIP), wrap-around benefits *must* include EPSDT.[12,13]

On May 3, 2006 Kentucky became the first state to be granted CMS approval to make changes to its Medicaid program under the DRA benefits and cost-sharing options. The Medicaid state plan changes approved by CMS will also impact a portion of Kentucky's SCHIP population because the state operates its SCHIP program as a combination program, and its approved Medicaid state plan amendment (SPA) identifies Medicaid expansion SCHIP enrollees among the groups that will be impacted by the changes. It is difficult to predict how many states with existing Medicaid expansion and/or combination programs will take up the DRA benefit and cost-sharing options over time, and whether those states will target Medicaid expansion SCHIP enrollees as a part of their DRA Medicaid SPAs.

Separate SCHIP Benefit Package

When BBA97 was enacted, three existing state-funded programs were "grandfathered" into SCHIP — in Florida, New York, and Pennsylvania. The remaining states choose from among three benefit options in creating their separate SCHIP plans including:

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[12] Wrap-around refers to situations in which the state provides a specific service (e.g., mental health services) to beneficiaries enrolled in a plan that does not cover that service.

[13] Under Medicaid, children under age 21 are entitled to *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services*. Under EPSDT, children receive well-child visits, immunizations, laboratory tests, and other screening services at regular intervals. In addition, medical care that is necessary to correct or ameliorate identified defects, physical and mental illness, and other conditions must be provided, including optional services that states do not otherwise cover in their Medicaid programs.

- Standard benchmark benefit package;
- Benchmark equivalent coverage; and
- Other Secretary-approved coverage.

Standard Benchmark Benefit Package. A standard benchmark benefit package is a set of benefits structured to be identical to one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the state involved, and (3) the health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

Benchmark-equivalent Coverage. Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state choosing to provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services, and well-baby and well-child care, including age-appropriate immunizations.

Benchmark-equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, mental health services, vision services, and hearing services. For example, if the benchmark coverage package offers prescription drugs coverage with an actuarial value of $100.00 per year, then the benchmark-equivalent coverage must include at least $75.00 in prescription drug coverage per year. By contrast, if the benchmark coverage package *does not* cover one or more of the four "additional benefits" listed above, then the benchmark-equivalent coverage package is *not required* to include coverage for that category of service. States are also encouraged to cover other categories of service not listed above. Finally, SCHIP funds may not be used to cover abortions, except in the case of a pregnancy resulting from rape or incest, or when an abortion is necessary to save the mother's life.

Other Secretary-Approved Coverage. Other Secretary-approved coverage is defined as any other health benefits plan that the Secretary of Health and Human Services (HHS) determines will provide appropriate coverage to the targeted population of uninsured children. To date, these programs offer comprehensive benefit packages similar to Medicaid, or to one of the benchmark packages with additional services. Based on regulations defining characteristics of Secretary approved coverage, a state may offer, for example, a Medicaid look-alike program where the benefit package is identical to that offered under their Medicaid state plan with the exception of EPSDT.[14]

State Experience with Separate SCHIP Benefit Coverage. Among the types of separate SCHIP programs, data from June 2003 indicate that most of the benchmark and benchmark-equivalent plans are based on the state employees' health plan, and most

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[14] See CRS Report RL32389, *A State-by-State Compilation of Key State Children's Health Insurance Program (SCHIP) Characteristics*, by Elicia J. Herz, Evelyne P. Baumrucker, and Peter Kraut.

Secretary-approved plans are modeled after Medicaid. There were 44 separate SCHIP programs across 36 states. Among the 23 benchmark and benchmark-equivalent plans, 14 offered coverage comparable to that provided for state employees, four offered FEHBP-like coverage, four offered coverage modeled after the largest commercial HMO in the state, and one offered plans reflecting the features of all three benefit coverage options. The remaining 21 plans provided an array of Secretary-approved coverage, usually offering comprehensive benefit packages similar to the state's standard Medicaid program, or similar to one of the benchmark packages with additional services.[15]

What Are SCHIP's Cost-sharing Rules?

Under SCHIP, states are allowed to require certain beneficiaries to share in the cost of some SCHIP services. Cost-sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan and includes (1) program participation fees, such as monthly premiums and enrollment fees; and (2) service-related cost-sharing, such as copayments and co-insurance. Federal law permits states to impose cost-sharing for some beneficiaries and some services under SCHIP.

Generally, states may impose higher cost-sharing amounts under separate SCHIP programs compared to Medicaid expansion programs. Under SCHIP, states must ensure cost-sharing for higher-income children is not less than cost-sharing for lower income children.

Cost-sharing Rules for SCHIP Medicaid Expansions

States that cover SCHIP children under Medicaid must follow Medicaid rules that prohibit cost-sharing for most children *under* the age of 18 (or at state option under age 21). However, targeted low-income children who are 18 years of age may be subject to service-related cost-sharing at state option. States that want to impose cost-sharing under their Medicaid expansions may seek CMS approval for a Section 1115 waiver program.[16] In addition, effective March 31, 2006, DRA provides an alternative option for states that wish to require premiums and service-related cost-sharing for certain eligibility groups that were established under Medicaid on or before February 8, 2006.

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[15] Six categories of Secretary-approved coverage are defined in SCHIP regulation (at 66 *Federal Register*, 33810, June 25, 2001). These include coverage that (a) is the same as the coverage provided to children under the state Medicaid plan; (b) is the same as the coverage provided to children under a comprehensive Medicaid Section 1115 waiver; (c) either includes the full Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit or that the state has extended to the entire Medicaid population in the state; (d) includes benchmark health benefits coverage plus any additional coverage; (e) is the same as the coverage provided under existing comprehensive state-based programs in Florida, Pennsylvania, or New York; or (f) is substantially equivalent to or greater than coverage under a benchmark health benefits plan, determined via a benefit-by-benefit comparison demonstrating that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan. Secretary-approved benefit plans are not limited to these six categories as long as the coverage provided is determined to be appropriate for the target population.

[16] New Mexico is an example of a state that has CMS approval to modify its cost-sharing rules for targeted low-income children under its Medicaid program.

DRA State Option for Alternative Premiums and Service-Related Cost-sharing. DRA allows states to impose premiums and cost-sharing for any group of individuals for any type of service, through Medicaid state plan amendments (rather than through Section 1115 waivers), subject to certain restrictions. In general, premiums and cost-sharing imposed under this option are allowed to vary among classes or groups of individuals, or types of service, and rules will vary by income (i.e., children in families with annual income between 100% and 150% FPL, and children in families with annual income above 150% FPL). Special rules apply to cost-sharing for prescription drugs and non-emergency care provided in emergency rooms.

For children in families with annual income between 100% FPL and 150% FPL no premiums may be imposed. Cost-sharing for any item or service *cannot* exceed 10% of the cost of the item or service, and total annual aggregate cost-sharing (including any cost-sharing for prescribed drugs and emergency room copayments for non-emergency care) *cannot* exceed 5% of family income applied on a quarterly or monthly basis as specified by the state.

For individuals in families with income above 150% FPL, the total aggregate amount of all cost-sharing (including premiums, cost-sharing for prescribed drugs, and emergency room copayments for non-emergency care) *cannot* exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state, and cost-sharing for any item of service *cannot* exceed 20% of the cost of the item or service.

Under DRA, certain groups of people cannot be charged cost-sharing under the new rules and certain other groups are exempted from cost-sharing but only for certain services. For example, children under age 18 regardless of family income are exempted from service-related cost-sharing for preventive services. States would, however, have the option under DRA to exclude SCHIP children from any/all cost-sharing.

Cost-sharing Rules for Separate SCHIP Plans

If a state implements SCHIP through a separate state program, premiums or enrollment fees for program participation may be imposed, but the maximum allowable amount is dependent on family income. As with Medicaid, states that want to impose cost-sharing beyond what is allowable in SCHIP law may request CMS approval under the Section 1115 waiver authority. To date, no state has used the waiver authority to modify cost sharing under a separate SCHIP plan.

For children in families with incomes under 150% FPL and enrolled in separate state programs, premiums may not exceed the amounts set forth in federal Medicaid regulations (i.e., prior to the enactment of DRA). Additionally, these children may be charged service-related cost-sharing, but such cost-sharing is limited to (1) nominal amounts defined in federal Medicaid regulations for those in families with income below 100% FPL, and (2) slightly higher amounts defined in SCHIP regulations for children in families with income between 101% and 150% FPL.

For children in families with income above 150% FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower income children. Finally, total annual aggregate cost-sharing (including premiums, deductibles, copayments, and any other charges) for all children in any SCHIP family may not exceed 5% of total family income for the year. In addition, states must inform

families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.

Exemptions from Cost-sharing. Native American and Alaskan Native children are exempt from cost-sharing. In addition, states may not impose cost-sharing requirements for preventive services for all children regardless of income. The Centers for Medicare and Medicaid Services (CMS) defines preventive services to include the following: all healthy newborn inpatient physician visits, including routine screening (inpatient and outpatient); routine physical examinations; laboratory tests; immunizations and related office visits; and routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays).

SCHIP Is Evolving Rapidly

SCHIP programs across states are evolving rapidly, as evidenced by the numerous changes states have made to their original state plans over time. States seek amendments to adjust their programs to meet changing needs. As of June 2006, CMS had approved 263 state plan amendments and 13 more were in review.[17] Most states submitted multiple amendments to, for example, make changes to their income eligibility thresholds, define new copayment standards, modify benefit packages, limit enrollment, and/or streamline their application process.

In addition to the amendment process, states that want to make changes to their SCHIP programs that go beyond the law may do so through a Section 1115 waiver. On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. This initiative is designed to encourage states to use Section 1115 waiver authority to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches to maximize private health insurance coverage options and target populations with income below 200% FPL. Waivers approved under the HIFA initiative may be financed, at least in part, with unspent SCHIP funds.

As of March 2006, 15 states had approved SCHIP and/or HIFA Section 1115 waivers that were financed at least in part by SCHIP appropriations.[18] In 12 of these states, SCHIP coverage is extended to include one or more categories of adults with children, typically parents of Medicaid/SCHIP children, caretaker relatives, legal guardians, and/or pregnant women. Four states, (Arizona, Michigan, New Mexico, and Oregon) also cover childless adults under their waivers. These coverage expansions have implications for SCHIP financing. DRA banned the use of SCHIP funds for covering childless adults for new waivers approved on or after October 1, 2005.

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[17] See [http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf]

[18] See [http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/Section1115ReportApprovedUnderReview.pdf].

SCHIP Reauthorization

The SCHIP program is considered by many to be a success. Despite its small size compared to Medicaid, SCHIP represents the largest federal health care investment in children since the creation of Medicaid in 1965 and has contributed to the reduction of uninsured children nationwide. In addition, it has served as an important model for the benefit and cost-sharing changes to the Medicaid program recently enacted under the Deficit Reduction Act (DRA, or P.L. 109-171).

The SCHIP program was designed to allow states maximum flexibility to design their programs within the constraints of a capped federal grant program. Within this context, the Congress may need to consider how to balance state flexibility with equity among states. For example, some states had Medicaid programs with very generous child health coverage before the enactment of SCHIP, while others were able to use their SCHIP federal allotments to established such coverage after SCHIP's enactment.

As the Congress turns its focus to SCHIP in anticipation of the program's reauthorization in FY2007, discussions surrounding the SCHIP funding formula and redistribution issues will likely dominate. Limited federal funding may require priority setting by federal and state governments.

Based on public forum discussions among SCHIP directors and other SCHIP stake holders, there is interest in examining and possibly redefining the SCHIP core populations to prioritize among eligible groups. Congress may be asked to consider extending program coverage to new groups such as children of state employees, legal immigrant children, pregnant women, parents and/or other adults. Any such expansions would be limited by available funds. Similarly, other options such as changes to benefit packages allowing states to use SCHIP funds to provide wrap-around coverage for under-insured groups would be limited by fiscal constraints. I look forward to continuing to support the Committee as you work through these and other SCHIP issues.

Appendix 1. SCHIP Enrollment Data for the 50 States and the District of Columbia for 2004

State	Date enrollment began	SCHIP upper income eligibility standard (% FPL)	FY2004 enrollment (number of children ever enrolled during year)			Adults ever enrolled in SCHIP demonstrations during FY2004
			Medicaid expansion	Separate child health program	Total	
Alabama (S)	2/1/98	200%		79,407	79,407	
Alaska (M)	3/1/99	175%	21,966		21,966	
Arizona (S)	11/1/98	200%		87,681	87,681	113,490
Arkansas [a] (M)	10/1/98	200%		799	799	
California (C)	3/1/98	250%	152,041	883,711	1,035,752	
Colorado[b] (S)	4/22/98	185%		57,244	57,244	NR
Connecticut (S)	7/1/98	300%		21,438	21,438	
Delaware (C)	2/1/99	200%	181	10,069	10,250	
District of Columbia (M)	10/1/98	200%	6,093		6,093	
Florida (C)	4/1/98	200%	2,031	417,676	419,707	
Georgia (S)	11/1/98	235%		280,083	280,083	
Hawaii (M)	7/1/00	200%	19,237		19,237	
Idaho (M)	10/1/97	185%	17,879	1,175	19,054	
Illinois (C)	1/5/98	200%	95,522	138,505	234,027	120,152
Indiana (C)	10/1/97	200%	55,187	25,511	80,698	
Iowa (C)	7/1/98	200%	14,996	26,640	41,636	
Kansas (S)	1/1/99	200%		44,350	44,350	
Kentucky (C)	7/1/98	200%	60,496	34,004	94,500	
Louisiana (M)	11/1/98	200%	105,580		105,580	
Maine (C)	7/1/98	200%	20,204	8,967	29,171	
Maryland (C)	7/1/98	300%	101,664	9,824	111,488	
Massachusetts (C)	10/1/97	200%	119,377	47,131	166,508	
Michigan (C)	5/1/98	200%	31,427	56,136	87,563	132,590
Minnesota (C)	10/1/98	280%	110	4674	4784	39,571
Mississippi (S)	7/1/98	200%		82,900	82,900	
Missouri (M)	9/1/98	300%	176,014		176,014	
Montana (S)	1/1/99	150%		15,281	15,281	
Nebraska (M)	5/1/98	185%	33,314		33,314	
Nevada (S)	10/1/98	200%		38,519	38,519	
New Hampshire (C)	5/1/98	300%	598	10,371	10,969	
New Jersey (C)	3/1/98	350%	39,870	87,374	127,244	88,826
New Mexico (M)	3/31/99	235%	20,804		20,804	
New York (C)	4/15/98	250%	136476	690,135	826,611	
North Carolina (S)	10/1/98	200%		174,434	174,434	
North Dakota (C)	10/1/98	140%	1,845	3,292	5,137	
Ohio (M)	1/1/98	200%	220,190		220,190	
Oklahoma (M)	12/1/97	185%	100,761		100,761	
Oregon (S)	7/1/98	185%		46,720	46,720	4,294

State	Date enrollment began	SCHIP upper income eligibility standard (% FPL)	FY2004 enrollment (number of children ever enrolled during year)			Adults ever enrolled in SCHIP demonstrations during FY2004
			Medicaid expansion	Separate child health program	Total	
Pennsylvania (S)	5/28/98	200%		177,415	177,415	
Rhode Island (C)	10/1/97	250%	24,089	1,484	25,573	23,327
South Carolina (M)	10/1/97	185%	75,597		75,597	
South Dakota (C)	7/1/98	200%	10,338	3,059	13,397	
Tennessee [c] (M)	10/1/97					
Texas (S)	7/1/98	200%		650,856	650,856	
Utah (S)	8/3/98	200%		38,693	38,693	
Vermont (S)	10/1/98	300%		6,693	6,693	
Virginia (C)	10/22/98	200%	41,651	57,918	99,569	
Washington (S)	2/1/00	250%		17,002	17,002	
West Virginia (S)	7/1/98	200%		36,906	36,906	
Wisconsin (M)	4/1/99	185%	67,893		67,893	123,999
Wyoming (S)	12/1/99	185%		5,525	5,525	
Total	—	—	1,773,431	4,379,602	6,153,033	646,159

Source: Data on date enrollment began is from the 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*, Feb. 6, 2002. The SCHIP upper income eligibility standards are taken from **Table 1** in *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Families and Children*, by Donna Ross and Laura Cox, The Kaiser Commission on Medicaid and the Uninsured, Oct. 2004. The state-reported SCHIP enrollment figures are taken from Centers for Medicare and Medicaid Services, *Revised FY2004 Number of Children Ever Enrolled in SCHIP by Program Type,* May 23, 2005. For states with combination programs, the "total" column shows the sum of the unduplicated number of children ever enrolled in the SCHIP Medicaid expansion program during the year and the unduplicated number of children ever enrolled in the separate SCHIP program during the year. Because a child may be enrolled in both programs during the year, there may be some double counting of children enrolled in these states. SCHIP enrollment figures for the territories are not available.

Notes: S — Separate child health programs; M — Medicaid expansion programs; C — Combination programs. NR — Indicates that state has not reported data via the SCHIP Statistical Enrollment Data System (SEDS). FPL = poverty level.

a. Arkansas did not report enrollment data for its SCHIP Medicaid expansion in the SEDS database for FY2004. Under its comprehensive Medicaid Section 1115 waiver, this state uses a combination of Medicaid and SCHIP funds to cover uninsured children through age 18 in families with income up to 200% FPL. Waiver documents indicate that 77,246 children were enrolled in this demonstration as of January 2004.

b. Colorado reported in a letter that due to a new system they were only able to provide accurate data for 10.5 months for FY2004.

c. Tennessee used SCHIP funds to expand its existing comprehensive Medicaid Section 1115 waiver program. Under the state's SCHIP Medicaid expansion, Tennessee began enrolling children in October 1997 through FY2002. In that year, enrollment reached 10,216. Eligibility for this Medicaid expansion program was limited to older children in families with income up to 100% FPL. As of October 1, 2002, all such children had to be covered under regular Medicaid, that is, they were no longer eligible for SCHIP coverage. Thus, Tennessee has no SCHIP enrollment subsequent to FY2002.

Memorandum August 7, 2006

TO: Senate Committee on Finance

FROM: Evelyne P. Baumrucker
Analyst in Social Legislation
Domestic Social Policy Division

SUBJECT: **Responses to *Questions for the Record* from Committee Members regarding the Senate Finance Committee Health Subcommittee Hearing on the Children's Health Insurance Program**

Senator Rockefeller has asked me to respond to a follow-up question for the record regarding changes *I* would recommend to address his goal of serving *all* children currently eligible but not enrolled in the State Children's Health Insurance Program (SCHIP). Congressional guidelines on objectivity and non-partisanship require that I confine my response to technical, professional, and non-advocative aspects of this issue. What follows is a summary of: (1) earlier work CRS completed on this issue during the start-up phase of SCHIP; (2) current program rules for enrollment facilitation under Medicaid and SCHIP; and (3) a literature review to capture current concerns and suggested strategies for how to reach populations that are eligible for, but not enrolled in SCHIP. This literature review is by no means exhaustive, but is meant to serve as a point-in-time look at some of the solutions SCHIP stakeholders have promoted to address the issue of enrollment penetration now that the SCHIP program has been operational for almost 10 years.

Background

Congress has shown an on-going commitment to improving children's access to health care as demonstrated through eligibility expansions of the Medicaid program since the 1980s, and the introduction of the State Children's Health Insurance Program (SCHIP) in the fall of 1997. In FY2005, Medicaid covered approximately 28.3 million non-disabled children,[1] and SCHIP extended coverage to an additional 6.1 million children.[2] Despite the financial eligibility of a majority of poor and near poor children for one of these programs, the Agency for Healthcare Research and Quality (AHRQ) estimates that among the 10.0 million uninsured children in 2002, 6.2 million were eligible for but not enrolled in Medicaid or SCHIP.[3]

Medicaid and SCHIP enrollment patterns are affected by complex interactions among economic trends, federal and state policies, program administrative procedures, and beneficiary perceptions. Research on this issue shows that reaching children who are currently eligible, but not enrolled in SCHIP is as much an issue of enrollment as it is of eligibility.[4]

Early CRS work on outreach and enrollment during the initial start-up phase of the SCHIP program indicated that successful enrollment penetration among all potential Medicaid and SCHIP eligible children depends at least in part on two different, but interrelated activities — enrollment facilitation and outreach.[5] The former includes strategies to simplify and expedite the eligibility determination and enrollment process (e.g., allowing applications to be submitted by mail or fax, eliminating face-to-face interviews or resource or asset tests). The latter includes strategies to market the program to the target population so they will perceive the benefits of participation and initiate the application process (e.g., advertising through radio, television and print media, establishing toll-free hotlines). Some activities can be classified as both (e.g., placing eligibility workers in non-welfare settings frequented by the target population, involving local businesses and community-based

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[1] Congressional Budget Office (CBO), *Fact Sheet for CBO's March 2006 Baseline: Medicaid and the State Children's Health Insurance Program,* available at [http://www.cbo.gov/budget/factsheets/2006b/medicaid.pdf.]

[2] Centers for Medicare and Medicaid Services, *FY2005 Number of Children Ever Enrolled Year–SCHIP by Program Type,* July 12, 2006.

[3] T.M. Selden, J.L. Hudson, and J.S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002: Improved Outreach, Reduced Stigma, and Simplified Enrollment Have Led to Large Increases in Children's Take-Up Rates," *Health Affairs*, Volume 23, Number 5, September/October 2004.

[4] T.M. Selden, J.S. Banthin, and J.W. Cohen, "Medicaid's Problem Children: Eligible but Not Enrolled," *Health Affairs* 17, no. 3 (1998): 192-200. See also D.M. Cutler and J. Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics* 111, no. 2 (1996): 391-430; L.C. Dubay, J. Haley, and G.M. Kenny, *Children's Eligibility for Medicaid and SCHIP: A View from 2000,* Assessing the New Federalism Series B, Number B-41 (Washington: Urban Institute, 2002); and M. Broaddus and L. Ku, *Nearly 95 Percent of Low-Income Uninsured Children Now Are Eligible for Medicaid or SCHIP* (Washington: Center for Budget and Policy Priorities, 2000).

[5] See CRS Report RL30556, *Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?* by Elicia J. Herz, and Evelyne P. Baumrucker, Updated January 8, 2001.

organizations in outreach and enrollment efforts). Ideally, mechanisms to simplify and expedite enrollment for families with eligible children are put into place prior to launching targeted outreach strategies. In practice, however, both types of activities may evolve and occur in tandem over time as barriers to enrollment and outreach are identified, and solutions are designed and implemented.

During the implementation of SCHIP, states instituted a variety of enrollment facilitation and outreach strategies to bring eligible children into Medicaid and SCHIP. Subsequently a fair amount of work was done to identify what worked, what did not, for whom, and at what cost.[6] In addition, under both Medicaid and SCHIP, states faced the additional challenge of preventing previously enrolled individuals who remain eligible from dropping out of the program — a phenomenon referred to as "churning."[7] As a result of this early work, substantial progress was made at the state level to simplify the application and enrollment process under SCHIP, and also to a lesser extent under Medicaid to find, enroll, and maintain eligibility among those eligible for the program.[8] Conversely, states have also used the flexibility allowed under the SCHIP statute and the understanding of the impacts of various policy choices to restrict program enrollment in response to changes in their economic and/or political environments.[9]

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[6] National Governors Association. Center for Best Practices, and the National Conference of State Legislatures. *State Children's Health Insurance Program, 1999 Annual Report,* 1999. See also Alliance for Health Reform. *Health Coverage: Outreach to Uninsured Kids.* May 1998; and Ross, D., and Cox, L. *Making it Simple: Medicaid for Children and CHIP income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey.* Washington, D.C., The Kaiser Commission on Medicaid and the Uninsured, October 2000; and Smith, V.K., and Rousseau, D.M. *SCHIP Enrollment in 50 States: December 2004 Data Update.* Washington, D.C., The Kaiser Commission on Medicaid and the Uninsured, September 2005.

[7] Haley, J.M., and Kenney, G.M. *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?* "New Federalism: National Survey of America's Families," Series B, Number B-35 (Washington: Urban Institute, May 1, 2001). See also Covering Kids and Families, A Project of the Robert Wood Johnson Foundation, *Tracking Your Success, Retention: Communication Strategies,* updated June 6, 2006; Families USA, *What Can Consumer Health Assistance Programs and States Do to Improve Medicaid and SCHIP Enrollment and Retention: Notes From Health Assistance Partnership Call*; 2004, and Pat Redmond, *Medicaid and SCHIP Retention in Challenging Times: Strategies from Managed Care Organizations;* Center on Budget and Policy Priorities, Washington, DC, Sept. 13, 2005.

[8] For more information see CRS Report RL30556, *Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?* by Elicia J. Herz, and Evelyne P. Baumrucker, Updated Jan. 8, 2001. Also see National Governor's Association. Center for Best Practices, and the National Conference of State Legislatures. *State Children's Health Insurance Program, 1999 Annual Report,* 1999; Alliance for Health Reform. *Health Coverage: Outreach to Uninsured Kids.* May 1998; and Ross, D., and Cox, L. *Making it Simple: Medicaid for Children and CHIP income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey.* Washington, D.C., The Kaiser Commission on Medicaid and the Uninsured, Oct. 2000.

[9] For more information on the potential impacts of fiscal pressures on SCHIP programs see Howell, E.; Hill, I., Kapustka, H., *SCHIP Dodges the First Budget Ax.* New Federalism: Issues and Options for States, Series A, Number BA-56 (Washington: Urban Institute, Dec. 2002); Hill, I., Courtot, B., and Sullivan, J., *Ebbing and Flowing: Some Gains, Some Losses as ASCHIP Responds to Third Year of Budget Pressure.* New Federalism: Issues and Options for States, Series A, Number A-68 (Washington: Urban Institute, May 2005).

Current Law Requirements for Enrollment Facilitation

SCHIP defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. Federal law requires that eligibility for Medicaid and SCHIP be coordinated when states implement separate SCHIP programs. In these circumstances, applications for SCHIP coverage must first be screened for Medicaid eligibility.

With respect to enrollment facilitation, federal law stipulates few documentation requirements for determining eligibility under Medicaid, and even fewer requirements under SCHIP.[10] And the burden of required verification lies with state agencies rather than with families, although states may choose to shift some of this responsibility to families. In sum, under Medicaid and even more so under SCHIP, states have enormous flexibility in facilitating application for and enrollment in these programs. **Table 1** provides a summary of the flexibility allowed under Medicaid and SCHIP regarding current law requirements for enrollment facilitation.

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[10] Centers for Medicare and Medicaid Services (then referred to as the Health Care Financing Administration) letter to SCHIP State Health Officials regarding application and enrollment simplification, Sept. 10, 1998.

Table 1. Enrollment Facilitation Requirements for Medicaid and SCHIP

Rule	Medicaid	SCHIP
Written application	State Medicaid agency requires a written application by parent or caretaker relative.	State permitted to use a joint Medicaid/SCHIP application or separate SCHIP application.
	Signature required under penalty of perjury.	Same as Medicaid.
Social Security Number	States must obtain the Social Security number (SSN) of children applying for Medicaid and the state must verify the SSN with the Social Security Administration.	Social Security number (SSN) not required under SCHIP.
Income — Thresholds	States must provide Medicaid coverage to children from infancy through age 5 with family income up to 133% of the federal poverty level (FPL), and up to 100% FPL for children ages 6 to 19.[a]	Lower bounds: Medicaid rules in effect in the state on March 31, 1997.
		Upper bounds: Up to 200% of the Federal Poverty Level (FPL). Alternatively, if the applicable Medicaid income level for children was at or above 200% FPL prior to SCHIP, the upper income limit may be raised an additional 50 percentage points above that level.
	Income counting rules may vary by state.[b]	Like Medicaid, income counting rules may vary by state.[b]
Information	Income and assets may be established through self-declaration, however, states are not required to apply a resource (or assets test).	Same as Medicaid.
Verification	Subsequent to initial application, states must request information from other federal and state agencies, to verify applicants' income and	Such verification *not* required under SCHIP.

Rule	Medicaid	SCHIP
	resources (e g., income from the Social Security Administration (SSA), unearned income from the Internal Revenue Service (IRS), and unemployment information from the appropriate state agency).	
Immigration status	Children applying for Medicaid who are qualified aliens must present documentation of their immigration status, which states must then verify with U.S. Citizenship and Immigration Services (USCIS) within the Department of Homeland Security (DHS). Illegal immigrants are barred from Medicaid eligibility.	Same as Medicaid. Same as Medicaid.
Citizenship status	Effective July 1, 2006, the Deficit Reduction Act of 2005 (DRA) prohibits states from receiving federal Medicaid reimbursement for individuals who have not provided satisfactory documentary evidence of citizenship or nationality during initial determinations (or redeterminations) of Medicaid eligibility.	Children who are citizens were permitted to establish their citizenship through self-declaration.
Insurance status	Not applicable.	States *cannot* use federal SCHIP funds to cover: · Children eligible for regular Medicaid, · Children covered by a group health plan or other assistance, · Inmates of public institutions, (e.g., inmates in detention facilities, or prisons), · Patients in an institution for mental disease, or · Children of state public employees.

Rule	Medicaid	SCHIP
Eligibility redeterminations	States are required to redetermine eligibility at least every 12 months with respect to circumstances that may change and affect eligibility.	Same as Medicaid.

Source: CRS Analysis of Medicaid and SCHIP program rules and regulations.

[a] In 2006, the poverty guideline in the 48 contiguous states and the District of Columbia is $20,000 for a family of four. ("Annual Update of the HHS Poverty Guidelines," 71 *Federal Register* 3848, Jan. 24, 2006.)

[b] Because eligibility for Medicaid and SCHIP is means-tested, states conduct income and assets tests on applicants to determine whether they meet a state's income eligibility thresholds. States have flexibility to decide what counts as income and assets and whether to disregard (not count) income or apply other types of resource or assets tests.

Literature Review: Current Concerns and Suggested Strategies to Improve Coverage Rates[11]

[11] Articles included in the literature review include: (1) Summer, L., and Mann, C., *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies,* The Commonwealth Fund, June 2006; (2) Dorn, S., and Kenny, G. M., *Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policy Makers,* The Commonwealth Fund, June 2006; (3) Remler, D.K., and Glied, S., "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Prorgams," *American Journal of Public Health,* 93,1 (Jan. 2003): 67-74; (4) Herman, M. *Who is Covered and Who's Not? The State of Children's Health Insurance: A Primer for State Legislators,* National Conference of State Legislatures, Policy Brief, February 2006; (5) Riley, T., Pernice, C., Perry, M., and Kannel, S., *Why Eligible Children Lose or Leave SCHIP: Findings From a Comprehensive Study of Retention and Disenrollment,* National Academy for State Health Policy and Lake Snell Perry and Associates, Feb. 2002, (6) Redmond, P., *Medicaid and SCHIP Retention in Challenging Times: Strategies for Managed Care Organizations,* Center on Budget and Policy Priorities, Washington, D.C., Sept. 13, 2005; (7) Horner, D., and Morrow, B., *Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance,* The Children's Partnership and the Kaiser Commission on Medicaid and the Uninsured, April 2006; (8) Bergman, D., *Perspectives on Reauthorization: SCHIP Directors Weigh In,* National Academy for State Health Policy, Prepared with support from the David and Lucile Packard Foundation, June 2005; and (9) Dorn, S., Riley, T., Rosenbaum, S., Ross, D.C., Ross, R., Rosselli, G., Shruptine, S., and Taylor, D., *Putting Express Lane Eligibility Into Practice: A Briefing Book and Guide for Enrolling Uninsured Children Who Receice Other Public Benefits into Medicaid and SCHIP,* A Publication of the Children's Partnership, and The Kaiser Commission on Medicaid and the Uninsured, Nov. 2000.

Now that the SCHIP program has been up and running for almost 10 years, stakeholders and state health officials have identified new changes they would like to see to facilitate their ability to structure their Medicaid and SCHIP programs to improve coverage rates. What follows is a summary of some of the themes that emerged through a review of the literature regarding suggestions for changes to Medicaid and SCHIP eligibility and enrollment facilitation rules.

Eligibility Expansions:

- *Extend coverage to parents of Medicaid and SCHIP-eligible children.* Proponents have argued that providing Medicaid and SCHIP to whole families may be a more effective mechanism for reducing the number of low-income children without health insurance than the current fractured set of eligibility rules.
- *Extend SCHIP coverage to dependents of state employees.* Proponents for the inclusion of dependents of state employees in SCHIP argue that state employees in low-paying jobs should not be subject to a different eligibility standard based solely on their employer especially given the fact that a similar SCHIP program exemption was not enacted for similarly situated federal employees in low-paying jobs.
- *Extend eligibility to legal immigrant children and allow the social security number in lieu of immigration documentation in determining eligibility.* Proponents of this idea argue that nearly half of states cover such children with state funds and would instead like to see these children covered under Medicaid and SCHIP. In addition, they argue that families are required to present proof of legal immigration status and/or citizenship when obtaining a social security number from the Social Security Administration, so they should not be required to repeat this process by providing satisfactory documentary evidence of citizenship of nationality to the Medicaid agency.

Strategies to Improve Program Efficiency and Coordination:

- *Allow some Medicaid-eligible children to enroll in SCHIP if this is preferred by the child and his or her family.* Depending on family makeup, income, and the children's ages, states may provide coverage to members of the same family under both Medicaid and the SCHIP program, and for these families the differences between the programs may create barriers to enrollment. Proponents of this strategy believe that enrollment flexibility to allow families to choose between Medicaid and SCHIP (in certain cases) could further the goal of increased coverage for low-income children.
- *Require states to implement an enrollment system through schools, hospitals, and other public programs.* Proponents of this approach hope to facilitate enrollment in Medicaid and SCHIP by providing families the opportunity to enroll at "convenient public access points." In addition, they hope that these strategies will target enrollment interventions at traditionally hard-to-reach populations.

- *Require state use of existing tools that have been shown to be effective in improving coverage rates.* Early work on outreach and enrollment has shown that strategies allowable under current law (such as state use of a shortened application form, presumptive eligibility, 12 months of continuous enrollment, and self -declaration of income) increase access to health insurance coverage. Proponents believe that mandating the state use of these and other process efficiency strategies (e.g., coordination of renewal dates among families with children in Medicaid, and simplification of premium payment requirements, etc.) would gain program efficiencies and increase enrollment penetration.
- *Require state use of existing tools that have been shown to be effective in maintaining coverage among enrolled individuals.* Proponents of these strategies promote effective communication with families to: (1) educate families about the renewal process; (2) remind them when to renew coverage; (3) make allowances for families fluid economic and personal lives through the implementation of grace periods if, for example, a family faces a financial hardship or loss of a family member, etc.; (4) provide additional training and support for SCHIP staff in making eligibility rederterminations, and (5) require followup with families who have not reenrolled in SCHIP.
- *Allow states to use income determinations from other public programs for Medicaid and SCHIP regardless of differences in methodology when determining initial eligibility or during an eligibility redetermination.* Proponents of these strategies believe that giving states the flexibility to grant health care coverage based on final income determinations from other means-tested programs (e.g., School Lunch, Supplemental Coverage for Women, Infants, and Children (WIC), and Food Stamps) will save in administrative costs and reduce enrollment barriers during times of eligibility determination (and renewal) particularly since these programs serve the same low-income families as Medicaid and SCHIP. In addition, during periods of eligibility redetermination such information sharing could also potentially eliminate the need for a renewal request by allowing the state to conduct internal eligibility reviews by examining federal records from other public programs (and then contacting the families only if additional information is needed).
- *Partner with Managed Care Plans to increase enrollee retention.* Proponents of this strategy believe that Medicaid and SCHIP Managed Care Organizations (MCOs) are a natural partner in educating and assisting enrollees with eligibility renewal. Although Medicaid and SCHIP eligibility systems are separate from the operations of the health plans, proponents believe that given the right tools to assist with eligibility renewal (e.g., obtaining members' renewal dates, establishing effective processes for working with local eligibility offices, addressing concerns about providing direct assistance to their members, determining whether there is sufficient return on investment for these activities) they could play an important role in promoting coverage retention.

Strategies to Expand Federal Resources that Support New Program Enrollment:

- *Establish new enrollment incentives including reliable federal funding and strong federal leadership to support the goal of improving coverage rates.* Proponents of these strategies want to ensure continued federal financial commitment to share in the cost of extending coverage to *new* program enrollees (particularly during times of economic strain) so states will not be forced to impose procedural barriers that ultimately keep children out of the system thereby reducing state health care costs. Proponents argue that without additional federal financial commitment, states will not have an incentive to implement strategies to increase their enrollment penetration.
- *Extend technology assistance grants to states, schools and other public program entities.* Supporters of this idea hope to make federal funds available for the improvement of computer systems that will, for example, allow for the verification of eligibility information already held by government agencies that administer health and non-health programs and allow for auto-enrollment in each. With technological improvements they hope to eliminate unnecessary documentation, create system efficiencies, and maintain program integrity across all federal programs. For example, upon redetermination of eligibility an individual would only be required to update any changes in circumstances, building on the information already held in agency databases. Proponents believe that these strategies will facilitate information transfers among other public coverage programs for children. In addition, state officials will be better situated to measure the effects of enrollment facilitation strategies to further demonstrate what works and pinpoint any needed adjustments.

Conclusion

Medicaid and SCHIP enrollment patterns are affected by complex interactions among economic trends, federal and state policies, program administrative procedures, and beneficiary perceptions. These interactions result in enormous enrollment variability across states despite the substantial progress made during the initial start up phase of SCHIP to simplify the application and enrollment processes under SCHIP, and also to a lesser extent under Medicaid to find, enroll, and maintain eligibility among those eligible for the programs. A review of current literature to capture current concerns and suggested strategies for how to reach populations that are eligible for, but not enrolled in SCHIP shows that stakeholders and state health officials promote further simplification of eligibility and enrollment facilitation rules, and streamlining enrollment processes. In addition, they have identified new changes they would like to see to facilitate their ability to structure their Medicaid and SCHIP programs to further improve coverage rates.

However, the goal of enrolling 100% of all eligible children comes at a price, and this goal competes with budget constraints that may result from any future economic downturns that may increase the number of individuals eligible for, and enrolling in these programs. In addition, it is important to note that when SCHIP was created under the Balanced Budget Act of 1997 (BBA97), Congress intended for this program to be a capped federal grant to states, not an individual, open-ended entitlement. With each passing year since the start of the program in 1998, more states have been able to spend their full federal allotments, leaving less and less funds to meet growing state financing needs. States' projected need for federal SCHIP funds for FY2007 points to a likely shortfall in 18 states.[12] In response, budget limitations will likely require state administrators to think carefully about expanding (or maintaining) their outreach and enrollment facilitation strategies to capture additional eligible but not enrolled individuals. States may instead be forced to cut back their programs through reducing the number of beneficiaries, limiting benefits, lowering provider reimbursement rates, etc.

[12] CRS has developed a model for projecting states' need for federal SCHIP funds based on current law assumptions. Results from this analysis are discussed in CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

SUBMITTED BY SENATOR BINGAMAN

American Academy of Pediatrics

TESTIMONY

of the

AMERICAN ACADEMY OF PEDIATRICS

Submitted for the Record of the Hearing Before the
Committee on Finance Health Care Subcommitee
July 25th, 2006

"CHIP at 10: A Decade of Covering Children"

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The American Academy of Pediatrics (AAP) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply committed to protecting the health of the millions of children and adolescents who receive health care throughout the State Children's Health Insurance (SCHIP) program.[1]

The Academy would like to provide comments on the importance of the history of SCHIP and its impact on decreasing the number and percentage of children without insurance in the United States.

BACKGROUND

The State Children's Health Insurance Program, enacted in 1997 as Title XXI of the Social Security Act, has achieved remarkable progress in its brief history. As a result of SCHIP, health insurance has been extended to millions of low-income children and rates of uninsurance among this population have declined by 2 percentage points, from 14% in 1997 to 12 % in 2004. Access to health care has been vastly improved. Specifically, SCHIP has resulted in more children having a usual source of care, receiving preventive care and immunizations, and reducing unmet need for dental care. Family satisfaction with care has also significantly improved under SCHIP as has a narrowing of income and racial/ethnic disparities in health insurance coverage and access to care. Importantly also, SCHIP has had positive spillover effects on the Medicaid program. As a result of SCHIP outreach, millions of potentially eligible but uninsured children have been enrolled in Medicaid. Eligibility determination processes have been simplified and coordination between these two public programs has become increasingly effective.

In 2005, SCHIP programs provided health insurance to 4 million children nationwide. States selected different approaches to provide health insurance under SCHIP -- 21 states created a combination Medicaid and non-Medicaid program, 18 states created a non-Medicaid program, and 12 states created a Medicaid program. In 27 states and the District of Columbia, eligibility levels are established at the Congressional target of 200% of the federal poverty level (FPL), and in 13 states, eligibility has been extended to children with family incomes above 200%, up to 300% FPL in 4 states and 350% FPL in one.

The original funding allocation formula for SCHIP, which will expire in 2007, is based on each state's share of low-income children, its share of low-income uninsured children, and the state's cost of providing health care services. Funds not spent by states with an allotted time are redistributed to other states according to a specific formula. Unfortunately, in fiscal year (FY) 2007, 18 states are facing SCHIP funding shortfalls, amounting to about $1B, according to the Center on Budget and Policy Priorities (http://www.cbpp.org/3-9-06health.htm). The Congressional Budget Office has concurred with this estimate. The current authorization levels, given the size of the uninsured children population, the growth in the low-income child population, and inflation are not sufficient to sustain existing programs.

In addition to the very serious federal budget shortfalls, states, since 2001, have experienced significant budget shortfalls that have adversely affected their ability to sustain their SCHIP programs. The most common cost-cutting response has been to limit outreach and

enrollment; few states have actually lowered eligibility or benefits or imposed significantly higher cost-sharing requirements (Cite).

The scope of coverage for SCHIP in the 39 states that are offering a non-Medicaid plan to some or all of its SCHIP enrollees, although not as comprehensive as Medicaid coverage, still (with few exceptions) far exceeds benefits in employer-sponsored health insurance. Similarly, although premium rates and co-payments and other dollar limits impose financial burdens for some families, they are still markedly less than in private health insurance plans and families, for the most part, consider them reasonable and affordable.

Provider payment rates, however, are generally low, well below commercial rates, and in many states at the same level as Medicaid's rates, which are on average only 70% of Medicare's rates. In fact, Medicaid professional fees were estimated to be about 70% of Medicare in 2004 according to the 2006 AAP Pediatric Medical Cost Model developed by actuaries at Reden & Anders, Inc. In comparison, commercial plans paid at 111% of Medicare.

The American Academy of Pediatrics has recommended the following improvements to strengthen SCHIP.

1. **Extending Eligibility and Enrollment**

    - Expand SCHIP to include adolescents ages 19 through 21.
    - Allow emancipated minors eligibility for SCHIP based on their own income.
    - Encourage higher income eligibility levels (above 200% FPL) and discontinue asset testing to extend eligibility to more uninsured children.
    - Offer SCHIP buy-in options for children whose family incomes are above their state's SCHIP eligibility level but who do not have access to or cannot afford comprehensive private health insurance.
    - Encourage CMS waiver application to expand SCHIP coverage to uninsured pregnant women and parents if states have already maximized comprehensive coverage and full enrollment of children.
    - Extend 12-month continuous eligibility for SCHIP- (and Medicaid-) enrolled children.
    - Adopt presumptive eligibility for all children, allowing health care providers and other designated agencies to grant eligibility for up to 60 days while a child goes through the enrollment process.

2. **Supporting Comprehensive Coverage**

- Preserve Medicaid benefit coverage in states with Medicaid SCHIP programs.
- Expand the breadth of coverage in non-Medicaid SCHIP programs. This could be accomplished by adding an EPSDT-like provision to pay for services considered medically necessary or by creating wraparound programs for children meeting specific chronic condition or special-needs criteria.
- SCHIP benefit packages should cover the services defined in the AAP policy statement, "Scope of Health care Benefits for Newborns, Infants, Children, Adolescents, and Young adults through Age 21 Years," including dental services and the full range of mental health services, including substance abuse treatment. Preventive care, immunization standards, and periodicity schedules should be consistent with current AAP requirements.
- Extend eligibility for the Vaccines for Children program to all children enrolled in non-Medicaid SCHIP programs.
- Adopt medical necessity standards that meet one or more of the following criteria: 1) the service is appropriate for the age and health status of the individual; 2) the service will prevent or ameliorate the effects of a condition, illness, injury, or disorder; 3) the service will aid the overall physical and mental growth and development of the individual; or 4) the service will assist in achieving or maintaining functional capacity.

3. **Maintaining Affordable Coverage**

- Eliminate differences in copayments and coinsurance for physical and mental health services.
- Adopt cost-sharing policies that do not shift cost to pediatricians, hospitals, and other providers and do not deter the use of medically necessary services. Point-of-service cost sharing holds the greatest risks for children failing to seek or receive needed care and preventive services. Deductibles and coinsurance should not be used; rather cost sharing in the form of income-adjusted premiums and copayments are more effective.
- Maintain policy stating that all preventive services under SCHIP are exempt.

4. **Improving Provider Payments and Network Capacity**

    - Establish reimbursement rates for pediatric services comparable to rates offered in private insurance plans or Medicare. Specifically, rates should be at least 90% of the usual, customary, or reasonable rates or equivalent to Medicare rates, whichever is higher.

    - Ensure adequate payment when new vaccines and other new technologies are introduced. Under capitated arrangement, states should ensure that provisions are made to reimburse physicians for the cost of the new vaccines until new contracts are negotiated. In addition, physicians should receive payment for the expenses associated with the administration of each vaccine.

5. **Strengthening Quality Performance**

    - Adopt a consistent conceptual framework (such as the Institute of Medicine's framework) to assess health care quality across SCHIP programs. Performance goals should include short-term and long-term health care outcomes, including monitoring eligibility thresholds and projected enrollment volume, program retention, access to medical care, assessments of process and outcomes of pediatric care, and family and provider satisfaction.

    - Involve pediatricians, pediatric subspecialists, pediatric mental health professionals, and other pediatric clinicians and families in continuously reviewing and evaluating each state's SCHIP program.

    - Authorize more funding for SCHIP evaluations and allow greater access to state data for research.

CONCLUSION

SCHIP has a proud history to build upon. To achieve continued success in reducing the number of uninsured children and assuring access to high quality pediatric care, the American Academy of Pediatric commends the Subcommittee, the Finance Committee and Congress as a whole on its endeavors to internalize the history of SCHIP before the reauthorization debate begins in earnest.

We would be happy to provide any information or input the subcommittee might need as it considers changes to this critical program for children.

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[1] Medicaid Statistical Reports (MSIS/2028 Reports) for Federal Fiscal Year 2002. *Centers for Medicare and Medicaid Services.*

Statement of the Honorable Orrin G. Hatch
Senate Finance Committee's Subcommittee on Health Care
Hearing on
CHIP at 10: A Decade of Covering Children

July 25, 2006

The Chair will call this hearing to order.

It is no coincidence that the inaugural hearing of the Subcommittee on Health Care is on the Children's Health Insurance, or CHIP, program.

Next year, Congress will focus on how to reauthorize and finance the CHIP program. Therefore, our Ranking Minority Member, Senator Rockefeller, and I believe it important for today's hearing to set the ground for that process by examining the history of the CHIP program and the successes it has had over the last decade.

The Balanced Budget Act of 1997 -- BBA 97 – created CHIP as Title XXI of the Social Security Act. Today, all 50 states, the District of Columbia and five territories have CHIP programs. As is allowed by the law, 17 states use Medicaid expansions, 18 states use separate state programs and 21 states use a combination approach of both their Medicaid program and the state program.

The CHIP program is financed through both the federal and state governments and is overseen by the states. States receive an enhanced federal match for the CHIP program – this federal match is significantly higher than the federal match that states receive through the Medicaid program. The Medicaid federal medical assistance percentage, known as F-MAP, ranges between 50% and 76% in FY 2006; the CHIP F-MAP ranges from 65% to 83.2%.

Through BBA 97, approximately $40 billion in federal funding was appropriated for the CHIP program. Collectively, states have spent $10.1 billion since it was first implemented through September 30, 2005.

I am extremely happy to report that 6.2 million children have their health insurance coverage through the CHIP program. As one of the original authors of the CHIP program with Senator Kennedy, Senator Rockefeller, and the late Senator Chafee, I am so proud of the program's successes.

When we drafted this legislation in 1997, our goal was to cover the several million children who had no insurance coverage. We have gone a long way in meeting that goal, but we are clearly not there yet. Coverage of these uninsured children should still be our top priority.

I know some may disagree with me, but in my opinion, we shouldn't consider expanding this program to other populations until we have covered all needy children who do not have health care coverage.

This fall, the Health Care Subcommittee will hold a second hearing to examine the more difficult issues facing Congress as it reauthorizes the CHIP program. These issues include the future financing of the program, who should be covered, and how to provide effective outreach to eligible children who are not covered.

The purpose of today's hearing is to focus on the successes of this very important program. Senator Rockefeller, I appreciate the hard work that both you and your staff

have put into today's hearing and look forward to working with you and the other Senators who have an interest in this issue.

Testifying before the Subcommittee today is Senator Ted Kennedy, whose vision and drive were integral to development of the CHIP program. Senator Kennedy was coauthor with me of the "CHILD" bill, which when melded with the Chafee-Rockefeller bill expanding Medicaid coverage for children, became CHIP.

On the second panel, we will hear from Administrator of the Centers for Medicare & Medicaid Services, Dr. Mark McClellan. He is accompanied by Dennis Smith, a Finance Committee alumnus who is now the Director of Medicaid and State Operations for CMS.

The last panel is made up of Ms. Evelyne Baumrucker and Mr. Chris Peterson -- both of whom are Congressional Research Service specialists on the CHIP program. Ms. Baumrucker will provide a broad overview of the program while Mr. Peterson will focus on the financing of the CHIP program.

I want to thank all of our witnesses for taking time out of their busy schedules to testify before the Subcommittee today.

Senator Rockefeller?

STATEMENT OF SENATOR EDWARD M. KENNEDY
FINANCE HEALTH SUBCOMMITTEE HEARING:
"CHIP AT 10: A DECADE OF COVERING CHILDREN"
JULY 25, 2006

I thank Chairman Hatch and Senator Rockefeller for inviting me to testify this afternoon. Your leadership in creating and sustaining the Children's Health Insurance Program has improved the lives of children across the nation.

Many of the best ideas in public policy are the simplest. CHIP is based on one simple and powerful idea – that the nation's children deserve a healthy start in life.

My own state of Massachusetts has long recognized the importance of this basic idea. In 1993, Massachusetts enacted the Children's Medical Security Plan to bring quality health care coverage to children in low income families not eligible for Medicaid.

That pioneering program owed much to the leadership of John McDonough, and he urged Congress to enact federal legislation to cover the nation's children.

Massachusetts provided the inspiration for another major element of our success ten years ago. In 1994, Massachusetts expanded eligibility for Medicaid, and financed the expansion through a tobacco tax – the same approach we used successfully a few years later for CHIP.

Rhode Island and other states took similar action, to create a nationwide call for action to address the health needs of children.

Congress acted on that call, and the result was CHIP, a program that can make the difference between a child starting life burdened with disease – or a child who is healthy and ready to learn and grow. In every state in the nation and in Puerto Rico, CHIP covers the services that give children the right start in life – well child care, vaccinations, doctor visits, emergency services, and many others.

That's why every organization representing children, or the health care professionals who serve them, recognizes that preserving and strengthening CHIP is essential to the health of children. The Children's Defense Fund, the National Partnership for Women and Families, the American Academy of Pediatrics, the March of Dimes, and countless other organizations dedicated to children all strongly support CHIP.

According to the American Academy of Pediatrics, "Enrollment in SCHIP is associated with improved access, continuity, and quality of care, and a reduction in racial/ethnic disparities. As pediatricians, we see what happens when children don't receive necessary health care services such as immunizations and well-child visits. Their overall health suffers and expensive emergency room visits increase."

Today, we are here to dedicate ourselves to the job begun ten years ago, and make sure that the lifeline of CHIP is strengthened and extended to more children.

Millions of children eligible for CHIP or Medicaid are not enrolled. Of the over eight million uninsured children, three quarters – or over 6 million -- already are eligible for Medicaid or CHIP. These programs are there to help them, but these children are not getting that help, because their parents are unaware of their eligibility or because there are barriers to enrollment.

We should look at innovative ways of working with our schools, our churches, and state and local governments to make sure that parents know that this health insurance is available for their children.

By improving outreach – and providing the funding needed to make that outreach a success – we can see that CHIP continues its remarkable success in reducing the percentage of children who are uninsured. Over the last decade, employer after employer has dropped coverage – yet, due to CHIP, the percentage of children who are uninsured has actually dropped over this period, from 22.6 percent in 1997 to 13.5 percent today.

To build on this success, Congress needs to renew its commitment to CHIP. The President's budget assumes that CHIP funding will remain at about $5 billion per year. But with rising health costs, we will need an additional investment of $12 billion over the five years between 2008 and 2012 just to break even. If we fail to provide that funding, the consequences will be disastrous.

Since its enactment, enrollment in CHIP has steadily increased – but this positive trend will be reversed if Congress does not increase funding for the program over this baseline. Without that additional investment, 1.5 million children will be dropped from the program, according to the CMS Actuary's own figures.

If funding is not increased, states across the nation will face worsening funding shortfalls, so that by 2012, 36 states will run out of the funds required just to meet current needs.

Our final priority should be not merely to hold on to the gains of the past, but to see that all children have an avenue to health coverage. Families with greater means should pay a fair share of the coverage. But every single parent in America should have the opportunity to meet the health care needs of their children.

I thank you for your time and attention, and I look forward to working with the members of the committee on this important legislation.

Testimony of

Mark B. McClellan, MD, Ph.D.

Administrator, Centers for Medicare & Medicaid Services

Before the Senate Finance Subcommittee on Healthcare

Hearing on

State Children's Health Insurance Program

July 25, 2006

Chairman Hatch, Senator Rockefeller, distinguished members of the subcommittee, thank you for the opportunity to discuss the State Children's Health Insurance Program (SCHIP). First, I would like to thank Chairman Hatch, Senator Rockefeller, and Senator Kennedy for the leadership they displayed in working to establish the SCHIP program. I also would like to acknowledge the contributions of Sen. Chafee's father, Sen. John Chafee, whose involvement in the SCHIP effort highlighted his dedication and commitment to children's health care needs.

SCHIP Nears 10-Year Anniversary

Next year marks the 10th anniversary of SCHIP, a program that provided health benefits to more than 6.1 million children in FY 2005. Enrollment of children now exceeds original expectations by more than 1 million, and the Administration remains committed to working with States to continue to serve children and families as effectively as possible, and to strengthen efforts to identify and enroll the many eligible but unenrolled children, as the President has made clear through his proposed "Cover the Kids" Initiative. As the Finance Committee works on the reauthorization of this important program, I want to work with you to build on the success of SCHIP.

Created as part of the Balanced Budget Act of 1997 (BBA), SCHIP reflected a bipartisan approach to address the growing number of children without health insurance. SCHIP is a partnership between the Federal and State government with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but cannot afford private coverage. SCHIP is the single largest expansion of

health insurance coverage for children since the initiation of Medicaid. The program provides each State with the flexibility to design its program within broad Federal guidelines in order to best meet the unique needs of the children and families it serves, and the circumstances of health insurance in the State. This flexibility has helped make SCHIP a clear success, because SCHIP took an innovative approach: flexibility for States to find the best way to provide coverage within broad Federal guidelines. SCHIP gives States the ability to adjust the program's coverage to reflect the particular needs and economic circumstances of the populations served, and to use new and creative approaches to provide health insurance coverage effectively.

SCHIP Enrollment Exceeds Original Goals

SCHIP funds became available to the States beginning October 1, 1997, and since then, the Centers for Medicare & Medicaid Services (CMS) has overseen the allocation of the approximately $40 billion the BBA appropriated to the program. As an incentive to expand coverage to reach low-income SCHIP children, the BBA provided States with the opportunity to receive an enhanced Federal matching rate of up to 85 percent for qualifying State SCHIP expenditures.

Enrollment of children in SCHIP programs has increased from 660,000 in FY 1998 to 6.1 million ever-enrolled for FY 2005. When the program began, CMS had estimated enrollment of only 5 million by FY 2005. CMS wants to build on the successful enrollment in SCHIP and is committed to finding and enrolling as many eligible children as possible. The President's proposed "Cover the Kids" initiative would provide $100 million annually for grants to the States, Tribes, schools, and faith-based and community organizations to increase enrollment of children in SCHIP at Medicaid.

CMS also is taking new steps to increase the quality of care in all SCHIP programs. As part of this effort, CMS is working with the States to develop long-term performance measures for SCHIP. CMS also is collaborating with the States to improve how performance measurement data are collected.

SCHIP Provides Coverage to Low-Income Children

SCHIP is designed to provide coverage to "targeted low-income children" and since September 1999 every State, the District of Columbia and all five territories has had a SCHIP plan in place. A "targeted low-income child" is one who resides in a family with income below 200% of the Federal Poverty Level (FPL) or whose family has an income up to 50 percent higher than the State's Medicaid eligibility threshold. Some States have expanded SCHIP eligibility beyond the 200% FPL limit, and others are covering entire families and not just children.

SCHIP provides States (including territories) with three options when designing a program. With their SCHIP allotment, States may expand Medicaid eligibility to children who previously did not qualify for the program (17 States and D.C.); design a children's health insurance program entirely separate from Medicaid (18 States); or, combine both the Medicaid and separate program options (21 States).

Typically, SCHIP benefits are available to uninsured children under age 19 who are not eligible for Medicaid and whose families have incomes below 200 percent of the Federal Poverty Level (FPL). The differences in populations and income levels covered have a significant impact on whether a State's SCHIP allotment is sufficient to cover the costs of its program.

SCHIP eligibility requirements vary by State and are based on the structure of the individual State's program. This flexibility allows States to use its SCHIP funding in the most appropriate way to respond to its unique demographics. Currently, 36 States have eligibility levels up to and including 200 percent of the FPL. An additional 14 States cover children above that level and five of those States set their eligibility up to and including 300 percent of the FPL. New Jersey has the highest eligibility limit and offers SCHIP to children up to 350 percent of the FPL (See Attachment 1).

In a State with a Medicaid expansion program, the requirements of the State Medicaid program apply to its SCHIP plan. There is greater flexibility for States that have

established separate SCHIP programs, including the option of placing certain limitations on enrollments. These States also have the discretion to determine if assets are considered, what income is counted, and whether income disregards are applied to reduce countable income.

When considering an enrollment application for SCHIP, States must have a process in place to screen for Medicaid eligibility and facilitate Medicaid enrollment as appropriate. States also have the discretion to allow for a period of presumptive eligibility during the application and enrollment process.

Another way that SCHIP ensures that only appropriate individuals gain access to the program is through the requirement that a State make sure that low-income individuals are not substituting SCHIP coverage for private, employer-sponsored coverage they previously had. This "crowd-out" requirement prohibits individuals from entering the program if they had employer-sponsored coverage within the past six months. This requirement is particularly meaningful for States covering higher-income SCHIP eligibles, who perhaps could not afford the entire share of the premium for employer-sponsored coverage without SCHIP assistance.

SCHIP Provides States with Flexible Benefit Design Options

While SCHIP is a partnership between the Federal and State governments, States have a high degree of flexibility in designing their programs, particularly those choosing to implement a separate program. Under the law, a State that opts for a Medicaid expansion must provide services under SCHIP that mirror the Medicaid services provided by that State in its State Medicaid Plan. States with a separate child health program have four options for structuring their benefit package: benchmark coverage, benchmark equivalent coverage, existing State-based comprehensive coverage, and Secretary-approved coverage.

Benchmark coverage is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option

Service Benefit Plan or a health benefits plan offered by the State to its employees. A health plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the State also is considered benchmark coverage. This option allows States to model their program's coverage on mainstream private coverage, and to coordinate with or subsidize employer coverage rather than financing a separate system.

States that elect to provide benchmark equivalent coverage must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. Benefits must include inpatient and outpatient hospital services, physician surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations. Plans also must provide at least 75 percent of the actuarial value of coverage under the benchmark plan for prescription drugs, and mental health, vision and hearing services.

The third option applies only to States that offered comprehensive coverage packages before the enactment of SCHIP. New York, Pennsylvania and Florida had existing programs that met SCHIP coverage requirements and therefore were "grandfathered" into the program.

Finally, States may also choose to design their program to best serve their populations, provided the Secretary approves the program design. This option is one of the hallmarks of the flexibility the statute gives States. For example, States may design their program to include the same benefits as the State's Medicaid program. States also may elect to provide coverage under SCHIP that is offered under a SCHIP or Medicaid section 1115 demonstration project. Such coverage may also include coverage that includes benefits in addition to benchmark coverage or coverage that is equivalent to the New York, Florida or Pennsylvania programs.

Regardless of the type of health benefits coverage provided by a State, there are certain services that all States must cover, including coverage for well-baby and well-child care,

immunizations and emergency services. States generally cannot exclude preexisting conditions from coverage. If SCHIP plans provide coverage through group health plans, preexisting condition exclusions must adhere to ERISA rules. States opting for a separate child health program must ensure that coverage provided under the SCHIP program does not substitute for private group health plan coverage. These protections against crowd-out may include a required waiting period without group health plan coverage.

SCHIP Cost-Sharing Requirements

Federal law and regulations restrict the level of cost-sharing States may impose on their SCHIP beneficiaries. For States that opt to expand Medicaid coverage, co-payments are restricted to the levels allowed by the Medicaid program. For States that offer separate SCHIP programs, co-payments, premiums and other cost-sharing mechanisms cannot exceed five percent of the family income for all children in the family. In addition, cost-sharing is not permitted for well-baby, well-child care, immunizations, or preventive dental services. When implementing co-payments, States may not favor higher-income children over children from lower-income families. Additionally, States are prohibited under Federal SCHIP regulations from imposing any charge or cost-sharing requirements on American Indian or Alaskan Native children.

SCHIP Demonstration Process Encourages Innovation

To provide States with the ability to structure their SCHIP plans to improve coverage and the quality of services available to beneficiaries, the Secretary has the authority to waive aspects of the Federal statute and regulations governing SCHIP. This allows States to amend their programs to increase health insurance coverage and encourage innovation. Using section 1115 of the Social Security Act, States can more effectively tailor their programs to meet local needs and can experiment with new approaches to providing health care services. These demonstrations have been used to provide health insurance to uninsured children, parents, caretaker guardians, and pregnant women. For example, CMS recently extended a demonstration in Minnesota that allows the State to use SCHIP funds to provide coverage to those with incomes from 100 to 200 percent of FPL who are parents and relative caretakers of Medicaid- and SCHIP-eligible children. Extending

coverage to parents and caretaker relatives not only serves to cover additional uninsured individuals, but it may also increase the likelihood that they will take the steps necessary to enroll their children. Extending coverage to parents and caretakers may also increase the likelihood that their children remain enrolled in SCHIP. For example, in New Jersey, which covers parents through a section 1115 demonstration, the State found that having one parent enrolled increased the likelihood that a child remains enrolled.

CMS has promoted a relatively new section 1115 approach, the Administration's Health Insurance Flexibility and Accountability (HIFA) demonstrations, to help States to develop comprehensive insurance coverage for individuals with income at or below 200 percent of the FPL using currently available SCHIP and Medicaid funds. These demonstrations target vulnerable, uninsured populations, such as pregnant women, parents and children on Medicaid and SCHIP, and other adult caregiver-relatives. CMS places a particular emphasis on broad statewide approaches that maximize both private health insurance coverage and employer sponsored insurance. As of January 2006, CMS has approved 13 HIFA demonstrations: Arizona, Arkansas, California, Colorado, Idaho, Illinois, Maine, Michigan, New Jersey, New Mexico, Oklahoma, Oregon, and Virginia.

Although the coverage of expansion populations promotes the objectives of SCHIP by providing health insurance coverage to those who were previously uninsured, SCHIP 1115 demonstrations must assure that all necessary SCHIP (title XXI) funds are available for children. Under the demonstrations, States are not permitted to limit or cap children's enrollment, and are required to prioritize the availability of funds for children over funding adult expansion populations.

States are using HIFA demonstrations to offer premium assistance to uninsured individuals who have access to employer-sponsored health plans. This allows the States to cover more people while maximizing the use of limited public resources. Premium assistance helps families afford private coverage and enables families to enroll in a single health insurance plan. This approach to helping families afford health insurance not only provides more efficient coverage than separate plans for different family members; it also

minimizes the risk of crowd-out.

As required by the Deficit Reduction Act (DRA) of 2005, CMS will no longer, as of October 1, 2005, approve new demonstration requests that would use SCHIP funds to provide coverage to non-pregnant childless adults, other than caretaker relatives. This prohibition, however, does not apply to current demonstrations or to the extension, renewal or amendment of existing demonstrations.

SCHIP Financing Based on Annual Allotment and Federal Matching Funds

SCHIP is jointly financed by the Federal and State governments and is administered by the States. As previously mentioned, within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to States on a matching basis for Federal fiscal years (FY) 1998 through 2007.

The amount of the Federal funds available for SCHIP is allocated based on a fiscal-year and on a State-specific basis. The statute appropriates the following amounts for allotment to States:

- $4,295,000,000 for FY 1998;
- $4,275,000,000 each year for FY 1999 through FY 2001;
- $3,150,000,000 each year for FY 2002 through FY 2004;
- $4,050,000,000 each year for FY 2005 through FY 2006; and,
- $5,000,000,000 for FY 2007.

State allotments for a fiscal year are determined in accordance with a statutory formula that is based on the "Number of Children" and the "State Cost Factor." For FY 2001 and succeeding years, the Number of Children factor is based on 50 percent of the low-income uninsured children in the State and 50 percent of the number of low-income children in the State. The State Cost Factor is a geographic cost factor that is based on annual wages in the health care industry for each State. Payment variability to the States

over time is limited by statutory floors and ceilings, which limit fluctuation from year-to-year and over the life of the program.

One of the primary data sources used in this formula is the Current Population Survey (CPS). The CPS provides data on the number of uninsured children in each State.

For qualifying expenditures, States receive an enhanced Federal matching rate that is equal to 70 percent of their Medicaid Federal Medical Assistance Percentage (FMAP) for the fiscal year plus 30-percentage points, not to exceed 85 percent. In addition to the limits imposed on the overall allotment amounts, there is a 10-percent limit on administrative expenditures (including expenditures for outreach) by each State that is applied on a fiscal year basis. This limit is referred to as the "10-percent administrative cap."

In general, State allotments for a fiscal year remain available for expenditure by that State for a 3-year period; the fiscal year of the award and the two subsequent fiscal years. For example, the 2004 allotment is available to States during Federal fiscal years 2004, 2005 and 2006. However, any allotment amounts for a fiscal year that a State fails to use within that 3-year period are subject to reallocation to States that spent their entire SCHIP allotment.

SCHIP Financing

At the beginning of SCHIP implementation, States were at various stages of providing coverage for children. Some States were already covering children at higher income levels prior to SCHIP. For example, Minnesota was covering children up to 275 percent of the Federal poverty level (FPL) before SCHIP was implemented. So, in order to reduce the rate of uninsurance in their State, Minnesota used title XXI funds to expand coverage to parents and later expanded coverage to unborn children. As a result, Minnesota and other States with similar approaches to reducing uninsurance became redistribution States, by maximizing title XXI funds that other States had not expended.

Also, at the beginning of SCHIP, States were growing their programs at various paces. Some States grew their programs very rapidly covering children up to higher income levels, while other programs grew incrementally in phases. For example, Massachusetts aimed at reducing the uninsured rate in the State by implementing MassHealth Family Assistance to uninsured children with family incomes from 150 to 200 percent of the FPL. In 2003 Massachusetts added presumptive eligibility for SCHIP as well as expanded coverage to unborn children up to 200 percent of the FPL. Most recently, Massachusetts expanded coverage to children up to 300 percent of the FPL. By expanding eligibility in the early years of SCHIP, States like Massachusetts took advantage of title XXI funds to reduce the rate of the uninsured in their State. Massachusetts became eligible and received redistribution funds for each year from 1998 through 2002.

Since fiscal year 2002, some States' total spending of title XXI funds has exceeded their annual original allotments. Shortfalls of Federal title XXI funds have been avoided by using leftover prior-year balances and by redistributing funds from States with unspent funds to States facing shortfalls. At the end of FY 2006 there is projected a total of $4.1 billion in unexpended allotments that will be available for expenditure in FY 2007. In addition $5 billion in FY 2007 allotments will become available in FY 2007. Therefore, a total of $9.1 billion will be available nationally to States in FY 2007. States' projected expenditures in FY 2007 are $6.4 billion. Therefore, from a national perspective, there are sufficient allotment funds available to address the States' total expected expenditures. However, even though the available expected SCHIP funds in FY 2007 will total over $9 billion, the shortfall for certain States in FY 2007 is projected to be about $906 million. This is because most of the $4.1 billion in unexpended SCHIP funds carried over from FY 2006 is unavailable for reallotment in FY 2007 to the States that may need it. The current law redistribution rules for title XXI funds mean that only a limited portion of these funds are available for reallocation. The President's FY 2007 Budget proposes to address projected shortfalls of any individual State and target SCHIP funds to States in a more timely manner.

In FY 2006, there are about $9.7 billion in available allotments in FY 2006 (not including the $283 million in DRA funds discussed below) which does include about $4 billion in FY 2006 allotments and about $5.7 billion in allotments carried over from FY 2005 (including $173 million in unexpended FY 2003 allotments). States projected expenditures in FY 2006 are about $5.8 billion.

However, even though from a national perspective there would be sufficient funds to meet the projected expenditures in FY 2006, there are 12 States that would have a total shortfall of about $456 million. The only funds available for redistribution in FY 2006 are the unexpended $173 million in FY 2003 allotments. Since amounts actually available for reallotment in 2006 do not prevent 2006 shortfalls, Congress appropriated $283 million ($456 million minus the $173 million in unexpended FY 2003 allotments) for purposes of providing additional allotments to shortfall States through the Deficit Reduction Act (DRA) of 2005. Shortfall States are those States that have insufficient Federal funding to fund the State's current title XXI programs. The 12 shortfall States are Illinois, Iowa, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Rhode Island, and South Dakota.

Prior to FY 2006, Congress took several other actions to reallocate title XXI funds to prevent State shortfalls in previous years. The Benefits Improvement and Protection Act (BIPA) of 2000 revised the allocation process to provide both retained and redistributed funds from the 1998 and 1999 SCHIP allotments and make these funds available through 2002. Public Law 108-74, which was signed by President Bush on August 15, 2003, extended the availability of the 1998 and 1999 SCHIP allotments again through 2004. This law also permitted States to retain 50 percent of the total amount of unexpended 2000 and 2001 allotments through 2004 and 2005 respectively. Public Law 108-74 also authorized "qualifying States" to use up to 20 percent of 1998, 1999, 2000 and 2001 allotments for Medicaid payments. (Qualifying States included Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin.) Then 2002 unspent funds were reallocated to States that had fully expended their 2002 allotments per the Secretary's authority granted

under title XXI. There is no provision in current statute to allow States that did not fully expend funds to retain any unspent funds.

Six of the States that had expended their full 2002 allotments (Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island) projected that their 2005 expenditures would exceed available SCHIP funding. CMS issued a final Federal Register notice in September 2005 that designated these States as "shortfall States" that would receive funding in the amount of the shortage.

This history illustrates that in the beginning of the SCHIP program States were still building their programs and some had unexpended funds available for redistribution.

However, as time progressed, the amount of available redistributed funds decreased and States began having shortfalls of SCHIP funds. The Administration and Congress have worked together successfully to address any State shortfalls. The FY 2007 Budget proposes to address State shortfalls for FY 2007 and we look forward to working with Congress on this issue.

Over the years, States have projected shortfalls for various reasons:

- Expansions under section 1115 authority to parents, childless adults or pregnant women;
- Coverage provided to children with SCHIP eligibility income thresholds above 200 percent of the Federal poverty level (FPL);
- Coverage to unborn children;
- Presumptive eligibility coverage provided through SCHIP; and/or
- The reduction in the availability of redistribution funds over time;

As we work to reauthorize the SCHIP program, we want to work with you to make sure that SCHIP allotments are distributed in a manner that meets State needs. We have an effective track record of assuring that available SCHIP funds are used where needed for coverage, to prevent any consequences from shortfalls in specific States.

Conclusion

Chairman Hatch, Senator Rockefeller, distinguished members of the subcommittee, thank you again for the opportunity to discuss the SCHIP program. The flexibility afforded under this program has allowed States to expand health care creatively to children nationwide. As we approach the 10-year anniversary of the program, I am excited for the opportunity to take stock of the success of SCHIP and begin the process of working with you to reauthorize this landmark health care program. I would be happy to answer any questions you may have.

Upper Income Thresholds for Pre-SCHIP Medicaid and State Children's Health Insurance Programs as of July 2006

	Percent of the Federal Poverty Level (FPL)					
	Traditional Medicaid Thresholds as of March 31, 1997				Thresholds as of July 2006[a]	
State	**Ages 0-1**	**Ages 1-5**	**Ages 6-13**	**Ages 14-18**	**M-SCHIP**	**S-SCHIP**
Alabama (S)	133%	133%	100%	15%	-	200%
Alaska (M)	133%	133%	100%	100%	175%	-
Arizona (S)	140%	133%	100%	30%	-	200%
Arkansas[b] (C)	133%	133%	100%	18%	200%	200%
California (C)	200%	133%	100%	82%	100%	250/300%[c]
Colorado (S)	133%	133%	100%	37%	-	200%
Connecticut (S)	185%	185%	185%	100%	185%	300%
Delaware (C)	133%	133%	100%	100%	200%	200%
District of Columbia (M)	185%	133%	100%	50%	200%	-
Florida (C)	185%	133%	100%	28%	200%	200%
Georgia (S)	185%	133%	100%	100%	-	235%
Hawaii[d] (M)	185%	133%	100%	100%	300%	-
Idaho (C)	133%	133%	100%	100%	134%[e]	185%
Illinois[f] (C)	133%	133%	100%	46%	133%	200%
Indiana (C)	150%	133%	100%	100%	150%	200%
Iowa (C)	185%	133%	100%	37%	200%[g]	200%
Kansas (S)	150%	133%	100%	100%	-	200%
Kentucky (C)	185%	133%	100%	33%	150%	200%
Louisiana (M)	133%	133%	100%	10%	200%	-

Program Type as of July 2006

Attachment 1

Upper Income Thresholds for Pre-SCHIP Medicaid and State Children's Health Insurance Programs

	Percent of the Federal Poverty Level (FPL)					
	Traditional Medicaid Thresholds as of March 31, 1997				Thresholds as of July 2006	
State	Ages 0-1	Ages 1-5	Ages 6-13	Ages 14-18	M-SCHIP	S-SCHIP
Maine (C)	185%	133%	125%	125%	150%	200%
Maryland (C)	185%	185%	185%	100%	200%	300%
Massachusetts (C)	185%	133%	114%	86%	150%[h]	300%[i]
Michigan (C)	185%	133%	100%	100%	150%	200%
Minnesota (C)	275%	275%	275%	275%	280%[j]	275%
Mississippi (S)	185%	133%	100%	34%	-	200%
Missouri (M)	185%	133%	100%	100%	300%	-
Montana (S)	133%	133%	100%	40.5%	-	150%
Nebraska (M)	150%	133%	100%	33%	185%	-
Nevada (S)	133%	133%	100%	31%	-	200%
New Hampshire (C)	185%	185%	185%	185%	300%[k]	300%
New Jersey (C)	185%	133%	100%	41%	133%	350%
New Mexico (M)	185%	185%	185%	185%	235%	-
New York (S)	185%	133%	100%	51%	-	250%
North Carolina (C)	185%	133%	100%	100%	200%[l]	200%
North Dakota (C)	133%	133%	100%	100%[m]	100%[n]	140%
Ohio (M)	133%	133%	100%	33%	200%	-
Oklahoma (M)	150%	133%	100%	48%	185%	-
Oregon (S)	133%	133%	100%	100%	-	185%[o]

Program Type as of July 2006.

Attachment 1

Upper Income Thresholds for Pre-SCHIP Medicaid and State Children's Health Insurance Programs

	Percent of the Federal Poverty Level (FPL)					
	Traditional Medicaid Thresholds as of March 31, 1997				Thresholds as of July 2006	
State	Ages 0-1	Ages 1-5	Ages 6-13	Ages 14-18	M-SCHIP	S-SCHIP
Pennsylvania (S)	185%	133%	100%	41%	-	200%
Rhode Island (C)	250%	250%[p]	100%[q]	100%	250%[r]	250%
South Carolina (M)	185%	133%	100%	48%	150%	-
South Dakota (C)	133%	133%	100%	100%	140%	200%
Tennessee[s] (M)	-	-	-	16%	-	-
Texas (S)	185%	133%	100%	17%	-	200%
Utah (S)	133%	133%	100%	100%[t]	-	200%
Vermont[u] (S)	225%	225%	225%	225%	-	300%
Virginia (C)	133%	133%	100%	100%	133%	200%
Washington (S)	200%	200%	200%	200%	-	250%
West Virginia (S)	150%	133%	100%	100%	-	200%
Wisconsin (M)	185%	185%	100%	45%	185%[v]	-
Wyoming (S)	133%	133%	100%	55%	-	200%

Source: CMS/Center for Medicaid and State Operations, information from SCHIP state plans.
See Notes on following page.

Program Type as of July 2006.

Attachment 1

Notes: [a] Some numbers may differ in practice because of the operation of an income disregard that has not been taken into account.
[b] Arkansas increased Medicaid eligibility to 200 percent of the FPL, effective September 1997, through section 1115 demonstration authority. This expansion was effective September 1997, which is after the SCHIP maintenance effort date.
[c] California's county program expanded eligibility to 300 percent of the FPL in four counties. Coverage for the unborn child goes to 300 percent of the FPL
[d] Hawaii covers children 200-300 percent of the FPL under s section 1115 demonstration.
[e] Idaho covers children ages 6 through 18 only.
[f] Illinois' SCHIP Medicaid expansion covers infants up to 200 percent of the FPL when the child is born to a woman in the Moms and Babies program. The separate child health program, KidCare Share covers children from 133--150 percent of the FPL, with modest co-payments. KidCare Premium covers children from 150-200 percent of the FPL, with modest premiums and co-payments.
[g] Iowa's SCHIP Medicaid expansion program covers infants over 185 percent of the FPL through 200 percent of the FPL.
[h] Massachusetts' SCHIP Medicaid expansion program covers infants in families with income up to 200 percent of the FPL.
[i] In Massachusetts, only children under age 0 are covered above 200 through 225 percent of the FPL through the SCHIP unborn child/prenatal state plan amendment option.
[j] In Minnesota, only children ages birth through two are eligible for the SCHIP Medicaid expansion.
[k] In New Hampshire, infants are covered through the SCHIP Medicaid expansion and children ages one through 18 are covered through the separate child health program.
[l] In North Carolina, children ages 0-5 are covered in the Medicaid expansion program; children ages 6-18 are covered in the separate child health program.
[m] In North Dakota, the age range is 14-17.
[n] North Dakota's SCHIP Medicaid expansion consists of children who became eligible for Medicaid when the state eliminated the Medicaid asset tests on January 1, 2002.
[o] Oregon increased eligibility to 185 percent of the FPL through a HIFA section 1115 Medicaid and SCHIP demonstration.
[p] In Rhode Island, the age range is 1-7.
[q] In Rhode Island, the age range is 8-13.
[r] For Rhode Island, an amendment to increase the SCHIP Medicaid expansion income threshold to 300 percent of the FPL has been approved, but has not been implemented.
[s] Tennessee provides coverage to children above the Medicaid state plan levels under a section 1115 demonstration. The demonstration covers: (1) Children without access to group health insurance up to 200 percent of the FPL; (2) Children enrolled as of 12/31/01 who have access to group health insurance up to 200 percent of the FPL; and (3) Children who are medically uninsurable with no upper income limit. Therefore, TennCare has no upper limit. TennCare recipients with incomes above the poverty level are charged a monthly premium based on a sliding scale. There are no premium subsidies for families with incomes > 400 percent of the FPL. The SCHIP Medicaid expansion covered children born before October 1, 1983 who enrolled in TennCare on or after April 1, 1997.
[t] In Utah, the age range is 14-17.
[u] Vermont's SCHIP covers uninsured children between 225 and 300 percent of the FPL. Other children in this income range that are ineligible for SCHIP are covered under the state's Medicaid Section 1115 waiver, which was implemented October 1998.
[v] In Wisconsin, once a child is enrolled, eligibility is maintained as long as income stays below 200 percent of the FPL.

Federal SCHIP Financing: Testimony Before the Senate Finance Health Subcommittee

July 25, 2006

Chris L. Peterson
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Chairman Hatch, Senator Rockefeller and other members of the Subcommittee, my name is Chris Peterson, and I am a Specialist in Social Legislation with the Congressional Research Service (CRS). I am pleased to be here to talk about the federal financing of the State Children's Health Insurance Program (SCHIP). In particular, I want to focus on some policy levers that could be used to affect the FY2007 shortfalls and the program's reauthorization. But to illuminate some of those future issues, a quick look back is necessary. **Table 1** summarizes SCHIP's federal financing for the current authorization of FY1998 to FY2007.

Table 1. Federal SCHIP Financing, FY1998-2007
(dollars in millions)

Fiscal Year	Original Allotments	Redistribution: Allotments unspent after 3 years	Spending	Shortfalls	Number of Shortfall States
1998	$4,235		$122		
1999	$4,247		$922		
2000	$4,249		$1,929	*	1
2001	$4,249	$2,034	$2,672	*	1
2002	$3,115	$2,819	$3,776		
2003	$3,175	$2,206	$4,276	*	1
2004	$3,175	$1,749	$4,645	$19	1
2005	$4,082	$643	$5,089		
2006	$4,082+$283 DRA+$173		$5,981	$2.75	4
2007	$5,040	$96	$6,342	$944	18

Source: CRS SCHIP Projection Model (See CRS Report RL32807).

* Less than $1 million.

Notes: Original allotments, redistribution and spending includes territories. FY2006 and FY2007 are projections, based on states' estimates provided to the Centers for Medicare and Medicaid Services (CMS) in November 2005. "$283 DRA" is the $283 million appropriation made through the Deficit Reduction Act of 2005 (P.L. 109-171).

The first column shows the federal SCHIP allotments made to states[1] and territories[2] every year over the program's history. These levels were originally set in the Balanced Budget Act of 1997 (BBA97, P.L. 105-33) at $40 billion over the 10-year period and have been altered only slightly since.[3]

BBA97 also put in place a formula that determines what each state's share of the total original allotment would be. This formula has also been largely unaltered and takes into account each state's number of low-income children, *uninsured*

[1] Including the District of Columbia.

[2] Puerto Rico, Guam, Virgin Islands, American Samoa, and the Northern Mariana Islands.

[3] Twenty million dollars was added to the FY1998 amount in §162 of P.L. 105-100. The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113) specified additional amounts to be appropriated to the territories for FY2000-FY2007.

low-income children, as well as states' average wages for employees in the health services sector as compared to the national average.

These SCHIP original allotments are available to states for three years, after which unspent funds are available for redistribution to other states. As you can see in the next column, in the first few years of redistribution, a lot of unspent money was at stake, and Congress intervened to change how these funds were distributed. However, as the amount up for redistribution has dropped over time, Congress has left the redistribution process up to the Secretary of Health and Human Services (HHS). These funds now go entirely toward states' projected initial shortfalls.[4] Looking ahead, less redistribution money[5] means states must place greater reliance on their own original allotments. Thus, both the national level of original allotments and the way it is divided among the states becomes increasingly critical.

The next column shows states' spending of federal SCHIP dollars, with amounts ever increasing since 1998. Based on states' projected spending, FY2006 appeared to be the first year in which numerous states faced shortfalls, totaling approximately $283 million. The first Senate-passed version of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) would have closed that shortfall, or come very close, without requiring an additional appropriation. It did so by reducing the period of availability of certain allotments (FY2004 and FY2005) from the standard three years to two years. In the end, however, Congress opted simply to appropriate $283 million to close these shortfalls.

As you can see in the lower right-hand corner of **Table 1**, CRS has projected a shortfall of just under $1 billion for 18 states in FY2007. As with the FY2006 numbers, these estimates are based on states' projections from November 2005. The Centers for Medicare and Medicaid Services (CMS) has projections from states six months more recent. I retain the earlier numbers (1) because it was the basis of the distribution of the DRA funds and (2) because it illustrates some fairly significant

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[4] A shortfall exists when all of a state's available federal SCHIP funds are exhausted in a given fiscal year (that is, when a state's projected spending for the year exceeds its available federal funds). The definition of "initial shortfall" is slightly different. "Initial shortfall" is the amount of a state's projected shortfall in a fiscal year *not including* redistribution funds available in that year. For example, for FY2006, the Centers for Medicare and Medicaid Services (CMS) had to determine how much of unspent FY2003 original allotments as well as the Deficit Reduction Act appropriation of $283 million would be distributed to which states. This was done on the basis of the initial shortfalls for the year.

[5] According to preliminary projections from the CRS SCHIP Projection Model (and assuming baseline original allotments into the future of $5 billion per year), funds available for redistribution will rise between FY2008 and FY2010. In FY2010, the preliminary projections estimate available redistribution funds to reach approximately $325 million. The post-FY2010 projections show declining redistribution amounts. The $325 million in redistribution estimated for FY2010 is still much less than amounts available historically in the current authorization shown in Table 1. The increases between FY2008 and FY2010 come from the redistribution of unspent FY2005-FY2007 original allotments — allotments of greater amounts than those from the so-called "CHIP dip," when total allotment levels were at their lowest, from FY2002 to FY2004 (and slated for redistribution in FY2005 to FY2007 respectively). Even with the modest increase in available redistribution funds between FY2008 and FY2010, preliminary projections indicate only increasing total shortfalls from FY2007 onward under baseline assumptions.

changes in state projections in a relatively short amount of time. This could be due to states altering their SCHIP programs, local economic factors, or the way states produce their projections. Regardless, a much larger appropriation would be required to eliminate the 2007 shortfall, compared to what was needed for 2006.

The President's Budget resurrected the idea of shortening the period of availability of original allotments, specifically just the FY2005 allotment. While CRS projects this would eliminate the projected shortfalls in FY2007,[6] the longer-term outlook regardless of action specific to 2007 indicates the possibility of more states facing shortfalls. Currently, 40 states spend more annually than they receive in their annual original allotment. Many of them do *not* face shortfalls currently because they have prior-year balances, redistributed funds, as well as the DRA appropriation to draw from. However, as more states spend more than they receive in their original allotments with less money available from other SCHIP accounts, more states face the prospect of chronic shortfalls over time. For example, continuing the FY2007 original allotment amount of $5 billion annually into the future[7] and increasing states' projected spending only by per-capita growth in health care expenditures,[8] 35 states could face shortfalls totaling nearly $4 billion in FY2013, based on estimates from the CRS SCHIP Projection Model.

Ten years ago, when SCHIP was created, it could not be predicted what various states would do, let alone whether they would exhaust their federal SCHIP funds years down the road. Now, however, we have years of experience, which raises new questions for reauthorization. For example, should the allotment formula incorporate states' spending or enrollment information that did not exist a decade ago? If allotments are inadequate to cover states' projected spending, spending and enrollment information that was not available a decade ago will also enable analysts like myself to make projections about which states might face what size shortfalls, based on whatever criteria Congress considers.

The continued potential for shortfalls then raises more fundamental questions about SCHIP, such as, how much responsibility does the federal government have to address shortfalls in this capped-grant program? If the goal is to prevent any state from experiencing shortfalls, Congress could choose to permit states to draw down federal SCHIP funds on an uncapped basis, or to appropriate additional funds to close shortfalls, as was done in DRA. Otherwise, the three major financial levers moving forward all pertain to the original allotments — their total level, how each state's share is determined, and how long the states have access to the funds.

These are difficult questions, and CRS looks forward to continuing to work with this subcommittee on these issues.

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[6] See tables 4 and 5 of CRS Report RL32807, included for the record.

[7] Congressional Budget Office (CBO) baseline assumptions, that the program will continue at its last appropriated level.

[8] Christine Borger et al., "Health Spending Projections Through 2015: Changes On The Horizon," *Health Affairs* Web exclusive , pp. W61-73, at [http://content.healthaffairs.org/cgi/reprint/25/2/w61.pdf, subscription required].

[For the record, two CRS reports are included along with the written testimony — CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson, May 8, 2006; and CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson, April 18, 2006.]

Additional Comments and Analysis

The two CRS reports I have included for the record describe in greater detail many of the federal financing issues I touched on in the preceding comments. I want to highlight some of the more critical points from those reports that I did not have time to make in my testimony. In addition, since the publication of those two reports, CRS has done additional analyses that I am providing here, which I hope the Subcommittee will also find informative. First, I look at the potential use for current-law Medicaid funding to reduce some of the FY2007 projected shortfalls in some states. Next, we analyze a few possible options for altering the SCHIP allotment formula. The first of those options looks at possible alternatives to the Current Population Survey as a source of data in the allotment formula. It is followed by an analysis of the estimated impact of excluding estimates of *uninsured* low-income children from the formula. Finally, we provide estimates of incorporating historical spending data into the allotment formula, projecting what impact this would have on shortfalls. Of course, the fact that I am providing these analyses should not be interpreted as any kind of recommendation for or against anything discussed.

Potential for Medicaid Funding to Narrow Shortfalls

States can cover SCHIP enrollees by expanding their Medicaid program or by creating a separate SCHIP program, or by a combination of both. If a state has a Medicaid-expansion SCHIP program, it can rely on Medicaid funds once its federal SCHIP funds are exhausted. Although the federal matching rate is lower for Medicaid than for SCHIP, these states experiencing shortfalls would at least receive most of the federal funds they would have received from SCHIP if the funds were available.[9] Of the 18 states projected to exhaust their federal SCHIP funds in FY2007, four (Georgia, Minnesota, Mississippi, and North Carolina) appear to have no alternative for federal funds besides SCHIP. This is because their SCHIP programs are separate from Medicaid. In the other 14 states, some portion of the SCHIP federal funds could be paid by Medicaid.[10] As shown in Table 3 of CRS Report RL32807, 14 are projected to be able to use federal Medicaid funds to ameliorate their projected FY2007 shortfalls. According to these projections, nearly $350 million in potential Medicaid funding would reduce the $944 million shortfall to just under $600 million.[11]

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[9] This refers to only the portion of a state's SCHIP program that is a Medicaid expansion.

[10] Rhode Island operates its SCHIP as a combination program. After the state has exhausted its available SCHIP allotment, in addition to reverting to regular Medicaid funds to provide coverage for their Medicaid expansion population, Rhode Island has CMS approval under the Section 1115 waiver authority to use regular Medicaid funds to provide coverage to its SCHIP state plan and Section 1115 waiver populations until further Title XXI federal funds become available.

[11] This is why SCHIP proposal in the President's Budget would likely close the $944 million shortfall yet was estimated by HHS and CBO to increase outlays by only roughly $600 million in FY2007 (Department of Health and Human Services, *Fiscal Year 2007 Budget in Brief*, available at [http://www.hhs.gov/budget/07budget/2007BudgetInBrief.pdf] and Congressional Budget Office, *Preliminary Analysis of the President's Budget Request for 2007* (Mar. 3, 2005), available at
(continued...)

Analysis of Certain Options for SCHIP Allotment Formula

Possible Alternatives to the Current Population Survey. Under current law, the formula for annually determining each state's share of original allotments uses data from the U.S. Census Bureau's Current Population Survey (CPS).[12] Specifically, the CPS provides estimates for each state of (1) the number of children whose family income is at or below 200% of the federal poverty threshold, and (2) the number of children who are *uninsured* and below 200% of the federal poverty threshold. At the time of BBA97, the CPS was the only federal data source that could provide such estimates for all the states.

Since survey estimates come from only a sample of the population, the estimates could differ from the results of a complete census using the same survey questions. It is possible to estimate this "sampling error" based primarily on the survey's sample size (that is, the number of respondents). Because sample sizes can be small in less populous states, results from multiple years are often averaged together to reduce the sampling error. Current law specifies that the CPS estimates used in the SCHIP allotment formula be based on a three-year average. For example, states' FY2006 original allotments were based on state-level CPS data from 2001, 2002 and 2003. Even with three-year averages, the variation from sampling error in the state-level estimates has led, according to one source, to "funding fluctuations [that] present significant problems for states as they develop budget priorities."[13]

One possible alternative to the CPS that was not available a decade ago is the U.S. Census Bureau's American Community Survey (ACS). The ACS is patterned after and replaces the "long form" of the decennial census. The "long form" questions, along with additional ones, are now being asked every year rather than every 10 years. The survey is now fully implemented and is mailed to 3 million addresses, covering every county in the country.[14] In contrast, the CPS obtains data from approximately 100,000 households.[15]

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[11] (...continued)
[http://www.cbo.gov/showdoc.cfm?index=7055&sequence=0&from=7]).

[12] In particular, the estimates are from what is officially known as the Annual Social and Economic (ASEC) Supplement of the CPS. It had been called the March supplement to the CPS because the health insurance questions were asked in March, but now that they are asked February through April the name was changed.

[13] Michael Davern et al., "State Variation in SCHIP Allocations: How Much Is There, What Are Its Sources, and Can It Be Reduced," *Inquiry*, vol. 40, no. 2, Summer 2003, pp. 184-197.

[14] U.S. Census Bureau, "Design and Methodology: American Community Survey," Washington, DC, May 2006, at [http://www.census.gov/acs/www/Downloads/tp67.pdf]. The ACS uses mail-out/mailback questionnaires with computer-assisted nonresponse follow-up interviews either in person or over the phone. Households' participation in the survey is mandatory, meaning that households are required by law to respond to the survey.

[15] U.S. Census Bureau, "Current Population Survey: 2005 Annual Social and Economic (ASEC) Supplement," Washington, DC, at [http://www.census.gov/apsd/techdoc/cps/cpsmar05.pdf]. The CPS uses computer-assisted interviews, either in person or over the phone. Households' participation in the survey is
(continued...)

Table 2 shows estimates provided by the Census Bureau displaying state-level estimates of low-income children (below 200% of the federal poverty threshold) from the CPS and the ACS in 2004. The table also shows the standard errors of those estimates. Standard errors are measures of the magnitude of sampling error — so, smaller is better. Because the ACS's sample size is so much larger than that of the CPS, the ACS standard errors from a single year are still much lower than the three-year averages from the CPS. Moreover, the ACS data shown in **Table 2** are from 2004, before the ACS full sample was implemented. In 2004, the ACS sample size was 800,000 addresses. The ACS currently in the field is fully implemented with 3 million addresses, so ACS standard errors with more recent data will be even lower.

Currently, the ACS does not ask about individuals' health insurance. Thus, although the ACS can be used to estimate the number of low-income children, it cannot estimate the number of *uninsured* low-income children. The Census Bureau recently completed testing a number of health insurance questions for possible inclusion in the ACS. The data are currently being compiled for review by the Census Bureau. Even if the results appear solid and a decision is made to include a health insurance question(s) in the ACS, it will be a couple of years before that data would be available.

There are well-documented, fundamental concerns with the CPS's estimates of the uninsured, which have been acknowledged by the Census Bureau.[16] Recently, some researchers suggested that the CPS be modified to address these concerns or that HHS's National Health Interview Survey (NHIS) be expanded to provide uninsured estimates for all the states.[17]

Analysis of Impact of Excluding Uninsured from Allotment Formula. In FY1998 and FY1999, the SCHIP allotment formula's "number of children" relied solely on the number of *uninsured* low-income children. As SCHIP

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[15] (...continued)
voluntary.

[16] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," Current Population Reports P60-299, Washington, DC, 2005, at [http://www.census.gov/prod/2005pubs/p60-229.pdf], p. 16.

[17] Genevieve Kenney et al., "Toward a More Reliable Federal Survey for Tracking Health Insurance Coverage and Access," *HSR: Health Services Research*, vol. 43, no. 1, part 1, June 2006, pp. 918-945. Regarding the ACS, the authors said, "In this review, we have focused on the federal surveys that currently measure health insurance coverage. However, the American Community Survey (ACS), which planned to sample three million households nationwide in 2005, could be modified to include questions on health insurance coverage and related topics (currently, it collects information that draws almost exclusively from the Census Long Form). Given the scale of this ongoing effort and the potential for developing annual estimates for areas of over 65,000 inhabitants (and the ability to develop estimates for smaller areas based on 3 or 5 years of data) at low marginal cost, it makes sense to explore the feasibility of at least expanding the content of the ACS to incorporate key information on health insurance coverage at a minimum. At the same time, however, it will be important that any new estimates derived from the ACS complement existing estimates and not create more confusion about the extent and nature of the uninsured problem in this country" (p. 940).

began to cover more low-income children, the formula relied less on the number of *uninsured* low-income children and more on the number of all low-income children. FY2000 was the transition year, in which the "number of children" funding-formula component was based on 75% of the number of *uninsured* low-income children and 25% of the number of all low-income children. For FY2001 onward, the "number of children" is weighted evenly between the number of uninsured low-income children and the number of all low-income children in each state.

Because of concerns with the CPS health insurance estimates and the decreasing emphasis on those estimates in the SCHIP allocation formula, **Table 3** is included to illustrate the potential impact on states' share of the FY2006 total original allotment level available to states had the allotment formula excluded the number of uninsured low-income children. One policy rationale for doing this would be as follows: The more successful a state is in reducing its number of uninsured through its SCHIP program, the less money it receives because of the inclusion of the number of uninsured low-income children in the allotment formula. On the other hand, states with a relatively high number of uninsured low-income children could argue that they need greater federal SCHIP allotments in order to expand coverage but that removing the uninsured piece of the formula would cause the state to receive a lower allotment.

According to the estimates shown in Table 3, if *uninsured* low-income children had not been part of the formula for the FY2006 original allotments, 33 states (including the District of Columbia) would have received an increase in their allotment, with an average increase of about 4%. Ten states would have experienced a decrease of an average of 3% from the current-law formula. Eight states would have experienced no change.[18]

Projections of Impact of Incorporating Historical Spending into Allotment Formula. As I mentioned in my testimony, historical state spending data is an additional option for possible inclusion in the allotment formula that was not available at SCHIP's inception. Based on the CRS SCHIP Projection Model, **Table 4** shows the impact on future projected shortfalls (FY2008-FY2012) of basing half of states' allotments for those years on actual FY2005 expenditures and half on the current formula.[19] FY2005 is the most recent year in which there is complete expenditure data. The projections of incorporating historical spending assume the same level of appropriations in SCHIP as in the baseline projections mentioned earlier (e.g., the total level for annual allotments continues at $5 billion, as in FY2007). The difference from the baseline projections of incorporating historical spending is how the allotments are distributed among the states.

The impact of incorporating historical (FY2005) state spending in the allotment formula is projected to reduce total state shortfalls in FY2008 by 22%. By FY2012, however, this option would reduce shortfalls by only 1% compared to

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[18] Eleven of the 18 FY2007 projected shortfall states would have received an increase, ranging from 0.4% (Illinois) to 9.6% (Maine). Three would have seen no change (Massachusetts, Minnesota and North Carolina) and two would have experienced a decrease (Georgia, 1.2%, and New Jersey, 2.4%).

[19] Projections for the "current formula" assume that the share of the total annual appropriation states were allotted in FY2006 will continue into the future.

baseline assumptions. This is because as the states with the most spending in FY2005 (and most likely to be shortfall states in the near future) receive a greater share of the allotments, less money is allotted to other states. By FY2012, those states that receive less money as a result experience shortfalls they otherwise would not have, or the shortfalls they were projected to experience under baseline assumptions are larger.[20] Over the five-year period (FY2008-2012), incorporating historical spending resulted in a total reduction in projected shortfalls by less than 10%.[21]

Conclusion. While there may or may not be advantages to altering the allotment formula in the ways just described, the impact of these changes on projected shortfalls tend to be rather modest, particularly in the long run. If one's goal in the federal financing of SCHIP is to prevent shortfalls, these tweaks to the allotment formula would be inadequate. Regardless, changes to the allotment formula could be made on the basis of improving the methods for determining how original allotments are distributed to states, even if the impact on the funds states' receive tends to be relatively modest.

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[20] Projections were also run basing the estimates on FY2004 historical spending and on FY2006 projected spending rather than FY2005 spending. Using the FY2004 and the FY2006 numbers both had little impact on the total shortfall by FY2012 compared to the projections using FY2005 spending. Projections were also run basing the *entirety* of the allotment formula on the spending data. Essentially, this doubled the percentages in Table 4, still resulting in little overall impact in FY2012.

[21] The total shortfalls over the five-year period would be reduced approximately $1.1 billion, from $12.1 billion projected under baseline assumptions to $11.0 billion under the option of incorporating historical spending.

Table 2. Estimates and Standard Errors of the Number of Low-Income Children from the American Community Survey (ACS) and the Current Population Survey (CPS), 2004

(numbers in thousands)

	Number of Low-Income Children			Standard Error of the Estimate (lower is better)		
State	ACS	CPS	3-year average CPS[a]	ACS	CPS	3-year average CPS
Alabama	513	506	486	14	53	35
Alaska	58	70	67	5	8	5
Arizona	757	728	685	24	69	47
Arkansas	369	343	352	14	35	24
California	4,216	4,371	4,218	50	169	126
Colorado	396	390	396	22	50	30
Connecticut	212	206	221	10	31	19
Delaware	68	69	66	3	9	6
DC	59	66	62	3	8	5
Florida	1,716	1,699	1,678	28	100	70
Georgia	1,048	1,092	953	20	79	59
Hawaii	104	88	103	7	12	9
Idaho	180	170	169	8	18	12
Illinois	1,191	1,235	1,256	22	86	60
Indiana	635	677	603	17	62	39
Iowa	254	256	244	14	32	20
Kansas	248	264	247	9	32	19
Kentucky	468	449	456	13	50	32
Louisiana	645	594	603	16	57	40
Maine	102	95	107	6	14	9
Maryland	365	416	373	14	50	31
Massachusetts	379	386	434	13	46	33
Michigan	986	1,014	958	19	76	51
Minnesota	359	297	311	11	41	27
Mississippi	421	403	404	11	39	27
Missouri	550	534	501	19	56	36
Montana	106	104	105	4	11	8
Nebraska	156	172	156	4	20	13
Nevada	277	243	246	14	29	17
New Hampshire	72	66	66	4	11	7
New Jersey	571	485	549	19	54	37
New Mexico	281	251	269	10	28	19
New York	1,884	1,937	1,974	32	109	74
N. Carolina	991	920	939	29	73	51
N. Dakota	51	56	55	3	7	4
Ohio	1,106	1,070	1,034	39	78	54
Oklahoma	409	387	411	15	43	29
Oregon	378	361	345	12	44	27
Pennsylvania	1,071	1,053	1,034	17	78	52
Rhode Island	94	100	91	4	13	7
S. Carolina	481	469	446	15	51	32
S. Dakota	74	75	73	2	8	5
Tennessee	614	587	601	18	58	43

State	Number of Low-Income Children			Standard Error of the Estimate (lower is better)		
	ACS	CPS	3-year average CPS[a]	ACS	CPS	3-year average CPS
Texas	3,148	3,168	3,193	41	146	107
Utah	296	298	285	12	29	19
Vermont	43	39	42	2	6	4
Virginia	597	566	557	19	57	42
Washington	581	580	567	16	59	41
West Virginia	186	177	197	10	19	13
Wisconsin	452	499	471	24	54	34
Wyoming	46	41	45	2	6	4
United States	**30,265**	**30,122**	**29,704**	**183**	**378**	**263**

Source: U.S. Census Bureau, with 3-year averages calculated by the Congressional Research Service

a. Average of estimates covering 2002-2004, which will be used in determining, in part, states' share of the total FY2007 original allotment.

Notes: "Low-income children" are those with family income at or below 200% of the federal poverty threshold. A description of the original allotment formula is in CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson, April 18, 2006.

Table 3. Estimated Impact on States' FY2006 SCHIP Original Allotments If the Number of *Uninsured* Low-Income Children Were Not in the Allotment Formula

State	Estimated Impact
Alabama	+4.4%
Alaska	+3%
Arizona	-5.4%
Arkansas	+5.5%
California	-1.1%
Colorado	-1.8%
Connecticut	+1.4%
Delaware	+4.1%
DC	+7.2%
Florida	-3.6%
Georgia	-1.2%
Hawaii	0%
Idaho	0%
Illinois	+0.4%
Indiana	+1.4%
Iowa	+5.2%
Kansas	+4.2%
Kentucky	+2.2%
Louisiana	+0.9%
Maine	+9.6%
Maryland	+2%

State	Estimated Impact
Massachusetts	0%
Michigan	+7.2%
Minnesota	0%
Mississippi	+3.3%
Missouri	+9.5%
Montana	-0.1%
Nebraska	+7%
Nevada	-7%
New Hampshire	+8.7%
New Jersey	-2.4%
New Mexico	0%
New York	+5.6%
N. Carolina	0%
N. Dakota	+4.9%
Ohio	+4%
Oklahoma	0%
Oregon	+0.5%
Pennsylvania	+1.7%
Rhode Island	+9.6%
S. Carolina	+5.4%
S. Dakota	+6.1%
Tennessee	+6%
Texas	-8.5%
Utah	+2%
Vermont	+1.8%
Virginia	+2.3%
Washington	0%
West Virginia	+8.3%
Wisconsin	+1.1%
Wyoming	-0.2%

Source: Congressional Research Service

Notes: "Uninsured low-income children" are those with family income at or below 200% of the federal poverty threshold and without health insurance. Excluding the number of uninsured low-income children was estimated to have no impact on Hawaii, Massachusetts, Minnesota, North Carolina and Washington because these states' share of the national allotment is lowered by the statutory ceiling, that their share cannot be 45% greater than their share in FY1999. New Mexico and Oklahoma were also estimated to be unaffected by the change, but because these states' share of the national allotment is raised by one of the three floors — specifically that their share cannot be below 70% of their share in FY1999. These states hit their respective ceilings and floors regardless of whether the number of uninsured low-income children is included. Two additional states were estimated to hit the statutory ceiling because of the change. The increase to Vermont's and Wisconsin's share of the total allotment was estimated to be high enough because of the change that they would hit the ceiling. The changes shown in the table reflect the statutory provision ensuring that their share does not exceed 145% of their FY1999 share. A description of the original allotment formula is in CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson, April 18, 2006.

Table 4. Reduction in Total Projected Shortfalls in Federal SCHIP Funds If Half of States' Allotments Are Based on FY2005 Spending

Fiscal Year	Reduction in Shortfalls
2008	22%
2009	14%
2010	12%
2011	7%
2012	1%

Source: Congressional Research Service (CRS) SCHIP Projection Model

Notes: The projections assume the same level of appropriations in SCHIP as in the baseline projections (e.g., the total level of annual allotments continues at $5 billion, as in FY2007). The half of states allotments not based on FY2005 spending is based on each state's share of the total FY2006 original allotment, which is also the basis of the distribution of the allotments under the baseline scenario. The difference from the baseline projections of this option is not in the total amount appropriated but in how the allotments are distributed among the states.

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CRS Report for Congress

SCHIP Financing: Funding Projections and State Redistribution Issues

Updated May 8, 2006

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SCHIP Financing: Funding Projections and State Redistribution Issues

Summary

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) created the State Children's Health Insurance Program (SCHIP), which is authorized through FY2007. The purpose of the program is to help states pay for health coverage of uninsured children in families whose income is above the levels that would allow them to be eligible for the state's Medicaid program as of March 31, 1997.

At the time of enactment, Congress appropriated to SCHIP nearly $40 billion for the 10-year period of its authorization, with each state receiving access to a portion of the annual amount. Because SCHIP is a capped-grant program, it is possible for states to exhaust all of the federal SCHIP funds available to them in a given year.

Only two states (Alaska and Rhode Island) have ever exhausted all of their available federal SCHIP funds. Alaska faced shortfalls in FY2000 ($419,000) and FY2001 ($2,000). Rhode Island faced shortfalls in FY2003 ($30,000) and FY2004 ($19 million). These states had the option to file most of their SCHIP claims under regular Medicaid when their SCHIP funds were exhausted. By claiming under Medicaid, however, they received a 17% to 19% smaller federal payment than they would have received under SCHIP for those claims.

Six states faced a shortfall of federal SCHIP funds in FY2005 (Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island). However, the Secretary of Health and Human Services was able to target unspent FY2002 allotments from other states to these six states' shortfalls. As a result, no state finished FY2005 with a shortfall of federal SCHIP funds.

The methodology that eliminated the FY2005 shortfalls could not cover the FY2006 projected shortfalls. For FY2006, the unspent funds available for redistribution were projected to be approximately $283 million shy of covering the shortfalls. To cover this difference, Congress appropriated $283 million in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). The Congressional Research Service (CRS) SCHIP Projection Model projects that four states will still experience shortfalls in FY2006, totaling $2.75 million. The relatively small shortfall left by the DRA funds will fall to states with SCHIP enrollees who are non-pregnant adults.

The CRS model projects that 18 states will experience shortfalls of federal SCHIP funds in FY2007. The amount of these shortfalls is projected to total $944 million, although some states may use Medicaid funds to cover some of that.

This report provides an overview of SCHIP financing and spending since the program's inception and provides state-level projections of the FY2006 and FY2007 shortfalls. The report also provides state-level projections of the impact of the SCHIP proposal outlined in the President's budget. Depending on the actual details of that plan, it may eliminate the FY2007 shortfalls. This report will be updated as new data become available that might substantially alter the results.

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SCHIP Financing: Funding Projections and State Redistribution Issues

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) created the State Children's Health Insurance Program (SCHIP), which is authorized for FY1998-FY2007. The purpose of the program was to help states pay for health insurance coverage of uninsured children in families whose income is above the levels that would allow them to be eligible for the state's Medicaid program as of March 31, 1997.[1] States can cover SCHIP enrollees by expanding their Medicaid program or by creating a separate SCHIP program, or by a combination of both.

At the time of enactment, Congress appropriated to SCHIP nearly $40 billion for the 10-year period of its authorization, as shown in **Table 1**, with each state entitled to a portion of the annual amount.[2] Besides these annual original allotments, states may access additional funds; states that exhaust a particular year's allotment receive access to a portion of other states' unspent allotment for that year.[3]

Because SCHIP is a capped-grant program, it is theoretically possible for states to exhaust all of the federal SCHIP funds available to them in a given year. For a state to experience such a shortfall, it would have to exhaust all of its available allotments as well as the available funds that had been redistributed to it from other states. To date, only two states, Alaska and Rhode Island, have ever exhausted all of their available federal SCHIP funds.

In FY2000, Alaska planned to spend $18.1 million in federal SCHIP funds. However, its prior-year balances of $9.9 million plus its newly available FY2000 original allotment of $7.7 million were insufficient to meet the demand for funds. Thus, Alaska experienced a shortfall of approximately $419,000.

In FY2001, Alaska's amount of planned spending of federal SCHIP funds increased to $24.0 million. Even though its FY2001 original allotment ($9.0 million) was higher than the previous year's ($7.7 million), the state had no rollover of prior-year funds. Its shortfall would have been quite large, except that FY2001 was the first year that redistributions took place. After an original allotment's three-year period of availability, any unspent funds are redistributed to states that had spent all

[1] For a more in-depth overview of the program, see CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, et al.

[2] For information on SCHIP original allotments, see CRS Report RL33366, *SCHIP Original Allotments: Funding Formula Issues and Options*, by Chris L. Peterson.

[3] In this report, "balances," "spending," and "expenditures" refer only to the federal dollars available, paid or claimed through the enhanced match; state expenditures are not provided or discussed in this report.

of that particular allotment, with some exceptions discussed later. As a result, for spending in FY2001, Alaska received $15.0 million from other states' unspent FY1998 original allotments. Thus, Alaska's shortfall was only about $2,000 in FY2001. Because Alaska's SCHIP program is a Medicaid expansion, the state was able to claim its shortfalls under regular Medicaid when its federal SCHIP funds were exhausted. Thus, Alaska received federal Medicaid payments that covered 83% of its federal SCHIP shortfall.[4] Since FY2001, Alaska has not had a shortfall, even though its annual federal SCHIP expenditures have been double or triple its annual original allotment. This is because of the additional funds provided by the redistributions from other states' unspent funds.

In FY2003, Rhode Island had approximately $38.6 million in SCHIP spending, resulting in a relatively small shortfall of approximately $29,000. This shortfall was simply rolled forward to FY2004 and covered with the newly available annual distribution of federal SCHIP funds. By the end of FY2004, however, Rhode Island had a shortfall of federal SCHIP funds of $19.0 million, according to estimates provided by the state. Because much of Rhode Island's SCHIP expenditures could also qualify for payment under Medicaid, Rhode Island opted to take most of that shortfall and receive federal Medicaid funds. In doing so, Rhode Island received 81% of the federal payment it would have received under SCHIP for those claims.

On September 29, 2005, nearly the last day of FY2005, a notice in the *Federal Register* announced the final form of the redistribution of unspent FY2002 original allotments for use in FY2005. The methodology, determined by the Secretary of Health and Human Services (HHS), eliminated what would have been a shortfall of federal SCHIP funds in six states (Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island) in FY2005.

The methodology that eliminated shortfalls for FY2005 was projected to fall short for FY2006. The pool of unspent funds available for redistribution were projected to be insufficient (by approximately $283 million) to prevent shortfalls of federal SCHIP funds in 12 states, according to the Centers for Medicare and Medicaid Services (CMS). To cover this shortfall, Congress appropriated $283 million in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). The CRS model projects that four states will still experience shortfalls in FY2006, totaling approximately $2.75 million. The relatively small shortfall left by the DRA funds will fall to states with SCHIP enrollees who are non-pregnant adults. These shortfalls are based on certain assumptions, discussed below.

The CRS model also projects that under current law, 18 states will experience shortfalls of federal SCHIP funds in FY2007, also shown in **Table 1**. The amount of these shortfalls is projected to total $944 million, although some states may use Medicaid funds to cover some of that. The SCHIP proposal in the President's Budget, depending on its details, may eliminate the FY2007 shortfalls.

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[4] As described in greater detail below, under SCHIP, states receive an "enhanced" federal matching percentage, whereas expenditures under Medicaid are reimbursed at the "regular" matching percentage, officially known as the Federal Medical Assistance Percentage (FMAP).

Table 1. National Figures on Federal SCHIP Financing
(in millions of dollars)

Fiscal year	SCHIP allotments	Spending (or projected demand)	Total amount of shortfalls	Number of shortfall states	Funds expiring
1998	$4,235	$122			
1999	$4,247	$922			
2000	$4,249	$1,929	[a]	1	
2001	$4,249	$2,672	[a]	1	
2002	$3,115	$3,776			
2003	$3,175	$4,276	[a]	1	
2004	$3,175	$4,645	$19	1	$1,281
2005	$4,082	$5,089			*$128*
2006	$4,082	*$5,981*	*$2.75*	*4*	
2007	$5,040	*$6,342*	*$944*	*18*	

Source: Congressional Research Service (CRS) SCHIP Projection Model and CRS analysis of data from the Centers for Medicare and Medicaid Services.

Note: Projected amounts are italicized.

a. Less than $1 million.

This report provides an overview of SCHIP financing and spending since the program's inception. The report then describes the CRS SCHIP Projection Model and the assumptions its results are based on. The report provides state-level projections of the FY2006 and FY2007 shortfalls as well as other key financing data. The report provides state-level projections of the impact of the SCHIP proposal outlined in the President's Budget. Depending on the actual details of that plan, it may eliminate the FY2007 shortfalls. It does so by redistributing additional funds from many non-shortfall states, the implications of which are discussed in the final section of the report. This report will be updated as new data become available that might substantially alter the model results.

If Congress intends to prevent state shortfalls of federal SCHIP funds in FY2007, legislative action will be needed. If, however, Congress decides that the intent of the original legislation was to ensure states did not treat the program as an open-ended entitlement, no action will be necessary, as the states with annual SCHIP spending well in excess of their annual allotments face the consequences of that spending through the shortfall of federal funds.

SCHIP Financing and Spending Overview

States that set up an SCHIP program are entitled to federal reimbursement, up to a cap, for a percentage of the incurred costs of covering enrolled individuals. This percentage, which varies by state, is called the enhanced Federal Medical Assistance Percentage (FMAP). It is based on the FMAP used for the Medicaid program but is higher in SCHIP than in Medicaid. In other words, the federal government

contributes more toward the coverage of individuals in SCHIP (65% to 83.2% in FY2006) than it does for those covered under Medicaid (50% to 76% in FY2006).[5]

States are reimbursed for their costs up to a capped amount. Nationally, the total annual federal allotments range from $3.1 billion (FY2002) to $5 billion (FY2007). The amount available to each state is determined annually through a formula that takes into account factors such as the state's number of low-income uninsured children. State allotment amounts are published annually in the *Federal Register* for each upcoming fiscal year. States' allotments for FY2006 were published June 24, 2005.

Under current law, a state's allotment for a given year is available for use for three years. For example, each state's FY1998 allotment was available through FY2000 (September 30, 2000). At the end of the three years, if there is still a balance in that "pot" of money, BBA 97 requires that the Secretary of Health and Human Services redistribute that money to those states which had exhausted that pot. Those states that exhausted a given year's pot are called redistribution states for that year. Under BBA 97, redistributed funds are available to those states for one year, after which the money expires, reverting back to the Treasury.

Rather than leave the redistribution process up to the Secretary, Congress intervened to determine in statute how much of the unspent funds from FY1998-FY2001 states would receive. Even though BBA 97 allowed for only redistribution states to receive unspent funds, the later laws enacted by Congress permitted those states that did not spend all of their original allotments to retain a portion. These states are called retention states. When both retention and redistribution states receive access to a portion of the unspent money, the process is often called reallocation instead of redistribution, the latter implying that only redistribution states receive access to the unspent funds. Congress also gave states more than one year to spend these reallocated funds.

Redistribution states receive funds from other states' unspent original allotments based in part on their "excess spending." Excess spending is defined as the difference between a redistribution state's spending during an original allotment's three-year period of availability and the amount of that allotment. For example, at the end of FY2000, when unspent FY1998 original allotment funds were redistributed, excess spending was calculated among redistribution states as the total federal SCHIP expenditures in FY1998, FY1999, and FY2000 (that is, the FY1998 original allotment's period of availability) minus the FY1998 original allotment amount.

It is worth noting that states which exhausted a pot of money were not necessarily out of federal money altogether. For example, states that exhausted their

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[5] For more information on the FMAP, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Christine Scott, and CRS Report RS22333, *Budget Reconciliation FY2006: Provisions Affecting the Medicaid Federal Medical Assistance Percentage (FMAP)*, by April Grady.

FY1998 original allotments did so in FY1999 or FY2000, by which time the original allotments for those years were also available.

In the program's first few years, because SCHIP was new and states were just getting their programs started, much of the original allotments were unspent. In fact, there was still money left for retention states even after covering *all* of the excess spending of redistribution states.

Annual Reallocations/Redistributions

Reallocation of Unspent FY1998 and FY1999 Original Allotments (P.L. 106-554). At the end of FY2000, each state's FY1998 original allotment pot was closed. The unspent money, totaling just over $2 billion, went into a pool to be reallocated as specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554). The territories (Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands) had 1.05% of that pool reserved for them. The redistribution states received access to an amount equal to all of their excess spending of nearly $700 million. The remaining $1.3 billion (65% of the total pot of unspent funds) was reallocated back to the retention states, based on their percentage contribution to the overall pool of unspent FY1998 original allotments.

Thus, at the beginning of FY2001, all states had balances available to them through the reallocation of unspent FY1998 funds. In addition, states would also have available any remaining balances from their FY1999 and FY2000 allotments, as well as the newly available FY2001 original allotment.

Typically, when states draw down federal SCHIP money, they must do so chronologically. For example, all available FY1998 funds (whether original allotments or reallocations) must be exhausted before funds from FY1999 or later can be drawn down. Once the reallocated FY1998 funds became available, those had to be drawn down before any more spending could occur out of the other available pots of federal SCHIP funds (in this case, FY1999, FY2000, and FY2001 original allotments). The exception is that the redistribution states may opt to have their redistribution pot drawn in a non-chronological order they specify. (It is still the case, however, that a pot must be exhausted before the next in the sequence can be tapped.)

Given the option to select a non-chronological order of spending, redistribution states have two primary competing incentives: (1) spend original allotment money first to ensure qualification as a redistribution state in the future, and (2) spend reallocated money first to minimize the amount of available money that expires. The order that states most commonly chose was to have spending from the FY1998 redistribution pot begin once the FY1999 original allotment pot was emptied. They generally opted to have the FY1999 pot drawn down first to ensure that they would qualify for the redistribution of other states' unspent funds from that year.

Redistribution states continued to choose non-chronological spending in which the first pot drawn down is the original allotment that will be up for reallocation at the end of the current fiscal year, followed by the reallocation(s) that will expire at

the end of the current fiscal year, and then alternating between the next original allotment and the next reallocation pots, for which the expiration dates are further out into the future. For example, beginning in FY2004, when the FY2001 reallocation and the FY2004 original allotment were first made available to states, the most common order of spending selected by the redistribution states was as follows: (1) FY2002 original allotment, which was up for reallocation at year's end; (2) FY1999 and FY2000 reallocated money, which would expire at year's end; (3) FY2003 original allotment, available through FY2005; (4) FY2001 redistribution, also available through FY2005; and (5) FY2004 original allotment, available through FY2006.

The reallocation of unspent FY1999 original allotments was similar to the FY1998 reallocation. When the FY1999 allotments were closed at the end of FY2001, the redistribution states received access to an amount equal to all of their excess spending of approximately $1.6 billion. This allowed nearly $1.2 billion (42%) of the unspent pool of $2.8 billion to be reallocated to the retention states.

Reallocation of Unspent FY2000 and FY2001 Original Allotments (P.L. 108-74). At the end of FY2002, the unspent pool of FY2000 original allotments was reallocated differently, according to the State Children's Health Insurance Program Allotments Extension Act (P.L. 108-74). The territories again received 1.05% of the total unspent funds. Then each retention state was reallocated half of its unspent funds. The balance was reallocated to the redistribution states based on their percentage of the overall excess spending. For the FY2000 reallocation process, the redistribution states' excess spending totaled nearly $2.2 billion; they received half of that, $1.1 billion, in the reallocation of FY2000 funds.

The reallocation of unspent FY2001 funds was calculated as in the FY2000 reallocation, where the retention states retained access to half of their unspent funds. The redistribution states received $856 million from the FY2001 reallocation, covering 22% of their excess spending of nearly $3.9 billion.

Although BBA 97 permits redistribution funds to be available for only one year before expiring, the new laws pushed off the expiration of reallocated FY1998-FY2000 funds to the end of FY2004. This permitted these reallocated funds to be available to states for two to four years. When these pots of money expired at the end of FY2004, $1.3 billion of reallocated money reverted back to the U.S. Treasury. The FY2001 reallocation pot expired after two years, at the end of FY2005, with $72 million reverting to the Treasury.

Reallocation of Unspent FY2002 Original Allotments Onward (Reversion to BBA 97, P.L 105-33). As previously mentioned, the final notice regarding the redistribution of unspent FY2002 funds was published in the September 29, 2005, issue of the *Federal Register*. Because no law was enacted specifying otherwise, the process took place according to BBA 97, which allows the Secretary to determine the process. One limitation under BBA 97 is that the Secretary may not distribute unspent funds to retention states.

As in previous reallocations, the territories first received 1.05% of the total unspent funds. States that were projected to exhaust all of their available federal

SCHIP balances in FY2005, based on their estimated FY2005 expenditures (provided to CMS in August 2005), received redistribution money equal to that estimated shortfall. These six "shortfall states" were Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island. The remaining balance of unspent FY2002 funds was divided among the 28 redistribution states, including the six shortfall states, based on their percentage of overall excess spending.[6] As a result, the six shortfall states received two sets of additional funds through the redistribution: (1) for qualifying as a shortfall state, and (2) for qualifying as a redistribution state. Also according to BBA 97, this reallocation pot expired at the end of one year, at the end of FY2005, with $56 million reverting to the Treasury. This amount, combined with the expired FY2001 reallocation funds, totals $128 million in federal SCHIP funds that expired at the end of FY2005.

The initial redistribution of unspent FY2003 original allotments and the allocation of the $283 million DRA appropriation for SCHIP, both of which are to be available for spending in FY2006 only, were announced by CMS in the *Federal Register* on April 21, 2006.[7] The amounts from both accounts were determined by the HHS Secretary, based on his broad discretion to allocate the funds to the FY2006 shortfall states.[8]

DRA said that "the Secretary shall allot to each shortfall State described in paragraph (2) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State." Paragraph (2) of §2104(d) defined shortfall states as those that projected their FY2006 expenditures to exceed the amounts available from (i) their balances of the FY2004 and FY2005 original allotments, (ii) the redistribution of funds from other states' unspent FY2003 original allotments, and (iii) the newly available FY2006 original allotment. Taking these funds into account, a shortfall of approximately $283 million was projected for the states. This was the basis for the $283 million appropriated in DRA.

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[6] As previously noted, excess spending is calculated as the difference between a redistribution state's spending during an original allotment's three-year period of availability and the amount of that allotment. It is worth noting that this schema causes a single year's SCHIP expenditures to be included in three years of redistribution calculations. For example, a state may have had unusually high SCHIP spending in FY2002. The FY2002 spending would have been a factor in determining whether the state qualified as a redistribution state (and the amount of redistributed funds the state would receive) in the reallocations that took place at the end of FY2002, FY2003, and FY2004. Respectively, these reallocations were of the unspent FY2000, FY2001, and FY2002 original allotments.

[7] Centers for Medicare & Medicaid Services, "State Children's Health Insurance Program (SCHIP); Redistribution of Unexpended SCHIP Funds From the Appropriation for Fiscal Year 2003; Additional Allotments to Eliminate SCHIP Fiscal Year 2006 Funding Shortfalls; and Provisions for Continued Authority for Qualifying States to Use a Portion of Certain SCHIP Funds for Medicaid Expenditures," 71 *Federal Register* 20697-20707, April 21, 2006.

[8] The funds from FY2003 available for redistribution could have gone to all redistribution states (those that had exhausted their FY2003 original allotment), but the Secretary targeted this redistribution to shortfall states, as was done in last year's redistribution.

However, DRA also included a provision that the territories would receive 1.05% of the $283 million appropriation (approximately $3 million). This percentage is consistent with the share the territories receive of the total annual original allotment and redistribution funds. The $3 million from the DRA funds for the territories means that the Secretary would not be able to eliminate the states' shortfalls altogether. In addition, the DRA funds come with limitations: "Additional allotments provided under this subsection [the $283 million] are only available for amounts expended under a State plan approved under this title for child health assistance for targeted low-income children." This prohibits states from using the DRA funds to pay for benefits of SCHIP enrollees who are non-pregnant adults.[9] Both of these factors — the DRA appropriation carved out for territories and the prohibition against it covering non-pregnant adults — raised the prospect that the Secretary would be unable to "eliminate the estimated shortfall."

To minimize the estimated shortfall, the DRA amounts were calculated first, before taking into account the redistribution of other states' unspent FY2003 funds. As stated in the *Federal Register*, "we incorporated the above definition of shortfall State under section 2104(d)(2) of the Act, except that we did not include the amount of any FY 2003 redistribution (number ii. above)."[10] Using the Secretary's broad discretion for the amounts to be distributed, the DRA appropriation to shortfall states first went to the eight shortfall states that covered only children ($142 million of the $280 million available to the states), to eliminate their shortfalls altogether.[11] The remaining $138 million was allotted to the four shortfall states that cover adults in their SCHIP programs (Illinois, Minnesota, New Jersey, and Rhode Island), taking care that the amount of the DRA funds to these states did not exceed their projected spending on children. By distributing the DRA funds in this way, the unspent FY2003 funds available to the states ($172 million), which were not limited to covered *children* only, could go entirely toward the four shortfall states that also cover adults. Using this methodology, these four states are projected to experience shortfalls totaling $2.75 million. This amount is due to the territories' portion of the appropriation that had not been taken into account when the $283 million amount was included in DRA. However, the Secretary's distribution of the funds placed the shortfall among only those states that cover adults.[12]

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[9] Pregnant women receiving SCHIP coverage may do so by virtue of the eligibility of their unborn children. The official guidance appears in 67 Federal Register 61956, Oct. 2, 2002. Because of this, pregnant women are not necessarily subject to the adult limitation under DRA, since their coverage is "for child health assistance for targeted low-income children."

[10] Centers for Medicare & Medicaid Services, "State Children's Health Insurance Program (SCHIP) ... ," 71 *Federal Register* 20700, April 21, 2006.

[11] These eight states (and their projected shortfalls eliminated by the DRA funds) were Iowa ($6.1 million), Maryland ($13.7 million), Massachusetts ($21.9 million), Mississippi ($73.6 million), Missouri ($8.0 million), Nebraska ($15.7 million), North Carolina ($2.8 million), and South Dakota ($0.5 million).

[12] In the previous version of this report, before the announcement of the distribution of the DRA funds and the unspent FY2003 funds, Minnesota and Rhode Island were projected to have FY2006 shortfalls totaling $20 million. The amounts projected for that version of the report were based on the assumption that the redistribution of unspent FY2003 funds would (continued...)

CRS SCHIP Projection Model

The Congressional Research Service (CRS) SCHIP Projection Model combines data available on federal SCHIP allotments, spending and reallocations in the program reported as of November 2005.[13] In order to make projections, these data are fed through the model's two discrete components. The first component projects individual states' and territories' demand for federal SCHIP funds for FY2006 and FY2007. Using this projected demand, the second component calculates the federal SCHIP funds that are available and drawn against each year.

Projecting Demand

Rather than just projecting *spending*, the model projects *demand* for federal SCHIP funds. If the model were to project only federal SCHIP *spending*, the maximum that a state could spend is its available balance. However, one purpose of the model is to capture the extent to which available SCHIP funds may be inadequate for a particular state. To capture this, states' *demand* for federal SCHIP funding must be projected — that is, the amount that states could be expected to spend if federal SCHIP funds were not capped.

Previous versions of the model projected demand in multiple ways. This was done partly because the estimates provided by states were only offered for the current fiscal year and the following fiscal year. As a result, the state did not provide projections through SCHIP's current authorization. Methods were then used to provide projections through FY2007. However, beginning with FY2006, which began October 1, 2006, states now provide projections through FY2007. These state projections are used in the model. Besides the previously mentioned exceptions, the state estimates used are from November 2005. These were used because they were the basis for the recently announced distribution of DRA funds and the redistribution of other states' unspent FY2003 funds.

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[12] (...continued)
be calculated *before* the distribution of the DRA funds and that the redistribution of the FY2003 funds would occur in the same way as the redistribution of the FY2002 funds in the previous year. Under that scenario, the adult limitation on the DRA funds was projected to result in the $20 million shortfall in Minnesota and Rhode Island. However, structuring the distribution of funds as was done by the Secretary in the April 21 *Federal Register* notice appears to have minimized the estimated shortfalls. Under the scenario previously projected by CRS, only two states would face shortfalls. The Secretary's distribution is expected to cause all four shortfall states that cover adults to share in the shortfall, though the total shortfall is much smaller ($2.75 million).

[13] For the CRS model, the state-level projections were updated for one state. California's amounts were updated to reflect implementation of its state plan amendment for prenatal coverage expansion (including coverage of pregnant women).

Availability of Federal SCHIP Funds: FY2006-FY2007

At the beginning of FY2006, a state could have had balances left in three original allotments — FY2004, FY2005, and the newly available FY2006 pots. These amounts calculated in the CRS model are identical to the balances published by CMS in the April 21, 2006, *Federal Register* notice. In addition, states projected to have inadequate federal funds from these three pots to cover their demand in FY2006 will also have access to funds from the redistribution of other states' unspent FY2003 original allotments, as well as from the DRA appropriation. These amounts as published in the April 21, 2006, *Federal Register* are used in the CRS model.

Based on these amounts and the projected demand for FY2006, the model draws down the available pots of money. Once that process is completed, the model calculates the amount of unspent FY2004 original allotment funds that will be redistributed and made available in FY2007. The balances that remain from the FY2005 and FY2006 original allotments, along with the new FY2004 redistribution and the FY2007 allotment, are available in FY2007.

Model Results

Current Law. Based on current law and assumptions about how funds will be allotted and redistributed, and given projected demand, the model identifies the states projected to deplete those funds in FY2006 and FY2007.

Table 2 shows the amount of DRA funds that 12 states are projected to spend in FY2006. Targeting these funds first to shortfall states that cover only children leaves the unspent FY2003 funds from other states able to go exclusively to the four shortfall states that cover adults. As a result, these states do not have any funds that they cannot spend due to the prohibition of spending on non-pregnant adults. However, the FY2003 funds available are inadequate to cover the shortfall in these four states, as previously discussed.

In FY2007, 18 states are projected to have inadequate balances in their FY2005, FY2006 and FY2007 original allotments to cover their demand for federal SCHIP funds. These states are projected to receive all of the unspent FY2004 original allotments from other states. However, the amount of these unspent funds is projected to be only $96 million. This would be the fifth year in a row in which the amount of unspent funds available for reallocation is smaller than any of the preceding years in which reallocations occurred (beginning in FY2001, with approximately $2 billion available for reallocation from states' unspent FY1998 original allotment). The shortfall among these 18 states in FY2007 is projected at $944 million, as shown in **Table 2**.

Table 2. Projected Final Distribution of DRA Funds and Projected Shortfalls of Federal SCHIP Funds, 2006 and 2007
(in millions of dollars)

State	DRA funds	2003 redistribution	Projected shortfalls	
	2006	2006	2006	2007
Alaska				$12.2
Georgia				$39.7
Illinois[a]	$56.2	$61.3	$0.98	$151.3
Iowa	$6.1			$28.0
Louisiana				$20.9
Maine				$0.9
Maryland	$13.7			$91.3
Massachusetts	$21.9			$101.4
Minnesota[a]	$7.1	$12.9	$0.21	$36.2
Mississippi	$73.6			$74.0
Missouri	$8.0			$45.6
Nebraska	$15.7			$12.2
New Jersey[a]	$50.5	$55.1	$0.88	$149.7
North Carolina	$2.8			$113.0
North Dakota				$5.6
Rhode Island[a]	$23.8	$42.3	$0.68	$46.6
South Dakota	$0.5			$6.7
Wisconsin				$8.6
Total[b]	$280.0	$171.6	$2.75	$943.7

Source: Congressional Research Service (CRS) SCHIP Projection Model and CRS analysis of data from the Centers for Medicare and Medicaid Services.

Notes: "DRA funds" refers to the $283 million for federal SCHIP funding appropriated in the Deficit Reduction Act of 2005 (P.L. 109-171).

a. States that cover non-pregnant adults.
b. Excludes projected DRA funds and shortfalls for territories.

Of the 18 states projected to exhaust their federal SCHIP funds in FY2007, four (Georgia, Minnesota, Mississippi, and North Carolina) appear to have no alternative for federal funds besides SCHIP. This is because their SCHIP programs are separate from Medicaid. In the other 14 states, some portion of the SCHIP federal funds could be paid by Medicaid, albeit at the regular FMAP instead of the enhanced rate, because these states have SCHIP programs that include, or are exclusively, a Medicaid expansion. The percentage of SCHIP expenditures that come from these states' SCHIP Medicaid expansions varies, from 10% (Illinois) to 98% (Nebraska), based on states' expenditure for FY2005.

Table 3 shows estimates of the net shortfall that would remain under current law after taking into account the federal Medicaid funds these states could draw for their Medicaid-expansion SCHIP programs. Column A of the table shows the same shortfalls as in **Table 2**. Column B provides estimates of the maximum amount of shortfalls payable by federal Medicaid funds. This was estimated by assuming states facing a shortfall would claim as much of its separate-SCHIP spending in its

available SCHIP balances, maximizing the amount of shortfall funds for which Medicaid funding could be received. Under this assumption, and reflecting Medicaid's regular FMAP versus the SCHIP enhanced FMAP, column B shows that $350 million of the projected SCHIP shortfall in FY2007 could be covered by federal Medicaid funds. This would leave a net shortfall of approximately $600 million in FY2007.

Table 3. Projected Shortfalls Net of Potential Federal Medicaid Funding, FY2007

(in millions of dollars)

	A	B	C
Shortfall states	**Shortfall**	**Potential federal Medicaid funding**	**Net shortfall (A-B)**
Alaska	$12.2	$10.0	$2.2
Georgia	$39.7	$0.0	$39.7
Illinois	$151.3	$30.0	$121.3
Iowa	$28.0	$16.9	$11.1
Louisiana	$20.9	$18.5	$2.4
Maine	$0.9	$0.7	$0.1
Maryland	$91.3	$70.2	$21.1
Massachusetts	$101.4	$78.0	$23.4
Minnesota	$36.2	$0.0	$36.2
Mississippi	$74.0	$0.0	$74.0
Missouri	$45.6	$38.5	$7.2
Nebraska	$12.2	$10.0	$2.2
New Jersey	$149.7	$36.1	$113.6
North Carolina	$113.0	$0.0	$113.0
North Dakota	$5.6	$4.8	$0.8
Rhode Island	$46.6	$21.3	$25.3
South Dakota	$6.7	$5.7	$1.0
Wisconsin	$8.6	$7.1	$1.6
Total	$943.7	$347.6	$596.1

Source: Congressional Research Service (CRS) SCHIP Projection Model and CRS analysis of states' FY2005 SCHIP expenditures and FY2007 FMAP rates from the Centers for Medicare and Medicaid Services (CMS).

It must be noted that there is some uncertainty about the limitations of claiming the regular Medicaid FMAP to cover SCHIP expenditures in a shortfall situation. There is little federal guidance on the issue. The only sizeable shortfall was experienced by Rhode Island ($20 million) in FY2004. State officials had informed CRS that they were able to claim approximately 95% of their SCHIP expenditures under regular Medicaid. They stated that most of the individuals covered under their separate SCHIP program still qualified for the regular Medicaid FMAP. CRS has not been able to confirm how this can occur. If separate SCHIP spending can be funded by federal Medicaid dollars in lieu of available SCHIP balances, then the amounts payable by Medicaid could be much higher than shown in column B of **Table 3**.

President's Budget. The SCHIP proposal in the President's Budget is to reduce the period of availability of the FY2005 original allotment from three years to two.[14] There may be additional details that have not yet been announced, but the effect of reducing the period of availability of the FY2005 original allotment is the focus of this section.

As previously mentioned, the amount of unspent funds available for redistribution has been decreasing over the past several years, as shown in **Table 4**. Historically these funds have been able to forestall much of the federal SCHIP shortfalls that would otherwise have occurred. FY2005 was the last year in which the amount available for redistribution was adequate to cover states' shortfalls of federal SCHIP funds. Because the $173 million available for redistribution in FY2006 was inadequate to cover the projected shortfalls, Congress appropriated an additional $283 million to SCHIP. In FY2007, only $96 million is projected to be available for redistribution, far short of the amount needed to cover the shortfalls.

The CRS model projects that at the end of FY2007 there will be approximately $155 million in unspent FY2005 original allotments. Assuming current authorization rules continue, this would be the amount available for redistribution in FY2008. This would be the first time in several years in which the amount of unspent original allotments at the end of its applicable period exceeded that of the previous year. This is because the total original allotments for FY2005 ($4.1 billion) were markedly higher than in FY2004 ($3.2 billion), resulting in some additional monies remaining at the end of the FY2005 original allotment's period of availability.

The president's proposal would make states' unspent FY2005 original allotments available for redistribution at the beginning of FY2007 rather than at the beginning of FY2008. As a result, unspent FY2005 funds available for redistribution would total $1,142 million, shown in **Table 4**. Although the details of the plan have not been released, the CRS projections assume that only funds necessary to close states' FY2007 shortfalls ($944 million), plus the territories typical 1.05% of the total unspent funds ($12 million), would be used from the unspent FY2005 original allotments. Based on these assumptions, the president's proposal would eliminate the FY2007 shortfall, with states that had unspent FY2005 original allotments at the end of FY2006 retaining about 16% of those funds ($186 million). Column D of **Table 5**, on the last page of this report, shows the projected amount that states would have redistributed from their unspent FY2005 original allotments to other states as a result of the president's proposal. Column E of the table shows the percentage of the $956 million redistributed to other states and territories that each state contributes.[15]

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[14] The President's Budget does not provide this detailed of an explanation, but individuals in the executive branch have confirmed this description.

[15] These results are not intended to approximate a cost estimate, like those done by the White House's Office of Management and Budget (OMB) or the Congressional Budget Office (CBO). Budgetary cost estimates take into account offsets and other effects that these projections do not attempt to address.

Table 4. Annual Historical and Projected Reallocation Amounts, by Fiscal Year
(in millions of dollars)

Fiscal year	Current-law reallocations				Additional reallocations due to President's Budget			
	Fiscal year reallocated	Total amount	Redist.	Retain	Fiscal year reallocated	Total amount	Redist.	Retain
2001	1998	$2,034	$720	$1,313				
2002	1999	$2,819	$1,638	$1,181				
2003	2000	$2,199	$1,099	$1,099				
2004	2001	$1,749	$875	$875				
2005	2002	$643	$643	$0				
2006	2003	$173	$173	$0				
2007	2004	$96	$96	$0	2005	$1,142	$956	$186

Source: Congressional Research Service (CRS) SCHIP Projection Model and CRS analysis of data from the Centers for Medicare and Medicaid Services.

Notes: "Total amount" is the total amount of unspent original-allotment funds available for reallocation. It is the sum of the amounts redistributed to other states (and territories) and retained by states that keep a portion of their unspent original allotments. The redistributed amounts include the 1.05% of the "total amount" provided to the territories. FY2006 and FY2007amounts are projections.

Analysis and Options

SCHIP was created in BBA 97 as a capped grant program to states. Fixed annual balances of federal funds are available to states, which they can exhaust. This contrasts with SCHIP's older and much larger companion in providing health insurance to low-income individuals, Medicaid, which was created as an individual entitlement program that states cannot exhaust.[16]

Although it is theoretically possible for states to be in a chronic state of shortfall of federal SCHIP funds, this had been avoided through FY2005 using the funds in the program's original appropriation. To cover shortfalls projected for FY2006, Congress appropriated an additional $283 million. To cover the shortfalls in FY2007, an appropriation of approximately $1 billion would be required. Alternatively, Congress could alter redistributions to tap into other federal money available in SCHIP. The president's proposal appears to do this by shortening the period of availability of the FY2005 original allotment from three years to two years. This was also part of the SCHIP package in the first Senate-passed version of DRA (S. 1932), which was ultimately replaced by the $283 million appropriation targeted to FY2006 and therefore not addressing the FY2007 projected shortfall.

Redistribution and appropriation are two alternatives if the policy goal is to ensure that states never exhaust their federal balances of SCHIP funds. In addition, the SCHIP program could be turned into an open-ended entitlement, perhaps by folding it into the Medicaid program. This would spare the administration and

[16] States have to provide matching funds, though, since Medicaid is a joint federal-state program.

Congress from having to periodically rearrange funds or funding methodologies to cover shortfalls. However, states would likely oppose folding SCHIP into Medicaid if it meant reverting to the regular FMAP and following all of Medicaid's other more restrictive rules. Federal policymakers may oppose this because they believe SCHIP as an individual entitlement could result in greater federal outlays than would occur under SCHIP as a capped grant program.

Although the SCHIP program has been successful in covering millions of uninsured children, and has therefore been politically popular, more states are poised to exhaust their federal SCHIP funds as early as next fiscal year. If Congress decides to prevent these shortfalls, legislative action will be needed. If, however, Congress decides that the intent of the original legislation was to ensure that states did not treat the program as an open-ended entitlement, no action will be necessary through the end of the program's authorization, as many states with annual SCHIP spending well in excess of their annual allotments face the consequences of that spending through the shortfall of federal funds.

Table 5. Characteristics of States Projected to Have Funds Redistributed Under President's SCHIP Proposal, FY2007

	A	B	C	D	E
State	Demand for federal SCHIP funds	Current-law beginning-of-year balances	Beginning-of-year balances under president's proposal	FY2005 funds redistributed under president's proposal (B-C)	State's portion of total FY2005 redistributed funds under president's proposal
Arkansas	$51.2	$132.5	$103.5	$29.0	3.0%
Colorado	$53.4	$173.0	$136.6	$36.4	3.8%
Connecticut	$18.0	$113.7	$83.1	$30.6	3.2%
Delaware	$8.2	$29.3	$21.7	$7.6	0.8%
DC	$8.2	$29.7	$22.7	$7.0	0.7%
Florida	$373.9	$585.8	$561.8	$24.0	2.5%
Hawaii	$13.4	$32.8	$28.5	$4.2	0.4%
Idaho	$31.5	$57.0	$47.8	$9.2	1.0%
Indiana	$89.3	$201.4	$169.4	$32.0	3.4%
Kentucky	$78.5	$144.3	$131.6	$12.8	1.3%
Montana	$15.8	$33.5	$28.9	$4.5	0.5%
Nevada	$31.2	$134.0	$100.2	$33.8	3.5%
New Hampshire	$9.4	$29.2	$22.0	$7.3	0.8%
New Mexico	$42.7	$134.9	$100.8	$34.1	3.6%
New York	$411.1	$700.4	$623.7	$76.7	8.0%
Oklahoma	$69.9	$141.5	$130.4	$11.1	1.2%
Oregon	$30.0	$152.0	$112.5	$39.6	4.1%
Pennsylvania	$168.9	$343.8	$306.8	$36.9	3.9%
South Carolina	$62.4	$148.8	$128.1	$20.6	2.2%
Tennessee	$3.9	$258.6	$192.5	$66.0	6.9%
Texas	$409.0	$1,431.5	$1,082.9	$347.7	36.4%
Utah	$39.2	$85.5	$74.2	$11.4	1.2%
Vermont	$2.9	$15.7	$11.6	$4.1	0.4%
Virginia	$106.4	$170.8	$163.1	$7.7	0.8%
Washington	$39.5	$209.3	$155.1	$54.2	5.7%
West Virginia	$41.2	$56.4	$52.9	$3.6	0.4%
Wyoming	$8.0	$17.5	$13.9	$3.7	0.4%
Total	$2,217.0	$5,563.0	$4,607.4	$955.6	100.0%

Source: Congressional Research Service (CRS) SCHIP Projection Model and CRS analysis of data from the Centers for Medicare and Medicaid Services.

Notes: The impact modeled is that the period of availability of the FY2005 original allotment will be reduced from three years to two. It is assumed that the FY2005 funds unspent as the end of FY2006 will be redistributed as necessary to meet states' shortfalls, as well as 1.05% of the unspent total going to the territories. These results are not intended to approximate a cost estimate, like those done by the White House's Office of Management and Budget (OMB) or the Congressional Budget Office (CBO). Budgetary cost estimates take into account offsets and other effects that these projections do not attempt to address.

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CRS Report for Congress

SCHIP Original Allotments: Funding Formula Issues and Options

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SCHIP Original Allotments: Funding Formula Issues and Options

Summary

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) authorized the State Children's Health Insurance Program (SCHIP) for FY1998-FY2007. In BBA 97, Congress appropriated annual funding levels totaling nearly $40 billion for the 10-year period of SCHIP's authorization, with each state receiving access to a portion of the annual amount. Each state's portion — the original allotment — is calculated based on a formula that has been altered one time since the program's inception.

SCHIP's authorization expires at the end of FY2007. When Congress takes up reauthorization, the focus regarding SCHIP original allotments will be on (1) setting the *national* annual appropriations for SCHIP, and (2) deciding how those funds will be allotted to individual *states.* Some of the issues are technical — for example, whether there is a better data source for estimating the number of low-income children. Other issues raise more fundamental questions about the program.

For example, beginning in FY2002, states' total spending of federal SCHIP funds has exceeded their annual original allotments, a trend projected to continue through the current authorization. Shortfalls of federal SCHIP funds have largely been avoided by leftover prior-year balances and because administrative actions targeted unspent funds from other states to those states facing shortfalls. However, the funds available for redistribution have been shrinking over the past several years. In fact, because such amounts will be inadequate to prevent shortfalls in FY2006, Congress appropriated an additional $283 million for projected shortfall states in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). As a result, how much is provided to states in their original allotments is becoming increasingly important.

Increasing current SCHIP appropriations across the board to match total national demand for funds would not necessarily prevent shortfalls because there is wide state-level variation between how much states are allotted and how much they spend. In reauthorization, Congress will have to decide the extent to which other factors, such as states' historical spending and the populations they cover under SCHIP, should be added to the original allotment formula.

If current allotment formulas continue to be used — for example, if states' SCHIP spending has *no* bearing on their original allotments, as is currently the case — then several states will face chronic shortfalls of federal SCHIP funds. However, such shortfalls are an inherent possibility in a capped-grant program such as SCHIP. Congress will be grappling with a number of issues in determining the level and distribution of original allotments in reauthorization. These include whether SCHIP is effectively operating as an open-ended entitlement to states and whether the current original allotment structure is inadequate.

This report describes how SCHIP original allotments have operated from FY1998 to FY2007, and discusses issues and options Congress might consider for reauthorization. This report will be updated as major developments occur.

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SCHIP Original Allotments: Funding Formula Issues and Options

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) authorized the State Children's Health Insurance Program (SCHIP) for FY1998-FY2007. In general, this program allows states[1] to cover targeted low-income children with no health insurance in families with incomes above Medicaid eligibility levels. In BBA 97, Congress appropriated annual funding levels totaling nearly $40 billion for the 10-year period of SCHIP's authorization, with each state receiving access to a portion of the annual amount. Each state's portion — the original allotment[2] — is calculated based on a formula that has been altered one time since the program's inception.

Each year's original allotment is available to states for three years. At the end of the three-year period of availability, unspent balances are to be redistributed to states that have exhausted that allotment, with some exceptions. This report does *not* analyze the impact or amounts of redistributed funds. Nor does this report quantify projected state shortfalls of federal SCHIP funds. Other CRS reports delve into these issues[3] and describe the characteristics of each state's SCHIP program.[4] This report is narrowly focused on the amounts and formulas for the original allotments. Other SCHIP issues are presented only to the extent that they inform the discussion of original allotments.

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[1] For this report, "states" includes the District of Columbia, since it is treated as other states for SCHIP purposes. Generally, the word "states" does not include the five territories, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands. These five "commonwealths and territories" are identified in §2104(c)(3) of the Social Security Act and are treated differently from states for purposes of calculating their original allotments. Unless noted otherwise, section references in law used in this report are to the Social Security Act.

[2] §2104 is the section entitled "Allotments." The term "original allotments" does not occur in the law. However, CRS uses this term to distinguish each year's original, or initial, allotment (paragraphs (a) through (e) of §2104) from the reallocation of the unspent balances of these funds available for redistribution to other states (paragraphs (f) and (g)).

[3] CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, et al. CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

[4] CRS Report RL32389, *A State-by-State Compilation of Key State Children's Health Insurance Program (SCHIP) Characteristics*, by Elicia J. Herz, et al.

SCHIP Appropriation: Total Amount of Original Allotments

BBA 97 established SCHIP under a new Title XXI of the Social Security Act. Section 2104(a) specified the total appropriation available in every fiscal year from FY1998-FY2007. The only change to these numbers since BBA 97 was to add $20 million to the total FY1998 appropriation.[5] The current-law numbers in Section 2104(a) are shown in column A of **Table 1**. For SCHIP's first four years, BBA 97 held the total appropriation constant. However, for FY2002-FY2004, the annual appropriation was $1.125 billion less than in FY1998-FY2001. This drop in funding, sometimes referred to as the "SCHIP dip," was written into BBA 97 due to budgetary constraints applicable at the time the legislation was drafted.

Sections 4921 and 4922 of BBA 97 called for $60 million to be used from the total SCHIP appropriation each year from FY1998-FY2002 for special diabetes grants.[6] These subtractions to the total original allotments available to states and territories are shown in column B of **Table 1**. Beginning in FY2003, these two diabetes programs have been funded by direct appropriations, not from the SCHIP appropriation.

Besides the $20 million adjustment to the total FY1998 SCHIP appropriation, all legislative changes to the total SCHIP appropriation since BBA 97 have affected only the original allotments to the five territories.[7] BBA 97 called for the territories to receive 0.25% of the amounts shown in column A of **Table 1**. The FY1999 Omnibus Appropriations Act (P.L. 105-277) appropriated $32 million for the territories' SCHIP original allotment for FY1999, in addition to the 0.25% of the total appropriation. The $32 million was approximately 0.75% of the $4.275 billion in column A of **Table 1**. The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113) specified additional amounts to be appropriated to the territories for FY2000-FY2007. The amounts specified for these years were exactly 0.8% of the total appropriations shown in column A of **Table 1**. Thus, for FY2000-FY2007, territories were slated to receive a total of 1.05% of the amounts specified in §2104(a), although only the 0.25% portion would reduce the amount of original allotments available to the states specifically.[8] Column C of **Table 1** shows the additional appropriations for the territories from these provisions.

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[5] §162 of P.L. 105-100 made changes "[e]ffective as if included in the enactment of ... the Balanced Budget Act of 1997." Paragraph (8)(A) increased the FY1998 appropriation of $4,275,000,000 by $20 million to $4,295,000,000.

[6] Public Health Service Act §330B and §330C.

[7] The appropriation of $283 million to SCHIP for FY2006 through the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) is not considered a legislative change to original allotments. The DRA appropriation for SCHIP is a special appropriation targeted to shortfall states. It did not go through the original allotment formula, nor is it available for three years.

[8] As discussed in other previously referenced CRS reports, the 1.05% amount is used in the annual reallocation of unspent original allotment funds after their three-year period of availability has passed. Of the total unspent funds, 1.05% is designated for the territories.

Column D of **Table 1** displays the total amount of federal SCHIP original allotments provided to the states and territories under current law. For comparative purposes, column E shows the total spending or demand for federal SCHIP funds in each of those years, projecting for FY2006 and FY2007. If the amounts represented only federal SCHIP "spending," the maximum that a state could spend is its available balance. For states that exhausted or are projected to exhaust all available balances, "demand" is used to reflect not only total spending but also the shortfall of federal SCHIP funds (that is, the additional amount of federal SCHIP funds the state would have used had the funds been available). The spending/demand is applied against *all* available federal SCHIP funds, not just the original allotments. Thus, even though the spending/demand for federal SCHIP funds has exceeded some years' total original allotments, state shortfalls of federal SCHIP funds have largely been avoided because of the redistribution of unspent funds.[9]

Table 1. Federal SCHIP Appropriations, Original Allotments, and Spending, FY1998-FY2007

	A	B	C	D = A-B+C	E
		Subtract	Add		
FY	Allotments specified in §2104(a)	Special diabetes grants	For territories per §2104(c)(4)	Original allotments to states and territories	Total spending/ demand
1998	$4,295,000,000	$60,000,000		$4,235,000,000	$121,800,000
1999	$4,275,000,000	$60,000,000	$32,000,000	$4,247,000,000	$921,800,000
2000	$4,275,000,000	$60,000,000	$34,200,000	$4,249,200,000	$1,928,800,000
2001	$4,275,000,000	$60,000,000	$34,200,000	$4,249,200,000	$2,671,600,000
2002	$3,150,000,000	$60,000,000	$25,200,000	$3,115,200,000	$3,776,200,000
2003	$3,150,000,000		$25,200,000	$3,175,200,000	$4,276,400,000
2004	$3,150,000,000		$25,200,000	$3,175,200,000	$4,644,700,000
2005	$4,050,000,000		$32,400,000	$4,082,400,000	$5,089,500,000
2006	$4,050,000,000		$32,400,000	$4,082,400,000	$5,983,700,000
2007	$5,000,000,000		$40,000,000	$5,040,000,000	$6,343,500,000
Total	$39,670,000,000	$300,000,000	$280,800,000	$39,650,800,000	$35,758,100,000

Source: Congressional Research Service (CRS) analysis and CRS SCHIP Projection Model.

Notes: Section numbers refer to Title XXI of the Social Security Act. The special diabetes grants are described in Public Health Service Act §330B and §330C. Numbers rounded to the nearest $100,000. "Spending/demand" is included for comparative purposes and is from all federal SCHIP funds — reallocated funds (that is, amounts from the redistribution and retention of unspent funds after original allotments' three-year period of availability) as well as from original allotments. Spending/demand for FY2006 and FY2007 are projections. If the projections were only of federal SCHIP spending, the maximum that a state could spend is its available balance. For states that exhausted (or are projected to exhaust) all available balances, demand reflects not only total spending but also the shortfall of federal SCHIP funds (the additional amount of federal SCHIP funds the state would have spent had the funds been available). For more details, see CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

[9] For additional details, see CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

Allotment Formulas for Territories and States

Territories

Of the total amount of original allotments available to territories (described above), a certain percentage is provided to each of the territories as its original allotment: Puerto Rico receives 91.6%, Guam 3.5%, the Virgin Islands 2.6%, American Samoa 1.2%, and the Northern Mariana Islands 1.1%. These percentages are specified in law and have been unaltered since BBA 97.[10]

States

Each state's original allotment is based primarily on two factors described in law as the "number of children" and a "state cost factor."[11] Once calculated, these two factors are multiplied by each other for each state, with the results added for a national total. Each state's percentage of the total, subject to floors and ceilings, is then multiplied by the total allotment funds available to states in that year (after the reductions for the territories and, for FY1998-FY2002, the special diabetes grants). The result is the amount allotted to each state for that fiscal year.

Number of Children. The "number of children" is composed of two estimates for each state:

- the number of low-income children without health insurance; and
- the number of all low-income children.

A low-income child is an individual under the age of 19 whose family income is at or below 200% of the poverty line.[12] The weight attached to each of the two factors varies by fiscal year. For FY1998 and FY1999, the "number of children" in each state relied solely on the number of *uninsured* low-income children, as shown in **Table 2**. As SCHIP began to cover more low-income children, the formula was designed to rely less on the number of *uninsured* low-income children and more on the number of *all* low-income children. FY2000 was the transition year, in which the "number of children" used 75% of the number of *uninsured* low-income children and 25% of the number of *all* low-income children, as illustrated in **Table 2**.[13] For FY2001 onward, the "number of children" is weighted evenly between the number of *uninsured* low-income children and the number of *all* low-income children in each state.

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[10] §2104(c)(2).

[11] §2104(b).

[12] For 2005, this measure of poverty for a family of three with two children was $15,735 [http://www.census.gov/hhes/www/poverty/threshld/thresh05.html]. At 200% of this level, the amount would be $31,470. The measures of poverty are discussed in greater detail in the technical appendix of this report.

[13] In BBA 97, FY2001 was slated to be the transition year rather than FY2000. The transition year was moved up by BBRA.

Table 2. Factors, with Associated Weights, for Calculating States' SCHIP Original Allotments, by Fiscal Year

FY	*State's original allotment = "number of children" x "state cost factor" (subject to floors and ceilings shown in Table 3)*			
	"Number of children" in §2104(b)(2) is the sum of the two factors below multiplied by the associated percentage		"State cost factor" in §2104(b)(3) is the sum of the two factors below multiplied by the associated percentage	
	Number of low-income children without health insurance	Number of all low-income children	Constant (at the national average)	Ratio of state's average annual wages (health services industry) to national average
1998	100%	0%	15%	85%
1999	100%	0%	15%	85%
2000	75%	25%	15%	85%
2001	50%	50%	15%	85%
2002	50%	50%	15%	85%
2003	50%	50%	15%	85%
2004	50%	50%	15%	85%
2005	50%	50%	15%	85%
2006	50%	50%	15%	85%
2007	50%	50%	15%	85%

Source: Congressional Research Service (CRS) analysis.

Table 3. Applicable Floors and Ceilings for Calculating States' SCHIP Original Allotments, by Fiscal Year

FY	Floor: state's minimum original allotment (greatest applicable factor applies)			Ceiling: state's maximum original allotment
	$2,000,000	90% of last year's original allotment	70% of 1999 original allotment	145% of 1999 original allotment
1998	X			
1999	X			
2000	X	X	X	X
2001	X	X	X	X
2002	X	X	X	X
2003	X	X	X	X
2004	X	X	X	X
2005	X	X	X	X
2006	X	X	X	X
2007	X	X	X	X

Source: Congressional Research Service (CRS) analysis.

Note: The "X" represents factors applicable for that fiscal year. Once a state's original allotment based on **Table 2** is calculated, it is tested against the applicable floors and ceilings in this table. The tests are evaluated in terms of the state's *percentage of the total original allotments to states* for each year, *not* on the dollar amounts. This is described in the text of the report.

The source of data for these state-level estimates is the March supplement of the Current Population Survey (CPS), which is administered by the U.S. Census Bureau. The CPS is a monthly survey of households that provides estimates of employment and unemployment in the U.S. Some time between February and April, respondents

are asked additional questions about their work experience, income, noncash benefits, migration and health insurance status in the previous year. Because the supplement is no longer given only in March, it has been renamed the Annual Social and Economic (ASEC) Supplement, though many analysts continue to call it the March supplement.

Since survey estimates come from only a sample of the population, the estimates could differ from the results from a complete census using the same survey questions. It is possible to estimate this "sampling error" based on the sample size (that is, the number of respondents). Because sample sizes can be relatively small in less populous states, results from multiple years are often averaged together to reduce the sampling error. Current law specifies that for estimating the SCHIP original allotment's "number of children," an average of the most recent *three* years is used.[14]

The original allotments for FY2006 were announced June 24, 2005.[15] The "number of children" for these allotments was based on ASEC data from 2001, 2002, and 2003. Data for 2004, collected in the 2005 ASEC, were not released until August 30, 2005. Regardless, that later data could not be used for calculating the FY2006 original allotments. The law specifies that the original allotment for a fiscal year must be based on "the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the calendar year in which such fiscal year begins."[16] FY2006 began (October 1, 2005) in calendar year 2005. Thus, the Centers for Medicare and Medicaid Services (CMS) interpreted the law to mean that, for the FY2006 original allotments, the CPS data can be no more recent than those available on December 31, 2004. On that date, the 2004 ASEC, providing data from 2003, was the most recent officially available. Thus, the FY2006 original allotments were based on data averaged over the three-year period 2001-2003.

State Cost Factor. The other major factor used in calculating states' portion of the total annual SCHIP appropriation is a state cost factor, based on wages of employees in the health services industry. The factor is intended to adjust for geographic variations in health costs. The national average is scaled to equal 1.00. States with above-average wages in the health services industry will have an amount greater than 1.00, which will increase the amount of their allotment — and vice versa. As shown in **Table 2**, 15% of state cost factor does not vary. In essence, that portion is held at 1.00, the national average. The remaining 85% reflects how different a state's average wages are compared to the national average.

The law specifies that the wage data are to be obtained from the Bureau of Labor Statistics (BLS) of the Department of Labor, using three-year averages for the same years used to calculate the number of children. The law also defines the "health

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[14] §2104(b)(2)(B).

[15] U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2006," 70 *Federal Register* 36615, June 24, 2005.

[16] §2104(b)(2)(B).

services industry" as employers with a Standard Industrial Classification (SIC) code of 8000.[17] However, in 2002, BLS replaced SIC with the North American Industry Classification System (NAICS). Although the mapping between the two systems for the health services industry was not identical, the NAICS wage data codes "represent approximately 98 percent of the wage data that would have been provided under the related SIC code 8000."[18] The NAICS codes now used are 621 (ambulatory health care services), 622 (hospitals), and 623 (nursing and residential care facilities). These three codes are under the broader category (62) for health care and social assistance. The only NAICS code from this category not used for the state cost factor is 624 (social assistance).[19]

The source of data BLS uses for calculating the average wages is from mandatory reports filed quarterly by every employer on their unemployment insurance contributions. BLS provides the data directly to CMS. Because the data cover all employers subject to unemployment insurance coverage under federal law (nearly 99% of employers), it is not technically a survey, but rather a census.[20] As a result, using a three-year average does not reduce sampling error, since censuses do not have sampling error.

Floors and Ceilings. For FY1998 and FY1999, the only adjustment to the calculated state shares of annual SCHIP appropriations was a floor, guaranteeing that every state would receive an allotment of at least $2 million, as shown in **Table 3**. No state's preadjusted allotment for FY1998 or FY1999 was below $2 million, so this floor never applied.

BBRA added two other tests to ensure states' original allotments did not drop below certain levels. The legislation also added a ceiling to cap the amount of the allotments to individual states based on certain prior-year allotments. These BBRA provisions were effective beginning with the FY2000 allotment. As previously mentioned, in calculating the allotment for each state, the number of children and the state cost factor are multiplied together, with the results added for a national total. Each state's percentage of the total — its "preadjusted proportion" — became the values against which BBRA's floors and ceilings are assessed. For the floor, two new tests were applied: (1) a state's original allotment could not be less than 90% of last year's, and (2) its original allotment could not be less than 70% of the FY1999 allotment, as shown in **Table 3**. For the ceiling, no state's original allotment could exceed 145% of the FY1999 allotment, also shown in **Table 3**. Once the floors and ceilings were applied to affected states to produce their *adjusted proportion*, the other states' proportions were adjusted equally to use exactly 100% of the original funding

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[17] §2104(b)(3)(B).

[18] U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2006," 70 *Federal Register* 36617, June 24, 2005.

[19] U.S. Census Bureau, "2002 NAICS Codes and Titles," Title 62, at [http://www.census.gov/epcd/naics02/naicod02.htm#N62].

[20] U.S. Department of Labor Bureau of Labor Statistics, "Quarterly Census of Employment and Wages: Overview," at [http://www.bls.gov/cew/cewover.htm].

for the year available to the states. **Table 4** shows how all of these factors were applied to calculate states' and territories' FY2006 original allotments.

Table 4. Derivation of FY2006 Federal SCHIP Original Allotments

	A	B	C=A*B			
State or territory	Number of children (000s)	State cost factor	Product	Pre-adjusted proportion	Adjusted proportion	Allotment
Alabama	289	0.9793	283.0266	1.5802%	1.5887%	$64,182,128
Alaska	38	1.0701	40.1300	0.2241%	0.2253%	$9,100,310
Arizona	434	1.0909	473.4557	2.6435%	2.6577%	$107,365,854
Arkansas	210	0.9178	192.7374	1.0761%	1.0841%	$43,795,428
California	2,531	1.1267	2,851.7012	15.9220%	16.0075%	$646,682,123
Colorado	248	1.0678	264.2903	1.4756%	1.4345%	$57,951,287
Connecticut	134	1.1365	152.2908	0.8503%	0.8549%	$34,535,088
Delaware	35	1.1396	39.8866	0.2227%	0.2239%	$9,045,121
D.C.	34	1.2395	42.1444	0.2353%	0.2366%	$9,557,107
Florida	1,062	1.0353	1,099.4804	6.1388%	6.1717%	$249,329,871
Georgia	555	1.0295	570.8758	3.1874%	3.2045%	$129,457,875
Hawaii	64	1.1167	71.4686	0.3990%	0.3071%	$12,404,524
Idaho	102	0.8911	90.8880	0.5075%	0.5102%	$20,610,739
Illinois	719	1.0384	746.1197	4.1658%	4.1882%	$169,198,045
Indiana	333	0.9667	321.9135	1.7973%	1.8070%	$73,000,528
Iowa	133	0.8948	119.0055	0.6644%	0.6680%	$26,986,944
Kansas	134	0.9080	121.2234	0.6768%	0.6805%	$27,489,909
Kentucky	267	0.9540	254.7259	1.4222%	1.4299%	$57,764,350
Louisiana	366	0.9306	340.1369	1.8991%	1.9093%	$77,133,066
Maine	59	0.8915	52.6004	0.2937%	0.2953%	$11,928,229
Maryland	201	1.0713	214.7894	1.1992%	1.2057%	$48,707,931
Massachusetts	246	1.1072	272.3684	1.5207%	1.4704%	$59,401,346
Michigan	506	1.0211	516.6683	2.8847%	2.9002%	$117,165,211
Minnesota	177	1.0242	181.2763	1.0121%	0.9747%	$39,376,933
Mississippi	243	0.9058	220.1172	1.2290%	1.2356%	$49,916,118
Missouri	264	0.9420	248.2235	1.3859%	1.3934%	$56,289,799
Montana	63	0.8860	55.3778	0.3092%	0.3109%	$12,558,064
Nebraska	82	0.9116	74.2934	0.4148%	0.4170%	$16,847,571
Nevada	155	1.1919	184.7509	1.0315%	1.0371%	$41,896,088
New Hampshire	39	1.0529	40.5358	0.2263%	0.2275%	$9,192,336
New Jersey	346	1.1420	394.5673	2.2030%	2.2148%	$89,476,287
New Mexico	166	0.9561	158.2400	0.8835%	1.0435%	$42,156,779
New York	1,111	1.0814	1,201.4443	6.7081%	6.7441%	$272,452,310
North Carolina	559	0.9900	553.4211	3.0899%	2.7292%	$110,255,024
North Dakota	32	0.8745	27.9849	0.1562%	0.1571%	$6,346,156
Ohio	568	0.9676	549.5955	3.0686%	3.0850%	$124,632,131
Oklahoma	258	0.8818	227.0515	1.2677%	1.4201%	$57,370,830
Oregon	205	1.0110	206.7594	1.1544%	1.1606%	$46,886,967
Pennsylvania	594	0.9955	591.3332	3.3016%	3.3193%	$134,097,011
Rhode Island	44	0.9803	43.1345	0.2408%	0.2421%	$9,781,641
South Carolina	247	0.9917	244.9403	1.3676%	1.3749%	$55,545,268
South Dakota	38	0.9205	34.5204	0.1927%	0.1938%	$7,828,211
Tennessee	348	1.0189	354.5737	1.9797%	1.9903%	$80,406,910
Texas	2,055	0.9758	2,005.2932	11.1962%	11.2563%	$454,741,626
Utah	160	0.8905	142.0277	0.7930%	0.7972%	$32,207,704
Vermont	23	0.9236	21.2435	0.1186%	0.1192%	$4,817,413

State or territory	A Number of children (000s)	B State cost factor	C=A*B Product	Pre-adjusted proportion	Adjusted proportion	Allotment
Virginia	315	1.0122	318.8368	1.7802%	1.7897%	$72,302,825
Washington	327	0.9914	324.1917	1.8101%	1.6017%	$64,705,479
West Virginia	114	0.9072	102.9648	0.5749%	0.5780%	$23,349,395
Wisconsin	245	1.0057	245.9053	1.3730%	1.3803%	$55,764,106
Wyoming	28	0.9430	25.9337	0.1448%	0.1456%	$5,881,004
		State subtotals	17,910.4652	100.0000%	100.0000%	
Total amount available to states = $4,050,000,000 less 0.25% for territories =						$4,039,875,000
Puerto Rico					91.6%	$38,952,900
Guam					3.5%	$1,488,375
Virgin Islands					2.6%	$1,105,650
American Samoa					1.2%	$510,300
N. Mariana Islands					1.1%	$467,775
Total amount available to territories = 0.25% of $4,050,000,000 + $32,400,000 =						$42,525,000
Total original allotments to states and territories						**$4,082,400,000**

Source: U.S. Department of Health and Human Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2006," 70 *Federal Register* 36619, June 24, 2005.

The decision to use the preadjusted proportion rather than the dollar amounts of the allotments for applying floors and ceilings was a practical one, particularly because of the impact of the SCHIP dip that occurred in FY2002. Using a hypothetical example to illustrate, assume that the preadjusted proportions for all the states were the same in FY2002 as in FY2001. Because of the SCHIP dip, every state in FY2002 would have been slated to receive 73.3% of the dollar amount of its FY2001 allotment, even if its preadjusted proportion was unchanged.[21] One of the BBRA's new floors specified that no state would have its allotment be less than 90% of the previous year's. In this hypothetical example, if that floor were applied to the *dollar* amounts calculated from the formula, then every state would have hit it. The BBRA's floors were not intended to prevent a state's allotment from falling below a particular dollar amount; rather, their purpose was to ensure that, regardless of whether the total amount available for allotments rose or fell, individual states' *share* of the overall appropriation would not vary substantially over time.

Issues and Options Affecting States

Total Appropriation

The last row of **Table 5** (below) shows that the FY2005 appropriation to states was $4.0 billion. However, federal SCHIP spending in FY2005 (the most recent full fiscal year) was $5.0 billion — 25% more than the total original allotments to states for that year, also shown in the table. Funds available in FY2005 in addition to the

[21] From column D of **Table 1**: 3,115,200,000/4,249,200,000 = 73.3%. Reducing both the numerator and the denominator by the 0.25% going to the territories would still yield 73.3%.

FY2005 original allotments were the FY2003 and FY2004 original allotments (if balances remained) and redistributed funds from other states' unspent FY2002 original allotments. With all of these funds, no state experienced a shortfall of federal SCHIP funds in FY2005.

In FY2006, the total appropriation to states is the same as in FY2005 ($4.0 billion), but states' demand for federal SCHIP funds is projected to be approximately $5.9 billion, 47% greater than the year's original allotments. In FY2007, the appropriation to states will rise to $4.9 billion, but states' demand for federal SCHIP funds is projected to be approximately $6.3 billion, 26% greater than the year's original allotments.[22]

For SCHIP's first four years (FY1998-FY2001), the total annual amount provided to states in original allotments exceeded federal SCHIP spending for the year. Beginning in FY2003, however, states' total annual spending exceeded the total annual original allotment amounts, resulting in a greater reliance by many states on unspent funds redistributed from other states. However, as more states spend more of their own allotments, less money is available for redistribution. Simultaneously, more states face the prospect of shortfalls as the gap grows between what they plan to spend in federal SCHIP funds and the amounts projected to be available. CRS projects that 18 states may likely face shortfalls of federal SCHIP funds in FY2007 under current law.[23] (As of the end of FY2005, no more than one state has ever experienced a shortfall in a given year.) If the total annual appropriated amount in reauthorization continues to be the same as the FY2007 amount, the number of states experiencing shortfalls will likely increase annually for several years, according to preliminary CRS projections.[24]

Original Allotment Formula

Once the total amount appropriated to states has been set, the original allotment formula determines how much each state will receive. This is as important to individual states as the total amount allotted nationally. For example, in FY2000, there were billions more dollars in federal SCHIP funds available to states through their allotments than were being spent. However, in that year, Alaska experienced a shortfall of federal SCHIP funds of about $419,000. Even though ample funds appeared available from a national perspective, the way in which those funds were allotted to individual states meant that Alaska exhausted all available federal SCHIP funds, with no capability to tap into other states' unspent funds that year.

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[22] For additional information on these projections, see CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson. States' demand for federal SCHIP funds in FY2006 and FY2007 is based on states' own projections provided to CMS.

[23] CRS Report RL32807, *SCHIP Financing: Funding Projections and State Redistribution Issues*, by Chris L. Peterson.

[24] Projections based on states' adjusted proportions for the FY2006 original allotments. Beginning in FY2008, demand for federal SCHIP funds is held at the FY2007 level increased by the projected growth rate of average per-capita health care expenditures, according to CMS Office of the Actuary.

(Redistribution of states' unspent original allotments to other states did not begin until FY2001.)

For many states, there is a disconnect between their original allotment level and their demand for federal SCHIP funds. **Table 5** shows every state's FY2005 original allotment compared to its FY2005 federal SCHIP spending (from all available federal SCHIP funds, not just the FY2005 original allotment). Only 16 states had total federal SCHIP spending in FY2005 that was less than their FY2005 original allotment. Tennessee is the lowest spender and Rhode Island is the highest spender relative to their original allotment amounts. Tennessee's federal SCHIP spending in FY2005 was only 4% of its FY2005 original allotment amount.[25] At the other extreme, Rhode Island spent six times what was allotted to it in FY2005.[26]

Table 6 shows similar information, but for all full fiscal years since SCHIP's inception. The same two states are at the extremes. From FY1998-FY2005, Tennessee's federal SCHIP spending was only 12% of its total original allotments, while Rhode Island had demand (i.e., actual spending plus shortfalls) for federal SCHIP funds amounting to 259% of its total original allotment funds.

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[25] Targeted low-income children are defined as those who, among other factors, must have family income that is above the Medicaid income eligibility level as of Mar. 31, 1997, per §2210(b)(4). On that date, Tennessee's Medicaid program covered children up to 400% of the federal poverty level (FPL). Tennessee had used SCHIP funds to expand its existing comprehensive Medicaid Section 1115 waiver program. Under the state's SCHIP Medicaid expansion, Tennessee began enrolling children in Oct. 1997. In FY2002, enrollment reached 10,216. Eligibility for this Medicaid expansion program was limited to older children in families with income up to 100% FPL. As of Oct. 1, 2002, all such children had to be covered under regular Medicaid — that is, they were no longer eligible for SCHIP coverage. Thus, Tennessee has had no SCHIP enrollment since FY2002. Since then, Tennessee's federal SCHIP expenditures have been limited to "20% spending." This type of spending, per §2105(g), permits 11 qualifying states to use federal SCHIP funds to cover the difference between the enhanced (SCHIP) and regular (Medicaid) federal medical assistance percentages (FMAPs) for Medicaid enrollees, who are under age 19 and whose family income exceeds 150% of poverty.

[26] Rhode Island covers targeted low-income children from conception (covering pregnant women) to age 19 with income up to 250% FPL. SCHIP coverage is available to Medicaid/SCHIP-enrolled children's parents and adult caretakers up to 185% FPL. For more information, see State of Rhode Island "RIte Care/RIte Share Fact Sheet," at [http://www.dhs.state.ri.us/dhs/reports/rc_rs_fact_sheet_eng.pdf].

Table 5. FY2005 Original Allotments and Federal SCHIP Spending, by State

(Millions of dollars; sorted by spending as a percentage of original allotment)

State	Original allotment	Spending	Spending as a percent of original allotment
Tennessee	$78.9	$3.4	4%
New Mexico	$42.2	$23.2	55%
Connecticut	$36.6	$20.5	56%
Washington	$64.7	$40.3	62%
Texas	$450.0	$287.7	64%
Nevada	$40.4	$26.6	66%
Colorado	$58.0	$38.7	67%
Delaware	$9.0	$6.4	71%
Vermont	$4.9	$3.7	75%
D.C.	$9.6	$7.4	77%
Idaho	$20.7	$16.6	80%
New Hampshire	$9.3	$7.6	82%
Oregon	$47.3	$38.6	82%
Wyoming	$6.4	$5.7	90%
Utah	$31.7	$28.7	91%
Florida	$249.2	$244.0	98%
Indiana	$73.4	$76.1	104%
Montana	$12.3	$12.8	104%
Virginia	$76.3	$79.8	105%
Hawaii	$12.4	$13.0	105%
South Carolina	$54.3	$57.3	106%
Pennsylvania	$131.0	$140.9	108%
Oklahoma	$57.4	$63.6	111%
California	$667.4	$760.0	114%
Alabama	$68.0	$80.2	118%
North Dakota	$6.4	$8.3	129%
Arkansas	$48.7	$63.0	130%
Kentucky	$54.1	$70.8	131%
New York	$270.1	$362.5	134%
West Virginia	$24.4	$33.3	136%
Ohio	$125.8	$172.3	137%
Louisiana	$77.5	$109.9	142%
Iowa	$28.3	$40.8	144%
South Dakota	$7.9	$11.9	151%
Kansas	$28.5	$43.1	151%
Georgia	$130.9	$201.6	154%
Michigan	$111.3	$172.2	155%
Missouri	$54.0	$88.7	164%
Maine	$12.5	$20.6	165%
Wisconsin	$51.9	$86.3	166%
Minnesota	$38.6	$71.5	185%
Arizona	$106.5	$198.0	186%
North Carolina	$110.3	$211.0	191%
Illinois	$164.9	$320.2	194%
Nebraska	$17.1	$34.0	199%
Massachusetts	$59.4	$121.5	204%
Mississippi	$48.2	$112.5	233%
New Jersey	$84.7	$204.9	242%
Maryland	$48.3	$122.4	253%
Alaska	$9.0	$24.4	271%
Rhode Island	$9.4	$56.4	603%

State	Original allotment	Spending	Spending as a percent of original allotment
State total	$4,040	$5,045	125%

Source: Congressional Research Service (CRS).

Table 6. Sum of FY1999-FY2005 Original Allotments and Demand for Federal SCHIP Funds, by State

(Millions of dollars; sorted by spending as a percentage of original allotment)

State	Sum of annual original allotments	Sum of annual spending/demand (i.e., expenditures and shortfalls)	Spending/demand as a percent of original allotments
Tennessee	$549.7	$68.0	12%
New Mexico	$374.1	$88.9	24%
Washington	$414.1	$109.8	27%
Delaware	$69.7	$23.5	34%
New Hampshire	$80.3	$28.6	36%
Arkansas	$357.5	$130.5	36%
Oregon	$335.7	$134.9	40%
Connecticut	$263.3	$109.5	42%
Wyoming	$51.7	$22.0	42%
Nevada	$252.1	$117.5	47%
Hawaii	$80.7	$38.1	47%
D.C.	$78.5	$37.7	48%
Oklahoma	$509.0	$255.3	50%
Vermont	$31.9	$16.8	53%
Texas	$3,469.5	$1,856.8	54%
Virginia	$525.4	$286.2	54%
Colorado	$349.9	$193.0	55%
California	$5,454.4	$3,009.3	55%
Idaho	$141.5	$83.3	59%
North Dakota	$44.9	$28.4	63%
Michigan	$798.0	$521.3	65%
Louisiana	$637.1	$423.2	66%
Utah	$209.3	$146.1	70%
Alabama	$541.1	$378.3	70%
Montana	$96.5	$70.0	73%
Illinois	$1,087.1	$818.2	75%
Pennsylvania	$934.4	$705.5	76%
South Carolina	$451.1	$359.1	80%
Florida	$1,780.4	$1,426.5	80%
Ohio	$955.4	$804.7	84%
South Dakota	$58.9	$50.4	86%
Iowa	$221.8	$190.8	86%
Georgia	$952.9	$835.4	88%
Indiana	$492.1	$439.0	89%
West Virginia	$167.8	$150.9	90%
Kansas	$219.3	$201.7	92%
Nebraska	$125.9	$125.4	100%
Arizona	$856.1	$856.6	100%
Missouri	$411.8	$415.9	101%
Minnesota	$255.5	$273.9	107%
North Carolina	$710.5	$765.2	108%
Kentucky	$381.4	$429.4	113%
Mississippi	$386.4	$450.9	117%

State	Sum of annual original allotments	Sum of annual spending/demand (i.e., expenditures and shortfalls)	Spending/demand as a percent of original allotments
New York	$2,067.0	$2,417.5	117%
Wisconsin	$354.8	$437.2	123%
Maine	$94.0	$115.8	123%
Massachusetts	$386.5	$501.9	130%
New Jersey	$660.0	$1,140.9	173%
Maryland	$383.3	$684.9	179%
Alaska	$61.0	$134.3	220%
Rhode Island	$71.7	$186.1	259%
State total	$30,243	$23,095	76%

Source: Congressional Research Service (CRS).

Separate from the issue of the allotments being sufficient to cover states' expenditures is states' concern that the formula causes substantial variation and unpredictability.[27] This unpredictability is partly driven by the relatively large standard errors associated with the two formula factors derived from the ASEC: the number of low-income children and the number of those children without health insurance. According to one source, "The funding fluctuations present significant problems for states as they develop budget priorities under difficult fiscal conditions."[28] **Table 7** shows this variation in states' original allotments, based on each state's percentage of the total appropriation available to states between FY1998 and FY2006. Over the nine-year period, the average difference between the lowest and highest amounts was 31%. This calculation takes into account that the amounts were limited in 19 states that hit the statutory floor and in 14 states that hit the statutory ceiling, also shown in the table.

[27] For example, see David Bergman, "Perspectives on Reauthorization: SCHIP Directors Weigh In," National Academy for State Health Policy, June 2005.

[28] Michael Davern et al., "State Variation in SCHIP Allocations: How Much Is There, What Are Its Sources, and Can It Be Reduced?" *Inquiry*, vol. 40, no. 2, summer 2003, p. 184.

Table 7. Variation in States' SCHIP Original Allotments (Adjusted Proportion of Total Appropriation Available to States) and Number of Years State Hit Floor or Ceiling, FY1998-FY2006, by Percentage Difference between Lowest and Highest

State	Lowest	Highest	Difference	Floor	Ceiling
Alaska	0.16%	0.24%	45%	0	1
Colorado	0.99%	1.43%	45%	0	2
Delaware	0.19%	0.28%	45%	2	2
Hawaii	0.21%	0.31%	45%	0	5
Idaho	0.38%	0.55%	45%	0	1
Illinois	2.90%	4.21%	45%	0	1
Massachusetts	1.01%	1.47%	45%	0	5
Michigan	2.17%	3.14%	45%	0	1
Minnesota	0.67%	0.97%	45%	0	4
North Carolina	1.88%	2.73%	45%	0	3
North Dakota	0.12%	0.17%	45%	0	3
Vermont	0.08%	0.12%	45%	0	4
Washington	1.10%	1.60%	45%	0	4
Wisconsin	0.96%	1.39%	45%	0	1
Nevada	0.72%	1.04%	44%	0	0
Oklahoma	1.42%	2.03%	43%	7	0
New Mexico	1.04%	1.49%	43%	7	0
Oregon	0.93%	1.30%	40%	0	0
Nebraska	0.35%	0.49%	39%	1	0
Utah	0.57%	0.80%	39%	0	0
Maryland	1.07%	1.46%	36%	1	0
Texas	9.79%	13.29%	36%	2	0
Ohio	2.74%	3.65%	33%	0	0
Tennessee	1.57%	2.05%	31%	0	0
Montana	0.28%	0.36%	30%	1	0
New Hampshire	0.23%	0.29%	30%	3	0
Alabama	1.58%	2.04%	29%	2	0
Louisiana	1.87%	2.41%	29%	2	0
Indiana	1.43%	1.82%	27%	1	0
Missouri	1.22%	1.56%	27%	0	0
New York	6.05%	7.66%	27%	0	0
California	16.01%	20.23%	26%	1	0
South Carolina	1.34%	1.70%	26%	1	0
Wyoming	0.15%	0.18%	25%	0	0
Iowa	0.63%	0.78%	25%	0	0
D.C.	0.23%	0.29%	25%	2	0
Florida	5.24%	6.40%	22%	1	0
Kentucky	1.18%	1.43%	21%	0	0
Connecticut	0.78%	0.94%	21%	1	0
West Virginia	0.50%	0.60%	20%	1	0
Pennsylvania	2.78%	3.32%	19%	0	0
Arkansas	1.08%	1.28%	18%	1	0
Mississippi	1.17%	1.38%	18%	0	0
Arizona	2.64%	3.10%	18%	0	0
Virginia	1.62%	1.89%	17%	0	0
Georgia	2.95%	3.41%	15%	0	0
New Jersey	2.05%	2.35%	15%	0	0
Rhode Island	0.22%	0.25%	14%	1	0
Kansas	0.68%	0.78%	14%	0	0
Maine	0.30%	0.33%	13%	0	0

State	Lowest	Highest	Difference	Floor	Ceiling
South Dakota	0.18%	0.20%	10%	0	0
All States			31% average	19 states	14 states

Source: Congressional Research Service (CRS) analysis using CRS SCHIP Projection Model.

Notes: Numbers displayed are rounded; calculations are based on unrounded numbers. The "adjusted proportion" is each state's percentage of the total appropriation available to states, taking into account the statutory floors and ceilings described earlier in the report.

Discussion

SCHIP has been lauded for the health insurance it provides to children and the flexibility states have in designing their SCHIP programs. With the expiration of SCHIP's current authorization looming, Congress is expected to examine some of the issues surrounding the SCHIP original allotment levels and formula. This section of the report discusses generally how these issues have played out in SCHIP's current authorization and how they could be handled in reauthorization.

Although SCHIP is a capped grant program to states, shortfalls of federal SCHIP funds have largely been avoided through congressional and administrative actions. These past actions highlight the tensions in a program that is popular because it provides health insurance to children, yet was not originally structured as an open-ended entitlement to states (or individuals). Comparing the experience of SCHIP in Rhode Island and Texas illustrates these tensions.

In FY2005, Rhode Island spent $56 million in federal SCHIP funds but had only $9 million available from its own available original allotments.[29] Redistributed unspent funds from other states covered the $47 million difference. As previously mentioned, Rhode Island's SCHIP program covers children in families with income up to 250% FPL and parents or adult caretakers of Medicaid/SCHIP-enrolled children with income up to 185% FPL. In fact, the state's SCHIP program had nearly as many adult enrollees as child enrollees.[30] Families with incomes between 150% and 250% of the FPL pay a monthly premium of $61, $77, or $92 per month, depending on their income.[31] Enrollees face no cost-sharing (e.g., copayments) for services.[32] Rhode Island has one of the lowest rates of uninsured children in the country, at 6.1%.[33]

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[29] In fact, the $9 million was entirely from its FY2005 original allotment, since the state had already depleted the balances in its FY2003 and FY2004 original allotments.

[30] **Table 1** of CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, et al.

[31] State of Rhode Island "RIte Care/RIte Share Fact Sheet," at [http://www.dhs.state.ri.us/dhs/reports/rc_rs_fact_sheet_eng.pdf].

[32] CRS Report RL32389, *A State-by-State Compilation of Key State Children's Health Insurance Program (SCHIP) Characteristics*, by Elicia J. Herz, et al.

[33] CRS Report 97-310, *Health Insurance: Uninsured Children by State*, by Chris L. Peterson. (Hereafter cited as CRS Report 97-310.)

On the other hand, Texas has the highest rate of uninsured children in the country, at 21.7%.[34] After three years' access to its FY2002 original allotment of $302 million, $105 million was unspent and redistributed to states like Rhode Island. Texas does not cover adults in its SCHIP program. Texas's SCHIP covers children in families with income up to 200% FPL. All of these enrollees face cost-sharing (i.e., copayments charged when receiving services). Families with incomes between 101% and 200% of the FPL pay a monthly premium of $15, $20, or $25 per month, depending on their income.[35]

Although the SCHIP programs in these two states vary along several dimensions, the biggest difference is Rhode Island's adult enrollment, which comprises a substantial portion of its SCHIP enrollees, while Texas reports no adult enrollees. If the goal is to reach as many children as possible, research has shown that extending coverage to parents is effective.[36] But in a program with capped federal funding, covering adults raises questions about the appropriate level of funds to be provided to each state. This is one example of the state-level differences in SCHIP that affect states' spending and could be used as factors for calculating future allotments.

One option for reauthorization is for Congress to continue with current appropriation levels and original allotment formula. Despite the variation in what states have been allotted, the same criteria have been in place for nearly a decade. Many states have expanded beyond the original populations targeted by the authorizing SCHIP language. To the extent that they have done so and this has led to potential shortfalls of federal SCHIP funds, Congress is not obliged to devise ways to prevent such shortfalls, even if some congressional action has been taken in the past. There has never been a guarantee that states would not face shortfalls. In fact, Rhode Island in particular is a state that has experienced shortfalls in years past. One may argue that the original allotment levels and formula are adequate, and states are ultimately responsible to deal with the consequences of their decisions to expand eligibility, covered benefits, and the like.

An opposing argument is that the appropriation levels and formula have been an inefficient way for Congress to allocate money among states, particularly when its attempts historically have demonstrated a desire to prevent any shortfalls of

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[34] Ibid.

[35] Centers for Medicare and Medicaid Services (CMS), "Texas Title XXI Fact Sheet," available at [http://www.cms.hhs.gov/LowCostHealthInsFamChild/SCHIPASPI/list.asp].

[36] See, for example, Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage under Medicaid," *Health Services Research*, vol. 38, no. 5, Oct. 2003, p. 1283. The article states, "Children who reside in states that expanded public health insurance programs to parents participate in Medicaid at a rate that is 20 percentage points higher than of those who live in states with no expansions. The Massachusetts expansion in coverage to parents led to a 14 percentage point increase in Medicaid coverage among children due principally to reductions in uninsurance among already eligible children."

federal SCHIP funds, with some exceptions.[37] If the goal is to expand coverage to as many children as possible, then some may argue that turning SCHIP into an open-ended entitlement, like Medicaid, would be most beneficial, as states would not fear the prospect of exhausting their federal funds for the program. If this were the case, one could argue, the only limitation to states expanding coverage to children would be each state's ability to pony up the state share of the costs of coverage. However, with a marked expansion of covered individuals on an open-ended basis, one might also expect a marked expansion in federal outlays.

Because the current levels of state spending reflect state-level decisions about their willingness to cover individuals in what are now relatively mature SCHIP programs, some may contend that original allotment levels in reauthorization should be set according to states' spending. This approach could be used rather than using the levels and formula that were originally created without the benefit of any SCHIP experience. Under such an approach, there would likely be a 25% or more increase in the national SCHIP appropriation compared to the last one slated to occur under the current authorization, in FY2007.[38]

Of course, this does not mean that every state would receive a 25% increase in its original allotment. An approach linking original allotments to actual spending would mean that some states would get markedly smaller original allotments compared to previous years, and other states would receive much larger ones. For example, CRS projects that under current law, Texas will receive an FY2007 original allotment of approximately $560 million but is projected to spend only $409 million that year. If its FY2008 original allotment were linked to its FY2007 expenditures, that allotment would be approximately $150 million less than the FY2007 one.

States that have annual spending less than their original allotments may argue that such an approach for original allotments would penalize them and make it more difficult for them to expand coverage or benefits in the future. Alternatively, there could be some blend between current allotment levels and states' recent expenditures, with some adjustments built in depending on Congress's willingness to cover populations not defined as SCHIP's targeted low-income children. In addition, flexibility could be built in to accommodate new expansions in some states, particularly those that had historically spent relatively smaller portions of their available funds, as well as other factors.

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[37] One exception is the possible impact of a provision in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). The administration projected an FY2006 shortfall of federal SCHIP funds amounting to $283 million, based on states' own projections of their FY2006 spending. DRA included a $283 million appropriation for shortfall states (and 1.05% of the appropriation for the territories). However, DRA specified that the funds could not be used for coverage of non-pregnant adults. Previously cited CRS projections find that two states, Minnesota and Rhode Island, will likely experience a shortfall because of this provision, totaling approximately $20 million. This is still a much smaller shortfall than these states would otherwise have experienced.

[38] As previously mentioned, in FY2007 the appropriation to states will rise to $4.9 billion, but states' demand for federal SCHIP funds is projected to be approximately $6.3 billion, 26% greater than the year's original allotments.

Another issue is the period of availability of the original allotment. Under current law, original allotments are available to states for three years.[39] The first Senate-passed version of DRA would have reduced the period of availability to two years for the FY2004 and FY2005 original allotments. The shortened period of availability of the FY2004 original allotment would have helped close projected shortfalls in FY2006; the redistribution of FY2005 original allotment funds would have occurred in FY2007. The enacted version of DRA dropped those provisions, instead appropriating an additional $283 million for FY2006. DRA did not address the projected shortfalls of federal SCHIP funds in FY2007. The President's FY2007 budget calls for shortening the period of availability of the FY2005 original allotment to two years to address the projected FY2007 shortfall.

Part of the rationale for shortening the period of availability of original allotments hearkens back to BBA 97. When SCHIP was first created, original allotments far outpaced states' spending, since they were still trying to get their programs started. After a decade, however, the states' SCHIP programs are arguably mature, and three years of availability is no longer necessary. Congress has yet to enact any legislation shortening the period of availability of original allotments. If, however, the period is shortened for the FY2005 original allotment for the benefit of shortfall states in FY2007, as proposed by the President, then a reversion back to the three-year period beginning with the FY2006 original allotment means that no redistribution of unspent funds would occur in FY2008.

Finally, SCHIP has been responsible for decreases in the percentage of children who are uninsured. This occurred in the face of significant drops in employer-sponsored coverage for both children and adults (and significant *increases* in uninsurance among adults). In FY1998 and FY1999, the original allotment formula's number of children relied totally on the number of *uninsured* low-income children, to provide funding for states' new SCHIP programs consistent with the number of children potentially eligible for SCHIP. Beginning in FY2001, the formula's number of children has relied equally on the number of *uninsured* low-income children and the number of *all* low-income children. Retaining the *uninsured* children as a factor gives states a somewhat perverse incentive — that as they increase coverage of children through SCHIP, their original allotments *drop*, all else being equal. The declining reliance on the uninsured factor between FY1999 and FY2001 was intended to ameliorate this perverse incentive. Whether Congress decides to continue that decline as part of reauthorization or leave it as it has been for several years is one of many questions to be answered.

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[39] §2104(e).

Technical Appendix: Sources of Data for Current Original Allotment Formula

If the components of the current original allotment formula are retained in reauthorization, the sources of data may merit some additional consideration. As previously mentioned, the SIC industry code used for the health services industry is no longer in use, and has been replaced by codes using NAICS. CMS has simply adopted the NAICS standard, but this could be updated in reauthorization. Additionally, because this data source for the state cost factor does not include the self-employed, some have argued that high rates of self-employment among physicians in some states artificially depresses their state-level factor in the allotment formula.

The other source of data in the formula is the Census Bureau's Current Population Survey (CPS), used for estimating the number of low-income children (below 200% FPL) and the number of those children who are uninsured. A three-year average is used in the formula to reduce the sampling error, as previously discussed. Even with that, however, there can be marked variation, raising questions about the reliability of the CPS estimates for purposes of calculating the original allotments. To address some of these concerns, BBRA appropriated an additional $10 million annually, beginning in FY2000, for the CPS to boost its sample size of children.

Even with the sample-size increase, the variation from year to year that may be attributable simply to small sample sizes is sometimes quite large. For example, Rhode Island has one of the lowest rates of uninsurance among children (6.1%), using a three-year average of the most recently available data. Taking into account the small sample size, there is in fact no significant difference, statistically speaking, between that rate and the lowest rate in the country, 5.5% in Vermont.[40]

Table 8. Estimated Percentage of Uninsured Children in Rhode Island and Vermont, 2002-2004

Year	Rhode Island	Vermont
2002	5.3%	5.8%
2003	5.8%	5.2%
2004	7.3%	5.5%
2002-2004 average	6.1%	5.5%

Source: Congressional Research Service (CRS) analysis of the Annual Social and Economic (ASEC) Supplement of the Current Population Survey (CPS). See also CRS Report 97-310, *Health Insurance: Uninsured Children by State*, by Chris L. Peterson.

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[40] CRS Report 97-310, which includes confidence intervals around each state's three-year average uninsurance rate.

As shown in **Table 8**, Vermont's 5.5% average is based on the estimate of 5.8% for 2002, 5.2% for 2003, and 5.5% for 2004. For Rhode Island, its 6.1% average was based on 5.3% in 2002 (less than the Vermont estimate for that year), 5.8% for 2003, and 7.3% for 2004. In the 2005 CPS (providing data on 2004), the number of children represented in the sample for Vermont was 848; for Rhode Island the number was 1,198. Looking at children specifically under 200% FPL, the sample size falls to 607 in Vermont and 750 in Rhode Island.

The Census Bureau's American Community Survey (ACS) is a new alternative data source not available when SCHIP was initially authorized. The ACS is an annual survey that replaces the decennial census's long form. Like the census, response to the ACS is mandatory. The CPS is a voluntary survey. The ACS has several times more households in the sample than the CPS.

The Census Bureau has also acknowledged that the CPS produces estimates of the uninsured that differ substantially from other nationally representative surveys.[41] Those other surveys have smaller sample sizes than the CPS, and are therefore not able to produce estimates for all the states. The ACS is also not presently an alternative for estimates of the uninsured because it does not include a question on health insurance coverage. A health insurance question is being tested in the ACS. However, if it were decided to add such a question to the survey, it would not be added until at least 2008.

FY2001 was the first year in which the original allotment formula is the same as the current one (i.e., the number of children is weighted evenly between the number of low-income children and the number of those children without health insurance). For reference purposes, **Table 9** shows the number of children based on the factors previously discussed for FY2001 and FY2006 (columns A and B), with the percentage difference between them (column C). The decrease in the total number reflects, among other factors, the decreasing rates of uninsurance partly due to SCHIP. For assessing the impact of these changes in the "number of children" on states' original allotments, the change in the number is not as important as the change in each state's share of the total, shown in column D. The state cost factors for FY2001 and FY2006, along with the percentage difference between them, are also shown in **Table 9** (columns E through F, respectively). The impact of these changes in the factors is mitigated by the applicable floors and ceilings.

As described in §2104(b)(2)(B), the number of low-income children and the number of uninsured low-income children are reported as defined in the CPS. The poverty line used by the Census Bureau, the *poverty thresholds*, is not the same typically used by the federal government for determining income-related program eligibility, the *poverty guidelines*. Except for the CPS estimates, SCHIP's targeted low-income children are those below 200% of the *poverty guidelines* (§2110(c)(5)). **Table 10** shows the 2005 poverty thresholds, and **Table 11** shows the poverty guidelines. If the poverty guidelines were used for the CPS estimates, the resulting changes in the number of children could affect states' original allotments.

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[41] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," p. 16, at [http://www.census.gov/prod/2005pubs/p60-229.pdf].

Table 9. Number of Children and State Cost Factor for SCHIP Original Allotment Formula, FY2001 and FY2006

	Number of children (in thousands)				State cost factor		
	A	B	C	D	E	F	G
State	2001	2006	Change	Change in proportion of total	2001	2006	Change
Alabama	302	289	-4.3%	4.1%	0.9659	0.9793	1.4%
Alaska	41	38	-8.5%	-0.5%	1.0392	1.0701	3.0%
Arizona	542	434	-19.9%	-12.9%	1.0514	1.0909	3.8%
Arkansas	277	210	-24.2%	-17.5%	0.8931	0.9178	2.8%
California	2,905	2,531	-12.9%	-5.2%	1.1108	1.1267	1.4%
Colorado	204	248	21.3%	32.0%	1.0017	1.0678	6.6%
Connecticut	162	134	-17.3%	-10.0%	1.1165	1.1365	1.8%
Delaware	51	35	-31.4%	-25.4%	1.0889	1.1396	4.7%
D.C.	42	34	-19.0%	-11.9%	1.296	1.2395	-4.4%
Florida	978	1,062	8.6%	18.1%	1.0305	1.0353	0.5%
Georgia	621	555	-10.7%	-2.9%	0.9953	1.0295	3.4%
Hawaii	74	64	-13.5%	-5.9%	1.169	1.1167	-4.5%
Idaho	110	102	-7.3%	0.9%	0.8893	0.8911	0.2%
Illinois	787	719	-8.7%	-0.7%	0.9966	1.0384	4.2%
Indiana	298	333	11.7%	21.5%	0.9234	0.9667	4.7%
Iowa	178	133	-25.3%	-18.7%	0.8469	0.8948	5.7%
Kansas	154	134	-13.3%	-5.7%	0.8719	0.9080	4.1%
Kentucky	276	267	-3.3%	5.2%	0.9276	0.9540	2.8%
Louisiana	396	366	-7.7%	0.4%	0.8876	0.9306	4.8%
Maine	68	59	-13.2%	-5.6%	0.9049	0.8915	-1.5%
Maryland	225	201	-10.9%	-3.1%	1.046	1.0713	2.4%
Massachusetts	292	246	-15.8%	-8.4%	1.0495	1.1072	5.5%
Michigan	573	506	-11.7%	-3.9%	1.0074	1.0211	1.4%
Minnesota	255	177	-30.6%	-24.5%	0.9824	1.0242	4.3%
Mississippi	289	243	-15.9%	-8.5%	0.8882	0.9058	2.0%
Missouri	326	264	-19.2%	-12.1%	0.9204	0.9420	2.3%
Montana	83	63	-24.7%	-18.1%	0.8415	0.8860	5.3%
Nebraska	102	82	-20.1%	-13.1%	0.8563	0.9116	6.5%
Nevada	120	155	29.2%	40.5%	1.1954	1.1919	-0.3%
New Hampshire	58	39	-33.6%	-27.8%	0.9826	1.0529	7.2%
New Jersey	403	346	-14.3%	-6.8%	1.1237	1.1420	1.6%
New Mexico	219	166	-24.4%	-17.8%	0.9225	0.9561	3.6%
New York	1,360	1,111	-18.3%	-11.1%	1.0841	1.0814	-0.2%
North Carolina	501	559	11.6%	21.4%	0.9899	0.9900	0.0%
North Dakota	48	32	-33.3%	-27.5%	0.8697	0.8745	0.6%
Ohio	675	568	-15.9%	-8.5%	0.965	0.9676	0.3%
Oklahoma	262	258	-1.7%	6.9%	0.8523	0.8818	3.5%
Oregon	228	205	-10.3%	-2.4%	1.0063	1.0110	0.5%
Pennsylvania	638	594	-6.9%	1.3%	0.9969	0.9955	-0.1%
Rhode Island	44	44	0.0%	8.8%	0.9785	0.9803	0.2%
South Carolina	294	247	-16.0%	-8.6%	1.0055	0.9917	-1.4%
South Dakota	43	38	-12.8%	-5.1%	0.8703	0.9205	5.8%
Tennessee	446	348	-22.0%	-15.1%	0.9991	1.0189	2.0%
Texas	2,028	2,055	1.3%	10.2%	0.9277	0.9758	5.2%
Utah	153	160	4.2%	13.4%	0.9059	0.8905	-1.7%
Vermont	29	23	-20.7%	-13.7%	0.8696	0.9236	6.2%
Virginia	350	315	-10.0%	-2.1%	0.9885	1.0122	2.4%
Washington	314	327	4.1%	13.3%	0.9467	0.9914	4.7%
West Virginia	108	114	5.1%	14.3%	0.8961	0.9072	1.2%

State	Number of children (in thousands)				State cost factor		
	A	B	C	D	E	F	G
	2001	2006	Change	Change in proportion of total	2001	2006	Change
Wisconsin	241	245	1.5%	10.3%	0.9438	1.0057	6.6%
Wyoming	38	28	-27.6%	-21.3%	0.8779	0.9430	7.4%
All states	**21,212 total**	**19,502 total**	**-11.0% average**	**-3.1% average**	**Not applicable**	**Not applicable**	**2.6% average**

Source: Congressional Research Service (CRS) analysis of "Corrected SCHIP Allotments for Federal Fiscal Year 2001," 66 *Federal Register* 6631, Jan. 22, 2001, and "State Children's Health Insurance Program Allotments for Federal Fiscal Year 2006," 70 *Federal Register* 36619, June 24, 2005.

Table 10. U.S. Census Bureau Poverty Thresholds, 2005

Size of family unit	Number of related children (under 18)								
	0	1	2	3	4	5	6	7	8+
One person									
Under 65 years	$10,160								
65+ years	9,367								
Two persons									
Householder under 65 years	13,078	13,461							
Householder 65 years and over	11,805	13,410							
Three persons	15,277	15,720	15,735						
Four persons	20,144	20,474	19,806	19,874					
Five persons	24,293	24,646	23,891	23,307	22,951				
Six persons	27,941	28,052	27,474	26,920	26,096	25,608			
Seven persons	32,150	32,350	31,658	31,176	30,277	29,229	28,079		
Eight persons	35,957	36,274	35,621	35,049	34,237	33,207	32,135	31,862	
Nine+	43,254	43,463	42,885	42,400	41,603	40,507	39,515	39,270	37,757

Source: U.S. Census Bureau.

Table 11. U.S. Health and Human Services Poverty Guidelines, 2005

Persons in family unit	48 contiguous states and D.C.	Alaska	Hawaii
1	$9,570	$11,950	$11,010
2	12,830	16,030	14,760
3	16,090	20,110	18,510
4	19,350	24,190	22,260
5	22,610	28,270	26,010
6	25,870	32,350	29,760
7	29,130	36,430	33,510
8	32,390	40,510	37,260
For each additional person, add	3,260	4,080	3,750

Source: U.S. Health and Human Services.

Memorandum August 9, 2006

TO: Senate Finance Committee
Attention: Susan Jenkins

FROM: Chris L. Peterson
Specialist in Social Legislation
Domestic Social Policy Division

SUBJECT: Responses to Questions for the Record from Committee Members

During the hearing before the Senate Finance Health Subcommittee on July 25, Chairman Hatch asked for information for the record regarding the approximately 4 million children who are uninsured and are *not* eligible for public coverage (Medicaid or SCHIP). The seminal research on this topic is done by researchers at the Agency for Healthcare Research Quality (AHRQ). Their latest article on the topic in the journal *Health Affairs* is attached, which shows in Exhibit 3 that among the 10.0 million uninsured children in 2002, 6.2 million were eligible for public coverage.

Also attached is the memorandum and tables from AHRQ that I cited during the hearing. The first table breaks uninsured children into two categories — those who were eligible for public coverage and those who were not — providing the characteristics of each group. The total number of children in the two categories vary slightly from the *Health Affairs* article. This is because the more detailed analysis requires merging on the previous year's (2001) data in order to report many of their characteristics.

The second table provided by AHRQ breaks the 6.7 million uninsured children who were eligible for public coverage in 2001 or 2002 into two groups — those who were eligible for Medicaid and those who were eligible for SCHIP.

I am attaching to this document the AHRQ material in its entirety as the most comprehensive answer to Chairman Hatch's question.[1] The remainder of this document contains the written questions submitted by Members after the hearing, with my responses.

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[1] My only substantive change to the tables was to calculate and report the 95% confidence intervals for the estimates, based on the standard errors AHRQ provided. A layman's way to describe the 95% confidence interval is to say that one can be 95% confident that the actual population parameter is within the range provided.

Question 1 (Senator Rockefeller)

In his testimony before the Committee, Dr. McClellan stated that, for FY2006, states have $9.7 billion in available allotments while expected expenditures are only about $5.8 billion. For FY2007, states will have $9.1 billion in available allotments and expected expenditures of only about $6.4 billion. Dr. McClellan indicated that, because available allotments exceed expected expenditures in FY2006 and FY2007, there is more than enough money in the CHIP program to meet projected demand. However, I think you would agree that this explanation is somewhat oversimplified. As you know, despite the available allotments, 12 states experienced federal CHIP funding shortfalls in FY2006 and another 18 states are expected to experience federal shortfalls in FY2007. Can you explain why these states are experiencing shortfalls even though there is technically excess money in the CHIP pot?

Answer 1

At the beginning of FY2006, states had three original allotments available — any leftover balances from FY2004 and FY2005 as well as the newly available FY2006 original allotment. The combined total amount available at the beginning of FY2006 was $9.5 billion (which excludes the $0.2 billion from the FY2003 redistributed funds discussed below). States projected their federal SCHIP spending for FY2006 at approximately $5.9 billion, according to their estimates provided to the Centers for Medicare and Medicaid Services (CMS) in November 2005. Although the amount of federal SCHIP funds available nationally exceeded states' projected expenditures for the year, original allotments are entitlements to states (that is, specific, capped amounts provided to each state). In other words, even though there is enough "money in the system," that money is walled off between states. This is how SCHIP financing was designed in the Balanced Budget Act of 1997 (BBA97, P.L. 105-33). Accounting for only these original allotments in FY2006, 12 states were projected to face "initial projected shortfalls" totaling $454 million.[2]

These allotments were not the only federal SCHIP funds available for FY2006. The FY2003 original allotment's 3-year period of availability ended at the end of FY2005, with unspent funds available for redistribution to other states. Congress also appropriated an additional $283 million through the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). The Secretary of Health and Human Services (HHS) was given authority to distribute both the unspent FY2003 funds and the DRA funds in a way to minimize the initial projected shortfalls of $454 million. Using states' spending projections from November 2005, the Secretary distributed the unspent FY2003 and the DRA funds in such a way that eliminated the initial projected shortfalls in eight of the 12 states. Four of the 12 states were still projected to experience an actual shortfall of federal SCHIP funds by the end of FY2006, but the FY2003 redistributed funds and the DRA funds reduced the shortfall amount substantially compared to those states' initial projected shortfalls. The initial projected shortfalls — that is, the amount of their projected shortfalls excluding both the FY2003 redistributed funds and the DRA funds — in those four states (Illinois, Minnesota, New

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[2] Centers for Medicare & Medicaid Services, "State Children's Health Insurance Program (SCHIP); Redistribution of Unexpended SCHIP Funds From the Appropriation for Fiscal Year 2003; Additional Allotments to Eliminate SCHIP Fiscal Year 2006 Funding Shortfalls; and Provisions for Continued Authority for Qualifying States to Use a Portion of Certain SCHIP Funds for Medicaid Expenditures," 71 *Federal Register* 20697-20707, April 21, 2006.

Jersey, and Rhode Island) was approximately $312 million. The FY2003 redistributed funds and the DRA funds to these four states amounted to approximately $309 million, leaving approximately $3 million in actual shortfalls of federal SCHIP funds in FY2006 that these states are projected to experience.[3, 4]

There is projected to be $9.0 billion available to states at the beginning of FY2007 through their own original allotments (that is, any leftover balances from the FY2005 and FY2006 original allotments as well as the newly available FY2007 allotment). The projected federal SCHIP expenditures are $6.3 billion in FY2007. Again, although the total allotments available exceeds the projected expenditures, those allotments are tied to individual states. Thus, 18 states face initial projected shortfalls of approximately $1.04 billion in FY2007. Besides the three available original allotments, there will also be unspent FY2004 funds available for redistribution. However, the FY2004 redistribution funds are projected to be less than $100 million. Assuming those funds are distributed among states facing initial projected shortfalls, as in recent years, actual shortfalls are projected to occur in those same 18 states totaling $944 million, based on state estimates from November 2005.

One policy goal for SCHIP financing may be to use existing funds "in the system" to eliminate states' shortfalls. This may be accomplished by lowering or eliminating the walls between the states' available original allotment funds. This was the proposal in the first Senate-passed version of DRA. That legislation reduced the period of availability of both the FY2004 and FY2005 original allotments from three years to two. At the time, CRS projected the legislation would have eliminated the FY2006 shortfalls and possibly the FY2007 shortfalls without an additional appropriation. Instead, the enacted version of DRA appropriated $283 million for FY2006, without addressing projected FY2007 shortfalls.

The President's Budget for FY2007 proposes reducing the period of availability of the FY2005 original allotment from three years to two. CRS projects this would eliminate the FY2007 shortfalls without requiring additional appropriated funds. In essence, this is one way to lower the walls between the states' original allotments to address the FY2007 shortfalls. By reducing the period of availability, federal funds that states would have spent from their own allotment in the third year would be redistributed to other states.

It is necessary to emphasize, however, that the proposal in the President's Budget is not enacted law. Under current law, CRS's present projections indicate that 18 states will experience shortfalls in FY2007 of $944 million; CMS's projection is FY2007 shortfalls totaling $906 million. Although "from a national perspective there are sufficient allotment funds available to address the States' total expected expenditures,"[5] SCHIP allotments are not distributed to states from a national perspective, with allotments available equally to all

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[3] Ibid. If the May 2006 state estimates are used and if CMS adjusts the redistribution of unspent FY2003 funds and DRA amounts accordingly, there may be no shortfall in FY2006.

[4] All CRS projections are from the CRS SCHIP Projection Model using state estimates from November 2005, with some adjustments. For FY2008 forward, baseline assumptions are that the $5.04 billion annual allotment continues, states' projected expenditures increase by CMS's projected per-capita increases in health care expenditures, and that states' share of original allotments remains constant at the percentages for the FY2006 allotment.

[5] Written testimony of Mark B. McClellan, Director of Centers for Medicare and Medicaid Services (CMS), before the Senate Finance Health Subcommittee, July 25, 2006, p. 10.

states from one national pot. SCHIP allotments are entitlements to states for the three years of availability under current law.

Hypothetically, if the walls between the states regarding their SCHIP original allotments were eliminated altogether beginning in FY2007 — that is, if existing and future ($5 billion annually) allotments were available in one national pot — the "money in the system" would prevent shortfalls through FY2008. In FY2009, all states would face shortfalls under that hypothetical scenario.[6]

Question 2 (Senator Rockefeller)

For FY2007, you estimate that 18 states will experience federal CHIP funding shortfalls of $944 million. The CMS Office of the Actuary has indicated that the FY2007 will be approximately $906 million. Can you explain the reasons for this discrepancy?

Answer 2

There are two reasons for the 4% difference ($38 million) in the amount of FY2007 shortfalls projected by CRS and CMS: (1) CMS used official amounts for the FY2007 original allotments that were not publicly available until after the hearing, and (2) CMS used more recent state spending estimates.

Official FY2007 original allotments. Since the hearing, CMS has published the share of the FY2007 original allotments that each state will receive.[7] CMS used this information in their projections, information that was not available to CRS prior to the hearing. This distribution of the FY2007 allotments reduces projected FY2007 shortfalls by approximately $12 million.

State estimates. The remainder of the difference ($26 million) is due to CMS using more recent state-provided estimates (from May 2006) of FY2006 and FY2007 federal SCHIP spending. Although this has the impact of reducing the FY2007 shortfalls to $906

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[6] Under these assumptions (and increasing states' projected spending by per-capita increases in overall health care spending), CRS projects $9.1 billion would be available at the beginning of FY2007 from the FY2003 to FY2007 original allotments. (The FY2003 original allotment of approximately $0.1 billion is assumed to be available in the national pot for spending in FY2007 rather than being tied to certain states through the traditional redistribution process.) Applied against $6.3 billion in projected spending, a balance of $2.8 billion would remain at the end of FY2007. Combined with $5.0 billion in the FY2008 original allotment under baseline assumptions, this could be used to cover projected FY2008 federal SCHIP spending of $6.7 billion, with $1.1 billion left at year's end. Combined with $5.0 billion in the FY2009 original allotment under baseline assumptions, this would fall short of covering the projected FY2009 federal SCHIP spending of $7.2 billion, by about $1 billion. In each future year, with no other federal SCHIP funds available besides the new annual allotment, the total shortfall would be equal to the difference between projected spending for the year and the $5 billion annual allotment.

[7] Centers for Medicare & Medicaid Services, "State Children's Health Insurance Program; Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2007," 71 *Federal Register* 42854-42859, July 28, 2006.

million (from CRS's estimated $944 million),[8] it also causes an *increase* in the projected FY2006 shortfalls to $35 million (from CRS's estimated $3 million). Under these assumptions, the states expected to actually experience shortfalls in FY2006 would be Illinois ($18.0 million), Massachusetts ($16.2 million), Nebraska ($0.4 million), and Rhode Island ($0.7 million).[9]

Comparing the first two columns in the last row of **Table 1**, the 18 states projected by CRS to face FY2007 shortfalls reduced their projections of FY2006 federal SCHIP spending overall by approximately $42 million. Although five of these states actually increased their FY2006 spending projections (by a total of $35 million), this was more than offset by decreased projections in 12 other shortfall states (by a total of $77 million).[10] Without estimating any readjustment of the FY2003 or DRA funds, four of the five FY2007 shortfall states that increased their FY2006 projected spending would experience shortfalls *in FY2006* totaling $35 million, as previously mentioned.[11] The states that received FY2003 and DRA funds and also *lowered* their spending estimates for FY2006 would, as a result, roll over more than $40 million to FY2007 that they otherwise would not have. This occurs because the distribution of FY2003 and DRA funds was based on the November 2005 estimates. By assuming that distribution is locked in while states experience lower actual FY2006 spending, these states are provided with FY2003 and DRA funds in excess of their need in FY2006.

If past is prologue, the HHS Secretary is likely to readjust the distribution of the FY2003 and DRA funds based on more recent estimates before the close of the fiscal year, even though the distribution of those funds to states has already been announced based on the November 2005 estimates. Such a readjustment occurred with respect to the redistribution of FY2002 funds. The amount that each state was to receive of the FY2002 funds was announced by the HHS Secretary in January 2005, based on states' estimates from November 2004. On September 29, 2005, however, the amounts were altered in a final announcement by the HHS Secretary, using states' estimates from August 2005 rather than November 2004.[12]

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[8] CRS's current baseline has 18 states facing shortfalls in FY2007. All but one of those states, Wisconsin, would still face shortfalls if the only change were to use states' May 2006 estimates.

[9] The FY2006 projected shortfalls in CRS's current baseline would total $3 million in four states (Illinois, $1.0 million; Minnesota, $0.2 million; New Jersey, $0.9 million; and Rhode Island, $0.7 million).

[10] Rhode Island's estimate did not change between November 2005 and May 2006.

[11] Even with the higher estimated spending, Louisiana is not projected to experience shortfalls in FY2006. Although it is projected to experience a shortfall in FY2007, Louisiana was not projected to face an FY2006 initial projected shortfall, did not therefore receive FY2003 or DRA funds in FY2006, and is projected to have enough federal SCHIP funds available in FY2006 to cover its FY2006 expenditures.

[12] For more information, see CRS Report RS22289, *Impact on States of Revised Redistribution of Unspent FY2002 SCHIP Allotments*, by Chris L. Peterson, Oct. 3, 2005, at [http://www.congress.gov/erp/rs/pdf/RS22289.pdf]. Although it may be more accurate for CMS to make its final determination later in the year, with final full-fiscal-year expenditure data, CMS considers itself constrained to make the final determination before the close of the applicable fiscal year.

Using the May 2006 state estimates without estimating any corresponding adjustment of the FY2003 or DRA funds, Dr. McClellan was able to report lower overall shortfalls projected for *FY2007*. Dr. McClellan did not provide an estimate of final shortfalls for *FY2006* based on these assumptions, which CRS estimates would be $35 million (up from $3 million using CRS's current assumptions).[13]

CRS estimates that if the distribution of FY2003 and the DRA funds were revised based on the May 2006 estimates, FY2006 shortfalls would be eliminated altogether. This would be the result of reducing the distribution of these funds to states that projected lower FY2006 spending in the May estimates. Because of this, FY2007 shortfalls would be approximately $940 million, since amounts states would be able to roll over to reduce their FY2007 shortfalls would be less. It must be noted that these estimates are highly speculative, since it is not known whether the Secretary will make an adjustment and, if so, precisely how it would be done. Moreover, a final adjustment would likely occur again right before the end of the fiscal year, by which time CMS will have different state estimates, from August 2006. Those new estimates will likely differ from those reported in May 2006 and November 2005.

Even if CRS had obtained both the FY2006 and FY2007 spending estimates from May 2006, I considered it useful to retain the earlier state estimates, from November 2005, because (1) they were the basis of the current distribution of the FY2003 and DRA funds, and (2) they illustrate some fairly significant changes in state projections in a short amount of time (six months). **Table 1** shows states' own projections of federal SCHIP spending in FY2006 and FY2007, comparing the estimates from November 2005 to those from May 2006. The 18 states projected by CRS to experience FY2007 shortfalls are shaded in the table.

Table 1. States' Estimates of Federal SCHIP Spending in FY2006 and FY2007, Provided in November 2005 and May 2006
(thousands of dollars)

State	States' projections for FY2006			States' projections for FY2007		
	Provided Nov. 2005	Provided May 2006	Change	Provided Nov. 2005	Provided May 2006	Change
Alabama	94,956	89,908	-5.3%	103,850	103,850	0.0%
Alaska	23,794	23,657	-0.6%	25,514	27,429	7.5%
Arizona	110,468	128,669	16.5%	107,366	116,906	8.9%
Arkansas	47,179	46,242	-2.0%	51,186	51,959	1.5%
California	1,082,970	1,155,609	6.7%	1,035,319	1,084,841	4.8%
Colorado	58,538	51,443	-12.1%	53,449	56,614	5.9%
Connecticut	18,651	20,805	11.5%	18,010	22,625	25.6%
Delaware	7,104	7,093	-0.2%	8,156	8,195	0.5%
Dist. Of Col.	8,219	9,435	14.8%	8,225	8,353	1.6%
Florida	374,893	376,069	0.3%	373,908	374,589	0.2%
Georgia	201,645	191,587	-5.0%	211,928	297,580	40.4%
Hawaii	13,604	15,143	11.3%	13,431	23,835	77.5%

[13] In his testimony (p. 11), Dr. McClellan did provide estimates of the FY2006 initial projected shortfalls ($456 million), amounts that by definition do not take into account the FY2003 and DRA funds. The initial projected shortfalls he cited were from the November 2005 state estimates, since those estimates remain the official basis for determining the distribution of the FY2003 and DRA funds.

State	States' projections for FY2006			States' projections for FY2007		
	Provided Nov. 2005	Provided May 2006	Change	Provided Nov. 2005	Provided May 2006	Change
Idaho	26,719	21,999	-17.7%	31,463	25,338	-19 5%
Illinois	328,534	345,564	5.2%	375,409	369,829	-1.5%
Indiana	81,415	82,136	0 9%	89,344	80,661	-9.7%
Iowa	53,332	50,799	-4.7%	64,188	63,260	-1.4%
Kansas	50,416	50,731	0 6%	56,559	55,371	-2.1%
Kentucky	78,109	78,109	0 0%	78,498	81,165	3.4%
Louisiana	135,152	135,755	0.4%	146,814	147,462	0.4%
Maine	24,033	24,859	3.4%	25,499	26,488	3.9%
Maryland	142,687	141,918	-0.5%	160,578	164,936	2.7%
Massachusetts	151,108	167,280	10.7%	184,912	194,625	5.3%
Michigan	176,702	176,751	0.0%	186,519	184,579	-1 0%
Minnesota	80,630	74,993	-7.0%	88,445	83,357	-5.8%
Mississippi	139,776	124,062	-11.2%	143,104	133,120	-7.0%
Missouri	101,300	94,613	-6.6%	119,728	109,856	-8.2%
Montana	15,876	16,846	6 1%	15,800	16,932	7 2%
Nebraska	33,163	33,522	1.1%	34,230	34,586	1.0%
Nevada	28,248	26,671	-5.6%	31,218	28,504	-8.7%
New Hampshire	7,341	7,425	1 1%	8,071	8,145	0.9%
New Jersey	245,705	234,954	-4.4%	275,305	258,449	-6.1%
New Mexico	31,118	29,552	-5.0%	39,361	52,633	33 7%
New York	395,003	323,272	-18.2%	411,099	377,679	-8.1%
North Carolina	223,362	211,576	-5.3%	260,539	265,304	1.8%
North Dakota	14,319	14,122	-1.4%	14,988	14,656	-2.2%
Ohio	179,140	172,195	-3 9%	184,334	184,334	0 0%
Oklahoma	69,798	81,709	17.1%	69,942	102,758	46.9%
Oregon	21,922	66,001	201.1%	29,987	60,948	103.2%
Pennsylvania	151,721	161,824	6 7%	168,879	175,902	4.2%
Rhode Island	76,558	76,558	0.0%	63,369	63,369	0.0%
South Carolina	59,080	58,354	-1 2%	62,436	62,436	0.0%
South Dakota	15,862	13,313	-16.1%	17,014	13,443	-21.0%
Tennessee	-	-	-	-	-	-
Texas	365,455	310,104	-15.1%	408,951	383,369	-6.3%
Utah	38,217	39,359	3.0%	39,159	38,983	-0.4%
Vermont	2,837	4,316	52.1%	2,855	4,337	51.9%
Virginia	96,377	98,442	2.1%	106,409	111,715	5.0%
Washington	30,902	34,921	13.0%	31,376	38,926	24.1%
West Virginia	37,277	34,549	-7 3%	41,206	37,928	-8 0%
Wisconsin	96,276	86,279	-10.4%	96,968	95,363	-1.7%
Wyoming	6,663	5,929	-11 0%	7,951	7,122	-10.4%
US total	**5,854,154**	**5,827,022**	**-0.5%**	**6,182,849**	**6,334,644**	**2.5%**
Shortfall states	**2,087,236**	**2,045,411**	**-2.0%**	**2,308,532**	**2,363,112**	**2.4%**

Source: State estimates provided to the Centers for Medicare and Medicaid Services.

Note: States in shaded rows are projected by CRS to experience FY2007 shortfalls of federal SCHIP funds. For its projections of shortfalls based on states' November 2005 estimates, CRS adjusted the California numbers upward based on information from the state regarding the addition of a prenatal care option that was not reflected in their November 2005 estimates. CRS also increased estimated spending in four states (New Hampshire, New Mexico, Tennessee and Washington) by a total of $16 million in FY2006 and $17 million in FY2007. This was to account for the extension of 20% spending (authorized in Section 2105(g) of the Social Security Act, for qualifying states) in the Deficit Reduction Act of 2005 (P.L. 109-171).

Although nationally the difference between the estimates is relatively small (0.5% lower for FY2006 and 2.5% higher for FY2007), there are some substantial changes by state. For example, among the FY2007 projected shortfall states, Georgia increased its FY2007 estimate by the largest percentage (40%). In November 2005, its estimate of federal SCHIP spending in FY2007 was approximately $212 million. In May 2006, its estimate increased to $298 million. According to state officials, the increase is attributable to two primary causes, each amounting to tens of millions of dollars: (1) converting the SCHIP program to managed care, requiring a costly one-time accounting adjustment from a cash basis to an accrual basis; and (2) increasing enrollment.[14] The FY2007 shortfall state with the largest percentage *decrease* in its FY2007 estimate between November 2005 and May 2006 was South Dakota (21%). CRS has not been able to reach state officials for information regarding the change.

Question 3 (Senator Rockefeller)

Isn't it correct that the budget baseline assumes CHIP is reauthorized, but funding remains frozen forever at fiscal year 2007 levels? Do you think it makes sense for any health care program not to take into account health care inflation or the number of people who will newly become eligible in its cost projections? I understand that, between 2006 and 2012, nearly 1.5 million children could lose their coverage if we don't fix this financing flaw. Mr. Peterson, what are your thoughts on this?

Answer 3

Baseline assumptions. SCHIP's current authorization expires at the end of FY2007. There are also no appropriations slated past FY2007. Nevertheless, for doing budget estimates, the Congressional Budget Office (CBO) and the executive branch use a "budget baseline" that assumes the SCHIP program will continue to operate with funding continuing at the last appropriated level ($5.04 billion for FY2007).[15]

Possible factors for determining original allotments. Whether a health care program should take into account health care inflation and the number of newly eligible enrollees depends upon the goals of the program, particularly with respect to financing. If the goal is to tie states' allotment levels to their projected spending, then the information you mentioned could be useful for those determinations. In particular, the information could be used to determine each state's *share* of the national allotment amount (through changes to the allotment formula) or to determine the *level* of the national allotment itself, or both. It is worth discussing the potential impact on shortfalls of altering these two factors.

Allotment formula (*share* of allotments). Of course, when the structure of SCHIP was created in BBA97, it was not known how many newly eligible enrollees states might have. Lacking that information, each state's *share* of the annual allotments was determined

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[14] Personal conversations with Abel Ortiz, health policy advisor to Georgia Gov. Sonny Perdue, and other staff, July 2006.

[15] Section 2104(a) of the Social Security Act appropriates $5.0 billion in federal SCHIP funds for the states and territories in FY2007. An additional $40 million is appropriated for FY2007 to the territories in Section 2104(c)(4) of the Social Security Act.

in BBA97 based on each state's number of low-income[16] children, number of *uninsured* low-income children, and a "state cost factor" based on average wages in the health care industry in the state compared to the national average.

Beginning on page 8 of my written statement for the hearing, I provided an analysis of the potential impact of incorporating states' actual FY2005 spending into the allotment formula: "The impact of incorporating historical (FY2005) state spending in the allotment formula [that is, basing half of states' *share* of allotments for FY2008-FY2012 on actual FY2005 expenditures and half on the current formula] is projected to reduce total state shortfalls in FY2008 by 22%. By FY2012, however, this option would reduce shortfalls by only 1% compared to baseline assumptions. This is because as the states with the most spending in FY2005 (and most likely to be shortfall states in the near future) receive a greater share of the allotments, less money is allotted to other states. By FY2012, those states that receive less money as a result experience shortfalls they otherwise would not have, or the shortfalls they were projected to experience under baseline assumptions are larger. Over the five-year period (FY2008-2012), incorporating historical spending resulted in a total reduction in projected shortfalls by less than 10%."

In response to your question, I estimated an additional hypothetical scenario, looking at what would occur if states' *projections* of spending in a given year were incorporated into the allotment formula (that is, basing half of states' *share* of allotments for FY2008-FY2012 on projected spending for those years and half on the current formula). The results are similar to the previous scenario — a 27% reduction in the FY2008 shortfalls, a 1% reduction in the FY2012 shortfalls, with an 11% reduction in total shortfalls over the period. In the short term, the alteration would provide higher-spending states with more funds, reducing their shortfalls. By FY2012, total shortfalls would be hardly different than under the baseline assumptions, although higher-spending states would experience lower shortfalls than they otherwise would have. Again by FY2012, those states that receive less money as a result experience shortfalls they otherwise would not have, or the shortfalls they were projected to experience under baseline assumptions are larger.

Although the allotment formula affects the *share* of the allotments each state receives, the *level* of those allotments is critical as well. As the gap between states' projected spending and the allotment levels grows under baseline assumptions, growing shortfalls are inevitable. Thus, both the national *level* and states' *share* of allotments will be important issues Congress may want to revisit in reauthorization, particularly if one's policy goal is to prevent shortfalls of federal SCHIP funds.

Appropriation (*level* of allotments). The national appropriated levels of allotments was approximately $4.2 billion for the first four years of the program, dropping to $3.1 billion to $3.2 billion for the next few years, rising to $4.1 billion in FY2005 and FY2006, and finally to $5 billion in FY2007. The drop in funding for FY2002-FY2004, sometimes referred to as the "CHIP dip," was written into BBA97 due to budgetary constraints applicable at the time the legislation was drafted. Although the CHIP dip occurred at a time when program expenditures were rising, the decrease in allotments was consistent with a different goal, of meeting a particular federal budgeting target. Moving forward into reauthorization, increasing appropriations to match states' spending may work against some federal budgetary goals, for example, but may help ensure a different goal, that states face

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[16] "Low-income" is having a family income under 200% of the federal poverty threshold.

smaller or no shortfalls in the future. If the latter is one's primary goal, the criteria you mention could be useful for determining future allotments levels.

In response to your question, I estimated a hypothetical scenario where allotment levels for FY2008 to FY2012 are raised to exactly the total amount states are projected to spend in those years. Although this reduces the shortfalls in those years by a total of 65%, 19 to 22 states still would face shortfalls in each of those years (a reduction from the 21 to 32 under baseline assumptions). This is based on the assumption that the current funding formula remains unaltered, which means that much of the increase in the allotment levels does not go directly toward states facing shortfalls. In other words, if one leaves the current funding formula unchanged, then to meet the goal of eliminating states' shortfalls, the level of allotments must be much higher than states' actual projected spending for the year. For example, if the only change one made to baseline assumptions for FY2008 was to increase the level of the total allotment, approximately $11.6 billion would have to be appropriated in order to eliminate the FY2008 shortfalls altogether (in a year with projected federal SCHIP spending of $6.7 billion).[17]

Projected spending as determinants of both share and level of allotments. The previous examples highlight the fact that altering only the share or the level of allotments separately to follow states' federal SCHIP spending is not entirely effective at eliminating shortfalls. If one's goal were to absolutely eliminate shortfalls, then one could directly match allotments to projected spending. In that case, both the *level* of original allotments and each state's *share* of the allotments would be based entirely on their projected spending for the year. The SCHIP program would then essentially be an open-ended grant program to states rather than a capped-grant program. This raises fundamental questions about the structure of the SCHIP program and the federal government's role to prevent or eliminate states' projected federal SCHIP shortfalls.

Until it is clear how the federal government will address some of these questions, states face dilemmas regarding how to handle their potential shortfalls of federal SCHIP funds. For example, in prior years, some states may have looked ahead and recognized that they were likely to face federal SCHIP financing shortfalls in FY2006. To prevent such shortfalls, some may have capped enrollment or taken other cost-saving measures. Others may have decided they would take no such action and see whether additional funds would be made available to prevent shortfalls. As it turned out, Congress did appropriate $283 million in additional funds to virtually eliminate projected FY2006 shortfalls. What action would states have taken had they known that FY2006 shortfalls would be virtually eliminated? What should states currently projected to face FY2007 shortfalls be doing? Should they be taking cost-saving measures, or should they continue with their current plan and wait to see what occurs at the federal level?

Impact of shortfalls on enrollment. The decline in enrollment you cite of 1.5 million children between FY2006 and FY2012, using baseline budget assumptions, has been estimated by CMS's Office of the Actuary. This decline is based solely on the projected increases in per-capita costs of SCHIP-enrolled children as the $5 billion annual SCHIP appropriation is held constant between FY2007 and FY2012. In other words, if the $5 billion appropriation in FY2007 pays for coverage of 3.9 million children through SCHIP when each

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[17] Based on the assumption that states' share of original allotments remains constant at the percentages for the FY2006 allotment.

child costs the federal government an average of $1,400, then only 2.9 million can be covered when each child costs $1,800 in FY2012.[18, 19] Compared to SCHIP enrollment in FY2006 of 4.4 million, the 2.9 million in FY2012 represents a 1.5 million person decline in enrollment.

These CMS estimates are admittedly back-of-the-envelope — probably designed more to provide a simple *measure* of the magnitude of potential shortfalls, rather than to project the actual *impact* of those shortfalls. The impact of shortfalls on child enrollment is difficult to project because states may respond to shortfalls in a number of ways. Rather than dropping child enrollees, states may decrease benefits, increase cost-sharing, or drop adult enrollees, for example. Although these may not be desirable steps, they could be used to decrease spending without directly cutting child enrollment. A state may also decide that once it exhausts its federal SCHIP funds, it will continue to cover those children at 100% state cost. On the other hand, a state may decide to drop all of its separate SCHIP program enrollees when its federal SCHIP funds are exhausted. Thus, any projections of the impact of shortfalls on enrollment will be highly speculative.

Increasing the total allotment levels by per-capita growth in health care expenditures (approximately 6% to 7% per year) would only reduce CRS-projected shortfalls in FY2008 by 10%, compared to baseline assumptions. The FY2012 shortfalls would be reduced by 40%, but would still amount to an estimated $2 billion in 28 states. Thus, *if* one's goal is to eliminate future shortfalls, then increasing the $5 billion allotment into the future by per-capita growth in health care expenditures and using the current-law formula for dividing that among states (which does *not* take SCHIP spending or enrollment into account) would not accomplish that goal by itself. As you consider possible options affecting original allotments, CRS would be happy to provide projections of the estimated impact of those provisions.

As a disclaimer, let me state explicitly that CRS has no position on whether Congress should or should not seek to reduce or eliminate states' shortfalls of federal SCHIP funds. As I mentioned earlier, there are potentially multiple goals for a program such as SCHIP, of which reducing or eliminating states' shortfalls of federal SCHIP funds is only one.

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[18] These enrollee estimates are person-years (full-year equivalents), which is not identical to the more widely cited ever-enrolled numbers.

[19] When federal SCHIP funds are exhausted, states generally cannot draw from any other federal funds for enrollees in a separate SCHIP program. For the portion of an SCHIP program that is a Medicaid expansion, states may draw from regular federal Medicaid funds when their SCHIP funds are exhausted, albeit at the lower Medicaid matching rate. The CMS estimates did not account for additional funds that states may obtain from Medicaid at the regular matching rate.

Tracking Changes In Eligibility And Coverage Among Children, 1996–2002

Improved outreach, reduced stigma, and simplified enrollment have led to large increases in children's take-up rates.

by Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin

ABSTRACT: Data from the 1996 Medical Expenditure Panel Survey (MEPS) reveal that 4.7 million children were eligible for Medicaid but were uninsured. Numerous changes have occurred in the landscape for children's health insurance since then, including welfare reform and implementation of the State Children's Health Insurance Program (SCHIP). We use data from the 1996–2002 MEPS to track changes in the eligibility and coverage of children. As of 2002, uninsurance among children remained as much a problem of participation as one of eligibility. Nevertheless, we find evidence of dramatic improvements in program participation, reflecting the success of efforts to improve outreach, simplify enrollment, and increase retention.

Between 1977 and 1987 the percentage of low-income children lacking health insurance climbed from 20.9 percent to 30.8 percent.[1] Spurred in part by this decline in coverage, federal and state governments have worked together to increase the availability of free or heavily subsidized public health insurance coverage for children. The poverty-related Medicaid expansions beginning in the late 1980s conferred eligibility to millions of children in families ineligible for welfare, the traditional pathway for children to receive Medicaid coverage. By 1996 the expansions had helped reduce the rate of uninsurance among low-income children to 23.0 percent.[2]

The pace of reform intensified in the late 1990s. Poverty-related Medicaid eligibility continued to expand, and in 1998 states began implementing the State Children's Health Insurance Program (SCHIP). By 2002, uninsurance among low-income children fell to 18.6 percent.[3] Medicaid covered 21.7 million children at some point during 2000, and SCHIP enrollment during the first quarter of 2002 grew to 3.8 million children.[4]

Although expansions in eligibility increased public coverage for children and

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helped reverse the rise in uninsurance, not all eligible children enroll in public coverage. Research using the 1996 Medical Expenditure Panel Survey (MEPS) found that 4.7 million children were eligible for Medicaid but were uninsured.[5] Approximately 40 percent of all uninsured children were eligible for public coverage in 1996, making uninsurance among children as much a problem of enrollment as one of eligibility.[6]

Since 1996 the economy has expanded and contracted, and private insurance premiums have outpaced the general rate of inflation. Both changes may have influenced trends in private and public coverage. Moreover, there have been several major changes in public policy. Welfare reform restricted immigrants' eligibility for public coverage and may have deterred some eligible immigrant families from enrolling.[7] Welfare reform also restricted eligibility for cash payments and severed the link between cash welfare and Medicaid. One consequence of this may have been reduced Medicaid enrollment, if fewer families applied for welfare or if applicants were not informed of their Medicaid eligibility.[8]

Concerns about Medicaid enrollment also led to concerns about enrollment in SCHIP.[9] Many children made eligible through the Medicaid expansions had failed to enroll, and in the absence of substantial outreach efforts, SCHIP enrollment rates seemed likely to be lower still. One reason for this is that enrollment rates decline with age, and SCHIP-eligible children are older on average than Medicaid-eligible children. Also, SCHIP-eligible children typically have working parents who may be unaccustomed to applying for public benefits.

Concerns about Medicaid and SCHIP enrollment have led to unprecedented efforts to improve outreach, reduce stigma, simplify enrollment, and retain eligible enrollees since 1996.[10] SCHIP may also have had a beneficial spillover effect on Medicaid enrollment, because its legislation requires states to screen SCHIP applicants for Medicaid eligibility.[11] Finally, expansions in family coverage under Medicaid may have increased enrollment among children.[12]

Given the many changes since 1996, it is useful to examine recent trends in eligibility and coverage among children. We rely on data from the 1996, 1998, 2000, and 2002 MEPS, combining a consistent data source with a consistent eligibility simulation methodology over time to estimate trends.

Data And Methods

The data for our analysis come from MEPS, a stratified and clustered random sample of households sponsored by the Agency for Healthcare Research and Quality (AHRQ).[13] When combined with sample weights, MEPS is designed to yield nationally representative estimates of insurance coverage, medical expenditures, and a wide range of other health-related and socioeconomic characteristics for the civilian, noninstitutionalized population. MEPS has an overlapping panel design, with data collected in five rounds over two and a half years. We focus on eligibility and enrollment of children age eighteen and under in the first part of each calen-

dar year. The number of sampled children varies from a low of 7,446 in 1996 to a high of 13,050 in 2002, for a total of 36,729 observations. All results discussed in the text are statistically significant at the 5 percent level unless otherwise noted. All standard errors and statistical tests are adjusted for the complex design of MEPS.

■ **Insurance coverage definitions.** We considered children to be covered if they had insurance covering physician and hospital care at any time during the round (typically four to five months). Thus, we classified children as uninsured only if they were continuously without coverage during the entire round. The 1–2 percent of all children who held both public and private coverage were classified as having public coverage.

■ **Income measurement.** We measured earnings from all jobs held during the interview week. Our earnings measure thereby corresponds as closely as possible to the period during which we measured insurance coverage. To measure unearned income from interest, dividends, Social Security, and pensions, we linked MEPS data to the National Health Interview Survey (NHIS). This survey provides us with indicators for income receipt by type, which we used in constructing cold-deck imputations from MEPS full-year data.[14] We obtained our estimate of assets by capitalizing interest and dividend income flows using the average return on six-month certificates of deposit.[15]

■ **Eligibility simulation.** Our eligibility simulation refines the approach previously used with the 1996 MEPS.[16] We used data on age, earned and unearned income, marital status, employment status, family structure, and state of residence, combined with detailed program eligibility rules by state and by year.[17] In particular, we applied detailed rules regarding income disregards, assistance unit composition, and asset tests.

We also simulated eligibility according to immigration status. Legal immigrant children often face more stringent eligibility criteria than citizen children, and undocumented aliens are rarely eligible for public coverage. Linked NHIS data provide information on nativity, length of time in the United States, and citizenship.[18] Among children in families under 200 percent of the federal poverty level in 2002, 4.4 percent of all children and 10.0 percent of uninsured children were ineligible for Medicaid and SCHIP solely based on their immigration status.[19]

We grouped children into three broad classes of eligibility. "Welfare-related" Medicaid eligibles include children in families eligible for welfare or (after welfare reform) Section 1931 family coverage. This group also includes children eligible through medically needy programs, the Ribicoff Children program, free Medicaid waiver programs targeting families, and separate state-funded programs providing similar coverage to immigrant families

"Poverty-related" Medicaid eligibles include children born after 30 September 1983 into families with net incomes below the federal poverty guidelines, children under age six in families below 133 percent of poverty, and those eligible through

state expansions covering older children and those in families with higher incomes. This category also includes remaining children eligible for free coverage through Medicaid waivers and through separate state-funded programs to provide similar coverage to immigrant children.

Finally, "SCHIP" includes children eligible for Medicaid SCHIP, separate state SCHIP, or separate state-funded programs to provide similar coverage to immigrant children. Also, some states expanded coverage before SCHIP implementation, providing SCHIP-like coverage to children later targeted by SCHIP. We therefore included in this group children eligible for public coverage via other non-SCHIP state programs or Medicaid waivers requiring (subsidized) premiums.

Study Results

■ **Insurance coverage by poverty status.** As of 2002, 61 percent of all children held private coverage, 26 percent held public coverage, and 13 percent were uninsured (Exhibit 1). Among poor children (below 100 percent of poverty), the dominant form of coverage was public insurance. Among near-poor children (100–200 percent of poverty), private and public coverage played approximately equal roles. For middle- and higher-income children (above 200 percent of poverty), private insurance was the dominant form of coverage.

EXHIBIT 1
Insurance Coverage Among Children Age 18 And Under, By Poverty Status, Selected Years 1996–2002

Poverty status/source of coverage	Population total (millions), percent in subgroup			
	1996	**1998**	**2000**	**2002**
All children	74.8 (2.1)	75.9 (2.0)	76.0 (3.4)	76.6 (2.0)
Private[a]	62.2% (1.2)	64.7% (1.1)	64.5% (1.3)	60.6% (1.0)
Public[b]	21.5 (1.0)	20.6 (0.9)	21.5 (1.0)	26.3 (0.9)
Uninsured	16.4 (0.8)	14.7 (0.7)	14.0 (0.9)	13.1 (0.5)
Poor (below 100% of poverty)	15.6 (0.9)	14.7 (0.7)	12.6 (0.9)	13.2 (0.7)
Private[a]	13.5% (1.7)	17.7% (1.4)	15.8% (2.1)	12.7% (1.2)
Public[b]	63.0 (2.4)	62.2 (2.0)	65.4 (2.7)	69.5 (1.6)
Uninsured	23.5 (1.9)	20.1 (1.5)	18.9 (1.9)	17.8 (1.3)
Near-poor (100–200% of poverty)	16.8 (0.8)	15.8 (0.8)	15.8 (0.9)	16.2 (0.7)
Private[a]	49.3% (2.3)	49.6% (1.9)	44.9% (1.9)	41.4% (1.6)
Public[b]	26.2 (2.0)	26.5 (1.7)	30.7 (1.9)	38.5 (1.7)
Uninsured	24.5 (2.1)	23.8 (1.7)	24.4 (1.8)	20.1 (1.3)
More than 200% of poverty	42.4 (1.4)	45.4 (1.5)	47.6 (2.5)	47.2 (1.3)
Private[a]	85.2% (0.8)	85.1% (1.0)	84.0% (0.9)	80.5% (0.9)
Public[b]	4.3 (0.5)	5.0 (0.6)	6.8 (0.6)	10.1 (0.7)
Uninsured	10.5 (0.8)	9.8 (0.8)	9.2 (0.8)	9.4 (0.6)
Number of observations	7,446	8,221	8,012	13,050

SOURCE: Authors' calculations using data from the 1996–2002 Medical Expenditure Panel Survey (MEPS).
NOTES: Results are for coverage at any point during the first part of the year. Standard errors (in parentheses) are adjusted to account for the complex design of MEPS.
[a] Includes children covered by CHAMPUS and TRICARE.
[b] Includes a small percentage of children covered by both public and private insurance during the round.

Uninsurance rates also varied by poverty level in 2002. Among poor children, nearly 18 percent were uninsured. The uninsurance rate among near-poor children was higher, although this difference is not statistically significant. Middle- and higher-income children, in comparison, had far lower rates of uninsurance.

Private coverage among all children rose and fell between 1996 and 2002, mirroring the economic expansion and contraction over the period.[20] By 2002, private coverage rates were slightly below 1996 levels (not a significant difference). In contrast, the percentage of children with public coverage rose five percentage points from 1997 to 2002, and the percentage without coverage fell steadily.

The largest increase in public coverage was among near-poor children. This twelve-percentage-point increase reflects declines in both uninsurance and private coverage.[21] In particular, private coverage among near-poor children declined by 7.9 percentage points between 1996 and 2002. This may reflect "crowd-out," whereby families dropped private coverage for their children when free or highly subsidized public coverage became available. Researchers have found evidence of this phenomenon in both the Medicaid and SCHIP expansions.[22] Declines in private coverage may also reflect premium increases. Clearly, the trends we present here are not sufficient to identify separately these two effects on private coverage.

■ **Eligibility for public coverage.** The number of children eligible for free or highly subsidized public coverage expanded from 21.4 million in 1996 to 36.0 million in 2002 (Exhibit 2). The proportion of all children eligible for such coverage rose from 28.6 percent in 1996 to 47.1 percent in 2002. This is almost entirely attributable to the introduction of SCHIP in 1998 and its subsequent expansions. By 2002, 19.6 percent of all children were eligible for SCHIP based on income and assets, and 8.8 percent also met SCHIP's requirement that they not be enrolled in private coverage.

■ **Uninsurance by eligibility status.** As eligibility for public coverage expanded, so did the number of eligible uninsured children (Exhibit 3).[23] By 2002, 2.8 million children age eighteen and under were uninsured but eligible for SCHIP. In contrast, the number of Medicaid-eligible but uninsured children declined by about a million from 1996 to 2002. This decline occurred mainly after 1998 and was concentrated among children eligible because of the Medicaid expansions.

■ **Take-up rates.** The take-up rate equals the number of children with public coverage divided by the number who were enrolled in public coverage or uninsured. Exhibit 4 reveals three key findings. First, although take-up among welfare-related, Medicaid-eligible children dipped slightly (but not significantly) in the wake of welfare reform, by 2002 take-up had returned to its 1996 level. If welfare reforms had the hypothesized negative effect on take-up, by 2002 that effect was offset by other factors such as improved outreach, simplified enrollment, and increased retention.

Second, and more remarkably, take-up rates among expansion-eligible children rose from 61 percent in 1996 to 68 percent in 1998 (the difference is only significant at the 10 percent level) and 77 percent in 2002. In 1996 Medicaid take-up rates among expansion-related eligibles were well below those among welfare-related

EXHIBIT 2
Eligibility For Public Coverage Among Children Age 18 And Under, Selected Years 1996–2002

Eligibility category	1996		1998		2000		2002	
	Number[a]	Percent	Number[a]	Percent	Number[a]	Percent	Number[a]	Percent
All children	74.8 (2.1)	100.0	75.9 (2.0)	100.0	76.0 (3.4)	100.0	76.6 (2.0)	100.0
Eligible for public coverage	21.4 (1.1)	28.6	25.2 (1.0)	33.2	33.4 (1.6)	43.8	36.0 (1.2)	47.1
Eligible for Medicaid	20.7 (1.1)	27.6	21.4 (0.9)	28.2	19.8 (1.2)	26.1	21.0 (0.9)	27.4
Welfare-related eligibles[b]	10.9 (0.7)	14.5	10.5 (0.6)	13.8	10.8 (0.8)	14.2	11.4 (0.6)	14.9
Expansion eligibles[c]	9.8 (0.8)	13.1	10.9 (0.6)	14.4	9.0 (0.6)	11.8	9.6 (0.5)	12.5
Eligible for SCHIP or SCHIP precursors (based on income and assets)[d]	0.7 (0.2)	1.0	3.8 (0.4)	5.1	13.5 (0.8)	17.8	15.0 (0.6)	19.6
SCHIP-eligible and not covered by private insurance	0.3 (0.1)	0.4	1.4 (0.2)	1.9	4.8 (0.4)	6.3	6.7 (0.4)	8.8

SOURCE: Authors' calculations using data from the 1996–2002 Medical Expenditure Panel Survey (MEPS).
NOTES: SCHIP is State Children's Health Insurance Program. Results are for the first part of each calendar year. Standard errors (in parentheses) are adjusted to account for the complex design of MEPS. See Exhibit 1 for number of observations.
[a] Millions.
[b] Includes children eligible through Aid to Families with Dependent Children (AFDC) (in 1996) and Medicaid Section 1931 (after 1996), as well as children eligible for Medicaid through the Ribicoff Children program, Medicaid medically needy coverage, Medicaid waivers providing free coverage to families, and separate Medicaid-comparable state programs for immigrants who would have been eligible for Medicaid through any of these programs apart from their immigration status.
[c] Includes children eligible through the poverty-related expansions for children, free Medicaid coverage through waivers targeted at children, and separate Medicaid-comparable state programs for immigrants who would have been eligible for Medicaid through any of these programs apart from their immigration status.
[d] Includes children with private coverage who would otherwise be eligible for SCHIP based on income, assets, and immigration status. Also includes a small number of children eligible for comprehensive public coverage that required payment of a premium, either through Medicaid Section 1115 waivers or through state-funded programs

eligibles. In a major reversal of this pattern, by 2002 take-up rates for these two groups had largely converged.

Third, SCHIP take-up rates rose throughout SCHIP's implementation. As expected, take-up rates were initially quite low. As of 2000, predictions that SCHIP take-up would be under 50 percent absent major improvements in outreach were largely correct.[24] However, SCHIP take-up continued to rise, and by 2002 it had reached 60.4 percent.

As a final step, we used multivariate analysis to examine whether the trends in Exhibit 4 might simply be attributable to changes in the mix of eligible children over time. We used a probit model for enrollment in public coverage, restricting the sample to children enrolled in public coverage or uninsured. This enabled us

EXHIBIT 3
Uninsured Children Age 18 And Under, By Eligibility Status, Selected Years 1996–2002

	Millions of uninsured children			
Eligibility status	**1996**	**1998**	**2000**	**2002**
All children	12.2 (0.7)	11.2 (0.6)	10.6 (0.8)	10.0 (0.5)
Eligible for public coverage	4.6 (0.4)	5.3 (0.3)	6.4 (0.5)	6.2 (0.4)
Eligible for Medicaid	4.5 (0.4)	4.4 (0.3)	4.0 (0.3)	3.4 (0.3)
Welfare-related eligibles[a]	1.9 (0.2)	2.1 (0.2)	2.1 (0.2)	1.9 (0.2)
Expansion eligibles[b]	2.6 (0.3)	2.3 (0.2)	1.9 (0.2)	1.5 (0.1)
Eligible for SCHIP or SCHIP precursors (based on income and assets)[c]	–[d]	0.9 (0.1)	2.4 (0.2)	2.8 (0.2)

SOURCE: Authors' calculations using data from the 1996–2002 Medical Expenditure Panel Survey (MEPS).
NOTES: SCHIP is State Children's Health Insurance Program. Results are for the first part of each calendar year. Uninsured children lack coverage throughout the round (typically four to five months in duration). Standard errors (in parentheses) are adjusted to account for the complex design of MEPS.
[a] See Exhibit 2, note b.
[b] See Exhibit 2, note c.
[c] See Exhibit 2, note d.
[d] Estimate is based on too few observations to be reliable. Children in this eligibility category are, however, included in our estimate of all children eligible for public coverage.

EXHIBIT 4
Public Coverage Take-up Rates Among Children Age 18 And Under, By Eligibility Status, Selected Years 1996–2002

	Take-up percentage			
Eligibility status	**1996**	**1998**	**2000**	**2002**
Eligible for public coverage	71.9 (2.0)	69.8 (1.7)	68.8 (1.9)	73.4 (1.3)
Eligible for Medicaid	71.9 (2.0)	72.2 (1.8)	73.9 (1.8)	79.1 (1.4)
Welfare-related eligibles[a]	79.7 (2.1)	75.9 (2.0)	77.1 (2.3)	80.3 (1.8)
Expansion eligibles[b]	60.6 (3.3)	67.8 (2.7)	68.8 (3.1)	77.3 (1.8)
Eligible for SCHIP or SCHIP precursors (based on income and assets)[c]	–[d]	43.5 (5.8)	53.9 (3.1)	60.4 (2.2)

SOURCE: Authors' calculations using data from the 1996–2002 Medical Expenditure Panel Survey (MEPS).
NOTES: SCHIP is State Children's Health Insurance Program. Results are for the first part of each calendar year. "Take-up" is the number of children enrolled in public coverage at any point during the round divided by the sum of children lacking coverage for the entire round plus children with public coverage at any point during the round. Standard errors (in parentheses) are adjusted to account for the complex design of MEPS.
[a] See Exhibit 2, note b.
[b] See Exhibit 2, note c.
[c] See Exhibit 2, note d.
[d] Estimate is based on too few observations to be reliable. Children in this eligibility category are, however, included in our estimate of all children eligible for public coverage.

to examine take-up rates over time, while controlling for a wide range of socioeconomic factors that might affect eligibility or enrollment.[25] Within welfare-related Medicaid, the adjusted increase in take-up between 1996 and 2002 was 3.2 percentage points (not statistically significant); it was 18.9 percentage points among expansion-related eligibles. Within SCHIP, the adjusted increase in take-up between 1998 and 2002 was 21.7 percentage points. Because our adjusted results mirror the unadjusted trends presented in Exhibit 4, we conclude that the trends in Exhibit 4 represent real increases in take-up rates that are not merely the result of changes in the mix of eligible children over time.

Limitations And Comparisons With Other Studies

■ **Limitations.** Our study has three notable limitations. First, although we are careful to account for rules governing family composition, income net of disregards, assets, and immigration status, all of these variables may be measured with error in our data. Also, we do not simulate transitional or continuation eligibility, disability-related eligibility, or presumptive eligibility. For this reason, we may underestimate the number of eligible children, the number of eligible but uninsured children, and take-up rates.

Second, we deem children to be uninsured only if they continuously lacked coverage during the round (typically four to five months). By ignoring shorter spells of uninsurance, our results may understate the true extent to which eligible children lack coverage. Third, an issue with all household surveys is the accuracy of coverage data. Comparisons with administrative data suggest that MEPS may modestly undercount enrollment in public coverage. Nevertheless, MEPS is widely regarded as providing more accurate and consistent public coverage estimates than the Current Population Survey (CPS), perhaps because MEPS asks numerous detailed questions regarding the presence, source, and duration of coverage.[26] Also noteworthy is that MEPS and the CPS find higher levels of uninsurance than either the National Survey of America's Families (NSAF) or the NHIS. Indeed, this difference has grown since the late 1990s, with NSAF and the NHIS showing faster declines in uninsurance and faster increases in public coverage than either MEPS or the CPS.[27]

■ **Comparison of results.** Given the potential for differences across surveys and eligibility simulations, it is useful to compare our results with other published estimates. Our estimates of uninsured eligible children in 2000 are close to those from the 1999 NSAF. We estimate that 6.4 million eligible children were uninsured throughout the round (4.0 million were eligible for Medicaid and 2.4 million for SCHIP). The 1999 NSAF estimate is that 6.8 million eligible children were uninsured as of the interview date (4.6 million were eligible for Medicaid and 2.2 million for SCHIP).[28] Similarly, our public coverage take-up rate for 2000 is 68.8 percent, which is close to the 68 percent take-up rate from the 1999 NSAF.[29] Our 2002 MEPS estimates are also close to a CPS-based study that found that 6.5 million children

"Children's enrollment in public coverage remains far from complete, yet dramatic progress has been made."

were eligible for Medicaid or SCHIP but were uninsured in 2002.[30] In contrast, adjusting CPS data in an effort to correct for undercounted public coverage yields an estimate that fewer than five million children in 2000 were eligible for Medicaid or SCHIP but were uninsured.[31] Clearly, no survey or eligibility simulation is free from potential errors, and estimates from any one survey or eligibility simulation should be interpreted with caution.

Discussion

Between 1996 and 2002 the proportion of all children who were eligible for free or heavily subsidized public health insurance coverage rose from 28.6 percent to 47.1 percent. Not surprisingly, the number of eligible uninsured children rose as well, from 4.6 million in 1996 to 6.2 million in 2002. As of 2002, more than 60 percent of all uninsured children were eligible for public coverage. What was true in 1996 was even more true in 2002: Participation remains a key problem among uninsured children.

Children's enrollment in public coverage remains far from complete, yet dramatic progress has been made. First, we observe no net decline in take-up among welfare-related eligible children. Early studies found evidence of declines in Medicaid participation in the wake of immigration and welfare reform.[32] Our results for 1996 to 1998 mirror those findings. However, if immigration and welfare reforms had the hypothesized negative effect on take-up, by 2002 those effects were offset by state efforts to improve outreach, simplify enrollment, and increase retention.

Second, we find large increases in take-up among Medicaid expansion–eligible children, from the low levels observed in 1996 to levels in 2002 that were close to those for welfare-related eligibles.[33] Third, we observe remarkable increases in take-up among SCHIP-eligible children. These findings are confirmed by our multivariate analysis, in which we controlled for a wide range of socioeconomic characteristics of children and their families.

We interpret our results as evidence of the effects of improved outreach, reduced stigma, enrollment simplification, continuous coverage, and the myriad other improvements in Medicaid and SCHIP implemented since the mid-1990s.[34] In many states, reform efforts focused on SCHIP, but we observe equally large improvements in the take-up rates of both Medicaid and SCHIP. This suggests that these programs may have important spillover effects on each other.

IT MAY BE OVERLY OPTIMISTIC to anticipate continued improvements in take-up rates beyond the period of our study. Recently, states have faced intense fiscal pressures. These pressures, combined with rapidly rising enrollment in public coverage, have led many states to begin rolling back SCHIP eligibility or the outreach programs and simplifications that are likely to have increased take-up rates.[35] Whether these gains can be preserved in the present fiscal climate is an important open question that we hope will be answered by future waves of MEPS.

The authors are grateful for the helpful suggestions of Cindy Brach, Randolph Capps, Lisa Dubay, Trena Ezzati-Rice, Sarah Grantham, Carol Irvin, Genevieve Kenney, Julie Martinez, John Moeller, and John Sommers, along with the expert programming assistance of Devi Katikineni and Jackie Malone of Social and Scientific Systems. They also thank Leighton Ku, Randolph Capps, Jeffrey Passel, Kenneth Sucher, and Carol Irvin for generously sharing data. Any remaining errors are the authors' own. The views expressed in this paper are those of the authors, and no official endorsement by the Department of Health and Human Services or the Agency for Healthcare Research and Quality is intended or should be inferred.

NOTES

1. R.M. Weinick and A.C. Monheit, "Children's Health Insurance Coverage and Family Structure, 1977–1996," *Medical Care Research and Review* 56, no. 1 (1999): 55–73. Estimate is for children age seventeen and under with family income below 200 percent of poverty and at least one parent or stepparent.
2. Ibid. See also J.S. Banthin and T.M. Selden, "The ABCs of Children's Health Care: How the Medicaid Expansions Affected Access, Burden, and Coverage between 1987 and 1996," *Inquiry* 40, no. 2 (2003): 133–145.
3. Authors' calculations (standard error = 1.0). Estimate is for children age seventeen and under with family income under 200 percent of poverty and at least one parent or stepparent.
4. Centers for Medicare and Medicaid Services, "Medicaid Eligibles—Fiscal Year 2000 by Age Group: All States," April 2004, www.cms.hhs.gov/medicaid/msis/00total.pdf (30 April 2004); and "The State Children's Health Insurance Program Quarterly Enrollment Report," July 2002, www.cms.hhs.gov/schip/enrollment/fy02sqer.pdf (30 April 2004).
5. T.M. Selden, J.S. Banthin, and J.W. Cohen, "Medicaid's Problem Children: Eligible but Not Enrolled," *Health Affairs* 17, no. 3 (1998): 192–200.
6. Ibid. See also D.M. Cutler and J. Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics* 111, no. 2 (1996): 391–430; L.C. Dubay, J. Haley, and G.M. Kenney, *Children's Eligibility for Medicaid and SCHIP: A View from 2000*, Assessing the New Federalism Series B, Number B-41 (Washington: Urban Institute, 2002); and M. Broaddus and L. Ku, *Nearly 95 Percent of Low-Income Uninsured Children Now Are Eligible for Medicaid or SCHIP* (Washington: Center on Budget and Policy Priorities, 2000).
7. M. Fix and J. Passel, "The Scope and Impact of Welfare Reform's Immigration Provisions," Assessing the New Federalism Discussion Paper no. 02-03 (Washington: Urban Institute, 2002).
8. L. Ku and B. Garrett, "How Welfare Reform and Economic Factors Affected Medicaid Participation: 1984–96," Assessing the New Federalism Discussion Paper no. 00-01 (Washington: Urban Institute, 2000); K. Kronebusch, "Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding," *Health Affairs* 20, no. 1 (2001): 97–111; and R. Kaestner and N. Kaushal, "The Effect of Welfare Reform on Health Insurance Coverage of Low-Income Women and Children," *Journal of Health Economics* 22, no. 6 (2003): 959–983.
9. T.M. Selden, J.S. Banthin, and J.W. Cohen, "Waiting in the Wings: Eligibility and Enrollment in the State Children's Health Insurance Program," *Health Affairs* 18, no. 2 (1999): 126–133.
10. D.C. Ross and L. Cox, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (Washington: Kaiser Commission on Medicaid and the Uninsured, 2002); National Governors Association, *MCH Update 2002: State Health Coverage for Low-Income Pregnant Women, Children, and Parents* (Washington: NGA, 2003); A.W. Dick et al., "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review* 23, no. 3 (2002): 65–88; I. Hill and A.W. Lutzky, *Is There a Hole in the Bucket? Understanding SCHIP Retention* (Washing-

ton: Urban Institute, 2003); and Lake, Snell, and Perry Associates, *Retaining Eligible Children and Families in Medicaid and SCHIP: What We Know So Far: A Review of Research Prepared for Covering Kids and Families* (Columbia, S.C.: Covering Kids and Families, 2003).

11. CMS, *The State Children's Health Insurance Program Annual Enrollment Report: Federal Fiscal Year 2001*, January 2002, www.cms.hhs.gov/schip/enrollment/schip01.pdf (30 April 2004).
12. Selden et al., "Waiting in the Wings."
13. J.W. Cohen et al., "The Medical Expenditure Panel Survey: A National Health Information Resource," *Inquiry* 33, no. 4 (1996): 373–389; and S.B. Cohen, *Sample Design of the 1996 Medical Expenditure Panel Survey Household Component*, MEPS Methodology Report no. 2, Pub. no. 97-0027 (Rockville, Md.: AHRQ, 1997).
14. Although MEPS also collects data on unearned income, they are collected in later rounds and are unavailable until nearly two years after the data we use become available.
15. U.S. Census Bureau, *Statistical Abstract of the United States: 2002* (Washington: U.S. Government Printing Office, 2003), Table 1168.
16. Selden et al., "Medicaid's Problem Children."
17. Sources for program rules include the Urban Institute's Welfare Rules Database, www.urban.org/Content/Research/NewFederalism/AboutANF/AboutANF.htm (12 July 2004); L. Ku, F. Ullman, and R. Almeida, "What Counts? Determining Medicaid and CHIP Eligibility for Children," Assessing the New Federalism Discussion Paper no. 99-05 (Washington: Urban Institute, 1999) and the associated database; D.C. Ross and L. Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Individual State Profiles*, Pub. no. 2191 (Washington: Kaiser Commission on Medicaid and the Uninsured, 2000); National Governors' Association, *MCH Update 2002* (Washington: NGA, 2002 and earlier years); M. Broaddus et al., *Expanding Family Coverage: States' Medicaid Policies for Working Families in the Year 2000* (Washington: Center on Budget and Policy Priorities, 2002); as well as information from state Web pages, CMS documents, and discussions with state program administrators.
18. Missing values were edited using hot-deck imputations. Prior to our 2000 data, the NHIS does not report citizenship for foreign-born residents, so we imputed citizenship based on nativity, arrival date, race/ethnicity, MEPS interview language, poverty level, age, family structure, education, and region. Although we did not observe the legal status of noncitizens, we adjusted our estimates using legal status probabilities, following Dubay et al., "Children's Eligibility for Medicaid and SCHIP." Legal status probabilities by age, poverty level, ethnicity, arrival date, marital status, education, region, and urbanicity were generously provided by Randolph Capps, Jeffrey Passel, and Kenneth Sucher (all of the Urban Institute). See also J.S. Passel and R.L. Clark, *Immigrants in New York: Their Legal Status, Incomes, and Taxes* (Washington: Urban Institute, 1998). For more on immigration status and program eligibility, see Zimmermann and Tumlin, *Patchwork Policies*; Fix and Passel, *The Scope and Impact of Welfare Reform's Immigration Provisions*; R. Capps, L. Ku, and M. Fix, *How Are Immigrants Faring after Welfare Reform? Preliminary Evidence from Los Angeles and New York City* (Washington: Urban Institute, 2002); and C. Schlosberg, *Immigrant Access to Health Benefits: A Resource Manual* (Boston: Access Project, 2002).
19. Authors' calculations (standard errors are 0.4 and 1.2, respectively). MEPS estimates trend upward from 1996 immigration impacts of 1.9 percent (s.e. = 0.3) and 3.3 percent (s.e. = 0.6), respectively. Corresponding estimates from Dubay et al., "Children's Eligibility for Medicaid and SCHIP," for 1999 are 2.3 percent and 8.0 percent.
20. Private coverage rates in 1996 were significantly below levels in 1998 and 2000 (jointly) at the 10 percent level. The joint test of private coverage rates in 1998 and 2000 versus 2002 is statistically significant at the 1 percent level.
21. The decline for near-poor children is significant only at the 10 percent level.
22. For Medicaid, see Cutler and Gruber, "Does Public Insurance Crowd Out Private Insurance?"; and L.C. Dubay and G.M. Kenney, "The Effects of Medicaid Expansions on Insurance Coverage of Children," *Future of Children* 6, no. 1 (1996): 152–161. For SCHIP, see A. LoSasso and T. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," NBER Working Paper no. 9405 (Cambridge, Mass.: National Bureau of Economic Research, 2002); and T. Buchmueller et al., "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers" (Presentation at the Twenty-fifth Annual Research Conference, Association for Public Policy and Management, Washington, D.C., 7 November 2003).
23. Our 1996 estimate is slightly below the estimate of 4.7 million eligible uninsured children in Selden et al., "Medicaid's Problem Children," because of refinements in our eligibility simulation. Corresponding estimates for eligible uninsured children age seventeen and under are 4.3 million in 1996 (s.e. = 0.4) and 5.7

million in 2002 (s.e. = 0.3).

24. Selden et al., "Waiting in the Wings."
25. We include age, sex, race/ethnicity, immigration status, self-reported health status, family income relative to the poverty level, family structure, family educational attainment, region, and urbanicity. We estimate separate models for each broad eligibility category.
26. A. Winter and M.E. Moyer, *Understanding Estimates of Uninsured Children: Putting the Differences in Context*, ASPE Research Note (Washington: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 1999).
27. U.S. Census Bureau, "Table HI-2, Health Insurance Coverage Status and Type of Coverage—All Persons by Age and Sex: 1987 to 2002," April 2004, www.census.gov/hhes/hlthins/historic/hihistt2.html (4 June 2004); G. Kenney, J. Haley, and A. Tebay, *Children's Insurance Coverage and Service Use Improve*, Snapshots of American Families III, no. 1 (Columbia, S.C.: Covering Kids and Families, 2003); and National Center for Health Statistics, "Appendix Table 1, Number and Percent of Persons Uninsured, with Public or Private Coverage, Based on the 1990 and 2000 Census Population Estimates, by Age Group: United States, 2000–2002," December 2003, www.cdc.gov/nchs/data/nhis/earlyrelease/200312_app.pdf (7 June 2004).
28. Dubay et al., *Children's Eligibility for Medicaid and SCHIP.* See also Broaddus and Ku, *Nearly 95 Percent of Low-Income Uninsured Children Now Are Eligible for Medicaid or SCHIP.*
29. J. Holahan, L. Dubay, and G. Kenney, "Which Children Are Still Uninsured and Why? The Future of Children" (Los Altos, Calif.: David and Lucile Packard Foundation, forthcoming).
30. American Academy of Pediatrics, "Fact Sheet: Children's Health Insurance and Medicaid" (Elk Grove Village, Ill.: AAP, 2003).
31. Covering Kids, "New Data: Nearly Five Million Children in America Are Needlessly Uninsured," Press Release, 1 August 2002, www.coveringkidsandfamilies.org/press/releases/index.php?PressReleaseID=5 (7 June 2004).
32. Kronebusch, "Medicaid for Children"; and Kaestner and Kaushal, "The Effect of Welfare Reform on Health Insurance Coverage."
33. Selden et al., "Medicaid's Problem Children."
34. See also G. Kenney, J. Haley, and A. Tebay, *Familiarity with Medicaid and SCHIP Programs Grows and Interest in Enrolling Children Is High*, Snapshots of America's Families III, no. 2 (Washington: Urban Institute, 2003).
35. See, for example, E.M. Howell, I. Hill, and H. Kapustka, *SCHIP Dodges the First Budget Ax*, New Federalism: Issues and Options for States no. A-56 (Washington: Urban Institute, 2002); D.C. Ross and L. Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge: A Fifty State Update on Eligibility, Enrollment, Renewal, and Cost-Sharing Practices in Medicaid and SCHIP* (Washington: Kaiser Commission on Medicaid and the Uninsured, 2003); and E. O'Brien and C. Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP* (Columbia, S.C.: Covering Kids and Families, 2003).

To: Chris Peterson, Congressional Research Service
From: Julie Hudson, Ph.D., Agency for Healthcare Research and Quality
Date: August 1, 2006 (initial communication: July 21, 2006)
RE: Special Request: Characteristics of Uninsured Children by Public Insurance Eligibility Status

Per your request, the attached tables present demographic and family characteristics of uninsured children by eligibility for public insurance. They provide additional details on the population of children studied in our 2004 Health Affairs publication, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," (Selden, Hudson and Banthin). The published paper presented estimates of health insurance coverage, uninsurance, public health insurance coverage and eligibility for public health insurance by year between 1996-2002 for children ages 0-18 in the Medical Expenditure Panel Survey.

For this request, I have subset the MEPS sample to children who were uninsured in 2001 and 2002. The MEPS data show that, on average across both years, about 10.7 million children were uninsured in the first half of the year[1]. Among the uninsured, 6.7 million children were eligible for public insurance through Medicaid (3.9 million) or SCHIP (2.9 million) and 4.0 million children were not eligible for public insurance[2]. Table 1 presents characteristics of uninsured children broken down by whether or not they were eligible for public health insurance. Table 2 presents the same characteristics for uninsured children who were eligible for public health insurance broken down by whether they were eligible for Medicaid or SCHIP.

We used the MEPS Household Component Point-in-Time files (HC34 and HC53) to obtain a nationally representative sample of the civilian, non-institutionalized population of children in the United States over the first part of the years 2001 and 2002. Eligibility for public insurance is obtained using a simulation model (KIDSIM) that combines Federal and State specific rules on Medicaid and SCHIP by year with family characteristics of children available in MEPS to simulate whether each child is eligible for Medicaid or SCHIP in a given year. Important child/family level characteristics considered in simulating eligibility include: earned and unearned family income, assets, family structure, age, citizenship, employment status of parents, and state of residence. Eligibility rules include state specific policies regarding income disregards, assistance unit composition and asset tests. Further details on MEPS and KIDSIM are available in the Health Affairs publication[3].

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[1] There were 9.1 million uninsured children ages 0-18 over the first part of 2005. (http://www.meps.ahrq.gov/CompendiumTables/05Ch1/T5_E05.pdf)
[2] Updated estimates of the number of children eligible for public insurance are not yet available.
[3] Selden, T.M., J.L. Hudson and J.S. Banthin. 2004. "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002." *Health Affairs* 23(5):39-50.

For this analysis, a child is defined as being uninsured if they did not hold health insurance for physician/hospital care for the entire survey round covering the first four to five months of the calendar year. Note that these estimates will differ from measures of the uninsured from other surveys that either: a) cover an entire calendar year or b) are measured at a single point in time. Characteristics of the uninsured are grouped into three categories: child characteristics, parent characteristics and family characteristics.

Child characteristics include age, gender, race, ethnicity, citizenship and health status. Medicaid and SCHIP rules often vary by the age of the child, with the most generous eligibility criteria applied to infants and pre-school age children. As a result, we present age as three categories most often seen as cutoffs in policy: Ages 0-5, Ages 6-12 and Ages 13-18. Race and ethnicity are reported for Hispanics and Non-Hispanic Whites and Blacks. Citizenship is presented for children of any race or ethnicity. We provide estimates of children in excellent/very good health and in good/fair/poor health as reported by a parent or head of household. Finally, we are unable to present separate estimates for uninsured infants under age 1 and for uninsured children of Other Non-Hispanic race/ethnicity due to small sample sizes.

Parental Characteristics are those characteristics that apply to the parent(s) of the child or to the adult relative(s) of the child if no parent is present in the household. Adult relatives tend to be grandparents or an aunt/uncle. Thus, in this section, "parent" may refer to either the biological/adoptive/step parent(s) or the adult relative(s) who most likely cares for the child. The table includes details regarding citizenship, health status, education, insurance coverage and labor force participation of parents. Some of these statistics apply to the presence of at least one parent – such as the presence of a noncitizen parent, a parent in fair/poor health, a parent who held private health insurance or a parent who had an offer for employer sponsored health insurance at their place of employment. While others, such as education, apply to the parent with the highest level of education. It is important to note that the variable indicating the presence of a parent with an offer for employer sponsored health insurance does not distinguish which type of policy was offered. For example, we do not know: a) whether the policy was for individual or family coverage, b) the generosity or scope of benefits of the policy, c) the cost of the policy to the parent and d) the percentage of the total cost borne by the parent.

Labor force characteristics are presented separately by the number of parents (or adult relatives) in the family. They include whether the child had an employed parent or had a parent working full time. For children with two parents in the household we also include the number of parents who are employed and the number working full time. Employment is defined as a parent holding a job or having a job to return to over the four to five months included in the survey period. Full time work is defined as a parent working at least 35 hours in a typical work week at their main place of employment at the time of the survey.

Family level characteristics include the number of biological/adoptive parents in the household, region and urban/rural location of the household, and family income. Family income is measured over a family unit defined as a Health Insurance Eligibility Unit

(HIEU). These are defined as individuals who could be dependents on a health insurance policy if one of the adults held private insurance. For children, an HIEU typically consists of the child, their siblings and parents. A child without a biological/adoptive parent is included in the HIEU of an adult relative such as a grandparent or aunt/uncle.

Family income is presented in several ways. First, average family income is presented in 2001/2002 dollars. We also show the distribution of families across various income brackets. Neither of these takes into account the size of the family, so finally, we present family income as a percentage of the Federal Poverty Guidelines.

We hope these tables inform your work on the reauthorization of SCHIP. MEPS in conjunction with our KIDSIM model is a powerful resource for studying policy related to public health insurance for children. Please let us know if we can be of any further help.

Table 1: Characteristics of Uninsured Children by Public Insurance Eligibility[a] Status: MEPS 2001-2002

	Eligible and Uninsured		Not Eligible and Uninsured	
	Estimate	*95% confidence interval*	***Estimate***	*95% confidence interval*
Number of Children (in millions)	**6.7**	±0 8	**4.0**	±0.6
Child Characteristics	***Percent***	*95% confidence interval*	***Percent***	*95% confidence interval*
Age/Gender				
Male	**52.5%**	±2.7%	**54.1%**	±3.1%
Ages 0 to 5	**26.7%**	±2.4%	**22.9%**	±3.3%
Ages 6 to 12	**38.3%**	±2.5%	**35.0%**	±4.3%
Ages 13 to 18	**35.0%**	±2.9%	**42.0%**	±4.1%
Race/Ethnicity/Citizenship				
Hispanic	**35.8%**	±5.1%	**28.8%**	±4.5%
White - Non-Hispanic	**44.4%**	±5.3%	**57.6%**	±5.3%
Black - Non-Hispanic	**15.6%**	±3.0%	**8.0%**	±2.5%
Noncitizen (Any race/ethnicity)	**7.6%**	±1.5%	**18.9%**	±2.7%
Health Status				
Excellent/Very Good	**74.1%**	±3.0%	**76.2%**	±3.3%
Good/Fair/Poor	**25.8%**	±3.0%	**23.8%**	±3.3%
Parent[b] Characteristics				
At least 1 noncitizen parent	**25.1%**	±4.3%	**30.0%**	±4.1%
At least 1 parent in fair/poor health	**20.9%**	±2.7%	**16.3%**	±3.3%
At least 1 parent holding private insurance	**17.4%**	±2.9%	**31.3%**	±4.1%
At least 1 parent with employer offer of private insurance	**31.6%**	±3.7%	**48.3%**	±5.1%
Highest Education of Parents				
Less than High School	**28.6%**	±3.5%	**17.1%**	±3.9%
High School Degree - GED	**45.4%**	±4.4%	**36.5%**	±4.3%
More than High School Degree	**23.7%**	±4.5%	**43.6%**	±5.5%
Any Parent Employed				
Single parent families	**69.2%**	±5.5%	**95.6%**	±2.5%
Two parent families	**91.1%**	±3.1%	**99.5%**	±0.4%
Components of 91.1% and 95.5%: Number of Parents Employed - Two parent familes				
1 Parent Employed	**56.0%**	±5.0%	**30.1%**	±5.1%
2 Parents Employed	**35.1%**	±5.0%	**69.4%**	±5.1%
Any Parent Working Full Time				
Single parent families	**45.8%**	±5.5%	**87.8%**	±5.0%
Two parent families	**79.2%**	±4.8%	**96.5%**	±1.6%
Components of 79.2% and 96.5%: Number of Parents Working Full Time - Two parent familes				
1 Parent Working Full Time	**63.3%**	±5.0%	**50.6%**	±5.3%
2 Parents Working Full Time	**15.8%**	±3.8%	**45.9%**	±5.2%

Source: Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey 2001-2002 (pooled).

a. Eligibility for MCD/SCHIP is simulated for children ages 0-18 using KIDSIM model
b. "Parent characteristics" refer to adult relatives for children with no parent who live in an adult relative HIEU
**** Too few obs in the sample to release estimate

Table 1: Characteristics of Uninsured Children by Public Insurance Eligibility[a] Status: MEPS 2001-2002

Family Characteristics	Eligible and Uninsured		Not Eligible and Uninsured	
	Percent	*95% confidence interval*	*Percent*	*95% confidence interval*
Number of Parents (Biological/Adoptive/Step)				
Single Parent	**38.3%**	±3.3%	**19.9%**	±3.7%
Two Parents	**54.1%**	±4.2%	**76.1%**	±4.1%
Family Income (HIEU)				
Average Income	**$19,883**	±$1,227	**$58,245**	±$5,921
Distribution of Income				
Below $10,000	**34.7%**	±3.9%	**5.5%**	±1.8%
$10,000 to $19,999	**22.5%**	±3.1%	**5.3%**	±1.8%
$20,000 to $29,999	**25.0%**	±3.1%	**7.6%**	±2.4%
$30,000 to $39,999	**11.2%**	±2.2%	**16.1%**	±2.7%
$40,000 to $49,999	***	***	**15.8%**	±3.5%
$50,000 and Above	***	***	**49.7%**	±4.9%
$40,000 and Above	**6.6%**	±2.0%	**65.5%**	±4.1%
Family Income to Poverty				
Below 100% FPL	**35.3%**	±3.4%	**5.7%**	±1.6%
100-199% FPL	**44.3%**	±3.6%	**13.3%**	±2.9%
200-299% FPL	**14.9%**	±2.3%	**31.7%**	±4.1%
300-399% FPL	****	****	**19.3%**	±3.3%
300% FPL and Above	**5.5%**	±1.7%	**49.3%**	±5.1%
400% FPL and Above	****	****	**30.1%**	±5.3%
Region - MSA				
Urban	**85.6%**	±3.8%	**81.1%**	±4.9%
Northeast	**11.9%**	±2.9%	**10.5%**	±3.3%
South	**40.8%**	±6.2%	**47.4%**	±6.9%
West	**28.7%**	±5.6%	**25.0%**	±6.7%
Midwest	**18.6%**	±5.1%	**17.1%**	±6.1%

Source: Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey 2001-2002 (pooled).

Definitions and Details:

Average population of uninsured children over 2001-2002 is 10.7 million (.6).
Average population of uninsured children eligible for public insurance over 2001-2002 is 6.7 million (.4).
Survey Round: typically 4-5 months
Uninsured: Continuously without insurance coverage for physician/hospital care for entire survey round
Employed: Held a job or had a job to return to during the survey round
Full Time Work: Worked at least 35 hours per week
HIEU: Health Insurance Eligibility Unit - typically children and their parents (or HIEU of an adult relative if no parent is present)

a. Eligibility for MCD/SCHIP is simulated for children ages 0-18 using KIDSIM model
b. "Parent characteristics" refer to adult relatives for children with no parent who live in an adult relative HIEU
**** Too few obs in the sample to release estimate

Table 2: Characteristics of Uninsured Children Eligible for Public Insurance By Type of Eligibility[a] (Medicaid/SCHIP): MEPS 2001-2002

	Medicaid Eligible and Uninsured		SCHIP Eligible and Uninsured	
	Estimate	*95% confidence interval*	*Estimate*	*95% confidence interval*
Number of Children (in millions)	**3.9**	±0.6	**2.9**	±0.4
Child Characteristics	*Percent*	*95% confidence interval*	*Percent*	*95% confidence interval*
Age/Gender				
Male	**52.5%**	±3.7%	**52.4%**	±3.7%
Ages 0 to 5	**32.4%**	±3.3%	**19.0%**	±3.1%
Ages 6 to 12	**35.4%**	±3.6%	**42.2%**	±3.7%
Ages 13 to 18	**32.2%**	±3.9%	**38.7%**	±4.3%
Race/Ethnicity/Citizenship				
Hispanic	**32.8%**	±5.8%	**39.9%**	±6.1%
White - Non-Hispanic	**45.3%**	±6.4%	**43.3%**	±6.5%
Black - Non-Hispanic	**17.8%**	±4.0%	**12.8%**	±3.9%
Noncitizen (Any race/ethnicity)	**5.1%**	±1.2%	**10.9%**	±2.9%
Health Status				
Excellent/Very Good	**74.3%**	±3.6%	**73.9%**	±4.5%
Good/Fair/Poor	**25.6%**	±3.6%	**26.1%**	±4.5%
Parent[b] Characteristics				
At least 1 noncitizen parent	**20.7%**	±3.9%	**31.1%**	±5.9%
At least 1 parent in fair/poor health	**21.8%**	±3.5%	**19.6%**	±3.9%
At least 1 parent holding private insurance	**10.2%**	±2.4%	**27.1%**	±5.3%
At least 1 parent with employer offer of priv ins	**23.1%**	±4.2%	**43.2%**	±5.7%
Highest Education of Parents				
Less than High School	**31.0%**	±4.4%	**25.3%**	±4.1%
High School Degree - GED	**42.8%**	±4.8%	**48.9%**	±6.1%
More than High School Degree	**22.4%**	±5.2%	**25.5%**	±5.7%
Any Parent Employed				
Single parent families	**55.4%**	±6.9%	**95.8%**	±2.6%
Two parent families	**83.7%**	±5.8%	**98.1%**	±1.7%
Components of 83.7% and 98.1%: Number of Parents Employed - Two parent familes				
1 Parent Employed	**57.3%**	±6.9%	**54.8%**	±6.1%
2 Parents Employed	**26.4%**	±5.8%	**43.3%**	±6.5%
Any Parent Working Full Time				
Single parent families	**28.9%**	±5.7%	**78.2%**	±6.6%
Two parent families	**66.0%**	±7.4%	**91.4%**	±3.6%
Components of 66.0% and 91.4%: Number of Parents Working Full Time - Two parent familes				
1 Parent Working Full Time	**58.4%**	±7.3%	**68.0%**	±5.7%
2 Parents Working Full Time	****	****	**23.4%**	±5.6%

Source: Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey 2001-2002 (pooled).

a. Eligibility for MCD/SCHIP is simulated for children ages 0-18 using KIDSIM model
b. "Parent characteristics" refer to adult relatives for children with no parent who live in an adult relative HIEU
**** Too few obs in the sample to release estimate

Table 2: Characteristics of Uninsured Children Eligible for Public Insurance By Type of Eligibility[a] (Medicaid/SCHIP): MEPS 2001-2002

	Medicaid Eligible and Uninsured		SCHIP Eligible and Uninsured	
Family Characteristics	***Percent***	*interval*	***Percent***	*interval*
Number of Parents (Biological/Adoptive/Step)				
Single Parent	**43.4%**	±4.6%	**31.4%**	±5.1%
Two Parents	**44.2%**	±5.3%	**67.5%**	±5.3%
Family Income (HIEU)				
Average Income	**$13,167**	±$1,387	**$28,937**	±$1,502
Distribution of Income				
Below $10,000	**57.1%**	±5.6%	****	****
$10,000 to $19,999	**23.8%**	±4.0%	****	****
$20,000 and Above	**19.1%**	±4.4%	**74.7%**	±4.5%
Below $20,000	**80.9%**	±4.4%	**25.3%**	±4.5%
$20,000 to $29,999	****	****	**38.5%**	±5.7%
$30,000 to $39,999	****	****	**21.5%**	±3.7%
$40,000 and Above	****	****	**14.7%**	±4.5%
Family Income to Poverty				
Below 100% FPL	**53.8%**	±4.9%	**10.4%**	±2.9%
100-199% FPL	**30.6%**	±4.3%	**62.7%**	±4.9%
200% FPL and Above	**15.6%**	±4.1%	**26.9%**	±4.5%
Region - MSA				
Urban	**86.2%**	±4.3%	**84.7%**	±5.3%
Northeast	**12.0%**	±3.7%	**11.7%**	±4.1%
South	**39.4%**	±7.1%	**42.8%**	±7.4%
West	**27.6%**	±5.8%	**30.3%**	±7.4%
Midwest	**21.1%**	±6.4%	**15.2%**	±4.5%

Source: Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey 2001-2002 (pooled).

Definitions and Details:
Average population of uninsured children over 2001-2002 is 10.7 million (.6).
Average population of uninsured children eligible for public insurance over 2001-2002 is 6.7 million (.4).
Survey Round: typically 4-5 months
Uninsured: Continuously without insurance coverage for physician/hospital care for entire survey round
Employed: Held a job or had a job to return to during the survey round
Full Time Work: Worked at least 35 hours per week
HIEU: Health Insurance Eligibility Unit - typically children and their parents (or HIEU of an adult relative if no parent is present)

a. Eligibility for MCD/SCHIP is simulated for children ages 0-18 using KIDSIM model
b. "Parent characteristics" refer to adult relatives for children with no parent who live in an adult relative HIEU
**** Too few obs in the sample to release estimate

Statement by Senator John D. (Jay) Rockefeller, Ranking Member, Senate Health Care Subcommittee
"CHIP at 10: A Decade of Covering Children"
(as prepared)
July 25, 2006

"I am pleased that we are here today to begin discussions on reauthorizing the Children's Health Insurance Program (CHIP). Next year will mark a decade of outstanding success for this landmark program. We must now ensure that CHIP and its benefits continue. Healthy children are more likely to become healthy adults. And health care dollars spent during childhood save many times over in health care spending during that child's life. So while we review our successes let us also keep an eye on long-term benefits.

"When we began this effort in 1997, there were over 10 million uninsured children in this country. The failed Clinton health reform initiative left us concerned that our children would not receive access to basic health care. Out of this came a bipartisan commitment to ensure the health of these children. My good friend and colleague, the late Senator John Chaffee, and Congressman John Dingell joined me in getting the ball rolling by introducing the Children's Health Insurance Provides Security Act of 1997. Putting that bill together was a monumental task. In the end, we came away with a cost-effective program to protect children's health.

"CHIP was an immediate success. Over its almost 10-year history, more than 6 million children have enrolled and received benefits.

"Furthermore, it provided states the flexibility to expand their programs - a challenge that many enthusiastically met. A notable example is the willingness of many states to cover pre- and post-natal care to low-income, pregnant women. This helps ensure that these women deliver healthy babies into this world. What better good can we provide than giving a new life the best chance at a healthy start?

"So now, here we are, with the task of determining ways to maintain the broad-based coverage offered through CHIP, while keeping the costs manageable and providing access for even more Americans.

"There is no question in my mind that reauthorization must not reduce the coverage provided under CHIP. We must not step backwards. States should be allowed to continue their ability to expand benefits as long as they have adequate funds to match federal contributions, while not jeopardizing any of the services guaranteed to the basic CHIP population.

"I am disturbed by rumors -- and rumors I hope have no legitimate basis -- that some of my colleagues would suggest that we end or cut back on CHIP. That, in my judgment, would be precisely the wrong approach. It would place the health of our

nation's children in jeopardy. I will fight any such attempt. We should all work together to m
aintain all of the good this program has brought to our nation.

"Over the coming months, we will again engage in considerable discussion, debate, and negotiation about CHIP. In the end, however, we must continue to ensure access to health care for low-income Americans and provide peace of mind to their families. To do otherwise, would be a mistake.

"Let me be clear about my position. I am as convinced as I was in 1997 - and, in fact, long before that - that having uninsured children in America is not acceptable. More than 8.4 million of our children still lack health coverage. Almost 70% of these children are eligible for Medicaid and CHIP. We must find ways to enroll them in the programs that work.

"But we cannot ignore the other 2.5 million children without any access to health insurance. With the rising costs of health care and health insurance, and as more employers cut back employee benefits, these numbers will certainly rise. We must find a way to expand CHIP to cover their health as well.

"In 1997 I made a promise to provide access to health care for the uninsured children of this country. I come before you today to reaffirm that promise. And I genuinely look forward to working with my colleagues on the Committee to do just that. CHIP was one of this Committee's finest moments - an accomplishment we can all feel proud of when we leave this place. I believe it is what we were sent here to do. Let's give the people we represent a reason to be proud once again."

COMMUNICATIONS

FOR THE RECORD

Statement
on
"State Children's Health Insurance Program (SCHIP) at 10:
A Decade of Covering Children"

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Submitted to the
U.S. Senate Committee on Finance

July 25, 2006

America's Health Insurance Plans (AHIP) strongly support the State Children's Health Insurance Program (SCHIP), and we applaud the Senate Finance Committee for focusing on the reauthorization of this vitally important program.

Over the past decade, SCHIP has proven to be highly successful in meeting the health care needs of millions of low-income children. By providing the states with the resources and flexibility to design innovative programs, SCHIP has demonstrated its value as an effective model for extending health coverage to a vulnerable population. As Congress prepares for the coming debate on reauthorization of SCHIP, we see an opportunity to build upon the program's past success with improvements that would enable the states to maintain their existing programs, while also offering coverage to a larger number of uninsured children and making coverage more affordable for their parents. This paper outlines three broad strategies for achieving these goals.

Increased Funding to Cover Shortfalls and Expand Coverage

A top priority in the SCHIP reauthorization process is ensuring that the states receive adequate funding to provide coverage for eligible children. Currently, a number of states are facing funding shortfalls that are threatening their ability to provide quality coverage to children already enrolled in their programs. These shortfalls also may discourage the outreach efforts that are needed to identify eligible children who are not yet signed up for SCHIP.

In addition to stabilizing existing SCHIP coverage, Congress should devote new funding to help states expand coverage to children who currently do not qualify for SCHIP assistance. An infusion of new funding would ensure that states could maintain existing enrollment, while also having greater flexibility to innovate and possibly expand enrollment in conjunction with broader innovations that leverage SCHIP dollars. By providing additional funding for this priority and promoting strategies that do not "crowd out" existing coverage, Congress could target assistance to a segment of the uninsured population – the "near poor" – that have seen a gradual decline in their access to coverage over the past decade.

Performance Standards Tied to Funding Bonus

Congress should establish performance standards to measure the extent to which states are achieving demonstrable improvements in child health. Such standards could focus on immunization rates for children, the percentage of infants receiving periodic screenings, the percentage of eligible children who remain continuously covered by SCHIP, and other measures for which data can be easily obtained and compared.

Moreover, these standards would help to promote accountability throughout the program if Congress provided a financial bonus to states that demonstrate strong success, based on the performance standards, in improving the health of their SCHIP populations. These incentives should be supported with *new funding* – on top of existing allotments – to allow states with highly successful SCHIP programs to take additional steps in developing initiatives that can serve as models for the entire nation.

Demonstration Programs to Coordinate With Private Coverage

Recognizing the need for greater innovation throughout the health care system, we believe Congress should authorize new demonstration programs that allow states to use streamlined procedures in coordinating SCHIP eligibility with private health insurance. These demonstrations could build upon SCHIP's existing premium assistance program, allowing states to assist the parents of eligible children in purchasing family coverage through their employers or other sources. Addressing the coverage needs of the entire family is beneficial to children as well as parents, as indicated by the findings of a 2002 Institute of Medicine (IOM) report which concluded that children are more likely to be taken to the doctor for regular checkups if their parents also have coverage.

Significantly, Massachusetts was one of the few states that used the current premium assistance option to maximize the value of its SCHIP and Medicaid funding. By pursuing this public-private partnership, Massachusetts was able to position itself for the broader reforms that its state legislature enacted earlier this year. To open the door for more states to pursue innovative strategies that meet the unique needs and circumstances of their own populations, Congress should encourage greater coordination between SCHIP and private health insurance.

Conclusion

AHIP members are strongly committed to the long-term success of SCHIP and we stand ready to work with the Senate Finance Committee and other members of Congress to strengthen the program.

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National Association of
Community Health Centers, Inc.

WRITTEN STATEMENT

U.S. SENATE FINANCE COMMITTEE HEARING

"CHIP AT 10: A DECADE OF COVERING CHILDREN"

July 25, 2006

In commemoration of the 10 year anniversary of the State Children's Health Insurance Program (SCHIP), the National Association of Community Health Centers is delighted to congratulate the program as it celebrates 10 years of promoting and providing comprehensive health insurance coverage to our nation's low-income children. Since its inception in 1997, SCHIP has covered more than four million children, most of whom would have been uninsured, and it undoubtedly has helped reduce the overall number of uninsured children in the nation. In addition, numerous research studies suggest that access to care has improved for children in the program, allowing more children a usual source of care for medical and dental services as well as preventive care.

As a provider of primary care medical care to over 15 million medically underserved patients a year, 36% of whom are Medicaid and SCHIP patients, community health centers are proud of the pivotal role played by SCHIP alongside health centers in helping to close the insurance gap for America's children and reduce the uninsured rate of low-income children. Although the proportion of health center children covered by SCHIP is smaller than might be expected, the combined impact of both programs unquestionably represents an important part of the nation's health care safety net for low income children.

It is therefore altogether fitting that our nation's community health centers pay tribute to SCHIP on this the 10th anniversary of its establishment, and applaud it for its overwhelming successful efforts to improve access to health care for millions of children over the last decade who otherwise may have gone without it.

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PREPARED STATEMENT OF THE NEW ENGLAND CAMPAIGN FOR CHILDREN'S HEALTH AND ITS PARTNER ORGANIZATIONS

July 28, 2006

The Honorable Orrin G. Hatch
The Honorable John D. Rockefeller
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Hatch and Senator Rockefeller:

Thank you for the opportunity to submit this letter in support of the SCHIP program. As we mark the ten year point of this highly successful program, we want to thank you and your colleagues for your leadership in providing healthcare coverage for America's children and supporting programs that have a positive impact on health outcomes.

We believe all of America's children should have quality, accessible healthcare. We know that healthy kids are a wise investment – they are better able to learn in school, participate in activities, and become productive adults. We also know that healthcare which is financed through SCHIP and Medicaid is highly cost-effective. As our country continues to grapple with the healthcare system as a whole, we can at least ensure that our children have the health coverage they need through these successful programs.

In New England, we are justifiably proud of our efforts to reach this goal of providing children's healthcare coverage. Since the inception of the SCHIP program, Medicaid and SCHIP together have worked in tandem to reduce the number of uninsured, low-income children nationwide and in our region. Nine out of ten (92%) of children in New England have health insurance coverage either through the private market or through Medicaid and SCHIP. The resources available through both SCHIP and Medicaid have been critical to our efforts to ensure that all of our children have the healthcare they need to grow and learn.

We are now asking you for your continued support of SCHIP and Medicaid so that we can build on their combined successes. We believe that this is a critical time to do more – not less – to help our children. These programs represent our commitment to American's children and our collective investment in a healthy future for our country.

We look forward to actively working with you in the months to come in support of SCHIP reauthorization.

Sincerely,

The New England Campaign for Children's Health
Bi-State Primary Care Association (Vermont and New Hampshire)
Boston Medical Center, Department of Pediatrics
Children's Alliance of New Hampshire
Children's Health Access Coalition (Massachusetts)
Children's Hospital Boston
Community Catalyst

Connecticut Children's Medical Center
Connecticut Voices for Children
Health Care for All (Massachusetts)
Institute for Health, Law & Ethics (New Hampshire)
Maine Equal Justice Partners
Massachusetts Coalition of School-Based Health Centers
Massachusetts Chapter of the American Academy of Pediatrics
Massachusetts Consortium for Children with Special Health Care Needs
Massachusetts Law Reform Institute
Massachusetts League of Community Health Centers
Massachusetts Hospital Association
New England SERVE
New Hampshire Healthy Kids Corporation
Parent/Professional Advocacy League (Massachusetts)
The Poverty Institute (Rhode Island)
Rhode Island Chapter of the American Academy of Pediatrics
Rhode Island Kids Count

cc: The Honorable Charles Grassley
The Honorable Max Baucus
The Honorable Jeff Bingaman
The Honorable Jim Bunning
The Honorable Bill Frist
The Honorable James Jeffords
The Honorable John F. Kerry
The Honorable John Kyl
The Honorable Rick Santorum
The Honorable Olympia Snowe
The Honorable Craig Thomas
The Honorable Ron Wyden
Connecticut Congressional Delegation
Maine Congressional Delegation
Massachusetts Congressional Delegation
New Hampshire Congressional Delegation
Rhode Island Congressional Delegation
Vermont Congressional Delegation

VOICES

FOR AMERICA'S CHILDREN

TESTIMONY SUBMITTED FOR THE HEARING "CHIP AT 10: A DECADE OF COVERING CHILDREN"

UNITED STATES SENATE

FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH CARE

JULY 25, 2006

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Washington, DC 20005
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www.voices.org

Voices for America's Children (Voices), a national, nonpartisan, nonprofit child advocacy organization committed to promoting the well-being of all children at all levels of government, appreciates the opportunity to offer testimony to the Senate Finance Health Subcommittee on the status of the State Children's Health Insurance Program (SCHIP) ten years after its enactment. The Senate Finance Committee has opportunities in 2007 to make advancements in meeting the health care needs of children through the reauthorization of SCHIP.

On behalf of our member advocates in nearly every state, Voices believes that all children in America deserve access to affordable, comprehensive, quality health care and services that support their health, growth and development. Children's health care needs should be addressed through treatment and management of health problems, and also through wellness and preventative services. The right care should be available at the right time and in the right place. As a nation, we still have more to do as over eleven percent of the nation's children lack any form of health insurance.[1]

To better address the health care needs of our children, particularly low- and moderate-income underinsured and/or uninsured children, Voices strongly urges Congress to reauthorize the State Children's Health Insurance Program in 2007 and to maintain and expand Medicaid services for children. Congress must ensure that SCHIP has the necessary funding for the program's successes to continue to grow and allow more children to receive quality health care coverage. SCHIP is an integral component of our nation's health care network for children, providing services for over 4 million children. Meanwhile, Medicaid remains the backbone of our nation's public health care system for children, providing services to over 25 million children. During the SCHIP reauthorization process, Medicaid must be maintained and enhanced so that our most vulnerable children are able to receive health care services.

Later this year, Voices will release policy recommendations to Congress regarding the SCHIP reauthorization. Voices' members are currently convening key stakeholders in individual states (including community leaders, state advocates and social service providers) to gather information, discuss the health care needs of children, gauge the current level of children's needs and address how both SCHIP and Medicaid are working to address these needs. As a result of this work, they will provide recommendations about how the programs could better serve children's needs in their states. Voices will base policy recommendations on the experiences of people in the states who are working directly to improve the lives of children in their communities.

Background

SCHIP was introduced in the 1997 Balanced Budget Act [42 U.S.C. 1397aa] and authorized $39 billion to states over 10 years to develop and implement a children's health insurance program. SCHIP was created in response to the estimated 14.8 percent, or 10.1 million uninsured children in 1996. The goal of SCHIP is to provide coverage options for children whose families' income exceeds the eligibility criteria for

[1]Kaiser State Health Facts. Accessible online at: www.statehealthfacts.org

Medicaid, but who are unable to afford private insurance. SCHIP allocates federal funds to states to oversee the development and implementation of health insurance programs for moderate-income, uninsured children. The amount allocated to each state is determined with a statuary formula based on two factors. The state cost factor is a geographic factor based on the annual wages in the health care industry for each state. The second factor, the population base, is 50 percent of the number of low-income, uninsured children in the state and 50 percent of the number of low-income children in the state. In an effort to reach uninsured children who qualify for either SCHIP or Medicaid, an estimated seven out of ten uninsured children,[2] states may use SCHIP funds for outreach and enrollment. SCHIP is the largest expansion of public health insurance coverage since the initiation of Medicaid and Medicare in 1965 and remains the largest national health care initiative since that time.

In recent years, funding has become a greater issue for the SCHIP program. Once states spend their allocation, they only receive additional money if other states have allocated funds remaining at the end of the year and funds are redistributed. In the early years of the program, enough states did not spend their entire allocation to make up for states that overspent. However, as more states have expanded eligibility, fewer states have surplus funds available. Estimates predict that 17 states will face a financing shortfall of $800 million by 2007.[3]

Children's Health Care Needs

Access to quality health care services is essential to the well-being and development of all children. Health care services that should be available to all children include: a medical home and relationship with a primary care physician; comprehensive health coverage which includes mental health services, vision, hearing and dental care; physical exams and periodic, or as-appropriate, screening services; immunizations according to the Centers for Disease Control and Prevention guidelines;[4] assessment, diagnostic services, and treatment to correct or improve medical conditions or congenital defects; lab tests appropriate for both age and risk factors; and access to specialists that meet their unique needs.

Uninsured children are far less likely than insured children to receive needed medical services. Research demonstrates that nearly 33 percent of uninsured children have not received even a basic checkup in the past year and 14 percent have gone over two years without any contact with a doctor.[5] While nearly 45 percent of insured children with emotional or behavioral problems use mental health services, only 13 percent of uninsured children with emotional or behavioral problems utilize mental health

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[2] Mann, C. *Children's Coverage at a Crossroads.* Georgetown University Health Policy Institute, Center for Children and Families, Washington, DC. July 2006.

[3] Broaddus, M. and Park, E., "SCHIP Financing Update: IN 2007, 17 States Will Face Federal Funding Shortfalls of $800 Million in Their SCHIP Programs." *Center on Budget and Policy Priorities.* June 5, 2006.

[4] Centers for Disease Control and Prevention. *General Recommendations for Immunization.* Available online at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5102a1.htm.

[5] "Going Without: America's Uninsured Children." State Health Access Data Assistance Center and the Urban Institute, August 2005 and Bloom, B., and Dey, A. (2006) "Summary of Health Statistics for U.S. Children: National Health Interview Survey, 2004". *Vital and Health Statistics*, Series 10, Number 227.

services.[6] Children in public health insurance programs are one-and-one-half times more likely to obtain well-child care than uninsured children.[7]

The link between children's health and learning is clearly documented. The 1.5 million American children considered to be in fair or poor health are more than seven times more likely to miss 11 or more days of school per year due to illness or injury than their healthier peers.[8] Access and utilization of health care services are critical to academic success.[9] Unmanaged chronic conditions affect children's academic performance. For example, each year children miss over 14 million days of school due to asthma. Access to the health care system allows children to better manage their conditions and reduces the number of days of school missed.[10] Health insurance is essential for children to access the health care they need to maintain a healthy and productive lifestyle.

Success of SCHIP

Over the past ten years, SCHIP has made a significant impact in improving children's access to affordable, comprehensive, and quality health care. In 2005, over 4.4 million children relied on the SCHIP program for access to health care services.[11] However, over 11 percent, or 8.4 million children, still lack health insurance in the United States.[12] Estimates indicate that up to 27 percent of children lack health insurance at some point during the year.[13]

The SCHIP program increases access to routine, acute and specialty care, as well as utilization of preventative care. A review of New York's SCHIP program found significant improvements in health care utilization pre and post enrollment. One year post-SCHIP enrollment 97 percent of enrollees surveyed had a consistent source of care, an 11 percent increase. Continuity of care also increased from 47 percent to 89 percent of enrollees using their primary care physician for most or all visits. Maintaining a relationship with a primary provider is crucial for children to receive necessary preventative care, such as routine childhood vaccines. Children with unmet health care needs dropped from 31 percent prior to enrollment to 19 percent one year following

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[6] Howell, E. "Access to Children's Mental Health Services under Medicaid and SCHIP" *The Urban Institute*. Series B, No. B-60, August, 2004

[7] Kenny, G., Heley, J., and Tebay, A. *Snapshots of America's Families*. The Urban Institute, July 2003.

[8] Bloom, B., and Dey, A. (2006) "Summary of Health Statistics for U.S. Children: National Health Interview Survey, 2004". *Vital and Health Statistics*, Series 10, Number 227.

[9] Walsh, M. E., and Murphy, J. A. (2003). Children, Health and Learning: A Guide to the Issues." Praeger: Wesport, CT.

[10] U.S. Department of Health and Human Services. *Asthma's Impact on Children and Adolescents*. Centers for Disease Control and Prevention, National Center for Environmental Health, 2005.

[11] FY 2005 Second Quarter Ever Enrolled Data by State – Total SCHIP, http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/list.asp#TopOfPage

[12] DeNavas-Walt, C., Proctor, B., and Lee, C. "Income Poverty and Health Insurance Coverage in the United States. 2004" *Current Population Reports*. August 2005.

[13] Congressional Budget Office. *How Many People Lack Health Insurance and For How Long*. Washington, DC: US Government Printing Office. 2003.

enrollment. The percentage of enrollees surveyed with a preventative care visit increased from 74 percent prior to enrollment to 82 percent following enrollment.[14]

A study of Colorado SCHIP enrollees found an increase in the perceived quality of care following SCHIP enrollment. Parents were asked, "How would you rate your child's health care in the previous months?" 35 percent reported the best ranking prior to SCHIP enrollment and 42 percent reported the best ranking following one year of SCHIP enrollment.[15] Studies of state programs indicate that SCHIP has been very successful in increasing access, continuity, and quality of health care for enrollees.

Much of the success of the SCHIP program is due to the flexibility that states have to design programs to meet the needs of their populations and political climates. States receive a set allocation of funds from the federal government and are responsible for covering the remainder of the costs out of the state budget. States have the option of using SCHIP funds to expand their current Medicaid program to create a separate program, or to use a combination of both. States have the flexibility to design their benefit packages, impose cost-sharing, and determine eligibility criteria. Currently, 13 states have set SCHIP eligibility above 200 percent of the Federal Poverty Level (FPL), 30 states have set eligibility at 200 percent of FPL and eight states have set eligibility below 200 percent of the FPL.[16] States can expand eligibility beyond children to include parents, unborn children, childless adults, and pregnant women.[17] Currently, 12 states offer prenatal coverage, seven states offer coverage for parents, and four states offer coverage for childless adults.[18] States that want to expand coverage to higher incomes have the freedom to do so by implementing cost-sharing and limiting benefits. Latitude to design their own programs allows states to tailor their program to their populations.

State flexibility in program operations has also led to innovations in enrollment, outreach, and program design, many of which carried over to the Medicaid program. Efforts to improve enrollment strategies include establishing continuous eligibility, adopting short, joint applications for Medicaid and SCHIP, eliminating face-to-face interviews and resources tests, allowing self-declaration of income and electronic submissions and using passage renewal systems. Outreach strategies include mass media campaigns and providing direct financial support for local application assistance.[19] Many of these outreach efforts have identified and enrolled children who were eligible but not enrolled in Medicaid.

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[14] Szilagyi, P., Dick, A., Klein, J., Shone, L., Zwanziger, J., McInerny, T. (2004) "Improved Access and Quality of Care After Enrollment in the New Your State Children's Health Insurance Program (SCHIP)" *Pediatrics*. 113, 5, 395-404

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Future Opportunities and Challenges

Congress has opportunities in 2007 to make advancements in meeting the health care needs of children through the reauthorization of SCHIP. Voices' top federal legislative priority is to inform and impact those decisions so that federal supports available to children through SCHIP and Medicaid not only continue, but are strengthened. Voices will release policy recommendations to Congress regarding the SCHIP reauthorization later this year. As described earlier, Voices' policy recommendations will be based on the experiences of people in the states who are working to improve the lives of children in their communities. Congress must secure the funding necessary to ensure that SCHIP is expanded to better address the needs of children with no health insurance coverage.

The opportunities for Congress to meet the gap in children's health insurance coverage include: expanding coverage; increasing enrollment of eligible, yet uninsured children; eliminating the public and private coverage divide for children; improving the affordability and range of coverage; and improving the overall quality and the ability to readily access services.

As health care costs continue to rise and more children lack employer sponsored health care, the cost of maintaining coverage at current SCHIP eligibility levels increases. Estimates indicate that if SCHIP funding remains flat over the next five years, states will face a funding shortfall of $10-$12 billion for the 2008-2012 period. If funding were to remain flat, 23 states will face a shortfall in 2008 equivalent to the cost of covering 700,000 children, and up to 36 states will face a shortfall in 2012 equivalent to the cost of covering up to 1.8 million children.[20]

The financial stability of SCHIP is critical to states. If states continue to face impending funding shortfalls, they may be forced to impose enrollment freezes, increase-cost sharing, and place greater restrictions on eligibility requirements. As of 2004, 20 states enacted legislation aimed at lowering SCHIP costs, either through enrollment freezes, restricting eligibility standards, increasing cost sharing or cutting benefits.[21] Limiting the program only to the "core" group of eligible children would deny states the flexibility to expand the program to higher income levels or other populations. Such a policy would also increase the number of uninsured individuals and hinder states' efforts to provide affordable, comprehensive, and quality health care to their citizens.

Conclusion

Voices for America's Children commends the Senate Finance Health Subcommittee for focusing on the impact of SCHIP in providing children with access to comprehensive and quality health care. It is critical that Congress reauthorizes SCHIP with adequate funding for the program to continue expanding child health assistance to uninsured low- and moderate-income children. As Congress takes action to strengthen the SCHIP

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program, we again mention that Medicaid is a vital source of health care services for millions of children and it must be maintained without any modifications that would limit children's coverage. Later this year, we will share with you our specific SCHIP policy recommendations.