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REAUTHORIZING SCHIP: PRINCIPLES, ISSUES AND IDEAS FROM STATE DIRECTORS

The State Children's Health Insurance Program (SCHIP) deservedly enjoys broad support as a successful program. That success rests on a legislative foundation enacted as a result of careful bi-partisan compromise. Title XXI of the Social Security Act established a federal-state partnership program with a delicate balance of state flexibility and core program requirements. SCHIP was created with the goal of providing health coverage for low-income, uninsured children. This essential program, now serving more than six million annually, is up for reauthorization this year.

Reauthorizing SCHIP is intended to inform federal policy makers working to review and renew SCHIP, as well as others concerned with its future, about the views of state SCHIP directors. It builds upon the 2005 report "*Perspectives on Reauthorization: SCHIP Directors Weigh In.*" These reports have been developed by the National Academy for State Health Policy (NASHP) through the generous support of the David and Lucile Packard Foundation as part of broader efforts to provide assistance for and report on state SCHIP programs over the past decade.

This document describes the current views of SCHIP directors on key issues being considered in the reauthorization process. During the development of *Reauthorizing SCHIP*, NASHP convened a workgroup of 15 states representing varying SCHIP program types from across the country to identify important issues, review information and recommendations from other key stakeholders, and discuss commonly held as well as differing views. The group met by phone and communicated electronically from January through March 2007.

The results of workgroup discussions were summarized in a draft of this document, which was shared with all SCHIP programs across the country, and then discussed at a March meeting attended by the majority of state programs. While this document does not capture all of the views of all of the states on all issues relevant to reauthorization, it represents the views of most states on issues of priority concern to them.

1. SCHIP funding should be renewed and increased substantially to provide sufficient and predictable funds for states to effectively manage programs and reduce the number of uninsured.

States responded to federal options in implementing programs to address state objectives.

State SCHIP programs now cover more than six million individuals annually. Most enrollees are children, but some states offer coverage to pregnant women and parents in need of health insurance support. Over the past decade, states have come to covering these individuals through different pathways and on different timetables. States successfully utilized the flexibility inherent in SCHIP to initiate and build programs in ways that fit the needs of their states' children and families as the programs started up and as needs changed over the past ten years.

The structure of SCHIP, especially the redistribution mechanism, and other federal policies, particularly federal encouragement and approval to utilize waivers to cover more of the uninsured, strongly influenced the decisions states made. The result today is a successful program that reflects the differential responses of states to federal policies and to their own needs and circumstances.

States started and evolved SCHIP programs to fit with their economies, health care systems, values, politics, and fiscal capacities. Nine states – most of which are spending all of their allotted funds – have not yet been able to set eligibility levels high enough to reach children with family incomes below 200 percent of the federal poverty level. Other states, many of which already were covering these low income children in 1997, have been able to reach uninsured children in families with somewhat higher incomes, or have covered parents or pregnant women with the intent of improving child coverage and health. State directors share a common vision and many common goals for coverage, access to quality care, and improved health for children, and ultimately, for everyone. However, states are at different points along a number of possible pathways to achieving the vision.

Future funding needs to be substantially increased over the course of the next five years.

SCHIP directors are united in concluding that SCHIP is a successful program that should be renewed with substantial additional funding that allows the program to grow and meet more of the needs in the nation for health insurance coverage. The highest yearly federal allotment provided in past years will not support the program today. Future funding levels need to be increased substantially to account for state success over the past decade in enrolling greater proportions of those eligible, and to support states in reaching more of the millions who are eligible but not enrolled.

State directors also strongly agree that funding should be stable and predictable in order to allow them to adequately plan for program maintenance and growth. The past decade's annual appropriation amounts provided many states with more funds than they could spend in the early start up years, and insufficient funds later on when their programs were more mature and serving more. This funding structure, coupled with the different starting points and pacing of states in developing their programs, led some states to rely on redistributed funding, and more recently, short-term federal relief for states experiencing shortfalls. The redistribution system provided little advance notice of amounts that might be available and just one year to spend the redistributed funds. This has made it very hard for states to plan and manage effectively.

Predictability and growth over time are critical for effective program management. SCHIP directors believe that the total SCHIP appropriation should increase steadily and predictably over the next five year authorization period, taking into account population growth and cost increases, including health care cost inflation. Predictable and steadily increasing funding coupled with adequate time to spend allocations (and redistributed funds if necessary) are essential for program maintenance, growth, and performance in achieving federal and state SCHIP objectives.

The funding structure needs to be reconsidered.

There is fairly broad agreement among state SCHIP directors that the funding formula needs to be revisited. In particular, directors are concerned that use of the number of uninsured children within the current formula can penalize states for being effective in enrolling more children. Collectively, SCHIP directors have identified a number of factors that federal policy makers might consider for inclusion in a revised formula. These potential formula factors include enrollment levels, eligible but unenrolled populations, regional differences in cost of living, and state coverage levels for children at the time of SCHIP enactment. Directors also have concerns about the use of Current Population Survey data in the formula, as these data are often inconsistent with data that many states collect. State directors urge careful analysis and consultation with states in consideration of any alternative funding formulas and data sources.

State SCHIP directors' views vary on the extent to which and how funding should be structured in covering target low income children, other children needing health insurance, pregnant women whose coverage can improve child health outcomes, parents whose coverage can boost rates of children's enrollment, or others. As noted previously, nine states have not been able to set program eligibility as high as the target level of 200 percent of poverty. Many other states have been able to reach uninsured children above that level, and a number of states cover parents and pregnant women. This variation again reflects the differing circumstances of states at the time of SCHIP enactment, as well as federal encouragement and approval for covering parents, pregnant women, and others.

2. SCHIP and Medicaid play vital, complementary roles in covering children and adolescents, and *each* program needs to be maintained and strengthened.

SCHIP and Medicaid work in tandem.

SCHIP was designed to build on Medicaid, to support states in covering uninsured children not eligible for Medicaid when SCHIP was enacted. States had the choice to implement SCHIP through a Medicaid expansion, a separate program that could work in conjunction with Medicaid to cover more uninsured children, or through a combination of both approaches. In 2005, approximately 28 million children were covered through Medicaid funds, and nearly 6 million through SCHIP funds.

As the nation and states focused attention on enrolling children eligible for SCHIP, both Medicaid and separate SCHIP programs developed policy and system improvements to make the programs more consumer friendly for families. The vast majority of states with separate SCHIP programs (31 of 39) use the same application for both programs, and the other states have other methods in place to coordinate eligibility. States have taken steps to simplify both programs and this simplification has been key to improving enrollment in both.

There should be greater consistency and more options for SCHIP and Medicaid eligibility.

SCHIP's successes have been built on the shoulders of the Medicaid program, and SCHIP has driven system improvements in both programs. State directors need continued flexibility to use and combine Medicaid and separate program approaches and to make the interface between them work smoothly for children and families.

State directors see elimination of inconsistent and inequitable federal eligibility rules as important to states and families. Currently, uninsured children whose parents are state employees cannot enroll in separate SCHIP programs, although they can enroll in Medicaid programs. Children of federal employees are not excluded from separate SCHIP programs. States would like the eligibility rules for separate SCHIP programs aligned with those of Medicaid expansion programs to allow for consistent and equitable treatment of children of state and federal employees.

States also would like the option to cover all legal resident children. The federal welfare reform law barred coverage of such children for the first five years of their residency. Some states cover these children with state funds, other states do not. Including these children as an optional group for states would enable more states to cover them and promote better health for all children.

Additional flexibilities also are needed to enroll or retain specific groups who otherwise are Medicaid eligible, in order to make the two programs as seamless as possible for families. Family income fluctuations mean that children frequently move between the two programs. Policies and procedures to avoid or diminish breaks in coverage are essential to assuring that children and families maintain access to critical preventive and treatment services. Directors

would like increased flexibility with eligibility rules in both Medicaid and SCHIP to ensure continuation of coverage for children whose family incomes change.

States also would like the option to give families who have children eligible for both programs the choice to enroll all children in a family in one program – either Medicaid or SCHIP – in order to keep the children together in one plan and reduce the burdens on parents. Since states get higher federal matching rates for children enrolled in SCHIP compared to Medicaid, state directors propose that states receive the Medicaid match for children who opt for SCHIP coverage over Medicaid. This would eliminate any financial incentive states might have to encourage families to choose SCHIP over Medicaid. State directors also would like states to have the option to give pregnant teens and women enrolled in SCHIP separate programs the option to stay in SCHIP, even if they become Medicaid eligible, in order to maintain continuity of vital prenatal care. Finally, some states have raised the possibility of giving states the option to cover youth up to age 21 with SCHIP funds, something that is possible in Medicaid.

3. The progress that states have achieved in simplifying enrollment for children and families should be supported and not hampered by federal program requirements.

Simplification is a state success story.

Some of the greatest state success stories in SCHIP are about the simplifications in enrollment and renewal processes for families. In 2005, nearly all states allowed mail-in applications, many had electronic applications, and the majority allowed families to apply at health care providers' locations. Most programs required participants to renew their eligibility every twelve months, reducing the chance that children would fall off coverage for failing to complete required paperwork.

New documentation requirements for citizens threaten to reverse this enrollment progress.

Provisions in the Deficit Reduction Act (DRA) of 2005 require citizens to prove their identity and citizenship in order to obtain Medicaid. The regulations include the need for presenting original (not photocopied) documents, a provision that especially undermines mail-in applications that were in use in almost all states prior to passage of the DRA. In many states, the new requirements are resulting in major delays – if not drops – in enrollment in public coverage. The rules apply to SCHIP Medicaid expansion programs, which must follow federal Medicaid policy. The new requirements also have a major impact on separate SCHIP programs. SCHIP programs must refer potentially Medicaid eligible children for enrollment in that program, so that these children are affected. Also, as noted earlier, most states with separate programs have one application form for both SCHIP and Medicaid, so that any new requirements attached to Medicaid can affect the application process for SCHIP eligible children unless the state reverses progress and separates the applications. Most SCHIP directors believe these citizenship documentation requirements should be rescinded or modified substantially, and should not be applied to separate SCHIP programs.

States need tools to carry out essential outreach, enrollment, and retention activities.

State experience has shown outreach, enrollment, and retention activities to be integral to effective program management in achieving SCHIP's goal of insuring children. Ongoing attention to these functions is critical, as the need to reach, enroll, and retain children and families is continual. Families move in and out of state, change jobs, their incomes fluctuate, and their access to employer sponsored insurance changes. To assure effective ongoing strategies, state programs need access to funding, research, and best practices. To effectively manage the program within capped funding, states need the flexibility to determine when outreach should be increased, and when it should be slowed down. While it should not come at the expense of funding for coverage, funding for outreach is critical. For this reason, state SCHIP directors recommend that outreach funding not be subject to the current 10% administrative cap.

Additionally, the directors seek flexibility to implement "express lane" or "auto" enrollment systems that allow enrollment or income determinations in certain other public programs to count as proof of eligibility for SCHIP. These streamlined approaches hold great promise for improving enrollment and retention. This authorization needs to be accompanied by assurances that such "deeming" will not be disallowed in federal audits.

4. State flexibility in specific areas of program design has been an important component of SCHIP's success and should be supported and enhanced.

State flexibility was part of SCHIP's design and has contributed to its wide base of support.

The state flexibility that was an integral part of the SCHIP program's design has been key to its success. States have tailored marketing, enrollment, benefits, service delivery systems, and other key features of their programs to the circumstances and culture of their states. This state tailoring has led to broad based support at the state and national levels. State directors believe maintaining such flexibility is vital to the continued support and success of SCHIP.

More flexibility to coordinate with private coverage could meet more of children's needs.

State SCHIP directors are very concerned with the erosion in employer based coverage, as well as market trends toward limited benefit health insurance products that may not address children's needs for preventive developmental services. Additionally, directors are keenly aware of substantial unmet service needs, particularly in the areas of oral health and mental health benefits. The directors would like to have more options to help families keep children and youth enrolled in the private market and have critical health needs met.

One option is providing assistance to families in paying private coverage premiums. While the SCHIP law allows states to provide such premium assistance, numerous programmatic and administrative requirements make it very difficult to operate a successful and cost-effective program under SCHIP regulations. In 2005, most of the states which had premium assistance programs paid for by SCHIP funds did so through federal waivers; no separate state SCHIP program operated a premium assistance program under SCHIP regulations.

States also would like the option to provide benefits that are not always covered for children enrolled in private plans. This could be done by amending the definition of targeted low income children to include those with creditable but less-than-comprehensive coverage, or by allowing states to offer supplemental benefits for children with private coverage that does not include services such as dental, mental health, vision, hearing, or prescription drugs. Another option is to allow states to offer supplemental benefits as a health services initiative, but as a category that is exempt from the 10 percent cap.

5. States should be supported in their efforts to improve program performance and promote access to quality care.

The federal-state partnership is the foundation for program improvement.

States are committed to effective program management and accountability, operating within the capped funding and program flexibility of SCHIP. The SCHIP statute provides a good framework for state reporting, and states worked cooperatively with the federal government to develop a standard reporting format that has been improved over time. States also worked with the federal government to develop core performance measures to be reported on a voluntary basis. While standard performance measures raised challenging technical and resource issues, within two years a majority of states were reporting on all four core measures. Beginning in FY 2006, states also now report on quality improvement initiatives.

States are implementing quality improvement strategies tailored to their states' systems.

States also have implemented various policies to ensure that program participants have access to quality care. These strategies differ by state and by delivery system (managed care, Primary Care Case Management-based, and fee-for-service). Most SCHIP programs that deliver services through managed care systems consider factors related to access and quality when selecting contractors; have contract provisions, including cultural and linguistic requirements, that promote access to quality care; and monitor contractor performance to ensure that program expectations are met. Many of these programs also use program performance data to help participants make a choice of health plans, produce public reports on health plan performance, and conduct quality improvement projects. PCCM-based programs use various reimbursement and provider requirements strategies to promote access. To ensure quality, programs with PCCM-based systems may conduct enrollee surveys to assess access and quality. In fee-for-service based systems, programs survey participants to gather information about access and quality, and promote medical homes, among other strategies.

Federal oversight is overly focused on payment errors, draining state resources.

Recent new federal requirements under the Payment Error Rate Measurement (PERM) system have directed limited administrative resources and state focus toward measuring errors. State directors believe that program accountability should continue to focus on performance in reaching and enrolling eligibles, reducing numbers of uninsured, and improving access and outcomes, and not disproportionately on the burdensome and bureaucratic federal payment error measurement system. As structured, PERM is working in contradiction to SCHIP program goals that states have been working hard to achieve.

PERM has not been implemented through a federal-state partnership approach. Methods were not developed in consultation with SCHIP directors, and were implemented with little advance notice or technical assistance. Auditors often are unfamiliar with program rules and policies established for SCHIP programs. Definitions of errors often are inconsistent with, and threaten to undermine, progress made in simplifying the program. The rules also do not provide adequate adjustment for services provided in a capitated versus a fee-for-service environment.

SCHIP directors believe that PERM has used a bureaucratic hammer in an area where significant problems have not been documented, and its implementation has been burdensome and expensive. In the case of SCHIP, which has an administrative cost cap, the resources that must be devoted to PERM audits take away from administrative efforts in outreach, enrollment, quality measurement, and improvement. The costs of PERM audits should be 100 percent federally funded and outside the 10 percent administrative cap. The Centers for Medicare and Medicaid Services (CMS) should be required to revisit the requirements, and to do so in consultation with state SCHIP directors, and bearing in mind the different incentives of capitated vs. fee-for-service environments. States included in the 2007 audits should be given additional time to set up infrastructure and obtain resources needed for the audits. Absent this additional time, CMS should be prohibited from requiring a uniform sampling platform, as has been required.

States want assistance to strengthen measurement and improve performance and quality

State directors found the federal technical assistance for SCHIP performance measurement that was provided for several years to be very important in helping states and the federal government develop and improve reporting of core performance measures. Technical assistance, which was discontinued, should be reinstated; the federal-state partnership for performance measurement needs to be renewed. The directors also believe the federal government should strengthen leadership and resources for working in partnership with states to review and develop optional new child health quality measures. These measures should be relevant to and used not only by SCHIP, but also by Medicaid and other programs funding or providing health services for children. Currently, standard measures are not available, and federal agencies do not have a well funded and coordinated effort in place to develop them. State SCHIP directors are ready and interested to work with other state and federal partners and experts to develop strategies to improve measurement of child health care quality.

CONCLUSION

State SCHIP directors are committed to working with federal and state policy makers, the private sector, advocates, and other key stakeholders to promote a successful reauthorization of the SCHIP program. SCHIP has been resoundingly successful over the past decade in providing coverage to uninsured children, and timely reauthorization that provides sufficient funding and retains and expands the kinds of flexibility that have contributed to SCHIP's success is essential. For more information about state SCHIP programs, go to www.chipcentral.org, or call NASHP at 202-903-0101.

Also Available from the National Academy for State Health Policy

Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs

This report examines the policies and strategies that states use to manage their State Children's Health Insurance Programs (SCHIP). It draws on information collected through a series of three surveys that NASHP conducted between 1998 and 2005. The most recent survey examined SCHIP programs as of July 31, 2005. *Charting SCHIP III* examines findings in program areas such as program design, management, eligibility, application and renewal processes, marketing and outreach, cost sharing, benefits, delivery of services, managed care plan selection and payment, and access and quality. The 160-page report also includes the survey instruments used in the 2005 survey. The development of the survey and report was supported by the David and Lucile Packard Foundation. Published September 2006.

Download: www.chipcentral.org/Files/Charting_CHIP_III_9-21-6.pdf

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