

SCHIP At A Crossroads: Experiences To Date And Challenges Ahead

Reauthorization offers the opportunity to address core issues within SCHIP and also to expand coverage to low-income families.

by **Genevieve Kenney and Justin Yee**

ABSTRACT: As reauthorization of the State Children's Health Insurance Program (SCHIP) looms, we examine the program's first decade and identify changes needed so that SCHIP can better serve its target population. We conclude that by many objective standards, SCHIP has been a success, but the challenge will be to maintain and build upon that success. Critical issues include the level and structure of federal funding; the continued problem of uninsurance among low-income children; the lack of information on quality, access, and costs; and whether SCHIP can serve as the foundation for addressing broader health care needs among low-income families. [*Health Affairs* 26, no. 2 (2007): 356-369; 10.1377/hlthaff.26.2.356]

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP), created nearly ten years ago, represents the largest single expansion in coverage for children since the creation of Medicaid in 1965. Enacted in August 1997 as Title XXI of the Social Security Act, SCHIP built upon the poverty-related expansions for children phased in under Title XIX/Medicaid that had started in the mid-1980s. SCHIP was funded as a capped block grant to states, providing \$40 billion in federal funds to states over a ten-year period. These funds were provided on a matching basis, at higher matching rates than available under Medicaid.

SCHIP programs are diverse in terms of their program structure. Forty states use a separate non-Medicaid program, either alone or in combination with a Medicaid program; and ten states and the District of Columbia rely exclusively on a Medicaid expansion.¹ Almost all separate SCHIP programs require waiting periods for children with employer coverage to avoid "crowding out" that coverage as provided in the statute; most states charge premiums for some or all enrollees; and around a fifth of the states use SCHIP funds to cover adults or to provide prenatal/maternity care to certain groups of pregnant women.²

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SCHIP's First Decade

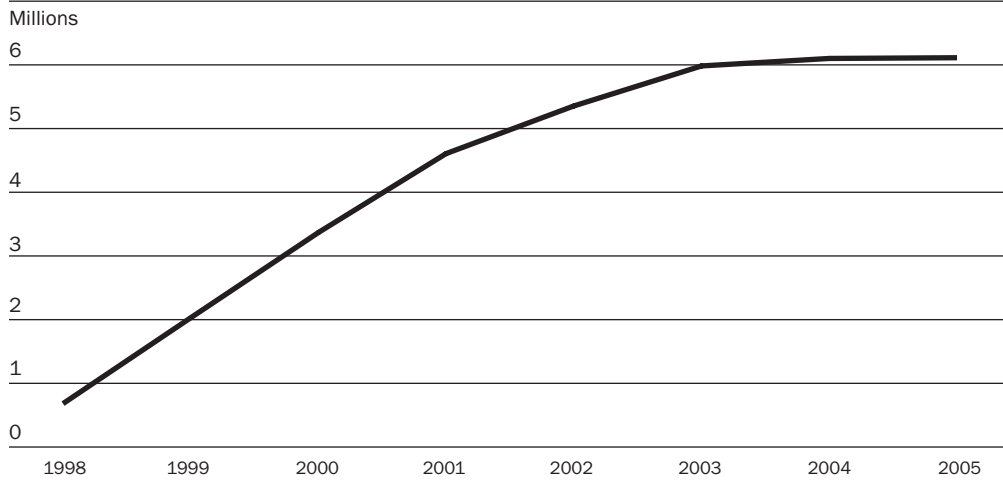
Although it was optional, within two years of SCHIP's inception, all states had used the program to expand coverage for children. Ultimately, all but eight states adopted eligibility thresholds at or above 200 percent of the federal poverty level.³ Moreover, SCHIP had an unprecedented focus on outreach and enrollment simplification, much of which had positive spillover effects on Medicaid.⁴

Although Medicaid remains a far larger program than SCHIP, covering more than four times as many children, SCHIP has become an important source of insurance coverage for children in this country.⁵ The most recent data available indicate that SCHIP provides coverage to more than six million children over the course of a year and more than four million at any given point in time.⁶ This implies that about 5 percent of all children rely on SCHIP for coverage at any point in time and that 7.7 percent have SCHIP coverage at some time over the course of a year. Moreover, it appears that SCHIP is covering approximately 29 percent of the children who meet the program's income requirements.⁷

■ **Enrollment trends.** Over the life of the program through fiscal year 2005, the number of children enrolled over the course of a year rose, until FY 2003, when enrollment began to level off (Exhibit 1). This pattern is consistent with enrollment figures that measure the number of children enrolled in SCHIP at a given point in time.⁸ Nevertheless, even though SCHIP enrollment has stagnated at the national level over the past several years, enrollment has continued to grow in most states. However, growth in these states was offset by enrollment declines in large states such as Texas and Florida. Between December 2003 and December 2004, thirteen states experienced declines in SCHIP enrollment; Texas accounted for 53 percent of

EXHIBIT 1

Number Of Children Enrolled In The State Children's Health Insurance Program (SCHIP) At Any Point During The Year, By Fiscal Year, 1998–2005



SOURCE: Centers for Medicare and Medicaid Services.

the total decline in these states, and Texas and Florida together accounted for 77 percent. However, even among the states still experiencing increases in SCHIP enrollment, growth rates tended to be lower during 2003–04 than in prior years.

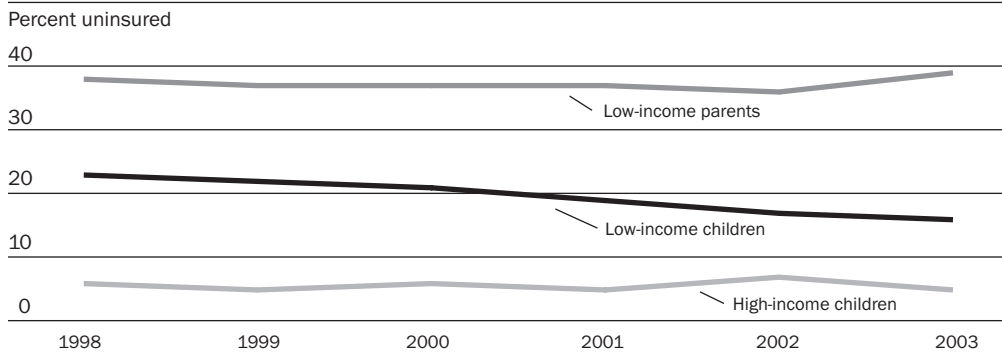
The loss of momentum in SCHIP enrollment is likely a natural consequence of the program's maturation and of improvements in the economy. But it is also likely a result of how states responded to the budget pressures and the economic recession they experienced earlier this decade, which led to increases in premiums, reductions in outreach, and the establishment of administrative barriers to enrollment and renewal—and in some cases, outright caps on enrollment.⁹

■ **Falling uninsurance rates.** Since the enactment of SCHIP, uninsurance rates have fallen for children, while, in contrast, coverage for adults did not improve.¹⁰ Between 1998 and 2003, the uninsurance rate fell from 23 percent to 16 percent among low-income children (with family incomes below 200 percent of poverty), who were the target population for both SCHIP and Medicaid coverage, while it remained around 5 percent among higher-income children and around 38 percent among low-income parents (Exhibit 2). Declines in uninsurance rates were highest for minority children.¹¹ Furthermore, coverage improvements occurred for both poor and near-poor children, which suggests that the outreach and enrollment efforts led to more coverage for both Medicaid- and SCHIP-eligible children alike.¹² More recently, from 2000 to 2004, uninsurance rates rose for adults, whereas they declined for children.¹³

■ **SCHIP's impact on coverage for children.** A number of econometric studies have assessed SCHIP's impact on insurance coverage for children, attempting to control for other factors that could affect coverage over time. Although the magnitude of the estimated impacts varies across studies, all studies found that SCHIP reduced uninsurance among children.¹⁴ This is consistent with the fact that uninsurance rates have declined for children who live in low-income families, while there

EXHIBIT 2

Trends In Uninsurance Among Children, By Income Group, And Among Low-Income Parents, 1998–2003



SOURCE: Urban Institute tabulations of data from the National Health Interview Survey, 1998–2003.

NOTE: Low-income families are those with incomes at or below 200 percent of the federal poverty level.

has been no change in those rates among higher-income children or low-income parents (Exhibit 2).

■ **The crowd-out factor.** These studies have also attempted to measure the extent to which SCHIP is substituting for private coverage by controlling for potentially confounding changes occurring over the same time period. Estimates of substitution vary widely across these studies, ranging from 10 percent to 70 percent, and are sensitive to the model specification and to the data set used. However, a number of state-specific analyses indicate that few children covered under SCHIP had employer-sponsored coverage before they enrolled in the program and that most do not have access to employer insurance that covers their parents.¹⁵ Recent national data also suggest that fewer than a third of all SCHIP-eligible children with public coverage have at least one parent with employer-sponsored coverage and that even fewer have both parents covered under job-based insurance.¹⁶ To the extent that these families have access to dependent coverage through an employer, no information is available on the cost or nature of that coverage.

Thus, while the econometric studies have produced a wide range of crowd-out estimates for SCHIP, it appears that most SCHIP enrollees are not forgoing employer-sponsored coverage. Moreover, the estimated share of enrollees with access to employer-sponsored coverage is below the projections made by the Congressional Budget Office (CBO) when SCHIP was enacted, which assumed that 40 percent of SCHIP enrollment would result from the substitution of SCHIP for private coverage.¹⁷

■ **Impact on access to care.** Numerous state-specific studies show that children who enroll in SCHIP experience improved access to care relative to the period before enrolling in SCHIP.¹⁸ In particular, children who enroll in SCHIP are more likely than others to have a usual source of care and to receive preventive care. They are also less likely than others to experience unmet needs and more likely to have parents who feel confident that they will be able to meet their child's health care needs. In addition, a national study found that children with chronic health problems made newly eligible under SCHIP and those who were already eligible for Medicaid coverage both experienced reductions in unmet need and out-of-pocket spending between 1997 and 2001.¹⁹ Also, a study in California found that SCHIP reduced ambulatory care-sensitive hospital admissions.²⁰

■ **Impact on children's health.** The evidence on the effect of SCHIP on children's health and functioning is mixed. A study of children with asthma in New York found improvements in functioning and reductions in the incidence and frequency of asthma attacks after the children enrolled in SCHIP.²¹ Following SCHIP enrollment, in Iowa parental ratings of child health were higher than before, and in California reported levels of health-related quality of life were improved, whereas no general improvement was found in a study in New York.²² In addition, no link was found between SCHIP expansions and changes in rates of childhood immunization among low-income children.²³

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■ **How racial/ethnic disparities have fared.** SCHIP, by targeting low-income children, appears to have contributed to reductions in racial and ethnic disparities with respect to access to care and service use.²⁴ Moreover, access improvements do not appear to be limited to one type of SCHIP program or to narrow subgroups of children. A study that examined experiences in two Medicaid expansions; two combination programs; and six separate, non-Medicaid programs found that enrollment led to improvements for children in all types of programs.²⁵ In addition, annual reports submitted to the Centers for Medicare and Medicaid Services (CMS) by seventeen states, representing a variety of program types, also found that many had reached their Healthy People 2010 goals for having a usual source of care. Of the six states that tracked changes in the extent to which children had a usual source of care relative to the pre-SCHIP period, five saw improvements in that rate after enrollment in SCHIP.²⁶ Access improvements following SCHIP enrollment have also been documented for children of different backgrounds, defined by their race and ethnicity, age, health status, and parents’ educational attainment.²⁷

Although many types of children appear to benefit from enrolling in SCHIP, some enrollees—namely, children with more-educated parents and those with English as their primary language—enjoy better access to care than others. Conversely, in one study, children with elevated health care needs were found to be more likely to have unmet needs and to have higher financial burdens associated with meeting those needs relative to other children enrolled in SCHIP.²⁸

Core Issues Confronting SCHIP

As SCHIP nears the ten-year mark, it is coming up for reauthorization. At stake is the adequacy of the federal funds available to support SCHIP and the viability of programs that have been established. For SCHIP to better serve its target population of low-income uninsured children, three fundamental issues need to be addressed. The first is whether states will have sufficient federal funds to sustain their programs. This is related to both the level of federal funds available to support SCHIP programs and their distribution across states. The second is whether public programs will make additional headway in reaching, enrolling, and retaining children in Medicaid and SCHIP who would otherwise be uninsured. The third is whether states will take more steps to monitor and improve access to and quality of care provided under SCHIP.

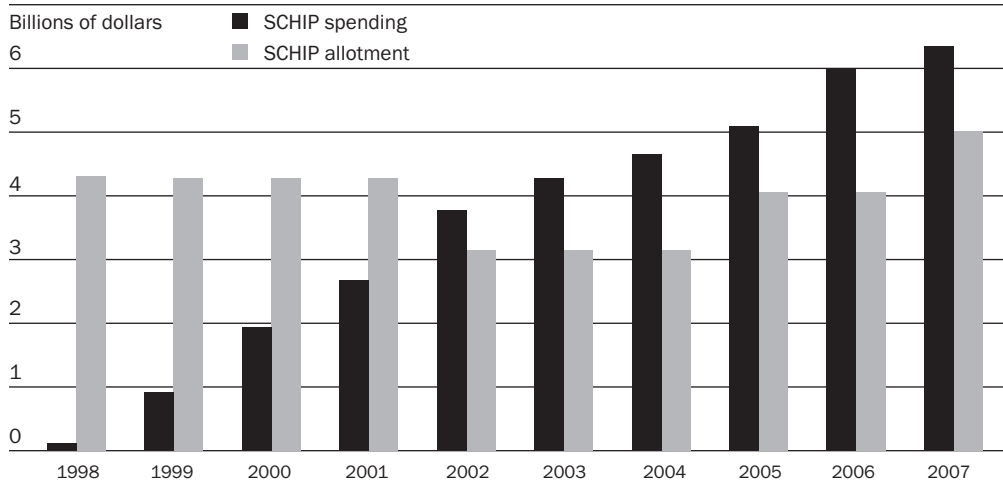
■ **Program financing.** An overriding concern is that federal funds to support states’ SCHIP programs may be inadequate in the coming years. Historically, the availability of federal funds has not acted as a constraint on most state SCHIP programs, largely because states had accumulated unspent balances in the early years

that could be applied to spending in later years. However, annual spending levels have outstripped new annual federal funding levels since FY 2002 (Exhibit 3). A looming question for SCHIP reauthorization is the level of federal funding that will be allocated to SCHIP in FY 2008 and beyond. The federal funding level for SCHIP included in CBO baseline projections is \$5.0 billion per year. This level was established in 1997 and was not based on projections of what states might need to sustain their programs ten years later. If federal funding for SCHIP is frozen at that level, it will likely be impossible for state programs to maintain their current enrollment levels, let alone expand to cover more of the close to two million remaining uninsured children who are eligible for SCHIP.²⁹ Indeed, according to the CMS Office of the Actuary, if the federal SCHIP funding level were held to \$5 billion annually, total SCHIP enrollment would fall from over 4.4 million in 2006 to 3.1 million in 2011.³⁰

Core federal funding level. The federal funding level required for states to maintain their current programs in the face of rising health care costs is not known with certainty. It has been estimated that more than \$12 billion in additional federal funds over FY 2008–2012 would be required on top of the CBO baseline funding level to sustain current programs.³¹ Allocating any additional federal funds to SCHIP beyond the \$5 billion in the CBO baseline projection could require identifying offsetting savings elsewhere in the budget, which may prove contentious, especially if the proposed funds were to come from Medicaid cuts.

Distribution of funds across states. An additional critical concern relates to the distribution of those funds across states. In the most recent year for which actual spending data are available (FY 2005), thirty-five states had spending levels that

EXHIBIT 3 Annual Federal State Children's Health Insurance Program (SCHIP) Allotment And Spending, By Year, 1998–2007



SOURCES: Congressional Research Service (CRS) analysis; and CRS State Children's Health Insurance Program (SCHIP) Projection Model.

NOTE: Spending amounts for 2006 and 2007 are projected.

exceeded their allotment for that year.³² According to projections, in FY 2007, 14–17 states will face shortfalls in the level of federal funds available to cover their SCHIP programs.³³ At the start of FY 2006, more than \$6 billion had accumulated in unspent federal funds, some of which, in principle, could be redistributed to the states that face shortfalls. However, redistributing these funds could leave some states with less SCHIP funds than needed to finance their programs in the future.³⁴ Legislation passed late in 2006 partially addresses the FY 2007 shortfalls by redistributing unspent funds to the states facing immediate funding gaps but will leave some states with shortfalls as early as May 2007.³⁵ The uncertainty around the adequacy of federal funds to support SCHIP has reportedly led some states to hold off on new initiatives to expand coverage under SCHIP.³⁶

Establishing state-level allotments that are in closer alignment with existing or potential program needs would require a fundamental reformulation of how federal funds are allocated across states. The current formula is based on estimates of the number of all low-income and uninsured low-income children in each state, which are estimated with error and which may have little relation to the spending level for a given state. For example, as indicated above, a number of states have tapped SCHIP funds to cover pregnant women and other adults. Moreover, the allotments do not take into account the fact that states with higher Medicaid eligibility thresholds before 1997 would be much more constrained than other states in their ability to use SCHIP funds to cover children compared to other states. If these states were placed on a more equal footing with other states and permitted to draw down the enhanced federal SCHIP match to cover more low-income children, it would remove an inequity that has existed since the start of the program, while at the same time further raising the level of federal funds needed to support SCHIP.

Tying federal allotments to historical spending patterns and allowing all states to use SCHIP funds to cover low-income children would likely reduce some of the imbalances in the current financing structure, requiring fewer reallocations of unspent resources across states in the future. However, for states that historically have not spent much on SCHIP because of, for example, having eligibility thresholds that are below 200 percent of poverty, closely linking future federal allotments to past spending patterns might make it more difficult to expand efforts to cover larger numbers of uninsured children in the future. In addition, the block-grant structure does not adjust allotments in response to changes in need, which could make SCHIP programs more vulnerable in future recessions, given that most states will not have a large cushion of unspent funds to draw upon. Fundamentally, although federal SCHIP funds could be targeted more efficiently across states, the single most critical issue to be considered during reauthorization will be how much federal support the program will receive and whether a block-grant funding structure can be responsive enough to changing program needs.

■ **Program participation and retention.** From the outset, one of the hallmarks

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of SCHIP was its emphasis on outreach and enrollment simplification efforts. In the early years of the program, states invested considerable resources in finding eligible uninsured children and enrolling them in Medicaid or SCHIP. Between 1999 and 2002, participation in both programs increased, as did awareness of SCHIP and familiarity with program rules.³⁷ However, many states cut back on outreach beginning in 2002, when faced with budgetary shortfalls.³⁸ Although both programs have made strides in providing coverage to uninsured children, it appears that at least nationally, progress has stalled. Current Population Survey (CPS) data suggest that uninsurance rates for children rose during the past two years, which reverses a trend of declining uninsurance rates for children since the late 1990s.³⁹ Moreover, the recent rise in uninsurance was concentrated among children with family incomes of 100–200 percent of poverty, many of whom are eligible for SCHIP coverage.⁴⁰

SCHIP programs appear to be reaching about 66 percent of the population of uninsured children who are eligible but not covered under a private insurance plan, which is somewhat lower than the rate found among uninsured children who are eligible for Medicaid.⁴¹ There is general consensus that enrollment levels decrease when there are more enrollment barriers, such as having lengthy forms, requiring that applications be made in person at a limited number of sites, and requiring extensive documentation.⁴² It is very difficult to assess the magnitude of the effects of individual program choices; however, the available evidence suggests that public premiums, enrollment and retention processes, parental coverage policies, and community-based outreach efforts affect take-up in public programs.⁴³

Thus, states can undertake a number of policies to raise SCHIP participation and reduce the number of uninsured children. However, it is not clear whether there will be a renewed focus on raising SCHIP participation and retention, especially in light of future funding uncertainties. It also appears that more than twice as many uninsured children are eligible for Medicaid as for SCHIP, which could deter some states from undertaking intensive outreach efforts, since states bear a higher proportion of the costs associated with covering children under Medicaid than under SCHIP.⁴⁴

■ **Benefits, access, and quality.** Much attention has been focused on monitoring program enrollment and understanding the policy levers that affect enrollment. Less effort has gone into tracking the level and adequacy of care provided to SCHIP enrollees and understanding how program features related to the benefit structure, cost-sharing requirements, and service delivery arrangements affect access to care. Routine, ongoing efforts to monitor quality and access across all SCHIP programs have been limited to date, with efforts focused on encouraging states to report on four child health performance measures that have been developed for Medicaid and

SCHIP: well-child visits in the first fifteen months of life; well-child visits at ages three, four, five, and six; use of appropriate medications for children with asthma; and having one or more visits to a primary care practitioner, which is defined for three different age groups.⁴⁵

Although there have been increased efforts to bring uniformity to what is reported and how individual measures are defined, as of 2003, no single quality performance measure was reported by all SCHIP programs, and among the states that did provide information on a given measure, there were important measurement and operational differences.⁴⁶ In addition, eight states provided information on all four of the child health performance measures that were recommended, but fourteen states did not report on any.⁴⁷ Moreover, even for this limited set of measures, no state appears to regularly provide information on how different subgroups of children—for example, those with special health care needs—are faring. This is a notable oversight because of concerns about access to care for this population, related to the adequacy of benefit packages in separate SCHIP programs and access to specialty care within both Medicaid and SCHIP.⁴⁸ In addition, these performance measures fail to address many important aspects of quality, for both outpatient and inpatient care.⁴⁹

Moreover, despite the ongoing debate as to whether Medicaid programs should become more like SCHIP (as reflected in the Deficit Reduction Act of 2005), or whether SCHIP programs should become more like Medicaid, particularly in terms of benefits and cost sharing, conclusive information is lacking on the impacts of different benefit packages and different cost-sharing arrangements, on average and for different subgroups of children. Likewise, little hard evidence exists on how much providers are being paid or how access to primary and specialty care varies across the two programs.

SCHIP As The Foundation For Better Health Policy

By many objective standards, SCHIP has been a successful program. It has become an important source of coverage for the children it targeted and has contributed to declines in uninsurance among both poor and near-poor children. Although SCHIP might substitute to a certain extent for employer-sponsored coverage, most SCHIP enrollees lack access to employer coverage. SCHIP has been found to improve children's access to primary health care and reduce their unmet needs, in different types of programs and among different subgroups of children. Finally, it appears that SCHIP has narrowed, but not eliminated, racial, ethnic, and income gaps in insurance coverage and access to care.

A vital question is whether states will be able to maintain and build upon these gains. For this to occur, several issues will have to be addressed as part of reauthorization or other federal legislation. The first relates to the adequacy of federal funding and other policy changes needed to maintain and potentially to expand SCHIP to cover more children; the second relates to access, quality, and cost.

“Expanding SCHIP’s mandate to encompass parents could help address the uninsurance problems faced by low-income parents.”

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■ **Maintaining/increasing coverage for low-income children.** The amount of federal funding set aside in the reauthorization process to support SCHIP will be a key factor in determining how much effort states devote to reaching and enrolling the remaining SCHIP-eligible, uninsured children. Unless the federal funding level takes into account potential increases in the demand for SCHIP coverage due, for example, to further erosion of employer-sponsored coverage or an economic downturn, the block-grant funding structure will place inherent limits on SCHIP’s ability to address coverage gaps among low-income children. Other changes are likely needed to trigger renewed investments in outreach and enrollment/renewal simplification targeted at both SCHIP- and Medicaid-eligible uninsured children.

Reward states for high participation. First, changing the federal funding structure to reward states that achieve high participation rates in both programs could stimulate renewed outreach efforts. In particular, one strategy worth considering would be to reward states that achieve low uninsurance rates or greater declines in uninsurance rates among low-income children with an enhanced federal matching rate on both Medicaid- and SCHIP-enrolled children. This would encourage states to address enrollment barriers (such as lack of coordination between Medicaid and the separate SCHIP program) and to adopt cost-effective outreach strategies. Rewarding states would also level the playing field between Medicaid and SCHIP, where, at present, states have to cover relatively more of the costs of covering children under Medicaid than they do under SCHIP. Given that more than twice as many uninsured children appear to be eligible for Medicaid as for SCHIP and that Medicaid-eligible children come from families that are poorer and have less access to employer-sponsored coverage, replacing the existing differential matching rates with a single, blended rate for both programs might be a key to reducing uninsurance rates among low-income children.⁵⁰

Institute automatic enrollment and expand outreach grants. Second, increasing state flexibility and funding to support automatic enrollment strategies and providing additional federal funding for outreach grants and state investments in information technology might also be needed to spark continued enrollment growth.⁵¹ Given the fluctuations that occur in families’ incomes and circumstances, achieving anything close to 100 percent participation in SCHIP is likely impossible without some type of automatic or default enrollment mechanism.⁵²

Roll back overly stringent documentation requirements. Finally, serious attention should be given to rolling back recent federal legislation that added new proof-of-citizenship requirements for enrollment and re-enrollment in Medicaid. This new requirement is likely to deter and even to prohibit some eligible children from gaining and retaining both Medicaid and SCHIP coverage.⁵³

■ **Monitoring access, quality, and costs.** To provide even greater health benefits to children, more attention will need to be focused on how well different SCHIP programs are providing high-quality, timely care to enrollees. As indicated above, despite the large numbers of children covered by both Medicaid and SCHIP, information on quality and access, which could be used to track how well both programs are doing overall and with respect to key subgroups and service areas, is lacking. Given the history here, a number of new policies would likely be required, to accelerate progress. Improving the measurement of quality under SCHIP (and under Medicaid as well) would likely require greater federal resources to support state efforts; technical assistance; and the imposition of a mandatory, standardized reporting system that includes a much more comprehensive set of pediatric measures (for example, capturing inpatient care as well) in place of the current voluntary one. Given the absence of a sound evidence base in this area and the growing prevalence of child health problems that are related to health behaviors, more demonstration projects are needed to test various approaches aimed at improving health care quality and children's health status and functioning.

Reauthorization could also be an appropriate vehicle for focusing on the costs and financing of care provided under SCHIP. No published study has examined the cost of providing care to SCHIP enrollees and how that might be shaped by policy choices. It is likely that in SCHIP, as in Medicaid, a small share of enrollees account for a large share of total program outlays. Developing efficient ways to manage these high-cost cases and to keep down growth in costs per enrollee could help alleviate some of the funding pressures programs will be facing.⁵⁴ Likewise, it will be important for states to assess whether they are taking advantage of existing private funding streams to support SCHIP coverage, for federal and state resources to be stretched further.⁵⁵

■ **At the crossroads.** Given the program's success, it is important to consider whether SCHIP could serve as a platform for addressing the broader health care needs of children and their families. For example, addressing the health care needs of more low-income children could hinge on changing federal laws that prevent SCHIP programs from covering various groups of immigrant children and from providing wraparound benefits to low-income children who have private coverage. Likewise, explicitly expanding SCHIP's mandate to encompass parents could help address the growing uninsurance problems faced by low-income parents and improve the health and well-being of their children as well.⁵⁶ When parents lack health insurance coverage, they are more likely to experience unmet health needs, which in turn can adversely affect them and their children.⁵⁷ Without greater federal subsidies for covering low-income parents, it is unlikely that their insurance picture will greatly improve.

REAUTHORIZATION OFFERS THE OPPORTUNITY to address core issues within SCHIP, but it could also serve as a springboard for addressing the broader set of health care needs facing low-income families. The past two decades have seen major attempts to address coverage gaps facing children, with the poverty-related expansions in the 1980s and the SCHIP expansion in the late 1990s. A key question will be whether SCHIP reauthorization leads to another major step forward in addressing uninsurance in this country.

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