



SCHIP Reauthorization: *Can The Nation Move Forward Without Going Backward?*

by **Cindy Mann and Michael Odeh**

As a way to limit the investment of new funds into children's coverage, the Bush Administration has proposed to restrict State Children's Health Insurance Program (SCHIP) coverage to children with family incomes below 200 percent of the federal poverty level. The proposal to impose a federal income eligibility cap in SCHIP has become part of the debate surrounding the 2007 reauthorization of SCHIP, and is often described as bringing SCHIP back to its original intent.¹

This paper reviews the eligibility provisions in the original SCHIP law, the experience across states since SCHIP was enacted, and the potential implications of moving in this direction.

Key Findings

- **The original SCHIP law gave state policymakers flexibility to set income eligibility in their states.** The flexibility is broad and longstanding, with states' ability to expand coverage constrained by capped federal SCHIP funding and the fact that states must spend their own funds to access federal funds.
- **The flexibility to set income eligibility allows states to consider differences in the cost of living and the cost of health care, which can affect a family's ability to afford health insurance for their children.** For example, families in some high-cost states may be paying more for housing, while families in rural areas may be paying more for gas and transportation.
- **Depending on how an income cap was designed, up to two-thirds of all states could be affected.** This number could grow; additional states are cur-

rently debating program expansions to reach more of their uninsured children.

- **While a large number of states would be affected, the federal savings achieved from an income cap would be small.** Currently less than nine percent of children covered in SCHIP have family with incomes above 200% of the federal poverty level.
- **A large portion of the children who could lose SCHIP coverage as a result of an income cap would become uninsured.** Lower-income children would also be affected; localities with broader coverage appear to have an easier time reaching eligible lower-income children.
- **If the federal government established an income cap, it would need to also adopt an array of detailed program rules in order for the cap to be effective.** These rules would intrude significantly on the flexibility accorded states in SCHIP and result in unintended consequences.

Assuring that children have health insurance coverage is a national priority that enjoys strong bipartisan and public support.² The country has been making significant progress closing the insurance gap for children as a result of SCHIP and its larger companion program, Medicaid. In fact, many states are poised to move forward to reach more of the currently eligible but unenrolled children and to expand coverage to uninsured children in families with modest incomes. A federally-imposed income cap could reverse progress that has been made and dampen the momentum for moving forward. The better path is to build on the success of SCHIP and Medicaid and assure that SCHIP reauthorization moves children's coverage efforts forward.

What Are the Current SCHIP Rules?

The SCHIP Law Permits State Policymakers Broad Discretion to Set Income Eligibility for Their State Programs

Created in 1997, SCHIP established a unique federal-state partnership for boosting efforts to cover children. “Enhanced” federal matching funds were made available to states to expand coverage to children whose family’s incomes were above the state Medicaid eligibility levels in effect at the time but still too modest to afford other insurance options. SCHIP funds are capped nationwide and for each state under a formula set out in the SCHIP law.

The flexibility to set income eligibility derives from several different provisions in the law. The law permits states to establish income eligibility thresholds in their SCHIP programs at 200 percent of the federal poverty level or 50 percentage points above their existing Medicaid eligibility levels.³ At the same time, it accords states discretion to set the rules for determining how income is counted (i.e., the income methodology rules). Income counting rules, such as state definitions of countable income, deductions and disregards, can have the effect of raising (or limiting) income eligibility levels.⁴ Income eligibility depends *both* on the thresholds and the methodology for calculating income.

The interplay between these concepts and provisions was well understood at the time of enactment – state flexibility was a guiding principle for the SCHIP law. Early on in the implementation of SCHIP, the Department of Health and Human Services (HHS), the federal agency that oversees SCHIP, issued guidance confirming that the law permitted states the flexibility to determine how to count income and apply deductions and disregards.⁵ Since then HHS has approved state plans that covered children in families with incomes above 200 percent of the federal poverty level (FPL).

An early snapshot of state eligibility rules under SCHIP provided to the Congress in the Congressionally-mandated evaluation of the program shows that in September 1999 – just one year after SCHIP dollars first became available to states – 10 states had income eligibility thresholds that were above 200 percent of federal poverty

level. In seven of these states the threshold was more than 50 percentage points above their 1997 eligibility levels. In addition, of the 25 states that reported income eligibility thresholds at 200 percent of the federal poverty level, 21 applied deductions or disregards (for example, for child care expenses or work-related costs, such as taxes) that in effect extended coverage to children in families with in-

NATHAN CHAPPELL

Fourteen year-old Nathan Chappell lives with his sister and parents in New Hampshire. Both parents are employed and together they earn between \$40,000 and \$50,000 annually, just above 200 percent of the federal poverty level for their size family. Nathan and his sister are covered through New Hampshire’s SCHIP program, called Healthy Kids, but proposals to limit or eliminate SCHIP coverage for families in their income range (i.e., above 200 percent of the federal poverty level) could result in the loss of their coverage. Since enrolling in Healthy Kids, the Chappells have paid either \$50 or \$90 a month in premiums for their children’s coverage (Mr. Chappell is a self-employed builder, and his income fluctuates).

As a toddler, Nathan regularly experienced ear infections and became antibiotic resistant. He saw his doctor frequently, at a cost of \$45 a visit and also required several prescriptions, each costing between \$50 and \$100. The family had insurance through Mr. Chappell’s job, but these costs were not covered because of the high deductible. The family was eventually forced to cancel the insurance because it was only adding to their debt. They were uninsured, and bills were backing up.

When Nathan was in third grade, the Chappells enrolled their two children in Healthy Kids. For the first time, Nathan’s parents felt secure about their ability to obtain and pay for the services Nathan needed. When Nathan later developed asthma, his care was covered. Through new medications and the family’s efforts to reduce allergens at home, Nathan’s asthma has been brought under control. He has not visited the emergency room in years.

Due to the cost of insurance, Mr. and Mrs. Chappell remain uninsured and are certain that without Healthy Kids, their children would be uninsured as well.

comes above 200 percent of the federal poverty level.⁶ (As discussed below, an income cap would affect an even larger number of states at this point in time.)

Why Do States Cover Families at Different Income Levels?

Families With Modest Incomes Often Cannot Afford Health Insurance Except Through Public Programs

The cost of health insurance is a key factor prompting states to expand their public coverage programs for children. Without public coverage, many families with modest incomes cannot afford insurance. Their children may

go without needed or timely care, and health care costs may leave them with crippling debt.

In 2006, the average yearly cost of a family's share of group health insurance (i.e., insurance available through an employer) was \$2,973 - more than the entire monthly income for a family of three at 200 percent of the federal poverty level.⁷ These average premium costs are higher for families whose employer pays less than the average employer contribution for family coverage, and these costs do not consider deductibles, copayments, and coinsurance, or the cost of uncovered services. Together, these could result in additional and often substantial out-of-pocket costs for families.

The Intersection of SCHIP and Private Coverage

As states expand SCHIP to cover uninsured children in families with more moderate incomes, a higher portion of potentially eligible children will have access to employer-based insurance. Under current law, federal SCHIP funds cannot be used to cover children with other insurance, and the law offers states various options for preventing the availability of SCHIP-funded coverage from encouraging families or employers to drop job-based coverage. All states that cover children above 200 percent of the FPL charge premiums or require copayments for families for incomes above those levels, partly to limit the incentives for families with access to affordable employer-based coverage to enroll their children in SCHIP. A few states prohibit children from enrolling in SCHIP if they have access to employer-based coverage with premiums below a certain percentage of their income. States with separate SCHIP programs may also

require children to be uninsured for a period of time before enrolling in SCHIP to discourage families from dropping coverage.

While crowd out was a significant area of concern for state and federal policymakers when SCHIP was first adopted, in general, states have found little or no evidence of families dropping affordable coverage to enroll in SCHIP. Several states, for example, have dropped or shortened their waiting periods because they have not found these policies to be needed and because waiting periods have the effect of delaying children's access to coverage.¹ The Congressionally-mandated evaluation of SCHIP found that eight of the 16 states with data on crowd out reported no evidence of children dropping private coverage to enroll in SCHIP, five states reported substitution rates of less than 10 percent, and three states reported rates between 10 and 20 percent.² State-

level studies that examine the experience of SCHIP enrollees typically show much lower incidence of crowd out than some econometrics studies (that attempt to model what level of private coverage would have been available in the absence of SCHIP). These studies necessarily build off a set of assumptions and often rely on a broader definition of substitution.³

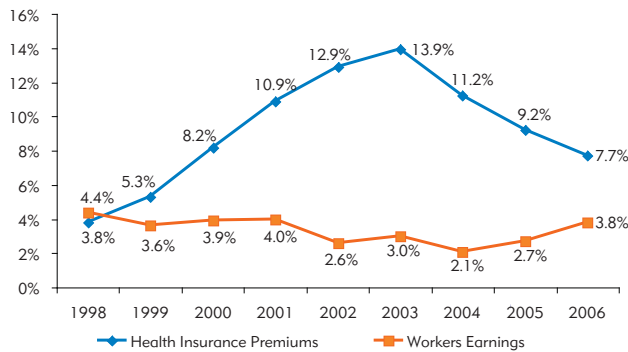
As states look to offer affordable coverage to uninsured children in families with incomes above 200 percent of the FPL, issues surrounding the intersection of public and private coverage will come up with greater frequency. SCHIP reauthorization offers an important opportunity to ensure that states have a range of policy levers to help them to integrate public and private coverage in ways that are cost effective and assure that children receive the coverage they need.

1 D. Cohen Ross, L. Cox, & C. Marks, *Resuming the Path to Health Coverage for Children and Parents*, Kaiser Commission on Medicaid and the Uninsured (January 2007).
 2 Rosenbach, et al., *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations*, Mathematica Policy Research, Inc. (March 2003).
 3 CBO recently reviewed the crowd out research including the studies relying on the econometric models; see Congressional Budget Office, *The State Children's Health Insurance Program* (May 2007).

Health Insurance Costs are Growing

States' growing interest in covering children in families with modest incomes reflects the fact that the health insurance affordability problem has been worsening over time. The average cost of employer-based family coverage has risen steeply every year since 1996, the year prior to SCHIP's original enactment. For example, in 2001, only two percent of families with employer-sponsored plans had monthly premiums over \$950, but in 2006, half of all families with employer-sponsored plans had monthly premiums above this level.⁸ The annual rate of growth has slowed somewhat in the past few years, but still in every year since 1999, premium costs have risen at rates that far outstrip increases in workers' earnings (Figure 1).

FIGURE 1
Premiums for Employer-Sponsored Coverage Are Growing Faster than Workers Earnings



Note: The annual growth for premiums is statistically significant from the prior year at $p < 0.05$ for every year except 2003.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006, (September 2006).

The Cost of Living and the Cost of Health Care Varies Widely Across States

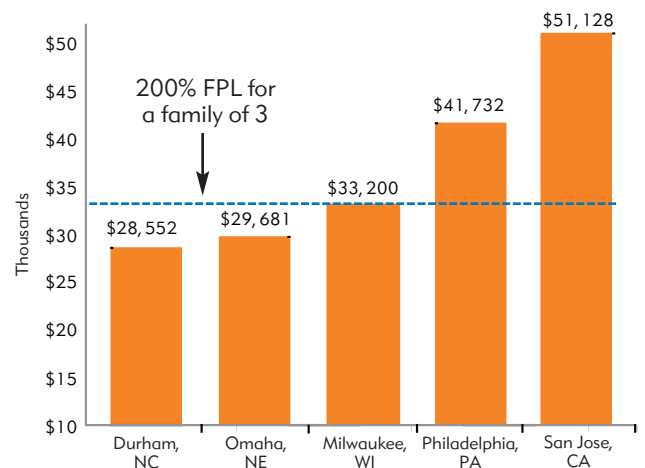
State SCHIP eligibility rules vary in part because the cost of living, the cost of health care, and state median income varies across the country. Urban areas also tend to have higher living costs and families in rural areas may experience added financial burdens due to certain types of expenses, such as transportation. The leeway granted to states in SCHIP to set their income rules allows states to consider these factors.

The federal poverty level equates to a specific dollar amount that does not vary for the 48 states in the continental United States. (The poverty level is higher for Alaska and Hawaii.) That dollar amount, however, will buy much more in Omaha, Nebraska or Durham, North Carolina than it will in Philadelphia, Pennsylvania, or San Jose, California. A survey of the cost of goods and services for urban areas illustrates the extent of the variation. The same goods and services that cost \$33,200 (the equivalent of 200 percent of the poverty level for a family of three in 2006) in Milwaukee, Wisconsin, a city with average costs, will cost \$29,681 in Omaha and \$51,128 in San Jose (Figure 2).

Health-related costs also vary considerably due to a number of different factors.¹¹ Private health insurance premiums often reflect these variations; a survey of plans available in the non-group market in the 100 largest cities in the United States showed that costs for a comparable family plan ranged from a low of \$159 in Grand Rapids, Michigan to a high of \$962 per month in Spokane, Washington.¹² Group or employer coverage plan costs also vary by region, with the lowest costs for family coverage in the South and the highest costs in the Northeast.¹³

FIGURE 2
The Cost of Living Differs Across the Country

The cost of goods and services worth \$33,200 in the average city, adjusted for the cost of living.



Note: In 2006, 200% FPL for a family of three was \$33,200 annually.
 Source: CCF analysis using 2006 ACCRA data.

FAMILIES PAY PREMIUMS FOR THEIR SCHIP COVERAGE

As states extend coverage up the income ladder, they typically charge family premiums consistent with federal SCHIP guidelines. According to a recent survey, as of July 2006⁹:

- All but one of the states that have SCHIP income eligibility thresholds above 200 percent of the FPL imposes premiums. Many also charge copayments.
- Of those states with eligibility thresholds above 200 percent of the FPL that charge premiums to families at 200 percent of the FPL, monthly premiums range from \$12 to \$250.
- Families with higher incomes are generally expected to contribute more toward the cost of coverage. For example, in New Hampshire's Healthy Kids program families with incomes at 200 percent of the FPL pay \$25 per child in monthly premiums while families at 300 percent of the FPL pay \$45 per child per month.¹⁰

SCHIP permits states the flexibility to decide, based on these and other indicators, the appropriate income level for covering children in their state — within the constraints of capped federal funding. A state need not consider such variations in costs, but the current structure of the program permits them to do so. If the federal rules were to eliminate this flexibility, a one-size-fits all income eligibility level would be imposed, giving rise to considerable inequities across the country.

Which States and Which Children Would Be Affected By a Limitation on Income Eligibility Rules?

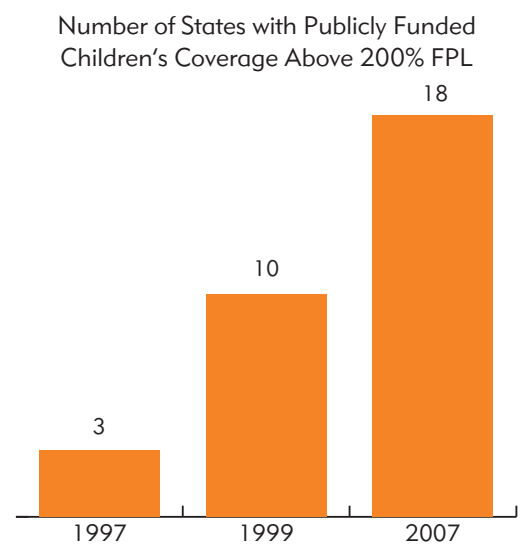
One-half to Two-thirds of All States Could be Affected — It Depends on How Any Such Restriction is Designed

Currently, 18 states have income eligibility thresholds above 200 percent of the federal poverty level. However, depending on the design of an income cap, children in as many as two-thirds of all states could be affected. In addition, several additional states are considering proposals to raise their income eligibility levels for children. An income cap could affect the following states:

- **States with Income Eligibility Thresholds Above 200 Percent of the Federal Poverty Level.** As of May 25, 2007, 18 states have income eligibility thresholds in their SCHIP-funded programs that are above 200 percent of the federal poverty level (Table 1).¹⁴ This group of states includes some that have covered children at this income level for many years as well as states that have more recently expanded coverage for uninsured children (Figure 3).
- **States That Apply Income Disregards and Deductions.** Children in at least 16 other states could also be affected by federal coverage restrictions, depending on how the new limits were designed. As shown in Table 1, of the 24 states that have set their SCHIP eligibility thresholds at 200 percent of the federal poverty level, 16 consider net, rather than gross, income when they determine eligibility for SCHIP.¹⁵ In these states (and also in some other states with lower eligibility thresholds), children in families with incomes above 200 percent of the federal poverty level can qualify for SCHIP if deduc-

FIGURE 3

States are Expanding Children's Eligibility for Coverage



Source: Rosenbach, et al, *Implementation of the State Children's Health Insurance Program*, Mathematica Policy Inc. (March 2003); and Cohen Ross, Cox, & Marks, *Resuming the Path to Health Coverage for Children and Parents*, KCMU (January 2007) as updated by CCF.

TABLE 1
SCHIP-funded Income Eligibility Levels¹ (as of May 25, 2007)

	States with Eligibility Below 200% FPL		States with Eligibility at 200% FPL		States with Eligibility Over 200% FPL		States considering proposals to expand eligibility above 200% FPL ⁴
	Gross Income Test ²	Net Income Test ²	Gross Income Test ²	Net Income Test ²	<= 50 percentage points above 1997 levels ³	> 50 percentage points above 1997 levels ³	
Alabama				x			
Alaska		154%					
Arizona			x				
Arkansas			x				
California						250%	300%
Colorado				x			
Connecticut						300%	
Delaware				x			
District Of Columbia				x			300%
Florida				x			
Georgia						235%	
Hawaii						300%	
Idaho	185%						
Illinois				x			
Indiana				x			300%
Iowa				x			
Kansas				x			
Kentucky				x			
Louisiana				x			300%
Maine			x				
Maryland						300%	
Massachusetts						300%	
Michigan				x			
Minnesota					275%		
Mississippi				x			
Missouri						300%	
Montana		150%					
Nebraska		185%					
Nevada			x				
New Hampshire						300%	
New Jersey						350%	
New Mexico					235%		
New York						250%	400%
North Carolina				x			
North Dakota		140%					
Ohio				x			300%
Oklahoma		185%					300%
Oregon	185%						
Pennsylvania						300%	
Rhode Island						250%	300%
South Carolina		185%					
South Dakota				x			
Tennessee					250%		
Texas			x				
Utah			x				
Vermont						300%	
Virginia			x				
Washington					250%		300%
West Virginia						220%	
Wisconsin		185%					300%
Wyoming			x				
TOTALS	2	7	8	16	4	14	10
	9		24		18		

1 This chart reflects the highest eligibility level funded by SCHIP, either in a separate SCHIP program or Medicaid expansion if there is not a separate SCHIP program. Current eligibility levels from D. Cohen Ross, L. Cox, & C. Marks, *Resuming the Path to Health Coverage for Children and Parents*, KCMU (January 2007), as updated by the Center for Children and Families. Note that South Carolina covers infants up to 185% FPL and Minnesota covers infants up to 280% FPL. Also note that Alaska's eligibility level is currently frozen at 175% of the 2003 FPL, which approximates 154% of the 2007 FPL.

2 States that use a net income test allow some income to be deducted or disregarded when calculating income for Medicaid/SCHIP eligibility. As a result, states with net income tests can effectively cover children in families with incomes higher than the nominal threshold. Data come from unpublished survey information on Medicaid & SCHIP disregards as of 2006 from Laura Cox at the Center on Budget and Policy Priorities. See also S. Rosenbaum & A. Markus, *State Eligibility Rules under Separate SCHIP Programs - Implications for Children's Access to Health Care*, George Washington University (September 2002); and M. Rosenbach, et al., *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations*, Mathematica Policy Research, Inc. (March 2003).

3 Current eligibility levels were compared to Medicaid Thresholds as of March 1, 1997 from M. Rosenbach, et al., *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations*, Mathematica Policy Research, Inc. (March 2003). Note that eligibility levels are more than 50 percentage points higher than 1997 levels for children 1-18 in California and Georgia and for children 6-18 in Rhode Island. When SCHIP was enacted, Tennessee had a Medicaid 1115 waiver in place that had no upper income eligibility, however, since then Tennessee has recently restructured its program and received federal approval to increase children's eligibility through a separate SCHIP program up to 250% FPL.

4 States considering expansion proposals as of May 25, 2007, with the exception of District of Columbia, New York, and Washington which have recently adopted legislation that reflects the expanded eligibility levels; based on Center for Children and Families, *Children's Health Coverage: States Moving Forward* (May 2007), with additional updates.

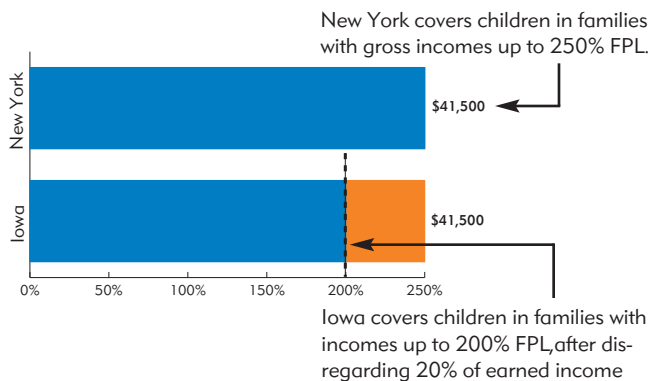
tions reduce their countable income below the 200 percent eligibility threshold.

Iowa, for example, sets its income threshold for its SCHIP program (“HAWK-I”) at 200 percent of the federal poverty level, but Iowa’s SCHIP rules allow a 20 percent disregard of earned income to reflect expenses, such as taxes and transportation, which limit a family’s ability to afford health insurance.¹⁶ By allowing this work-related deduction, Iowa in effect covers children up to 250 percent of federal poverty level. The income range of children covered in Iowa is therefore the same as the income range of children currently covered in New York’s SCHIP program. New York has an income eligibility threshold of 250 percent of the federal poverty level, but uses gross, not net, income (Figure 4).

FIGURE 4

States Can Cover Children With Similar Incomes in Different Ways

For a family of three earning \$41,500 in 2006



Source: CCF analysis of Iowa and New York state eligibility rules.

It is not clear whether states like Iowa with income thresholds at 200 percent of federal poverty level that consider net income would be affected by proposals to restrict eligibility. If so, this change would affect children’s coverage in up to two-thirds of all states – the states that have income eligibility thresholds above 200 percent of the federal poverty level and the states that effectively cover children in this income range due to their income counting

rules. If these states are not affected, then inequities could arise between states that use different types of rules to cover children in the same income range. In addition, without eliminating the flexibility to apply deductions and disregards, the changes under consideration could be easily circumvented. A state seeking to expand above 200 percent of the federal poverty level could disregard income to accomplish that result even with a cap on allowable income thresholds.

■ **States That Are Moving Forward to Increase Coverage.** States are moving in the direction of expanding, rather than contracting, coverage. In just the past year, strong bipartisan and public support for children’s coverage has prompted several states to adopt children’s coverage improvements.¹⁷

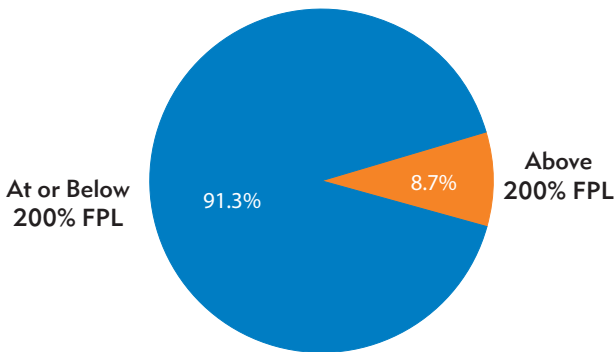
- In 2006, several states implemented policies or passed legislation that expanded coverage for children with incomes above 200 percent of the federal poverty level, including Illinois and Pennsylvania. Massachusetts, extended coverage through SCHIP and Medicaid to children up to 300 percent of the federal poverty level as part of its broader health insurance reform plan.
- In 2007, nine states and the District of Columbia have considered or are still debating eligibility expansions above 200 percent of the federal poverty level (Table 1). Two states (New York and Washington) and the District of Columbia have adopted but not yet implemented expansions. While it is not clear how many of the other pending state proposals will ultimately be adopted, if each were adopted, nearly half of all states (23 state plus DC) would have income eligibility thresholds above 200 percent of the federal poverty level.

How Many Children Above 200 Percent of the Federal Poverty Level Does SCHIP Now Cover?

Despite the attention to this issue, the number of children with family incomes above 200 percent of the federal poverty level in these states is relatively small, and therefore the cost of covering these children has only a modest impact on SCHIP costs. According to a report issued by

the Congressional Research Service, about half a million children fall into this category, or about nine percent of all children enrolled in SCHIP in 2006 (Figure 5).

FIGURE 5
Most Children Covered by SCHIP have Family Incomes Below 200% FPL



6.7 million children enrolled in SCHIP, 2006

Note: The reporting classification of a child with family income above 200% FPL who is determined to be eligible at or below 200% FPL due to deductions or disregards (i.e., a net income test) is up to the discretion of the state and constrained by their reporting systems.

Source: CCF analysis using enrollment data from C. Peterson & E. Herz, *Estimates of SCHIP Child Enrollees Up to 200% of Poverty, Above 200% of Poverty, and of SCHIP Adult Enrollees*, Congressional Research Service (March 13, 2007).

How Will Children Be Affected by Restricting a State's Ability to Set Income Levels?

Children Are Likely to Become Uninsured

While there is no research that looks specifically at the impact of an income cap, there is strong evidence to suggest that a large portion of the children who might lose coverage under an income cap (or not gain coverage that they would have otherwise qualified for) will be uninsured. Most children with family incomes between 200 and 300 percent of the federal poverty level have insurance through their parents' job, but about one out of three do not.¹⁸ For them, SCHIP-funded coverage is often the only affordable option. Most children who are enrolled in SCHIP do not have access to employer-sponsored coverage through their parents.¹⁹

The most comprehensive review of children leaving the SCHIP program was conducted under the Congression-

ally mandated evaluation of SCHIP. Based on a survey of disenrollees in ten states, that study found that 73 percent of all children who left SCHIP and were ineligible for Medicaid became uninsured. The number without coverage who were not eligible for Medicaid or SCHIP declined somewhat after six months to 65 percent.²⁰ Similarly, a 2006 examination of the Oregon's SCHIP program (income eligibility in that program extends to 170 percent of the federal poverty level) found that two-thirds of the children who disenrolled, mostly because of a rise in family income, were uninsured.²¹

Lower Income Children Would Also Be Negatively Affected

An important but often overlooked benefit of state coverage expansions is that they help to bring previously eligible children into coverage. Restrictions in children's coverage could set back efforts to enroll these eligible but uninsured children and have a negative impact not just on children whose family incomes are above 200 percent of the federal poverty level, but on lower income children as well.

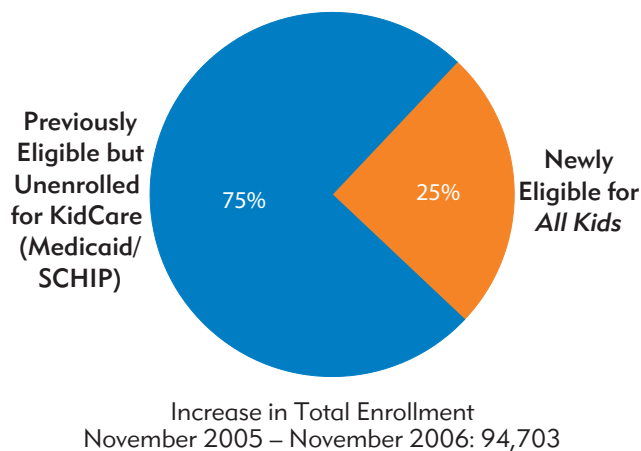
A reason most often cited for why many currently eligible children are uninsured is that their parents do not believe they are eligible.²² As more families, health care providers, schools, and others working with children have contact with the program and become familiar with the income guidelines, coverage expansions help dispel misconceptions about eligibility for publicly-subsidized insurance for children.

There is strong evidence of this phenomenon. When states expanded children's coverage following the enactment of SCHIP, states reported that they often enrolled as many, or even more, previously eligible children into Medicaid.²³

More recent state and local coverage expansions have similarly found that their expansions boosted participation rates among children who had been eligible for coverage before the expansion. An evaluation of the effort in Santa Clara county, California, to cover all children with incomes below 300 percent of the federal poverty level showed that enrollment in Medi-Cal (Medicaid) and Healthy Families (SCHIP) grew by 28 percent, or 13,000

children, above the levels that would have occurred without the local expansion.²⁴ More recently, Illinois found that low-income children previously eligible for SCHIP or Medicaid accounted for 75 percent of the rise in enrollment following its coverage expansion above 200 percent of the federal poverty level (Figure 6).²⁵

FIGURE 6
Increase in Children's Enrollment
with Implementation of Illinois' All Kids



Source: Annual survey by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured (January 2007) using data from the Illinois Department of Healthcare and Family Services.

Broadening children's coverage programs appears to be a particularly important way to overcome long-standing misperceptions among low-income working families that their children are not eligible for coverage. Policies that deter or even roll back these coverage initiatives, therefore, will likely have a negative impact on lower income as well as more modest income children.

How Would Program Rules Have to Change In Order to Impose an Income Cap?

Detailed New Federal Income Counting Rules May Be Needed

As discussed above, states cover children at income levels above 200 percent of the federal poverty level either by adopting higher income eligibility thresholds, or by adopting methods of counting income (e.g., deductions or

disregards) that in effect expand coverage to some families with incomes over 200 percent of the federal poverty level, or both. If federal rules were changed to stop states from covering children in this income range (or to limit the matching rate applied to children in this income range), extensive new federal rules would need to be imposed.

In addition to setting a limit on income eligibility thresholds, federal rules would need to be devised to address matters now left to the states to decide, such as:

- **Whose income is counted?** States now decide whose income to count; such as, if they will count a grandparent or step-parent's income when determining a child's eligibility for SCHIP. Utah, for example, currently exempts a child's income (e.g., from social security benefits or part-time earnings) when it calculates family income.²⁶ Continued state flexibility on these matters would erode an income eligibility cap.
- **Which types of income must be counted?** Similarly, states now decide what types of income they will count. For example, they may decide to exclude certain unemployment compensation or child support or family gifts. Again, if a uniform income cap were the goal, federal rules directing states to count (or not count) certain types of income would be needed.

Imposing new federal rules in these areas would significantly intrude on the flexibility states now have to design their SCHIP program. States would have to change their rules along with their applications and computer systems, and the new federal rules would have other unintended consequences. The rules would likely be different (and more restrictive) from the federal rules for Medicaid since Medicaid requires states to consider certain expenses, such as child care, but allows states the flexibility to adopt less restrictive rules. Different SCHIP and Medicaid rules could interfere with states' ability to use the same income counting rules in Medicaid and SCHIP to promote enrollment coordination between the two programs.²⁷

Conclusion

The imposition of an income ceiling on the SCHIP program as part of SCHIP reauthorization may sound like a simple measure to help control program growth. In reality, it could lead to a significant disruption of existing programs and a cost shift for states that have expanded coverage under longstanding program rules. It would also result in inequities for families in states with higher living

costs and cause a major shift in the federalism paradigm that has guided the program to date. Most significantly, it could cause hundreds of thousands of children to lose coverage and slow or even reverse the progress that states have been making in covering children and that many more are planning to make. The impact will be felt by children in a diverse and large number of states and would include children with modest family incomes as well as children with much lower family incomes.

Endnotes

- 1 For instance Secretary of Health and Human Services, Michael O. Leavitt, has written, “we must continue to fund Medicaid and SCHIP, but redirect SCHIP toward its original target—low-income, uninsured children;” see M. Leavitt, “Return SCHIP to Its Roots,” *Modern Healthcare* and The Commonwealth Fund (April 23, 2007).
- 2 For example, a New York Times/CBS News poll conducted in February 2007, found that 84 percent of those polled supported expanding SCHIP to cover all uninsured children. R. Toner and J. Elder, “Most Support U.S. Guarantee of Health Care,” *New York Times*, March 2, 2007. Other polls consistently show similar public support for SCHIP; see, for example, a poll conducted for the Center for Children and Families by Lake Research Partners (December 2006) found at <http://ccf.georgetown.edu/pdfs/1210lakeresearch.pdf>; a poll by Dan Jones and Associates for Voices for Utah Children (February 2007) at http://www.utahchildren.org/documents/CHIPFactSheet_000.pdf; and a poll by the New England Alliance for Children’s Health (March 2007) at <http://www.childrenshealthne.org/download/Full%20New%20England%20SCHIP%20Poll%20Report.pdf>.
- 3 Title XXI of the Social Security Act, section 2110(b)(1).
- 4 Section 2102(b)(1) permits states to establish eligibility rules including those relating to income and resources. There is no provision in the SCHIP law that defines income, limits states’ authority to decide how to calculate income, or restricts state’s authority to consider net versus gross income. Income counting rules can restrict as well as expand eligibility.
- 5 The preamble to the proposed regulations for the program issued by the Secretary of HHS in November 1999 states: “With the exception of income that cannot be counted because of a prohibition in another Federal statute, a State can determine what constitutes income, what income is counted and what is excluded or disregarded. A State can calculate eligibility using either gross income or net income after deductions and disregards. A State can also determine who is in a child’s family and therefore, whose income will be counted and under what circumstances.” *Federal Register*, 64 (8 November 1999): 60900.
- 6 M. Rosenbach, et al., *Implementation of the State Children’s Health Insurance Program: Synthesis of State Evaluations*, Mathematica Policy Research, Inc. (March 2003).
- 7 Kaiser Family Foundation/HRET, *Survey of Employer Health Benefits 2006* (September 2006). In 2006, 200 percent of the federal poverty level for a family of three was equivalent to monthly income of \$2,767.
- 8 op. cit (7); Exhibits 1.1 and 1.13.
- 9 D. Cohen Ross, L. Cox, & C. Marks, *Resuming the Path to Health Coverage for Children and Parents*, Kaiser Commission on Medicaid and the Uninsured (January 2007).
- 10 See New Hampshire Healthy Kids 2007 Income Guidelines at <http://www.nhhealthykids.com/pdfs/Income%20Guidelines2007.pdf>.
- 11 According to the Government Accountability Office, “Geographic differences in health care spending are due to differences in utilization – the amount and type of health services used – and price – the amount paid to physicians, hospitals and other providers.” GAO, *Federal Employees Health Benefit Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices*, (August 2005), GAO-05-856; <http://www.gao.gov/new.items/d05856.pdf>.
- 12 Survey conducted by SHADAC for ehealthinsurance.com, *The Most Affordable Cities for Children’s and Family Health Insurance* (July 19, 2006). The plan priced in the various cities was for a family of four, with specified ages and no pre-existing medical conditions.
- 13 op. cit (7); Exhibit 1.11. For a family of four, the average annual employer health plan premiums for covered workers for all plans ranged from a low of \$10,936 in the South to a high of \$12,062 in the Northeast.
- 14 Fourteen of these states have expanded their programs beyond 50 percentage points above eligibility levels in place when SCHIP began.
- 15 Based on unpublished survey information on Medicaid and SCHIP income rules as of 2006, Center on Budget and Policy Priorities; S. Rosenbaum & A. Markus, *State Eligibility Rules under Separate SCHIP Programs – Implications for Children’s Access to Health Care*, George Washington University (September 2002); M. Rosenbach, et al., *Implementation of the State Children’s Health Insurance Program: Synthesis of State Evaluations*, Mathematica Policy Research, Inc. (March 2003); and other state updates by CCF.
- 16 SCHIP State Plan for the state of Iowa, section 4.1.3. Available online at <http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/IACurrentSCHIPStatePlan.pdf>.
- 17 See Center for Children and Families, *Children’s Health Coverage: States Moving Forward* (May 2007).
- 18 K. Schwartz, C. Hoffman, & A. Cook, *Health Insurance Coverage of America’s Children*, Kaiser Commission on Medicaid and the Uninsured (January 2007).
- 19 G. Kenney & A. Cook, *Coverage Patterns Among SCHIP-Eligible Children and Their Parents*, Urban Institute (February 2007).
- 20 J. Wooldridge, et al., *Congressionally Mandated Evaluation of the State Children’s Health Insurance Program: Final Report to Congress*, Mathematica Policy Inc. and Urban Institute (October 2005).
- 21 J. Mitchell, S. Haber & S. Hoover, What Happens to Children Who Lose Public Health Insurance Coverage, *Medical Care Research and Review*, Vol, 63, No. 5, (October 2006). Children who had been enrolled in Oregon’s smaller SCHIP-funded premium assistance program known as “FHIAP” were somewhat more likely to have insurance when leaving SCHIP. The results of SCHIP disenrollees who become uninsured are similar to those found in other surveys, such as E. Ziller & S. Loux, *Children’s Disenrollment from MaineCare: A Survey of Disenrolled Families*, Muskie School of Public Service (May 2003).
- 22 G. Kenney & J. Haley, *Why Aren’t More Children Enrolled in Medicaid or SCHIP?*, Urban Institute, (2001); and G. Kenney, J. Haley and A. Tebay, *Familiarity with Medicaid and SCHIP Program Grows and Interest in Enrolling Children is High*, Urban Institute (July 2003).
- 23 G. Kenney & D. Chang, “The State Children’s Health Insurance Program: Successes, Shortcomings, and Challenges,” *Health Affairs* 23, no. 5 (2004): 51-62.
- 24 C. Trenholm, *Expanding Coverage for Children: The Santa Clara County Children’s Health Initiative*, Evaluation of the Santa Clara County Children’s Health Initiative, Issue Brief Number 1 (April 2005).
- 25 D. Cohen Ross, L. Cox, & C. Marks, *Resuming the Path to Health Coverage for Children and Parents*, Kaiser Commission on Medicaid and the Uninsured (January 2007).
- 26 Utah CHIP Manual, section 420; available online at <http://www.utahcares.utah.gov/infosourcechip/>
- 27 D. Horner & B. Morrow, *Opening Doorways for Health Care for Children*, Kaiser Commission on Medicaid and the Uninsured and the Children’s Partnership (April 2006).



**GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE
CENTER FOR CHILDREN AND FAMILIES**

BOX 571444 ■ 3300 WHITEHAVEN STREET, N.W., SUITE 5000
WASHINGTON, DC 20057-1485

(202) 687-0880 ■ FAX (202) 687-3110 ■ WWW.CCFGEORGETOWN.ORG