SCHIP Reconsidered

Reauthorization of SCHIP offers an opportunity to consider the program with a fresh eye and to view this modest program in the broader context of recent changes in Medicaid.

by Sara Rosenbaum

ABSTRACT: The reauthorization of the State Children’s Health Insurance Program (SCHIP) in Congress offers an opportunity to assess the legislation in light of recent developments in Medicaid and states’ health coverage reform efforts. Fundamental child health goals can be achieved while still affordings states additional flexibility to invest in populations of all ages. [Health Affairs 26, no. 5 (2007): w608–w617 (published online 14 August 2007; 10.1377/hlthaff.26.5.w608)]

The State Children’s Health Insurance Program (SCHIP) represents an important effort to improve children’s health insurance coverage; however, additional reforms remain essential. In 2005, 8.7 million children were uninsured; nearly three-quarters had family incomes low enough to qualify for Medicaid or SCHIP.1 Enrollment remains complicated and unstable; according to one study, two-thirds of all children losing public insurance experience a break in coverage.2 As of 2006, SCHIP’s twelve-month continuous enrollment option was a feature of only sixteen state programs.3 The reauthorization of SCHIP offers an opportunity to consider the program with a fresh eye and to view this modest program in the broader context of recent changes in Medicaid program structure and design and ongoing comprehensive state health reform efforts.

Background And Overview

Enacted in 1997, SCHIP was one of two federal laws (the Health Insurance Portability and Accountability Act of 1996, or HIPAA, being the other) whose passage in the wake of the 1994 failure of national health reform signaled an important and renewed effort by a Congress and a president of different parties to find common ground in U.S. health policy.⁴

The purpose of SCHIP was to expand health insurance coverage for uninsured, “targeted” low-income children with family incomes no more than twice the federal poverty level, or fifty percentage points higher than the state’s Medicaid eligibility level, whichever is higher.5 From a policy and political perspective, SCHIP offers a small but classic illustration of how competing visions and values are rec-

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onciled in law. The legislation was designed to accommodate all sides in the debate over the proper role of legal entitlements, federalism, and markets in U.S. health policy.

To satisfy those who oppose legal entitlements for the poor and favor broad state flexibility, the law provides states with an alternative, nonentitlement pathway for insuring a group of children whose coverage already was a state Medicaid option at the time of SCHIP’s enactment. Unlike Medicaid, whose status as an enforceable legal entitlement for children remains firm despite some erosion, the SCHIP statute explicitly creates no federal legal entitlement for children. To accommodate the interests of those who favor a market-based approach to coverage, the law emphasizes a coverage approach that turns on the purchase of “benchmark” products whose design is tied to actuarial value and market conditions rather than a detailed statutory benefit design. (As of 2002, virtually all state Medicaid programs and twenty-seven SCHIP programs enrolled most or all children in privately purchased coverage arrangements operated by insurers or managed care organizations.)

Even as it offers an alternative nonentitlement, actuarially linked pathway to coverage, SCHIP also allows states to implement the law as a Medicaid expansion. The law also contains provisions to ensure that states selecting a nonentitlement approach do so without disturbing Medicaid’s underlying entitlement and benefit design structure. Thus, states may use their federal SCHIP allotments to expand Medicaid, establish separate SCHIP programs that effectively sit atop and augment their Medicaid program “platforms,” or combine the two approaches, expanding Medicaid for lower-income children while adding a separate program for children with slightly higher family incomes.

Whether applied toward a Medicaid expansion, a separate program, or both, the federal SCHIP allotment is simultaneously generous and restrictive. Its generosity can be seen in the fact that under SCHIP, the federal financial participation rate is much higher than a state’s regular federal Medicaid assistance rate. At the same time, the allotment is limited by a national aggregate cap unrelated to either the actual number of children who need assistance or changes in health care costs. Consistent with Medicaid’s entitlement status, states that invest in Medicaid expansions are required to extend Medicaid coverage at the regular Medicaid contribution rate to all children who qualify, in the event that the number of children who seek coverage exceeds the number whose coverage can be financed using the federal SCHIP allotment.

Separate administration has proved to be the more popular implementation approach. As of 2005, thirty-nine states had opted for separate administration, either in whole or in part. This state response suggests the popularity of being able to control enrollment, even while risking funding caps and their potential consequences. Despite the fact that Medicaid expansion states avoid this dilemma by using federal Medicaid contributions to cover additional children, in 2005, only
eleven states employed a strictly Medicaid expansion approach.\textsuperscript{13}

Beyond the aggregate cap on funding, SCHIP’s separate-administration option comes with certain restrictions designed to prevent the federal allotment from being used to supplant other coverage, including Medicaid. First, SCHIP programs must conform their administration to the underlying Medicaid entitlement, by determining children’s Medicaid eligibility prior to enrollment in a separate program.\textsuperscript{14} Although Medicaid-expansion and separate-administration states must comply with this requirement, Medicaid-expansion states simply face a “back-end” accounting matter of allocating between enhanced-rate and regular-rate coverage. Separate-administration programs face the task of front-end compliance as well, since dual-eligibility determinations through a screening process become necessary to avert enrollment of Medicaid-eligible children into SCHIP.

Second, separate-administration states of course actually can run out of federal funding; a Google search of SCHIP funding shortfall stories as of May 2007 produced more than 76,000 separate entries. Indeed, over- and underspending have been consistent SCHIP themes since its enactment.\textsuperscript{15} By contrast, because Medicaid is a federal legal entitlement to states, states can continue to receive federal Medicaid payments if SCHIP funding runs out. Thus, although a Medicaid expansion obligates states to cover all eligible children, coverage of children, which is relatively inexpensive, may turn out to be less of an issue than having to say “no” to eligible families.

Third, separate SCHIP programs have an obligation to comply with stringent “anti-crowd-out” rules.\textsuperscript{16} As the Congressional Budget Office noted earlier in 2007, health insurance crowd-out is a reality in any type of incremental coverage reform.\textsuperscript{17} Recognizing the issue and having to deal with it as a matter of program administration are two different matters, however. Separately administered programs must institute anti-crowd-out procedures that bar enrollment of even seriously uninsured low-income children, if other coverage is present. This strategy can create problems, particularly in the case of children who require relatively costly but uncovered primary or specialized health care services.

By contrast, since its original enactment, Medicaid has operated without crowd-out provisions, since one of its essential roles is to augment other coverage, whether Medicare or private health insurance. Medicaid achieves this result through coordination-of-benefits requirements structured to ensure that where available, other payers operate as “first dollar” to Medicaid and that Medicaid supplements other sources of coverage.\textsuperscript{18}

States that elect separate administration avoid not only Medicaid’s legal entitlement structure but also Medicaid’s considerable coverage obligations applicable to beneficiaries under age twenty-one. Medicaid’s pediatric coverage rules arise from its comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, the most comprehensive pediatric coverage standard ever codified in law.\textsuperscript{19} But separate SCHIP programs are explicitly tied to the commercial
insurance market through a “benchmark” coverage standard that carries no statutory defined-benefit coverage requirements other than well-baby care, well-child care, and certain actuarial expenditure targets.20

This flexibility, along with greater flexibility over premiums and cost sharing, gives SCHIP its market orientation. At the same time, of course, this flexibility carries certain risks in view of the limited nature of commercial insurance in relation to the developmental needs of children, particularly children with chronic and serious physical, developmental, and mental conditions.21 Low-income children resemble poor children in their elevated risk for physical, mental, and developmental conditions and may encounter strict benefit limits in states with separate programs tied to benchmarks.22 Some separate-administration states have taken steps to ensure that their plans encompass broad coverage classes.23 However, it is often the less visible limitations, exclusions, and definitions (including the definition of medical necessity) that pose the most serious problems for children with disabilities and special needs.24

SCHIP’s Contribution To Child Health Policy

SCHIP has had a major impact on coverage—indeed, one that extends well beyond its modest size—because of its power to identify and enroll children eligible for a state’s underlying Medicaid program. In 2006 federal SCHIP allotments financed health care for some 6.6 million children, who were enrolled in SCHIP at some point through either a Medicaid expansion or a separately administered program.25 How much Medicaid might have been affirmatively expanded (beyond the program’s need-driven growth under existing, lower eligibility standards) can really never be known. But SCHIP’s combined growth incentives—an enhanced contribution, nonentitlement alternative, flexibility in coverage design, and a great deal of political good will surrounding the legislation’s enactment—undoubtedly had an important effect.

Between 1980 and the end of the Medicaid reform cycle for children, which decategorized eligibility and phased in a dramatic increase in the mandatory financial eligibility standards for children under age eighteen, children’s Medicaid enrollment leaped from under ten million to more than twenty million.26 Between 1997 and 2004, enrollment in the two programs again grew dramatically, from twenty-one million to thirty-four million, including more than a million parents.27 As a hybrid source of funding for child health coverage, SCHIP essentially forged a pathway that permitted states to bypass the political and social tensions that have plagued Medicaid seemingly since its enactment.

SCHIP also has elevated policy interest in the effectiveness of coverage for children and the quality of pediatric care. As with Medicaid, which has produced seminal studies over the years into the effectiveness of coverage for children, SCHIP has generated considerable research examining its impact on coverage, health care access and use, and the appropriateness of health care use.28
Finally, SCHIP redrew the political landscape in terms of government’s role in directly subsidizing coverage of children. In truth, at the time of SCHIP’s enactment, Medicaid’s special state options regarding the definition of income and resources permitted states to cover any child deemed to be low income by the state. But this state-flexibility option was obscure, never implemented through regulation, and known to child health policy cognoscenti but not by a general policy-making audience.

As a visible advance, SCHIP succeeded in making twice the federal poverty level a well-accepted standard of governmental health care financing assistance, just as the Medicaid reforms of the 1980s succeeded in making the federal poverty level the starting point for further reforms. Indeed, in the current debate, twice the federal poverty level has served as a beginning point for debate over government’s role in covering children, with some arguing for retention of this standard and others calling for expanded income flexibility.

But even as SCHIP’s contributions to child health policy are evident, so are its limitations. SCHIP’s aggregate funding limits subject separate-administration states—and more importantly families in those states—to continuing uncertainty regarding the program’s stability and accessibility. One might be tempted to feel only modest sympathy: After all, states could administer their SCHIP programs as Medicaid expansions (thereby avoiding the federal cap and funding shortfalls); alternatively, states certainly could support children as a matter of state entitlement and with state funding in the event of a federal shortfall. (None appears to do so.) But whatever one’s view, the evidence underscores the peril of coverage inadequacy facing children. Furthermore, a constant sense that the program is on the verge of running out of money does little to engender confidence in either the insurers that do business with state programs or the health care providers who furnish care. The supplemental appropriations legislation signed into law in May 2007 offers a short-term fix; however, the shortfall problem inevitably will reemerge as separately administered programs experience greater-than-projected enrollment or unanticipated surges in health care costs.

Another shortcoming of SCHIP is its benefit design. To be sure, studies have demonstrated SCHIP’s positive impact on access to care. But of necessity, health services researchers necessarily must ask broad questions aimed at measuring large events, such as whether coverage is associated with any use of physician services or the number of visits. This type of information really does not provide insight regarding whether, in light of personal health status, particular children are receiving enough care, the right mix of care, or the right ancillary equipment and supplies (for example, a wheelchair or other equipment and supplies).

This question of performance of health care financing at the individual patient level goes to the heart of health insurance. Beyond population financing, health insurance is a guarantee of coverage at the individual level. Health services research can point to the broad policy direction that insurance should take, but it tends to
be less useful in considering the impact of broad policy choices on small patient subgroups, such as children with advanced health care needs. Health services research by its nature cannot typically shed much light on more nuanced questions, such as whether the treatment and service limits that are customary in commercial insurance plans (which serve as the model for SCHIP) reduce coverage below effective levels in the case of children with major physical, mental, and developmental conditions. At least one study of separately administered SCHIP plans suggests important coverage limitations and gaps. Indeed, a sign of the limited effectiveness of private coverage in the case of children with disabilities is legislation championed by Sen. Charles Grassley (R-IA) and enacted as part (sec. 6062) of the Deficit Reduction Act (DRA) of 2005, which allows states to liberalize Medicaid rules to supplement coverage for moderate-income, privately insured children with disabilities.

The Changing Landscape

Two important developments raise important questions regarding the appropriate legislative goals of SCHIP reauthorization.

- **DRA.** The first development is the DRA. In addition to altering Medicaid rules for children with disabilities, as noted above, the DRA made other fundamental changes in the structure of Medicaid for children in ways that have great relevance to the SCHIP debate. Specifically, it extended SCHIP’s “benchmark” approach as a state Medicaid coverage option in the case of children entitled to assistance based on low family incomes (the lower-income version of targeted low-income children described in SCHIP). This amendment extends the SCHIP benchmark approach for low-income children generally, not just those enrolled in separately administered SCHIP plans. Under the DRA option, Medicaid “benchmark” states must continue to supplement benchmark coverage with EPSDT benefits that are not part of the benchmark. At the same time, however, the DRA formally encourages commercial insurance purchasing, with EPSDT as a “wraparound” (in DRA parlance) to ensure appropriate coverage for children who need additional assistance.

For years, state Medicaid managed care systems have experimented with what is essentially tiered coverage in the case of children through managed care arrangements that include fewer than all EPSDT benefits. In a very real sense, the DRA simply formalizes this approach, thereby leading to an obvious question: Why not use SCHIP to expand Medicaid and give all children insurance coverage, with an EPSDT supplement? This approach would allow further expansion of commercial markets in states that wish to do so, while ensuring that all eligible children can be served and that children with heightened health care needs have appropriate coverage.

- **Uninsurance.** A second development has been the rising number of uninsured people and a growing sense of urgency on the part of states, many of which are seeking broader solutions. The health insurance picture looks worse today—for both
children and adults—than it did a decade ago. Between 1999 and 2004, the number without coverage climbed from 40.0 million to 45.5 million people, and it climbed still further in 2005. Indeed, 2005 marked the first year during this decade that Medicaid and SCHIP failed to replace lost private coverage among children, thereby increasing the number of uninsured children.

Although the number of uninsured children under age nineteen has once again crept upward, the most distressing numbers of all may be for older adolescents and young adults ages 19–26, many of whom are low-income young people who might have “aged out of” Medicaid and SCHIP. As of 2006, federal statistics on the uninsured showed more than ten million uninsured young adults—an astonishing uninsurance rate of 33.2 percent.

These numbers have helped propel more-aggressive state action. The past year has witnessed surging state interest in reforms aimed at the broader population of children and adults, to make affordable coverage available regardless of age. How decisively states are able to pursue this broadening agenda will depend in great part on the latitude they are given over available federal funding; indeed, the wide-ranging Massachusetts reforms of 2006 rest on a long-standing and successful Medicaid expansion that includes comprehensive coverage of children.

**Rethinking Policy Options**

In light of these two developments, the question becomes what to do about SCHIP. Specifically, what types of coverage options advance children’s coverage while also meeting broader health reform needs?

One strategy that would appear to be supported by the overlapping structure of Medicaid and SCHIP, as well as by the evidence of need, would be to allow states that reach certain designated milestones in coverage of children to use their allotments to extend their coverage beyond the original SCHIP child cohort. Despite objections by the Bush administration and some members of Congress, it is uninsured adults, not children, who experience the most serious coverage deficits where federal financing options are concerned.

Several SCHIP reauthorization measures introduced as of May 2007 would permit coverage of other populations in need of assistance such as children aging out of SCHIP, pregnant women, and parents. Although pregnant women and parents are both recognized federal eligibility categories under Medicaid and states thus have an alternative means of securing federal funding to assist them, poor young adults are a particular noteworthy group in relation to existing federally assisted coverage options. States’ current option to assist children and adolescents ends at age twenty-one. At this point, young adults become especially vulnerable because they lack any attachment to a source of federally subsidized insurance. Included in this population are a considerable number of adolescents aging out of child welfare programs, foster care placements, and special education programs. These young special-needs adults now face the prospect of a total lack of coverage until
or unless they become pregnant, parents (in some states), or sufficiently disabled to qualify for Supplemental Security Income (SSI) benefits.

Augmenting states’ SCHIP flexibility to include the young adult subpopulation would make sense, particularly given the breadth of the state option to reach low-and moderate-income children under Medicaid. For example, were a state willing to use its Medicaid expansion options to increase Medicaid eligibility levels for these children (for example, up to 300 percent of poverty), to adopt streamlined enrollment and coverage continuity practices, and to offer either traditional coverage or coverage via a DRA-sanctioned benchmark plan with an EPSDT wraparound, there would appear to be no reason why the state should be prevented from reaching young adults, especially those with special needs. Congress could formalize this type of arrangement as an additional SCHIP option, giving states the flexibility to redesign the federal financial investment as well as their own, to maximize the reach of their programs. Despite Medicaid’s broad coverage, financing medical assistance for children is so inexpensive—even with comprehensive coverage, children cost Medicaid $719 each, on average, in 2001—that many states might respond to this opportunity to secure funding for older children, pregnant women, and parents.40 Furthermore, the Medicaid coverage option permits states to ensure comprehensive coverage for the highest-need children while also taking advantage of Medicaid’s generous funding policies for certain services, particularly the 100 percent federal funding contribution rate for vaccines through Medicaid’s Vaccines for Children (VFC) program, as well as the 90 percent federal funding rate for family planning services and supplies.41 In light of recent developments in vaccine technology, particularly the advent of a vaccine to help prevent cervical cancer, the financial benefits of VFC and increased family planning payments are not inconsiderable.

 Recommending a Medicaid expansion as a means of enhancing SCHIP might seem at odds with the desire on the part of some to preserve the federal SCHIP allotment, to reallocate the allotment to states that wish to maintain low Medicaid coverage standards, while still covering more children. This dilemma is the same one that Congress confronted ten years ago, of course, since Medicaid options existed even then. At the time, lawmakers opted at the time for heavily incentivizing coverage of children, even though the financial incentives created by SCHIP essentially duplicated existing Medicaid options.

Today the picture is different, particularly because of the 2006 addition of Medicaid’s expanded benchmark coverage flexibility option in Medicaid. Furthermore, in the intervening ten years since SCHIP’s enactment, the number of uninsured Americans has climbed by an additional ten million, which makes it particularly important to invest all federal coverage funding in ways that maximize their utility.

It is easy to say that using SCHIP to cover adults is contrary to the interests of children. This argument is simplistic, however. It ignores the essential interaction
between Medicaid and SCHIP policy while also denying the considerable evidence showing the value to children of covering family members and failing to recognize states’ urgent need for additional financing for other populations. Not only would a Medicaid incentivization strategy ensure that children have comprehensive coverage, but it also would end the cycle of state funding shortfalls by moving child health financing firmly onto a more secure financial base while also helping other family members.

The reauthorization of SCHIP offers Congress an opportunity to take stock of the current policy framework and revise the program in ways that make sense for the health of both children and other populations in need. Over the years, the SCHIP debate has tended to treat SCHIP as if it existed apart from other programs and populations in need of assistance. More effective policy making means placing SCHIP within a broader policy context, so that an important opportunity to align federal financing with the welfare of both children and the overall population need is not lost.

NOTES
5. Sec. 1397jj(c)(4).
9. SCHIP statute, sec. 1397aa(a).
10. Ibid., sec. 1397dd(b)(4).
11. Ibid., sec. 1397dd(a).
13. Ibid.
18. SCHIP statute, sec. 1396a(a)(25).
20. SCHIP statute, sec. 1397cc(a).
23. Kaye et al., Charting SCHIP III.
25. CBO, The State Children’s Health Insurance Program.
29. SCHIP statute, sec. 1396a(r)(2).
32. Ibid.
34. Social Security Act, sec. 1937, as added by the DRA, sec. 6044.
41. Regarding VFC, see SCHIP statute, sec. 1396s. Regarding family planning, see ibid., sec. 1396b.