The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 143 June 2007

Principles for SCHIP Reform

Congress passed the State Children's Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997. The goal was to provide health coverage for uninsured children from modest-income families that earned too much to qualify for Medicaid.

However, two things have recently become clear: (1) SCHIP has expanded far beyond its intended goal, even covering hundreds of thousands of adults, and (2) it is encouraging millions of those with private insurance to drop it for the government-subsidized coverage.

SCHIP is now up for reauthorization, and many members of Congress are pushing for an even greater expansion of the program. We think there is a better way. By focusing on truly needy children and encouraging families to keep their existing coverage, SCHIP can expand coverage and provide more cost-effective health insurance. Better yet, turn the funds over to eligible, modest-income families and let them choose qualified plans available in the marketplace.

The Creation of SCHIP. The Balanced Budget Act of 1997 provided some $40 billion in federal block-grant money over 10 years for states to use in covering uninsured children. SCHIP enabled states to create or expand health coverage for children from families with incomes below 200 percent of the federal poverty level (FPL), with some adjustments for differences in local health care costs. Each state's funding was based on its share of the nation's poor, uninsured children. States had to match the federal funds, but at rates lower than Medicaid matching rates, making SCHIP a better deal for states than Medicaid.

No Longer Just for Poor Children. SCHIP was supposed to target poor children, but some exceptions were made.

- States that had expanded Medicaid eligibility for children beyond 200 percent of FPL prior to the passage of SCHIP were allowed even higher eligibility limits — as much as 50 percentage points above their existing limits.
- The Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) allowed states to apply SCHIP to health coverage for uninsured children at any income level.
- And in 2000, CMS ruled that states could extend SCHIP benefits to low-income parents and pregnant women within available funding limits.

Over the next several years, state legislatures greatly expanded SCHIP enrollment beyond its original intent — obtaining waivers to cover qualifying parents and unborn children. CMS reports a total of 6,114,018 children and 638,789 adults were enrolled in SCHIP at some point during 2005.

Moreover, 41 states opted to cover children in families with incomes at 200 percent of FPL or higher, with seven of these states covering children in families with incomes at 300 percent of FPL or higher.

As of February 2007, the Government Accountability Office (GAO) said 14 states had waivers in place to cover adults, including parents and caretaker relatives of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

New Proposals for Expansion. SCHIP supporters aren't satisfied with the previous expansions; they are calling for even more.

There are proposals to include not just children but adults in families with incomes as high as 400 percent of FPL. This means, for example, that a family of four making $82,600 would be eligible for this welfare program.

Back to Basics. The SCHIP program needs to return to its roots. This over-stretched program should provide safety-net coverage for the nation's poor children, not subsidized coverage to middle- and even upper-income parents who can afford to purchase coverage, but choose not to.

It is also necessary to point out that having insurance coverage is not the same as having access to health care. In many states SCHIP is tied to the Medicaid program, and Medicaid's low provider-reimbursement rates have led to reduced access to care. For example, the Milwaukee Journal Sentinel has reported on an overly bureaucratic SCHIP enrollment process. Many counties in Illinois have no participating physicians. And Connecticut Senate President Pro Tempore Donald E. Williams, Jr., has suggested in press reports that 75 percent of appointments for the state's HUSKY program are rejected.

Congress and SCHIP can do better, and here's how:

1. Cover low-income kids first. According to the latest SCHIP annual enrollment report, adults account for about 10 percent of SCHIP enrollment. The GAO reports that while SCHIP spending was initially low, it now exceeds available funding.

Since 1998, some states have consistently spent more than their allotments, while others spent consistently less. However, the states that overspent were rewarded with the funds from the states that under spent. As a result of this spending growth, the pool of federal funds available for redistribution has shrunk considerably. The GAO recently reported that 18 states were projected to have SCHIP-fund shortfalls, and Congress had to appropriate an additional $283 million for fiscal year 2006 to aid these states. So while millions of low-income children remain uninsured, hundreds of thousands of adults are getting coverage with SCHIP funds.

Congress should limit SCHIP coverage to kids whose families earn no more than 200 percent of poverty. If there are funds left over, then Congress should ensure that health care providers are being adequately reimbursed so that SCHIP enrollees can see a doctor.

2. Do not crowd out private health insurance coverage. A recent Congressional Budget Office (CBO) report suggests that 25 to 50 children out of every 100 enrollees are dropping their private coverage to enter in SCHIP. This practice is known as "crowd out," and it is one of the hazards of expanding government health insurance programs. Current proposals to expand SCHIP eligibility up to 300 or 400 percent of FPL will only exacerbate the crowd-out effect, because so many people in those income ranges already have private coverage.

3. Utilize employer-provided coverage. Many employer plans allow parents to pay extra — which often includes some employer subsidy — to put their kids on the employer's health insurance policy. However parents, especially those with lower incomes, oftentimes cannot afford to do so.

One simple solution is to allow parents to use SCHIP funds to pay the employee's portion of the child's health insurance premium. This approach has the advantage of keeping the family in the same health insurance plan and accessing the same network of health care providers.

4. Get the subsidies right. When Congress created the federal-state funding for SCHIP, it got the incentives mixed up. The federal government pays an average of 70 percent of SCHIP costs but only about 57 percent of Medicaid costs.

As a result, the states have a tremendous incentive to expand the SCHIP rolls as compared to the Medicaid rolls — and that's exactly what they are doing. In fact, that's one of the reasons for the inclusion of adults — three states cover more adults than children — into a children's program.

Congress needs to get the state subsidies, and the economic incentives they create, right. Fortunately, the Bush administration and some members of Congress are trying to address this disparity. The Deficit Reduction Act of 2005 prohibited any new states from using SCHIP funds to cover childless adults. And the recent 2007 SCHIP funding provisions in the National Institutes of Health Reform Act provides the lower Medicaid match rate for non-pregnant adults, rather than the enhanced match rate.

Should We End It Rather Than Mend It? Rather than looking for ways to reform or more narrowly focus SCHIP, Congress appears willing to dramatically expand it. But at a time when presidential candidates, as well as others, are calling for more consumer freedom and choice, isn't there a better way?

- Wouldn't it make more sense to turn funds over to eligible, modest-income families and let them choose qualified plans available in the marketplace?
- Wouldn't it make more sense to let low-income parents choose what best fits their children's needs than let politicians and bureaucrats make those decisions for them?

Conclusion. SCHIP is quickly morphing from a limited, low-income children's program to a large, unlimited health care entitlement for millions of Americans. The states have been willing accomplices because the matching rate is so high. And many advocacy groups are backing the expansion as a way to swell government-run health insurance at the expense of the private market. But it is time to say STOP! SCHIP needs to return to its roots, which will help preserve the federal budget *and* quality health care.

For the GAO report see: http://www.gao.gov/new.items/d07558t.pdf

For the CBO report see:
http://www.cbo.gov/ftpdoc.cfm?index=8092&type=0&sequence=2

For the White House report see:
http://www.whitehouse.gov/omb/pubpress/2007/factsheet_schip.pdf

For the CMS report see:
http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/FY2005AnnualEnrollmentReport.pdf

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