



## Reauthorizing SCHIP: A Summary of Selected Issues

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*OVERVIEW — This document provides a brief overview of some of the policy and programmatic issues that were addressed in legislation to reauthorize the State Children's Health Insurance Program (Title XXI of the Social Security Act) during the summer and fall of 2007. This overview provides a background for understanding the elements for a second round of reauthorization that will likely be debated in the early days of the 111th Congress. The paper reviews several of the key issues under discussion and summarizes some of the related provisions in the reauthorization bills that were considered in 2007.*

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The State Children's Health Insurance Program (SCHIP) was created as part of the Balanced Budget Act of 1997. The new program offered nearly \$40 billion over ten years (1998 through 2007) to states in the form of capped allotments to expand health insurance coverage to uninsured, low-income children. The states could use the funds to expand their existing Medicaid programs, create a separate children's coverage program, or use a combination of the two approaches. The funding for these expansions was made available to states through a matching arrangement in which the states contribute a portion of the funding and the federal government provides matching funds. The SCHIP "enhanced" matching rate is based on a state's Medicaid matching rate and increased proportionately based on a number of factors. As a result, the federal government pays for between 65 and 83 percent of the costs of SCHIP coverage. In general, the states' share of expenditures under SCHIP is 30 percent less than under Medicaid.<sup>1</sup>

All of the states elected to adopt SCHIP programs, to expand eligibility to higher income levels, and to conduct outreach to children and their families. More than 7 million children were served by SCHIP in 2007.<sup>2</sup> At the same time, outreach efforts have helped states identify millions of additional children who are eligible for Medicaid; in fact, states anecdotally reported that in the early years they enrolled two children in Medicaid for every child found eligible for SCHIP. Despite the perceived success of these outreach efforts, more than 5 million children remain eligible for publicly financed coverage but have not enrolled.<sup>3</sup>

The discussion around the program elements that should be addressed by SCHIP reauthorization began to unfold early in 2007. One of the most significant areas of focus and agreement was the need to develop mechanisms to reach those children who were already eligible for Medicaid and SCHIP but were not enrolled. Key stakeholders also agreed that some elements of the financing structure

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needed to be refined in order to make the calculation and distribution of the SCHIP allotments each year more consistent and predictable for states. However, there were many other areas where consensus could not be reached, ultimately leading to an interim program extension that will expire on March 31, 2009.

### SCHIP: The Basics

**Eligibility** — SCHIP was originally designed to serve “targeted low-income children,” defined in the statute as uninsured children under age 19 in families with incomes at or below 200 percent of the federal poverty level (FPL), \$35,200 for a family of three in 2008. However, states have flexibility to set their own eligibility levels, and 44 states have since expanded Medicaid/SCHIP to 200 percent of the FPL or higher. Children who are otherwise eligible for Medicaid or have other insurance coverage are generally not eligible for SCHIP.

**Benefits** — States creating Medicaid expansion programs must provide the full Medicaid benefit package. For separate SCHIP programs, states have four options:

- **Benchmark coverage.** This includes coverage that is the same as the BlueCross/BlueShield plan offered to federal employees, a coverage plan that is offered to state employees, or a coverage plan that is offered by a health maintenance organization (HMO) and has the largest commercial enrollment in the state.
- **Benchmark-equivalent coverage** that includes basic services (inpatient and outpatient hospital, physician, medical and surgical, laboratory and x-ray, and well-baby/well-child care, including immunizations) and has at least the aggregate actuarial of the value of one of the benchmark benefit packages.

- Existing comprehensive coverage that Florida, New York, and Pennsylvania used in their state-based programs before the enactment of SCHIP.
- Secretary-approved coverage in which states may propose another benefit package and request approval from the Secretary of Health and Human Services.

**Cost Sharing** — States with Medicaid expansion programs are required to follow the Medicaid cost-sharing rules. For separate SCHIP programs:

- Cost sharing for families with incomes at or below 150 percent of the FPL is limited, and states may generally charge no more than a \$5 copayment per office visit.
- For families with incomes above 150 percent of the FPL, the total amount of cost-sharing charges (including premiums, deductibles, enrollment fees, and copayments) may not exceed 5 percent of the family’s annual income.

**Financing** — SCHIP provided a capped amount of funds to states on a matching basis for federal fiscal years 1998 through 2007. (SCHIP is operating under a funding extension that expires on March 31, 2009.) Each state receives annual SCHIP allotments that can be spent over a three-year period. At the end of three years, any unspent funds are redistributed to those states that have spent all of their individual allotments. States have one year to spend the redistributed funds. If any funds remain unspent after the redistribution period, those funds revert to the federal Treasury.

## THE BACKSTORY

The SCHIP program began with strong bipartisan support, due in large part to the flexibility it offered states in implementing coverage expansions. It is also worth noting that the program was conceived during a period of economic prosperity in which the Congress had an opportunity to balance the budget while also creating a new coverage program. Over time, the SCHIP program became a vehicle for a larger discussion about the appropriateness of publicly subsidized health coverage and health reform overall, and along with Medicaid, may become part of the foundation for expanding coverage more broadly.

### Evolution of the 2007 Debate

Over the summer of 2007, using SCHIP reauthorization as the vehicle, Congress considered a number of proposed bills to expand access to health coverage for children. Sen. Jay Rockefeller (D-WV) and Sen. Hillary Rodham Clinton (D-NY) introduced bills, as did the chairman of the House Energy and Commerce Committee, Rep. John D. Dingell (D-MI). On August 1, 2007, the House passed its version of a reauthorization bill, known as the Children’s Health and Medicare Protection Act (the CHAMP Act, H.R. 3162), that also included several modifications to the Medicare program. The CHAMP Act would have provided an additional \$50 billion for SCHIP over the next five years. The amount would have resulted in total five-year funding for the program of \$75 billion. (The baseline funding for the program is assumed to be \$25 billion over five years.) (See Table 1.)

**TABLE 1: FY 2008 SCHIP Financing Proposals**

	Bush Administration	CHAMP	CHIPRA I
<b>Base</b>	\$25.0 billion	\$25.0 billion	\$25.0 billion
<b>Increase</b>	\$4.8 billion	\$50.0 billion	\$35.0 billion
<b>Total</b>	\$29.8 billion	\$75.0 billion	\$60.0 billion

On August 2, 2007, the Senate passed the Children’s Health Insurance Program Reauthorization Act of 2007 (CHIPRA, S. 1893). That bill and the CHAMP act were ultimately combined, and a compromise bill (H.R. 976), now known as CHIPRA I, was approved by the

House and the Senate and sent forward to President Bush for signature. CHIPRA I included elements of the CHAMP Act but primarily represented the Senate's approach (from S. 1893). CHIPRA I would have offered states an additional \$35 billion over five years and would have made health coverage available to almost 4 million additional uninsured children, according to Congressional Budget Office estimates.<sup>4</sup> CHAMP would have been financed by a combination of savings from reductions in Medicare Advantage payments and a 45-cent increase in the tobacco tax.<sup>5</sup> CHIPRA I would have relied exclusively on a 61-cent increase in the tobacco tax as the funding source for the expansion.

Throughout the course of the debate within Congress, the Bush administration consistently registered its opposition to expanding funding for SCHIP. The President's budget proposal for fiscal year (FY) 2008 included an increase of \$4.8 billion in SCHIP funding over the next five years. The Congressional Budget Office (CBO) estimated that this amount would not have been sufficient for states to maintain existing coverage levels. In addition, the administration proposed to limit SCHIP funding to children in families with incomes at or below 200 percent of the federal poverty level (FPL). The administration indicated its intention to veto any reauthorization bill that included significant funding increases and that did not cap eligibility at a specific level; on October 3, 2007, President Bush vetoed the CHIPRA conference agreement.

Congress reconvened negotiations and developed a second compromise package, known as CHIPRA II (H.R. 3693), which attempted to address some of the administration's concerns about the potential for substitution of private coverage ("crowd-out") and clarified limitations on coverage of immigrant children, parents of children enrolled in SCHIP, and adults without children. The new bill placed a limit on SCHIP eligibility at 300 percent of the FPL and required states to take additional steps to verify citizenship status and prevent crowd-out. Although these concessions had been worked out by both Democrats and Republicans, the President vetoed CHIPRA II on December 12, 2007, and Congress once again failed to override.

Seeing no chance for reconciliation before adjourning for the holidays, Congress on December 19 passed a simple extension of the program, providing a slight increase in funding to cover projected shortfalls. President Bush signed the Medicare, Medicaid and SCHIP

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Extension Act of 2007 (S. 2499) on December 29, 2007. This is the extension scheduled to expire on March 31, 2009.

## KEY PROVISIONS OF THE 2007 BILLS

Some of the key provisions of the bills that shaped the reauthorization debate in 2007 will likely be discussed as Congress prepares a new version for consideration in 2009. As described above, the Congress considered three versions of SCHIP reauthorization legislation: the CHAMP Act, CHIPRA I, and CHIPRA II, the compromise bill designed to respond to the President's veto. The descriptions that follow focus primarily on the elements of CHAMP and CHIPRA I; however, relevant changes that were included in CHIPRA II are noted as appropriate in order to provide a fuller illustration of the negotiations that took place.<sup>6</sup>

### Eligibility

**Children and Pregnant Women** — All of the bills that were considered as part of the SCHIP reauthorization process would have significantly increased funding for the program and would have potentially added nearly 4 million uninsured children to Medicaid and SCHIP coverage by FY 2012.<sup>7</sup> Unlike the subsequent bills, CHAMP did not include an upper limit on income eligibility. (The original 1997 SCHIP legislation targeted children with incomes up to 200 percent of the FPL, but 24 states have since expanded eligibility to children with incomes above that level.)<sup>8</sup> Perhaps most significantly, the CHAMP Act would have provided for optional coverage of legal immigrant children and pregnant women (but included an explicit prohibition on federal funding for coverage of undocumented immigrants), thereby removing the five-year ban on federally funded coverage for immigrants (see text box, next page). In addition, CHAMP gave states the option to provide SCHIP coverage to low-income pregnant women and to offer family planning services without the need for a “waiver” of program rules.

CHIPRA proposed to increase the targeted eligibility level for SCHIP to 300 percent of the FPL, or \$52,800 for a family of three in 2008. CHIPRA did not include a “hard” cap on income eligibility levels for the program but did specify that coverage was to be targeted at families with incomes at or below 300 percent of the FPL in order to receive the enhanced federal matching rate.<sup>9</sup> Coverage would still

have been permitted above 300 percent of the FPL, but states would receive only the lower Medicaid matching rate for coverage of children at higher income levels.<sup>10</sup> CHIPRA II would have prohibited SCHIP funding altogether for eligibility expansions using income disregards<sup>11</sup> above 300 percent of the FPL; however, the legislation may still have permitted financing such coverage with Medicaid funds. The CHIPRA compromise did not restore coverage for legal immigrant children and pregnant women, but it would have created a state option for coverage of pregnant women, using SCHIP funds, without need for a waiver.

### Health Coverage of Immigrant Children

The debate around providing health coverage to immigrants has been one of the more intense discussions in recent history. The welfare reform law that was enacted in 1996 includes far-reaching exclusions and limitations on the use of federal funds for providing health and social services to noncitizens. The statute included, among other provisions, a prohibition on Medicaid eligibility for legal immigrants for the first five years they reside in the United States. This “five-year ban” was extended to the SCHIP program when it was created in 1997. (Undocumented immigrants are permanently excluded from federally financed coverage.) However, about half of the states have elected to continue to provide coverage for legal immigrants during their first five years in the country, using state-only funds.

Over the years, states and advocates working on behalf of immigrants have voiced concerns about the fairness and complexity of these requirements, and the issue was formally raised during the SCHIP reauthorization debate in the summer of 2007. As noted in the text, the CHAMP Act included a restoration of federal funding for coverage for legal immigrant children, but the CHIPRA legislation did not include such a provision. (Coverage for illegal or undocumented immigrants would have continued to be prohibited.)

There was also a separate bill, known as the Legal Immigrant Children’s Health Improvement Act of 2007 (ICHIA) that would give states the option of offering Medicaid and SCHIP coverage to children and pregnant women who are legal U.S. residents. The discussion about coverage of legal immigrants in Medicaid and SCHIP will very likely be a key part of the next round of reauthorization negotiations.

**Adults** — Over the years, the federal government has approved several states' requests for a waiver of SCHIP rules that enabled them to receive the SCHIP matching rate for coverage of parents of children enrolled in SCHIP. In addition, a handful of states received approval from the Centers for Medicare & Medicaid Services (CMS) to cover adults without children (commonly referred to as childless adults) under SCHIP. However, these waivers generated concerns about the appropriate use of SCHIP funds. In 2002 and 2004, the General Accounting Office (GAO, now the Government Accountability Office) published reports suggesting that the use of SCHIP funding for childless adults was "inconsistent with SCHIP's statutory objective to expand coverage to low-income children" and creates a situation in which funding could be diverted away from coverage of children.<sup>12</sup> In response, the Deficit Reduction Act of 2005 prohibited any additional states from using SCHIP funds to cover childless adults.

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Both CHAMP and CHIPRA addressed the issue of SCHIP-financed coverage of adults and stated the intent that SCHIP funding be focused on children. CHIPRA included compromise language that meant, in general, that coverage of adults would ultimately be phased out of SCHIP<sup>13</sup> and no new waivers would be permitted. The 11 states operating parent coverage waivers would have been permitted to continue for a two-year transition period. At that point, the parent coverage would have been funded out of a separate capped allotment, assuming the state met certain parameters.<sup>14</sup> Coverage of childless adults would have been phased out more quickly. The four states with existing SCHIP waivers for childless adults would have been permitted to apply for a Medicaid waiver to cover those adults currently enrolled in SCHIP during a two-year phase out period (one year under CHIPRA II). If approved, this transition would have enabled states to continue coverage for adults, but at the lower Medicaid matching rate.

### Outreach, Enrollment, and Express Lane Eligibility

A key area of agreement and subsequent attention in the legislation was the need to develop more effective strategies to reach children who are eligible for SCHIP or Medicaid but are not enrolled. CBO has estimated that between 5 million and 6 million uninsured children are eligible for Medicaid or SCHIP,<sup>15</sup> and the reauthorization



legislation would have potentially enabled states to provide coverage to at least 3.4 million of these children over five years.<sup>16</sup>

The original SCHIP statute did not include a great deal of language regarding outreach, aside from requiring states to describe their outreach strategies in the state plan that is approved by CMS. In fact, the law included a limitation that outreach and administrative activities could not exceed 10 percent of the program's expenditures. Often for the first time, states embraced the idea of using outreach and marketing strategies, and many states developed creative names and approaches to encourage families to apply for SCHIP. The effectiveness of these efforts has been widely documented.<sup>17</sup> However, as states repeatedly experienced economic downturns over the past decade, outreach was often the first budget item to be cut, both because of the cost of conducting outreach and because of the new enrollment and service costs that resulted.

Both the CHAMP Act and CHIPRA I included strategies and incentives for states to improve outreach and enrollment. The CHIPRA I bill included slightly more refined strategies, since it was passed after CHAMP. CHIPRA I allocated \$100 million in outreach and enrollment grants above and beyond the regular SCHIP allotment to augment existing enrollment efforts. Ten percent of the allocation would have been dedicated to a national enrollment campaign and 10 percent would have been targeted to outreach for Native American children. The remaining 80 percent would have been distributed to state and local governments and to community-based organizations for purposes of conducting outreach campaigns, with particular focus on rural areas and underserved populations.

CHAMP and CHIPRA I would have established a series of performance bonuses to make it more financially appealing for states to conduct outreach and enroll eligible children. States would receive financial rewards for streamlining enrollment procedures and for successful enrollment efforts. Specifically, states could receive a federal payment for each child enrolled above a target level. In order to be eligible for the performance bonuses, states would need to adopt at least four of seven (or five of eight under CHIPRA II) designated "best practices" for simplifying enrollment and renewal procedures.<sup>18</sup>

Another key element of enhancing enrollment efforts is the adoption of "Express Lane" eligibility as an option for states. The concept of Express Lane is to rely on income and other information previously

collected for purposes of establishing eligibility for another public program to facilitate enrollment in SCHIP and Medicaid. For example, states would have the option to use income information from a child's enrollment in the school lunch program to determine whether he or she might be eligible for SCHIP or Medicaid. CHIPRA I would have also increased states' access to other data sources that might contain information that would facilitate enrollment and minimize the burden on the family (while also ensuring their privacy).

Finally, the CHIPRA I legislation would have extended the requirement for documentation of U.S. citizenship as a condition of enrollment in both Medicaid and SCHIP. However, in response to state reports that the citizenship documentation requirement has resulted in eligible U.S. citizens' being denied or disenrolled from Medicaid coverage, the legislation included provisions designed to facilitate the documentation process. For example, CHIPRA I included an option for states to submit the names and social security numbers of individuals enrolled in Medicaid and SCHIP to the Social Security Administration for a data match. If no match were found, states would have been responsible for working to address the problem before taking steps to disenroll the individual. CHIPRA I would have also allowed the family a reasonable amount of time to provide sufficient documentation before being disenrolled. (States would have been subject to penalties if more than 3 percent of the requested data matches were deemed invalid.)

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### Financing

By law, each state receives an annual SCHIP allotment based on a formula that uses the number of uninsured low-income children, the number of all low-income children, and a factor representing state variation in health care costs.<sup>19</sup> States have three years to use each annual allotment. The result of this formula over time has been that some states have not used all of the funds allocated to them, while other states (sometimes referred to as shortfall states) run out of funds at some point during the fiscal year. To compensate for this possibility, the original law gave the Secretary of Health and Human Services broad authority to establish a method to redistribute unused funds to states that have exhausted their allotments. States have one year to use redistributed funds, after which any unused funds revert

to the Treasury. While this process has largely been helpful to states, many states disproportionately rely on redistributed funds to operate their SCHIP programs.

CHAMP and CHIPRA I addressed the imbalance in state allocations by changing the way that allotments are determined on the front end. Both bills proposed a new formula that used a state's actual expenditures in a base year and "rebased" the expenditures every second year, so that actual expenditures (including funds from both allotments and redistributions) would have been the basis for future allotments. In addition, the allotment would have been adjusted annually to account for population growth and growth in health care expenditures.

CHAMP and CHIPRA I also included provisions to deal with potential shortfalls in funding. The intention of these provisions was to assure more stable funding for the program and to enable states to make budgetary decisions earlier. Both bills would have shortened the amount of time states have to use their allotments from three years to two years so that funds could be redistributed more quickly. CHAMP would have also increased allotments for states with shortfalls when SCHIP enrollment exceeded a certain target. CHIPRA I would have established a capped child enrollment contingency fund, to be held by the U.S. Treasury, that could be used to cover shortfalls when a state met enrollment targets. These extra funds would have been built into future allotments. Both bills would have permitted unused funds to remain in the program rather than reverting to the Treasury, as they do under current law. Under CHAMP, unused funds would have remained available for future redistribution. Under CHIPRA I, the funds would have been available in the contingency fund and could also have been used for performance bonuses. CHIPRA II did not alter the financing provisions of CHIPRA I. (See Table 2, next page.)

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*CHAMP and CHIPRA I included provisions intended to assure more stable funding for the program.*

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### Quality

By law, each SCHIP plan must include a description of strategic objectives, performance goals, and performance measures that the state will use to evaluate its performance in regard to ensuring quality health care services for enrollees. CMS has recommended that states use four core measures that are relevant for children: (i) well-child

visits in the first 15 months of life, (ii) well-child visits in the third, fourth, fifth, and sixth years of life, (iii) children’s and adolescents’ access to primary care practitioners, and (iv) use of appropriate

**TABLE 2: Key Changes to SCHIP Financing Under CHAMP And CHIPRA I**

Provisions	Existing Law	CHAMP/CHIPRA I
<b>Allotment Criteria</b>	Each state’s allotment is established based on the number of low-income children, uninsured low-income children, and health care costs in the state.	Each state’s allotment is established based on previous expenditures in a base year, adjusted annually for health care cost and population growth. The base year is updated every two years.
<b>Allotment Period</b>	Allotments are available for three years.	Allotments are available for two years
<b>Redistribution</b>	Secretary of HHS establishes a method to redistribute unused funds to states that have expended their allotments.	The bill specifies a method for redistribution of unused funds for 2005 allotments in order to transition to the revised methodology.
<b>Shortfalls</b>	States that expend allotments must rely on redistributions (no contingency fund).	<b>CHIPRA I</b> – Establishes a separate contingency fund for states with shortfalls that exceed their target number of SCHIP enrollees.  <b>CHAMP</b> – Includes a performance-based adjustment for shortfall states that exceed a target number of SCHIP enrollees.
<b>Outreach and Administration</b>	Outreach and administrative costs are limited to 10 percent of program costs.	<b>CHIPRA I</b> – Payment Error Rate Measurement (PERM) activities, outreach for premium assistance, and outreach for Native American children are not subject to the 10 percent cap on administrative costs.  <b>CHAMP</b> – No provision.

*Note: CHIPRA II would have made no changes to the CHIPRA I financing provisions.*

medications for children with asthma.<sup>20</sup> States report on these and other measures in required annual reports that are submitted to CMS. While most states do use these or similar measures in their quality improvement programs, the way data are collected and reported varies significantly.

CHAMP and CHIPRA I included provisions that were intended to strengthen child health quality measurement. Both bills required the Secretary to establish a child health quality measurement program for Medicaid and SCHIP. However, the specific measures would have been recommendations rather than requirements. CHAMP was somewhat more specific than CHIPRA I in the areas that would have had to be addressed by the quality measures; however, the intent of both bills was to greatly expand the measures that were recommended and to establish a standard reporting format that permits comparison across states, health plans, and providers.

CHIPRA I would have supported the development and implementation of quality measures by providing an enhanced matching rate to states for administrative functions related to collecting data and reporting on performance measures. The bill would have funded grants for up to ten states and providers to test child quality measures and to develop health information technology. It also would have required the Secretary to establish a program to encourage the development of a model electronic health record for children in Medicaid and SCHIP.

Both bills would have applied certain Medicaid managed care protections to SCHIP. These protections address a wide range of issues, including the circumstances under which beneficiaries may disenroll from managed care organizations (MCOs), the types of information about coverage that must be made available to beneficiaries, the provisions that must be included in states' contracts with MCOs (such as the coverage that will be provided, coverage of emergency room services, the MCO's internal grievance procedures, and demonstration of adequate capacity and services), state quality assurance and improvement strategies (including access standards, monitoring procedures, and periodic review), external independent review of managed care activities, protections against fraud and abuse, and restrictions on marketing.

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### Crowd-Out

One of the main points of contention during the 2007 reauthorization debate was how to ensure that children enrolling in SCHIP are uninsured and are not dropping private coverage in order to access publicly subsidized coverage. This concept of substitution, or crowd-out, has been a concern since well before the enactment of SCHIP in 1997, and the original legislation emphasized that the program is targeted at uninsured, low-income children. Experts agree that the potential for crowd-out increases considerably as eligibility levels go up the income scale, but the question of how to define substitution (for example, does the coverage have to be affordable?) remains unresolved. In response, CHIPRA I and CHIPRA II would have required states (particularly those covering children at higher income levels) to develop and implement strategies to limit the potential for crowd-out. The bills also would have requested that the GAO and the Institute of Medicine conduct studies to identify a set of best practices for limiting crowd-out that would eventually be recommended for use by the states.

### Premium Assistance

Under existing law, states may provide coverage to SCHIP-eligible children by subsidizing the cost of coverage that is available through a parent's employer-sponsored insurance (ESI, also referred to as group health insurance). When deciding whether to offer premium assistance, states review available ESI plans to determine whether they meet the SCHIP benefit and cost-sharing requirements. (See text box on "SCHIP: The Basics," above). ESI that does not meet the SCHIP requirements can not be subsidized, unless the state provides additional, "wrap-around," coverage to supplement the group health benefits.

States also may subsidize coverage for noneligible family members when it is cost-effective, that is, when the family group health plan premium is no more than the cost of covering the child in the state's SCHIP plan. A number of states offer premium assistance in their Medicaid and section 1115 demonstration programs; however, enrollment in these programs is limited and there are no active SCHIP premium assistance programs in effect. Many factors contribute to the limited use of premium assistance programs in SCHIP, including low offer rates by employers of low-income workers and small

businesses, the rising costs of premiums in the private market, and the complex administration involved with qualifying group health plans for participation.<sup>21</sup>

To address some of the barriers to premium assistance, CHIPRA I included several provisions designed to better facilitate information sharing between states and the employer community. Perhaps most significantly, the bill would have required employers to provide states with information about benefits and other features of their coverage that states need to determine whether the ESI qualifies for subsidies. Lack of cooperation from employers in providing this information has often been a stumbling block for premium assistance programs. CHIPRA I would also have required group health plans to permit an employee or dependent to enroll when gaining or losing eligibility for Medicaid or SCHIP, making such an eligibility change a “qualifying event.” Under existing law, employees often must wait until an open enrollment period, which usually occurs only once per year, to join the group health plan. Finally, CHIPRA I would have revised the cost-effectiveness test so that when parents and other noneligible family members are covered, the cost of premium assistance is compared to the cost of covering the whole family (rather than only the child) in the state’s regular SCHIP.

CHIPRA I also would have established two new options for premium assistance programs. One option would have permitted states to establish purchasing pools for employers with fewer than 250 employees. The pool would have had to offer at least two private health plans that met SCHIP benefit requirements. The second option would have established premium assistance programs in which the cost-effectiveness test would be deemed to be met under certain conditions. For example, states would not have been permitted to require enrollment in premium assistance and would have to provide parents the opportunity to opt out of the employer plan and enroll the child in the state’s regular SCHIP plan at any time. States would also have been required to count total employee and child cost-sharing contributions toward the 5 percent cap on out-of-pocket costs for enrollees. (Currently, only the child’s cost-sharing obligations are counted toward the 5 percent cap.) In addition, employers would have been required to contribute at least 40 percent toward the cost of the premium.<sup>22</sup>

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*CHIPRA I would have required employers to provide states with information about benefits and other features of their coverage.*

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## OTHER PROVISIONS

The proposed bills also included a number of other modifications and additions to the SCHIP benefits and cost-sharing standards:

**Dental services** — Although all states now provide dental coverage, these services are optional under SCHIP. Both bills would have required states to provide dental services. CHIPRA I identified three benchmark dental benefit plans from which states could choose.

**Mental health services** — Neither bill would have required states to provide mental health services as part of the SCHIP benefit package, consistent with current law. However, although each bill took a different approach, both sought to strengthen mental health services when they are offered by a state. CHAMP would have raised the required actuarial value of the mental health services included in a benchmark-equivalent benefit package from 75 percent to 100 percent of the value of mental health services provided for in the benchmark plan. CHIPRA I would have required that the financial requirements and treatment limitations for mental health services be no more restrictive than those for other medical services.

**Federally qualified health centers (FQHCs) and rural health clinics (RHCs)** — CHAMP would have required states to cover services provided through FQHCs and RHCs. Both bills would have required the use of a prospective payment system for these facilities, rather than the cost-based reimbursement system in place in most states.

**Benefit packages** — CHAMP proposed revising the definitions of two SCHIP benefit packages described in the existing statute. Currently, states may provide coverage that is the same as any offered to state employees. CHAMP specified that the state employee plan must be the one selected most frequently by employees seeking dependent coverage. For Secretary-approved coverage, CHAMP would have required that this coverage be at least equivalent to one of the benchmarks. However, it is unclear how the latter definition would differ from the existing definitions of SCHIP benchmark or benchmark-equivalent coverage.

**Premiums** — Both bills would have required a grace period of at least 30 days for individuals to pay their premiums before taking action to disenroll them.



## CONCLUSION

Despite the increased pressure being put on public program budgets by the current economic downturn, it appears that the Congress is likely to continue its consideration of whether and how significantly to expand the coverage that is available through SCHIP. Recent predictions signal that the Congress will advance a SCHIP reauthorization bill independently of the economic stimulus package that is under development.

Regardless of the vehicle, there is some degree of urgency, both as a public policy matter and as a budgetary issue. With the extension of SCHIP funding levels set to expire on March 31, 2009, states are anxiously awaiting the signal that they can make critical budgetary decisions and plan for the future of their programs.

## ENDNOTES

1. This matching arrangement is often called an “enhanced match” because the rate is based on a state’s Medicaid matching rate and then “enhanced” to provide a financial incentive for states to pursue SCHIP coverage programs. For more information about the basic elements of the SCHIP financing structure, see Jennifer Ryan, “The Basics: SCHIP Financing,” National Health Policy Forum, March 28, 2007; available at [www.nhpf.org/pdfs\\_basics/Basics\\_SCHIPFinancing.pdf](http://www.nhpf.org/pdfs_basics/Basics_SCHIPFinancing.pdf).
2. Centers for Medicare & Medicaid Services (CMS), “SCHIP Ever Enrolled in Year”; available at [www.cms.hhs.gov/NationalSCHIPPolicy/downloads/SCHIPEverEnrolledYearGraph.pdf](http://www.cms.hhs.gov/NationalSCHIPPolicy/downloads/SCHIPEverEnrolledYearGraph.pdf).
3. Peter R. Orszag, Congressional Budget Office (CBO), letter to Senate Finance Committee Chairman Max Baucus, September 24, 2007; available at [www.cbo.gov/ftpdocs/83xx/doc8357/07-24-Estimates\\_of\\_Uninsured\\_Children.pdf](http://www.cbo.gov/ftpdocs/83xx/doc8357/07-24-Estimates_of_Uninsured_Children.pdf).
4. CBO, “CBO’s Estimate of Changes in SCHIP and Medicaid Enrollment of Children under H.R. 976, the Children’s Health Insurance Program Reauthorization Act of 2007,” August 24, 2007; available at [www.cbo.gov/ftpdocs/85xx/doc8584/08-28-CHIP.pdf](http://www.cbo.gov/ftpdocs/85xx/doc8584/08-28-CHIP.pdf).
5. The CHAMP Act relied on \$50 billion in funding derived from savings from Medicare Advantage payment reductions and \$26 billion in tobacco tax revenues.
6. For a side-by-side comparison of the three SCHIP reauthorization bills, see Center for Children and Families, “Key Differences Among Major SCHIP Bills,” Georgetown University Health Policy Institute, December 16, 2008; available at [http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/schip\\_reauth/schip\\_side-by-side.pdf](http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/schip_reauth/schip_side-by-side.pdf).
7. CBO, “CBO’s Estimate of Changes.”

## ENDNOTES (continued)

8. The SCHIP statute gives states flexibility to set eligibility levels, and there is currently no federal upper income limit. A dozen states have set eligibility for SCHIP at 300 percent or higher, and 44 of the states have eligibility levels at or above 200 percent of the federal poverty level (FPL). For a specific state-by-state listing, see Center for Children and Families, "Eligibility Levels in Medicaid & SCHIP for Children, By State as of October 1, 2008," Georgetown University Health Policy Institute, updated October 20, 2008; available at <http://ccf.georgetown.edu/index/cms-filessystem-action?file=statistics/eligibility%20expansions%20by%20state.pdf>.
9. CHIPRA II included a specific prohibition of federal funding for coverage above 300 percent of the FPL, with an exception for New Jersey where eligibility is currently set at 350 percent of the FPL.
10. The bill included a "grandfather" clause for those states that had already implemented coverage or enacted legislation to cover children above 300 percent of the FPL. Those states were to receive the enhanced matching rate but would have been subject to other restrictions.
11. It is common practice in Medicaid and SCHIP for states to apply certain deductions, known as disregards, from an individual's or family's income in determining eligibility for coverage. For example, many states disregard up to \$200 per month in child care expenses. In SCHIP, several states have developed what are sometimes known as block-of-income disregards, whereby any income above a certain level (for example, between 200 and 250 percent of the FPL) is disregarded for purposes of determining eligibility. While this practice enables states to enroll more children in coverage, it can challenge the public's understanding of who is eligible for the program.
12. Kathryn G. Allen, General Accounting Office (GAO, now the Government Accountability Office), "SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals," letter to Senate Finance Committee Chairman Max Baucus, GAO-04-166R, January 5, 2004, available at [www.gao.gov/new.items/d04166r.pdf](http://www.gao.gov/new.items/d04166r.pdf); GAO, *Medicaid and SCHIP: Recent Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817, July 2002; available at [www.gao.gov/new.items/d02817.pdf](http://www.gao.gov/new.items/d02817.pdf).
13. A capped funding amount would be available to states that had parent waivers in place in October 2007.
14. The enhanced matching rate under the parent coverage allotment would be modified downward over time.
15. Orszag, letter to Baucus.
16. CBO, "CBO's Estimate of the Effects on Direct Spending and Revenues of the House Amendments to the Senate Amendments to H.R. 976, the Children's Health Insurance Program Reauthorization Act of 2007," September 24, 2007; available at [www.cbo.gov/ftpdocs/86xx/doc8655/hr976.pdf](http://www.cbo.gov/ftpdocs/86xx/doc8655/hr976.pdf).
17. For more information, see Jennifer Ryan, "The State Children's Health Insurance Program: Past, Present, and Future," National Health Policy Forum, Forum Session, July 21, 2006; available at [www.nhpf.org/pdfs\\_fs/FS\\_07-21-06\\_SCHIPUpdate.pdf](http://www.nhpf.org/pdfs_fs/FS_07-21-06_SCHIPUpdate.pdf).

## ENDNOTES (continued)

18. The best practices include: (i) adopting continuous eligibility, (ii) eliminating asset tests for children, (iii) eliminating the in-person interview requirement, (iv) using joint applications and comparable enrollment procedures in Medicaid and SCHIP, (v) permitting administrative renewals in SCHIP and Medicaid, (vi) offering presumptive eligibility, (vii) electing to implement Express Lane eligibility, and under CHIPRA II, (viii) utilizing premium assistance.

19. The number of low-income children is taken from Current Population Survey (CPS) data. These data are generally considered to be reliable on the national level; however, state-specific numbers are often questioned because of the small sample size in many states. In fact, some states have enrolled many more low-income children than CPS data indicated as uninsured for that year.

20. The measures are based on the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set. They were selected as a result of the Performance Measurement Partnership Project (PMPP), a collaborative effort between federal and state officials convened by CMS to develop a national set of performance measures that SCHIP and Medicaid programs could report on a voluntary basis. See Thomson/Medstat, Thirteen State Medicaid Core Performance Measure Reporting Summary: Highlighting Model Practices, prepared for CMS, September 30, 2006; available at [www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/13.pdf](http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/13.pdf).

21. For more information on premium assistance programs, see Jennifer Ryan and Cynthia Shirk, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum, Issue Brief 812, July 17, 2006, available at [www.nhpf.org/pdfs\\_ib/IB812\\_PremiumAssist\\_07-17-06.pdf](http://www.nhpf.org/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf); Joan Alker, "Choosing Premium Assistance: What Does State Experience Tell Us?" Kaiser Commission on Medicaid and the Uninsured, May 2008, available at <http://ccf.georgetown.edu/index/cms-file-system-action?file=ccf%20publications/program%20design/choosing%20premium%20assistance.pdf>.

22. In the original proposed SCHIP regulation, CMS included a requirement that employers contribute 60 percent toward the cost of coverage in order to qualify for premium assistance. However, this contribution level proved to be a barrier for states in recruiting employers to participate, so the requirement was abandoned in the final SCHIP regulation, in the belief that a substantial employer contribution would be necessary to meet the cost-effectiveness test. In the CHIPRA I bill, the employer-sponsored insurance was deemed to meet the cost-effectiveness test if all other requirements were met.