State Children's Health Insurance Program (SCHIP) Overview of Program Rules Testimony Before the Senate Finance Health Subcommittee

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Evelyne P. Baumrucker
Analyst in Social Legislation
Domestic Social Policy Division

Congressional Research Service *Washington, D.C. 20540-7000*
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Good morning Chairman Hatch, Senator Rockefeller, and Members of the Subcommittee on Health. My name is Evelyne P. Baumrucker and I am a health policy analyst at the Congressional Research Service. In an attempt to help set the stage for your policy discussions in anticipation of the FY2007 reauthorization of the State Children's Health Insurance Program (SCHIP), my testimony provides a brief legislative history of the period prior to the enactment of SCHIP. I will also provide an overview of the SCHIP program including (1) what SCHIP is; (2) who is eligible; (3) how the program is structured; (4) what benefits are covered; and (5) what the cost-sharing rules are. My colleague Chris Peterson, will follow with testimony regarding federal financing issues facing SCHIP.

Legislative History of SCHIP

I was asked by the Committee to provide a brief legislative history of the SCHIP program and to highlight some major themes that may have been influential in shaping the SCHIP program. The following is a summary of some of the major legislative activity (including Public Laws and key health care proposals) that may have impacted the design of SCHIP:

- ***Incremental expansion of Medicaid (1986-1991).*** Beginning in 1986, Congress mandated a number of incremental Medicaid expansions intended to broaden health care coverage of children. Both mandatory and optional coverage groups of children and pregnant women were added to the law. Eligibility was also extended to Medicare beneficiaries with annual incomes substantially higher than those of other Medicaid recipients, and Congress added requirements regarding benefits, reimbursement of providers, and new, more extensive standards for nursing home care.
- ***Comprehensive Health Care Reform (1993-1994).*** In reaction to increasing numbers of uninsured individuals and health care costs nationwide, the 104th Congress considered comprehensive reform proposals including President Clinton's Health Security Act (H.R. 1600, S. 1757). This bill would have guaranteed health insurance coverage to most Americans through a combination of mandated employer contributions and government subsidies. When it was apparent that majority support could not be achieved for this proposal, some in Congress backed alternative measures to expand access to health insurance solely for children.
- ***104th Congress' attempt to block grant Medicaid (1995-1996).*** Following the debate on comprehensive health reform, the 104th Congress considered proposals that would have dramatically restructured the Medicaid program by transforming it into a capped block grant program. This occurred in response to the increasing cost of the Medicaid program and concern among state Governors and the Congress that projected Medicaid program growth was unsustainable at both the federal and state levels.[1] Under this proposal, most current law federal eligibility and benefit requirements would have been eliminated and states would have been permitted to define the scope of their Medicaid programs through Medigrant plans submitted to the Centers for Medicare and Medicaid Services (CMS), (formerly the Health Care Financing Administration (HCFA)). While President Clinton vetoed the legislation, it set the stage for moving away from costly and unpredictable mandatory spending on individual entitlements to capped federal grant programs, culminating in the passage of the Personal Responsibility and Work Opportunity

[1] As of January 1998, the Congressional Budget Office (CBO) projected Medicaid's annual average rate of growth to be 6.7% for the period between FY1998 and FY2003.

Reconciliation Act of 1996 (P.L. 105-33 or PRWORA) which created the Temporary Assistance for Needy Families (TANF) federal block grant to states.

- ***State Children's Health Insurance Program (SCHIP) created as a part of the Balanced Budget Act of 1997 (BBA97, P.L. 105-33).*** It is in this historical context that SCHIP was enacted. SCHIP entitles *states* with approved state SCHIP plans to pre-determined capped federal allotments to offer health insurance to low-income uninsured children (explained further below). SCHIP was crafted to maximize state flexibility in program design and was intended to look like private health insurance coverage in terms of federal rules regarding covered benefits, cost-sharing, and so forth. It provided an incremental vehicle that allows states to expand health care coverage over that available under the existing Medicaid program.

What Is SCHIP?

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program under a new Title XXI of the Social Security Act.[2] In general, this program builds on Medicaid by providing federal matching funds that allow states to provide health insurance coverage to certain uninsured low-income children either under Medicaid, under a separate SCHIP program, or a combination of both approaches.

FY2004 annual enrollment estimates as reported by the states show that there were 6.2 million children ever enrolled in the SCHIP program.[3] Of those, about 1/4 or 1.8 million targeted low-income children were covered under Medicaid with the remaining 4.4 million covered under separate SCHIP programs. In addition, 646,000 adults were ever enrolled in SCHIP (in eight states). These adults include mostly parents of SCHIP and Medicaid-eligible children. State variation in program enrollment ranged from just over 5,000 children in North Dakota to over 1.3 million in the state of California. (See **Appendix 1** for FY2004 SCHIP annual enrollment data and program types in the 50 states and the District of Columbia).

Title XXI entitles *states* to pre-determined capped federal allotments. In terms of federal funding, SCHIP is small compared to Medicaid. The Congress appropriated approximately $40 billion dollars in federal funds over 10 years. Of that amount approximately $4.6 billion in new federal grants for SCHIP was available in FY2004. By contrast, federal spending under the Medicaid program for non-disabled adults and children (i.e., populations comparable to those served under SCHIP) was approximately $50 billion. This represents ten times the amount of federal dollars spent on SCHIP. Despite its relative size, SCHIP represents the largest federal health care investment in children since the creation of Medicaid in 1965 and has served as an important model for the benefit and cost-sharing changes to the Medicaid program recently enacted under the Deficit Reduction Act of 2005 (DRA, or P.L. 109-171).

Like Medicaid, SCHIP is a federal-state matching program, but to encourage participation in SCHIP, state dollars are matched with available federal funds at an enhanced

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[2] For more information on the State Children's Health Insurance Program, see CRS Report RL30473, *State Children's Health Insurance Program(SCHIP): A Brief Overview,* updated August 20, 2006, by Elicia J. Herz and Chris L. Peterson.

[3] Ever enrolled refers to unduplicated enrollment counts.

rate. While the Medicaid federal medical assistance percentage (FMAP) ranges from 50% to 76.00% in FY2006, the enhanced SCHIP FMAP ranged from 65% to 83.2% across states.[4] Details regarding SCHIP financing are discussed in companion testimony by my colleague, Chris Peterson.

Within this financing structure, SCHIP was designed to provide states with considerable flexibility so that the program could, at state option, look more like private health insurance coverage. The statute outlines key program features including eligibility, benefit, and cost-sharing requirements, as well as federal funding and allotments to states.

Since SCHIP was established, the number of uninsured children has declined nationwide, particularly among those who are near poor. According to the Centers for Disease Control (CDC) National Health Interview Survey, the percentage of uninsured children declined from 13.9% in 1997 to 8.9% in 2005, and the percentage of near poor uninsured children (i.e., those in families with annual incomes between 100% and 200% of the federal poverty level (FPL))[5] from 22.8% in 1997 to 14.7% in 2005. In 2004, more than 1/4 of all children (29.9%) in the United States were covered by public health insurance plans.[6,7]

Who Is Eligible for SCHIP?

Financial Eligibility Standards

States have considerable flexibility to determine who has access to SCHIP coverage. In general, SCHIP defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997.

Federal law allows states to set the upper income eligibility limits for targeted low-income children up to 200% FPL. Alternatively, if the applicable Medicaid income level for children was at or above 200% FPL prior to SCHIP, the upper income limit may be raised an additional 50 percentage points above that level. For example, a state with a Medicaid income threshold of 200% at the start of SCHIP would be permitted to raise the state's income eligibility for SCHIP up to 250% FPL. As of October 2004, 39 states covered at least some groups of children in families with annual income at or above 200% of the federal

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[4] *Federal Register*, Federal Financial Participation in State Assistance Expenditures, FY 2006, Volume 69, Number 226. Notices. Pages 68370-68373, November 24, 2004.

[5] In 2006, the poverty guideline in the 48 contiguous states and the District of Columbia is $20,000 for a family of four. ("Annual Update of the HHS Poverty Guidelines," 71 *Federal Register* 3848, Jan. 24, 2006.)

[6] Centers for Disease Control and Prevention, *Health Insurance Coverage: Estimates from the National Health Interview Survey, 2005: Early Release of Health Insurance Estimates Based on Data from the 2005 National Health Interview Survey,* by Robin A Cohen, Ph.D., and Michael Martinez, M.P.H.; Division of Health Interview Statistics, National Center for Health Statistics, Released June 2006.

[7] For the purposes of the 2005 National Health Interview Survey, "public coverage" includes Medicaid, the State Children's Health Insurance Program (SCHIP), state-sponsored or other government-sponsored health plan, Medicare (disability), and military plans.

poverty level (FPL). To date, the upper income eligibility threshold under SCHIP has reached 350% FPL in one state (i.e., New Jersey).[8] (See **Appendix 1** for FY2004 SCHIP upper income eligibility thresholds in the 50 states and the District of Columbia.)

Because eligibility for SCHIP is means-tested, states conduct income and assets tests on applicants to determine whether they meet a state's income eligibility thresholds. States have flexibility to decide what counts as income and assets and whether to disregard (not count) income or apply other types of resource or assets tests.[9] For example, in a given state with an SCHIP upper income eligibility threshold of 200% FPL, some families with income above 200% FPL may be eligible due to the amount of annual income that is disregarded when determining SCHIP eligibility.

States may (or may not) choose to take advantage of this flexibility allowed under SCHIP. For example, Minnesota was already generous under Medicaid before the start of SCHIP. The state offered Medicaid coverage to children under age 18 in families with annual incomes up to 275% FPL. Under SCHIP, the state enacted a modest expansion of Medicaid to uninsured children under two years of age in families with annual income between 275% and 280% FPL. Later the state was granted CMS approval under the Section 1115 waiver authority (named for the section of the Social Security Act that defines the circumstances under which such waivers may be granted) to extend SCHIP coverage to parents and relative care takers of Medicaid and SCHIP-eligible children in families with annual incomes between 100% and 200% FPL. FY2004 state reported annual enrollment estimates show that Minnesota extended SCHIP coverage to approximately 4,784 children and 39,571 adults. By contrast, Rhode Island used SCHIP funds for a broader expansion (as compared to Minnesota's expansion) to extend coverage to uninsured children age 8 through 18 in families with annual income between 100% and 250% FPL. In addition, the state was granted CMS approval under the Section 1115 waiver authority to extend SCHIP coverage to parents of Medicaid or SCHIP-eligible children with income between 100 and 185% FPL, and pregnant women with income between 185-250% FPL. FY2004 state-reported annual enrollment estimates show that Rhode Island enrolled approximately 25,573 children and 23,327 adults.

Non-Financial Eligibility Standards

Title XXI allows states to use the following *non-financial standards* in determining SCHIP eligibility: age (e.g., subgroups under 19); geography (e.g., sub-state areas, as in the

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[8] The SCHIP upper income eligibility standards are taken from **Table 1** in *Beneath the Surface:Barriers Threaten to Slow Progress on Expanding Health Coverage of Families and Children*, by Donna Ross and Laura Cox, The Kaiser Commission on Medicaid and the Uninsured, Oct. 2004.

[9] Income disregards are specified dollar amounts subtracted from gross income to compute net income, which is then compared to the applicable income criterion. Such disregards may *increase* the *effective* income level above the stated standard. States may apply resource or asset tests in determining financial eligibility but are not required to do so. Individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage. States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, tax credits, etc.

case of California which has CMS approval for county-based SCHIP programs); residency; disability status (so long as any standard relating to that status does not restrict eligibility); access to, or coverage under, other health insurance (to establish whether such access/coverage precludes SCHIP eligibility); duration of SCHIP enrollment; and citizenship status. Specifically, certain qualified aliens who entered the United States on or after August 22, 1996 are eligible for SCHIP after five years.[10]

States *may not* use federal SCHIP funds to cover children eligible for regular Medicaid, children covered by a group health plan or other assistance, inmates of public institutions (e.g., inmates in detention facilities, or prisons), patients in an institution for mental disease, or children of state public employees. In addition, illegal immigrants are barred from SCHIP eligibility.

How Is SCHIP Structured?

Under SCHIP, states may cover targeted low-income children under their Medicaid programs (often referred to as SCHIP Medicaid expansion programs) and/or they can create separate SCHIP programs. In both cases the federal share of program costs comes out of the federal SCHIP appropriation. For states that provide Medicaid coverage to targeted low-income children, Medicaid rules typically apply. By contrast, when states provide coverage to children through separate SCHIP programs, Title XXI rules typically apply.

SCHIP Medicaid Expansion Programs

SCHIP Medicaid expansion programs provide Medicaid coverage to new groups of children either by establishing a new optional eligibility group and/or by liberalizing the financial rules for any of several existing Medicaid eligibility categories.[11] Medicaid coverage for these "targeted low-income children" is considered an *individual entitlement*, but unlike regular Medicaid coverage, it is paid for out of the SCHIP appropriation and matched at the SCHIP enhanced matching rate. States with Medicaid expansion programs that have exhausted their available federal SCHIP allotments may also finance coverage for such children by accessing federal Medicaid funds at the regular Medicaid FMAP rate. In addition, such states *cannot* cap enrollment in their Medicaid expansion programs, but are permitted to submit a state plan amendment (SPA) to CMS for approval to reduce or otherwise remove the Medicaid eligibility expansion.

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[10] Eligible qualified aliens include (1) those in the United States before August 22, 1996; (2) refugees, asylees, and certain Cuban, Haitian and Amerasian immigrants; (3) unmarried dependents of veterans and active duty military; and (4) those entering the United States after August 22, 1996 as lawful permanent residents with continuous residence for five years.

[11] Under Medicaid law, Section 1902(r)(2) authority may be used to liberalize income and resource methodologies for a number of groups, including, for example, poverty-related children (i.e., those under six in families with income up to 133% FPL and those between 6 and 18 in families with income up to 100% FPL). Family coverage is provided under Section 1931, which has its own provisions for liberalizing income and resource standards.

Separate SCHIP Programs

By contrast, Title XXI does not establish an *individual entitlement* to benefits for children covered under separate, non-Medicaid SCHIP programs. Instead, Title XXI entitles *states* with approved plans to pre-determined federal allotments. Unlike states with Medicaid expansion programs, states operating separate SCHIP programs that exhaust their available federal SCHIP allotments are permitted to submit a state plan amendment for CMS approval to institute program waiting lists and/or to cap their SCHIP program enrollment.

What Benefits Are Covered Under SCHIP?

SCHIP Medicaid Expansion Benefit Package

States that offer Medicaid coverage to targeted low-income children must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their state Medicaid plans. In addition, effective March 31, 2006, as an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act (DRA) gives states the option to enroll state-specified groups (i.e., that were established under Medicaid on or before February 8, 2006) in new benchmark and benchmark-equivalent benefit plans. These plans are nearly identical to the benefit packages offered through separate SCHIP programs (described below). However, states may choose to provide other wrap-around and additional benefits. For any child under age 19 in one of the major mandatory and optional Medicaid eligibility groups (including targeted low-income children under SCHIP), wrap-around benefits *must* include EPSDT.[12,13]

On May 3, 2006 Kentucky became the first state to be granted CMS approval to make changes to its Medicaid program under the DRA benefits and cost-sharing options. The Medicaid state plan changes approved by CMS will also impact a portion of Kentucky's SCHIP population because the state operates its SCHIP program as a combination program, and its approved Medicaid state plan amendment (SPA) identifies Medicaid expansion SCHIP enrollees among the groups that will be impacted by the changes. It is difficult to predict how many states with existing Medicaid expansion and/or combination programs will take up the DRA benefit and cost-sharing options over time, and whether those states will target Medicaid expansion SCHIP enrollees as a part of their DRA Medicaid SPAs.

Separate SCHIP Benefit Package

When BBA97 was enacted, three existing state-funded programs were "grandfathered" into SCHIP — in Florida, New York, and Pennsylvania. The remaining states choose from among three benefit options in creating their separate SCHIP plans including:

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[12] Wrap-around refers to situations in which the state provides a specific service (e.g., mental health services) to beneficiaries enrolled in a plan that does not cover that service.

[13] Under Medicaid, children under age 21 are entitled to *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services*. Under EPSDT, children receive well-child visits, immunizations, laboratory tests, and other screening services at regular intervals. In addition, medical care that is necessary to correct or ameliorate identified defects, physical and mental illness, and other conditions must be provided, including optional services that states do not otherwise cover in their Medicaid programs.

- Standard benchmark benefit package;
- Benchmark equivalent coverage; and
- Other Secretary-approved coverage.

Standard Benchmark Benefit Package. A standard benchmark benefit package is a set of benefits structured to be identical to one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the state involved, and (3) the health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved.

Benchmark-equivalent Coverage. Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state choosing to provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services, and well-baby and well-child care, including age-appropriate immunizations.

Benchmark-equivalent coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, mental health services, vision services, and hearing services. For example, if the benchmark coverage package offers prescription drugs coverage with an actuarial value of $100.00 per year, then the benchmark-equivalent coverage must include at least $75.00 in prescription drug coverage per year. By contrast, if the benchmark coverage package *does not* cover one or more of the four "additional benefits" listed above, then the benchmark-equivalent coverage package is *not required* to include coverage for that category of service. States are also encouraged to cover other categories of service not listed above. Finally, SCHIP funds may not be used to cover abortions, except in the case of a pregnancy resulting from rape or incest, or when an abortion is necessary to save the mother's life.

Other Secretary-Approved Coverage. Other Secretary-approved coverage is defined as any other health benefits plan that the Secretary of Health and Human Services (HHS) determines will provide appropriate coverage to the targeted population of uninsured children. To date, these programs offer comprehensive benefit packages similar to Medicaid, or to one of the benchmark packages with additional services. Based on regulations defining characteristics of Secretary approved coverage, a state may offer, for example, a Medicaid look-alike program where the benefit package is identical to that offered under their Medicaid state plan with the exception of EPSDT.[14]

State Experience with Separate SCHIP Benefit Coverage. Among the types of separate SCHIP programs, data from June 2003 indicate that most of the benchmark and benchmark-equivalent plans are based on the state employees' health plan, and most

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[14] See CRS Report RL32389, *A State-by-State Compilation of Key State Children's Health Insurance Program (SCHIP) Characteristics,* by Elicia J. Herz, Evelyne P. Baumrucker, and Peter Kraut.

Secretary-approved plans are modeled after Medicaid. There were 44 separate SCHIP programs across 36 states. Among the 23 benchmark and benchmark-equivalent plans, 14 offered coverage comparable to that provided for state employees, four offered FEHBP-like coverage, four offered coverage modeled after the largest commercial HMO in the state, and one offered plans reflecting the features of all three benefit coverage options. The remaining 21 plans provided an array of Secretary-approved coverage, usually offering comprehensive benefit packages similar to the state's standard Medicaid program, or similar to one of the benchmark packages with additional services.[15]

What Are SCHIP's Cost-sharing Rules?

Under SCHIP, states are allowed to require certain beneficiaries to share in the cost of some SCHIP services. Cost-sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan and includes (1) program participation fees, such as monthly premiums and enrollment fees; and (2) service-related cost-sharing, such as copayments and co-insurance. Federal law permits states to impose cost-sharing for some beneficiaries and some services under SCHIP.

Generally, states may impose higher cost-sharing amounts under separate SCHIP programs compared to Medicaid expansion programs. Under SCHIP, states must ensure cost-sharing for higher-income children is not less than cost-sharing for lower income children.

Cost-sharing Rules for SCHIP Medicaid Expansions

States that cover SCHIP children under Medicaid must follow Medicaid rules that prohibit cost-sharing for most children *under* the age of 18 (or at state option under age 21). However, targeted low-income children who are 18 years of age may be subject to service-related cost-sharing at state option. States that want to impose cost-sharing under their Medicaid expansions may seek CMS approval for a Section 1115 waiver program.[16] In addition, effective March 31, 2006, DRA provides an alternative option for states that wish to require premiums and service-related cost-sharing for certain eligibility groups that were established under Medicaid on or before February 8, 2006.

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[15] Six categories of Secretary-approved coverage are defined in SCHIP regulation (at 66 *Federal Register*, 33810, June 25, 2001). These include coverage that (a) is the same as the coverage provided to children under the state Medicaid plan; (b) is the same as the coverage provided to children under a comprehensive Medicaid Section 1115 waiver; (c) either includes the full Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit or that the state has extended to the entire Medicaid population in the state; (d) includes benchmark health benefits coverage plus any additional coverage; (e) is the same as the coverage provided under existing comprehensive state-based programs in Florida, Pennsylvania, or New York; or (f) is substantially equivalent to or greater than coverage under a benchmark health benefits plan, determined via a benefit-by-benefit comparison demonstrating that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan. Secretary-approved benefit plans are not limited to these six categories as long as the coverage provided is determined to be appropriate for the target population.

[16] New Mexico is an example of a state that has CMS approval to modify its cost-sharing rules for targeted low-income children under its Medicaid program.

DRA State Option for Alternative Premiums and Service-Related Cost-sharing. DRA allows states to impose premiums and cost-sharing for any group of individuals for any type of service, through Medicaid state plan amendments (rather than through Section 1115 waivers), subject to certain restrictions. In general, premiums and cost-sharing imposed under this option are allowed to vary among classes or groups of individuals, or types of service, and rules will vary by income (i.e., children in families with annual income between 100% and 150% FPL, and children in families with annual income above 150% FPL). Special rules apply to cost-sharing for prescription drugs and non-emergency care provided in emergency rooms.

For children in families with annual income between 100% FPL and 150% FPL no premiums may be imposed. Cost-sharing for any item or service *cannot* exceed 10% of the cost of the item or service, and total annual aggregate cost-sharing (including any cost-sharing for prescribed drugs and emergency room copayments for non-emergency care) *cannot* exceed 5% of family income applied on a quarterly or monthly basis as specified by the state.

For individuals in families with income above 150% FPL, the total aggregate amount of all cost-sharing (including premiums, cost-sharing for prescribed drugs, and emergency room copayments for non-emergency care) *cannot* exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state, and cost-sharing for any item of service *cannot* exceed 20% of the cost of the item or service.

Under DRA, certain groups of people cannot be charged cost-sharing under the new rules and certain other groups are exempted from cost-sharing but only for certain services. For example, children under age 18 regardless of family income are exempted from service-related cost-sharing for preventive services. States would, however, have the option under DRA to exclude SCHIP children from any/all cost-sharing.

Cost-sharing Rules for Separate SCHIP Plans

If a state implements SCHIP through a separate state program, premiums or enrollment fees for program participation may be imposed, but the maximum allowable amount is dependent on family income. As with Medicaid, states that want to impose cost-sharing beyond what is allowable in SCHIP law may request CMS approval under the Section 1115 waiver authority. To date, no state has used the waiver authority to modify cost sharing under a separate SCHIP plan.

For children in families with incomes under 150% FPL and enrolled in separate state programs, premiums may not exceed the amounts set forth in federal Medicaid regulations (i.e., prior to the enactment of DRA). Additionally, these children may be charged service-related cost-sharing, but such cost-sharing is limited to (1) nominal amounts defined in federal Medicaid regulations for those in families with income below 100% FPL, and (2) slightly higher amounts defined in SCHIP regulations for children in families with income between 101% and 150% FPL.

For children in families with income above 150% FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower income children. Finally, total annual aggregate cost-sharing (including premiums, deductibles, copayments, and any other charges) for all children in any SCHIP family may not exceed 5% of total family income for the year. In addition, states must inform

families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.

Exemptions from Cost-sharing. Native American and Alaskan Native children are exempt from cost-sharing. In addition, states may not impose cost-sharing requirements for preventive services for all children regardless of income. The Centers for Medicare and Medicaid Services (CMS) defines preventive services to include the following: all healthy newborn inpatient physician visits, including routine screening (inpatient and outpatient); routine physical examinations; laboratory tests; immunizations and related office visits; and routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays).

SCHIP Is Evolving Rapidly

SCHIP programs across states are evolving rapidly, as evidenced by the numerous changes states have made to their original state plans over time. States seek amendments to adjust their programs to meet changing needs. As of June 2006, CMS had approved 263 state plan amendments and 13 more were in review.[17] Most states submitted multiple amendments to, for example, make changes to their income eligibility thresholds, define new copayment standards, modify benefit packages, limit enrollment, and/or streamline their application process.

In addition to the amendment process, states that want to make changes to their SCHIP programs that go beyond the law may do so through a Section 1115 waiver. On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. This initiative is designed to encourage states to use Section 1115 waiver authority to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches to maximize private health insurance coverage options and target populations with income below 200% FPL. Waivers approved under the HIFA initiative may be financed, at least in part, with unspent SCHIP funds.

As of March 2006, 15 states had approved SCHIP and/or HIFA Section 1115 waivers that were financed at least in part by SCHIP appropriations.[18] In 12 of these states, SCHIP coverage is extended to include one or more categories of adults with children, typically parents of Medicaid/SCHIP children, caretaker relatives, legal guardians, and/or pregnant women. Four states, (Arizona, Michigan, New Mexico, and Oregon) also cover childless adults under their waivers. These coverage expansions have implications for SCHIP financing. DRA banned the use of SCHIP funds for covering childless adults for new waivers approved on or after October 1, 2005.

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[17] See [http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf]

[18] See [http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/Section1115ReportApprovedUnderReview.pdf].

SCHIP Reauthorization

The SCHIP program is considered by many to be a success. Despite its small size compared to Medicaid, SCHIP represents the largest federal health care investment in children since the creation of Medicaid in 1965 and has contributed to the reduction of uninsured children nationwide. In addition, it has served as an important model for the benefit and cost-sharing changes to the Medicaid program recently enacted under the Deficit Reduction Act (DRA, or P.L. 109-171).

The SCHIP program was designed to allow states maximum flexibility to design their programs within the constraints of a capped federal grant program. Within this context, the Congress may need to consider how to balance state flexibility with equity among states. For example, some states had Medicaid programs with very generous child health coverage before the enactment of SCHIP, while others were able to use their SCHIP federal allotments to established such coverage after SCHIP's enactment.

As the Congress turns its focus to SCHIP in anticipation of the program's reauthorization in FY2007, discussions surrounding the SCHIP funding formula and redistribution issues will likely dominate. Limited federal funding may require priority setting by federal and state governments.

Based on public forum discussions among SCHIP directors and other SCHIP stake holders, there is interest in examining and possibly redefining the SCHIP core populations to prioritize among eligible groups. Congress may be asked to consider extending program coverage to new groups such as children of state employees, legal immigrant children, pregnant women, parents and/or other adults. Any such expansions would be limited by available funds. Similarly, other options such as changes to benefit packages allowing states to use SCHIP funds to provide wrap-around coverage for under-insured groups would be limited by fiscal constraints. I look forward to continuing to support the Committee as you work through these and other SCHIP issues.

Appendix 1. SCHIP Enrollment Data for the 50 States and the District of Columbia for 2004

State	Date enrollment began	SCHIP upper income eligibility standard (% FPL)	FY2004 enrollment (number of children ever enrolled during year)			Adults ever enrolled in SCHIP demonstrations during FY2004
			Medicaid expansion	Separate child health program	Total	
Alabama (S)	2/1/98	200%		79,407	79,407	
Alaska (M)	3/1/99	175%	21,966		21,966	
Arizona (S)	11/1/98	200%		87,681	87,681	113,490
Arkansas [a] (M)	10/1/98	200%		799	799	
California (C)	3/1/98	250%	152,041	883,711	1,035,752	
Colorado[b] (S)	4/22/98	185%		57,244	57,244	NR
Connecticut (S)	7/1/98	300%		21,438	21,438	
Delaware (C)	2/1/99	200%	181	10,069	10,250	
District of Columbia (M)	10/1/98	200%	6,093		6,093	
Florida (C)	4/1/98	200%	2,031	417,676	419,707	
Georgia (S)	11/1/98	235%		280,083	280,083	
Hawaii (M)	7/1/00	200%	19,237		19,237	
Idaho (M)	10/1/97	185%	17,879	1,175	19,054	
Illinois (C)	1/5/98	200%	95,522	138,505	234,027	120,152
Indiana (C)	10/1/97	200%	55,187	25,511	80,698	
Iowa (C)	7/1/98	200%	14,996	26,640	41,636	
Kansas (S)	1/1/99	200%		44,350	44,350	
Kentucky (C)	7/1/98	200%	60,496	34,004	94,500	
Louisiana (M)	11/1/98	200%	105,580		105,580	
Maine (C)	7/1/98	200%	20,204	8,967	29,171	
Maryland (C)	7/1/98	300%	101,664	9,824	111,488	
Massachusetts (C)	10/1/97	200%	119,377	47,131	166,508	
Michigan (C)	5/1/98	200%	31,427	56,136	87,563	132,590
Minnesota (C)	10/1/98	280%	110	4674	4784	39,571
Mississippi (S)	7/1/98	200%		82,900	82,900	
Missouri (M)	9/1/98	300%	176,014		176,014	
Montana (S)	1/1/99	150%		15,281	15,281	
Nebraska (M)	5/1/98	185%	33,314		33,314	
Nevada (S)	10/1/98	200%		38,519	38,519	
New Hampshire (C)	5/1/98	300%	598	10,371	10,969	
New Jersey (C)	3/1/98	350%	39,870	87,374	127,244	88,826
New Mexico (M)	3/31/99	235%	20,804		20,804	
New York (C)	4/15/98	250%	136476	690,135	826,611	
North Carolina (S)	10/1/98	200%		174,434	174,434	
North Dakota (C)	10/1/98	140%	1,845	3,292	5,137	
Ohio (M)	1/1/98	200%	220,190		220,190	
Oklahoma (M)	12/1/97	185%	100,761		100,761	
Oregon (S)	7/1/98	185%		46,720	46,720	4,294

State	Date enrollment began	SCHIP upper income eligibility standard (% FPL)	FY2004 enrollment (number of children ever enrolled during year)			Adults ever enrolled in SCHIP demonstrations during FY2004
			Medicaid expansion	Separate child health program	Total	
Pennsylvania (S)	5/28/98	200%		177,415	177,415	
Rhode Island (C)	10/1/97	250%	24,089	1,484	25,573	23,327
South Carolina (M)	10/1/97	185%	75,597		75,597	
South Dakota (C)	7/1/98	200%	10,338	3,059	13,397	
Tennessee [c] (M)	10/1/97					
Texas (S)	7/1/98	200%		650,856	650,856	
Utah (S)	8/3/98	200%		38,693	38,693	
Vermont (S)	10/1/98	300%		6,693	6,693	
Virginia (C)	10/22/98	200%	41,651	57,918	99,569	
Washington (S)	2/1/00	250%		17,002	17,002	
West Virginia (S)	7/1/98	200%		36,906	36,906	
Wisconsin (M)	4/1/99	185%	67,893		67,893	123,999
Wyoming (S)	12/1/99	185%		5,525	5,525	
Total	—	—	1,773,431	4,379,602	6,153,033	646,159

Source: Data on date enrollment began is from the Centers for Medicare and Medicaid Services, *The State Children's Health Insurance Program, Annual Enrollment Report Federal Fiscal Year 2001: October 1, 2000-September 30, 2001,* Feb. 6, 2002. The SCHIP upper income eligibility standards are taken from **Table 1** in *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Families and Children*, by Donna Ross and Laura Cox, The Kaiser Commission on Medicaid and the Uninsured, Oct. 2004. The state-reported SCHIP enrollment figures are taken from Centers for Medicare and Medicaid Services, *Revised FY2004 Number of Children Ever Enrolled in SCHIP by Program Type,* May 23, 2005. For states with combination programs, the "total" column shows the sum of the unduplicated number of children ever enrolled in the SCHIP Medicaid expansion program during the year and the unduplicated number of children ever enrolled in the separate SCHIP program during the year. Because a child may be enrolled in both programs during the year, there may be some double counting of children enrolled in these states. SCHIP enrollment figures for the territories are not available.

Notes: S — Separate child health programs; M — Medicaid expansion programs; C — Combination programs. NR — Indicates that state has not reported data via the SCHIP Statistical Enrollment Data System (SEDS). FPL = poverty level.

a. Arkansas did not report enrollment data for its SCHIP Medicaid expansion in the SEDS database for FY2004. Under its comprehensive Medicaid Section 1115 waiver, this state uses a combination of Medicaid and SCHIP funds to cover uninsured children through age 18 in families with income up to 200% FPL. Waiver documents indicate that 77,246 children were enrolled in this demonstration as of January 2004.

b. Colorado reported in a letter that due to a new system they were only able to provide accurate data for 10.5 months for FY2004.

c. Tennessee used SCHIP funds to expand its existing comprehensive Medicaid Section 1115 waiver program. Under the state's SCHIP Medicaid expansion, Tennessee began enrolling children in October 1997 through FY2002. In that year, enrollment reached 10,216. Eligibility for this Medicaid expansion program was limited to older children in families with income up to 100% FPL. As of October 1, 2002, all such children had to be covered under regular Medicaid, that is, they were no longer eligible for SCHIP coverage. Thus, Tennessee has no SCHIP enrollment subsequent to FY2002.