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CONGRESSIONAL TESTIMONY

Keeping SCHIP Focused on Federal Objectives

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My name is Nina Owcharenko. I am Senior Health Care Policy Analyst at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

For the first time in ten years, the State Children's Health Insurance Program (SCHIP) is due for congressional reauthorization. Reauthorization provides an opportunity for policymakers to review and assess the program's goals and objectives and make whatever adjustments and reforms may be necessary to improve it.

The Unique Characteristics of SCHIP

It is important to recognize the unique characteristics of the SCHIP program. Although often discussed in conjunction with Medicaid, SCHIP is a distinctly different program with a different scope, focus, and approach. First, it is not an entitlement program, as Medicaid is, but a capped spending program. Second, unlike Medicaid, which provides health care services to a very broad and diverse population with multiple eligibility standards, SCHIP has a simpler, more targeted purpose: to address the needs of uninsured *children* whose families earn too much to qualify for Medicaid but not enough to purchase private health care coverage on their own. Finally, the benefit structure and options under SCHIP are more flexible than Medicaid and more closely reflect the structure of private coverage.

Unlike federally administered programs, the very nature of a joint federal-state program results in state variations. There are funding variations, eligibility variations, and even structural and administrative variations. While variations support the principles of federalism, they also can make it difficult to evaluate SCHIP's performance. Thus, it is equally as important that federal policymakers establish clear federal policy objectives to measure the effectiveness of the program and ensure that it remains focused on its purpose.

Setting Federal Policy Objectives

There are three key policy areas that federal lawmakers should evaluate with a view to strengthening federal guidelines and objectives.

> ***Funding*.** As mentioned, SCHIP is a capped spending program. Each state receives an annual fixed federal contribution that is based on a variety of factors, such as the number of uninsured children in the state. States have three years to spend their allocation. At the end of three years, any unused federal allotments are subject to a reallocation process. The process divides states into two categories: states that have exhausted their original allocations (referred to as "redistribution" states) or states that have not done so (referred to as "retention" states), and unused funds are distributed to the states based on these categories.[1]

[1]Elicia J. Herz, Bernadette Fernandez, and Chris L. Peterson, "State Children's Health Insurance Program (SCHIP): A Brief Overview," Congressional Research Service *Report for Congress*, August 4, 2005, p. 5.

Original state allotments give states a predictable but fixed federal funding source that forces states to decide the best and most efficient way to use those funds to reach the targeted populations in a fiscally prudent manner. However, the SCHIP reallocation process focuses solely on state spending and actually rewards states for overspending by giving them additional funds through the reallocation process. In FY 2001, 12 states were considered "redistribution states"; by FY 2005, the number had increased to 28 states.[2] This raises the question of whether the reallocation process discourages states from being fiscally prudent, as states realize that unused federal funds will be taken from their states and redistributed, even to those states that outspend their allotments.

Recommendation: Federal policymakers should restructure the reallocation process to ensure that it is focused on meeting certain federal goals and objectives. Specifically, priority should be given to states facing funding shortfalls but have not yet reached federally established benchmarks. The reallocation process should not be based on whether a state has outspent its federal allotment.

***Eligibility*.** As previously mentioned, SCHIP is intended to target children whose family incomes are too high for traditional Medicaid but not high enough to afford private coverage on their own. The legislative language itself defines "targeted low-income children" as children whose family income is at or below 200 percent of the poverty line.[3] For states with Medicaid eligibility at or above 200 percent FPL prior to enactment of SCHIP, the law enables them to target children 50 percent above the Medicaid level.[4]

These basic thresholds are important in evaluating whether the program remains focused on its specific federal target. Prior to enactment of SCHIP, there were only four states with Medicaid eligibility at or above 200 percent FPL.[5] Today, there are 15 states with SCHIP eligibility above 200 percent FPL, and nine of these 15 states have eligibility at or above 300 percent FPL.[6] Twenty-six states maintain SCHIP eligibility at the 200 percent FPL threshold, and eligibility in nine states is below 200 percent FPL.[7]

Seven of the 18 states projected to face a funding shortfall in FY 2007 have set SCHIP eligibility above 200 percent FPL.[8] Furthermore, the four states that face funding shortfalls in FY 2006 are states that also cover adults.[9] Both of these

[2] *Ibid.*, p. 20.
[3] 42 U.S. Code 1397jj.
[4] *Ibid.*
[5] Data provided by U.S Department of Health and Human Services, Centers for Medicare and Medicaid, Centers for Medicaid and State Operations, October 5, 2006.
[6] *Ibid.*
[7] *Ibid*.
[8] Chris L. Peterson, "SCHIP Financing: Funding Projections and State Redistribution Issues," Congressional Research Service *Report for Congress*, May 8, 2006, p. 11, and data provided by U.S Department of Health and Human Services.
[9] Peterson, "SCHIP Financing: Funding Projections and State Redistribution Issues," p. 8.

examples raise the question of whether these states are expanding beyond the scope of the program and beyond their means. Finally, eligibility levels are not an accurate measure of success. A state with eligibility at 300 percent FPL may only have 40 percent enrollment, while a state with eligibility at 185 percent FPL may have 80 percent enrollment.

Recommendation: Federal policymakers should enforce the existing federal poverty and population eligibility standard. Moreover, lawmakers should establish enrollment targets to measure the effectiveness of the program.

Benefit Structure. States have the ability to select the type of benefit structure for their respective SCHIP programs. States have three options: expand traditional Medicaid, create a separate SCHIP plan, or a combination of the two.[10] Twelve states have set up a Medicaid expansion, 18 states have set up a separate SCHIP plan, and 21 states have chosen a combination approach.[11]

The SCHIP benefit package, specifically for the separate SCHIP option, references and is fashioned after private coverage. However, administrative changes by some states have softened this private coverage model.[12] Administrative changes, such as limiting or eliminating premiums and co-pays, diminish the correlation between SCHIP and private coverage and, at the same time, reduce the distinction between SCHIP and traditional Medicaid. Furthermore, although states are expected to minimize the "crowding out" effect, some states have adopted administrative changes that nullify such provisions: for example, removing the "uninsured" waiting periods before children can enroll in SCHIP.[13]

On the other hand, administratively burdensome rules and regulations discourage states from taking full advantage of premium support models where states use SCHIP funds to enroll children in existing private coverage options, typically by signing the child up for dependent coverage through a parent's place of work.[14]

Recommendation: Federal policymakers should augment the private coverage model in SCHIP, including a more flexible premium assistance option. SCHIP should be a program that helps mainstream children in working families into private health care coverage, not a program that supplants it.

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[10]States choosing to set up a separate SCHIP plan can select a benchmark benefit package option, a benchmark equivalent option, a Secretary-approved coverage option, or designate an existing comprehensive state-based coverage option (specifically selected states only).
[11]Data provided by U.S. Department of Health and Human Services.
[12]Donna Cohen Ross and Laura Cox, "In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families," Henry J. Kaiser Family Foundation October 2005, pp. 57 and 61, at *www.kff.org/medicaid/upload/In-a-Time-of-Growing-Need-State-Choices-Influence-Health-Coverage-Access-for-Children-and-Families-Report.pdf* (November 14, 2006).
[13]*Ibid.*, p. 33.
[14]Cynthia Shirk and Jennifer Ryan, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards," National Health Policy Forum *Issue Brief* No. 812, July 17, 2006, at *www.nhpf.org/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf* (November 14, 2006).

Conclusion

Undoubtedly, funding will dominate the upcoming SCHIP reauthorization debate. However, federal lawmakers have the responsibility to look beyond funding and evaluate the effectiveness of the funding and the policies impacting its implementation. In its reauthorization, federal policymakers should consider setting clear federal goals and measures for the program. These additions would be useful and would ensure that the program is meeting federal objectives effectively.

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