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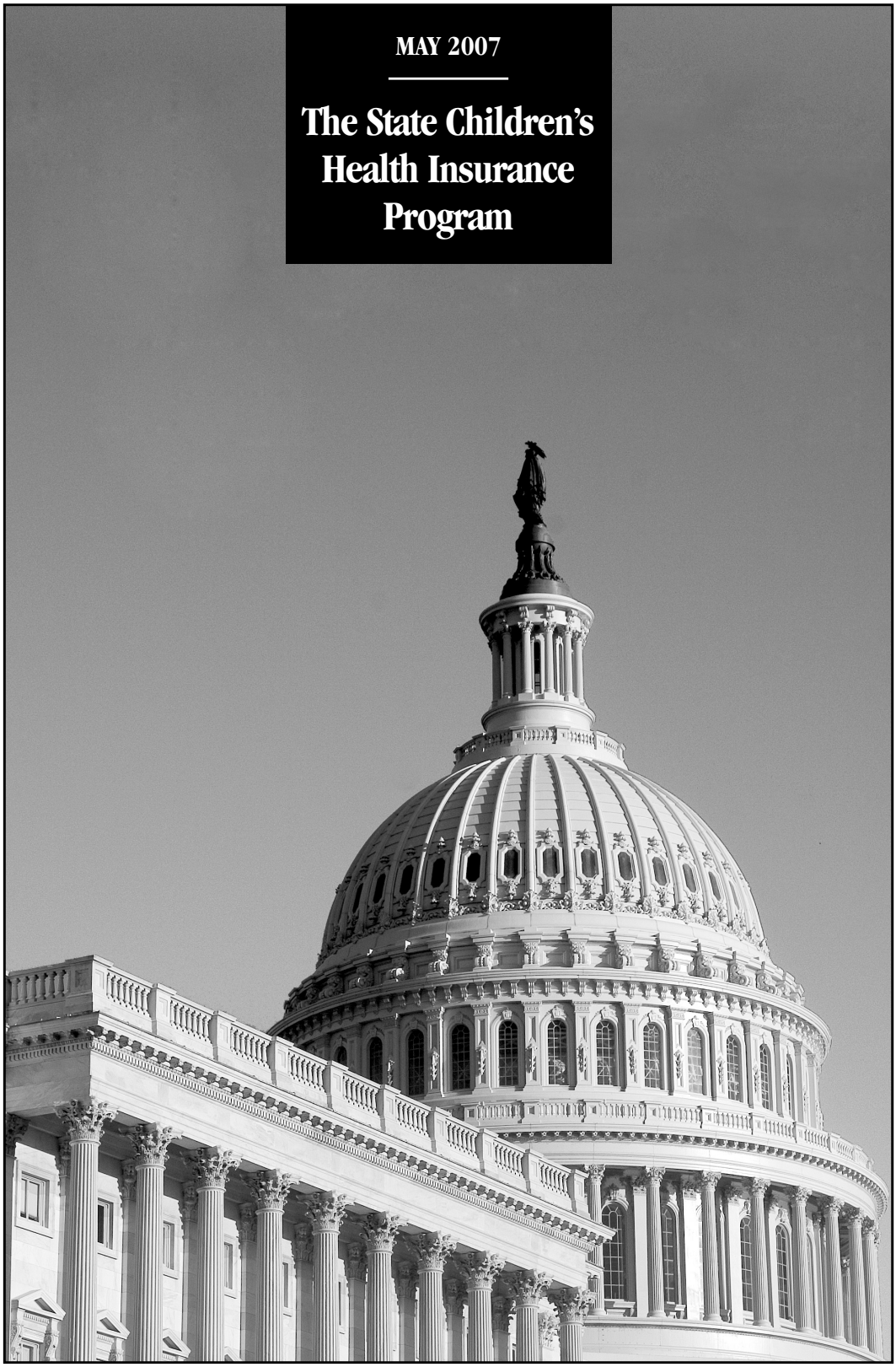
PAPER

MAY 2007

The State Children's Health Insurance Program



Pub. No. 2970

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May 2007

The Congress of the United States ■ Congressional Budget Office

Notes

Unless otherwise indicated, the years referred to in this report are fiscal years.

References to “states” include all 50 states and the District of Columbia.

Preface

Enacted as title XXI of the Social Security Act in 1997, the State Children's Health Insurance Program (SCHIP) provides health insurance coverage for uninsured children living in families with income that is modest but too high for them to be eligible for Medicaid. This Congressional Budget Office (CBO) paper—prepared at the request of the Chairman and Ranking Member of the Senate Finance Committee—summarizes the key features of SCHIP, provides information on historical trends in enrollment and federal spending, summarizes the evidence on the effects of the program on children's insurance coverage, and discusses key issues that are likely to arise as the Congress considers reauthorization of the program this year. In keeping with CBO's mandate to provide objective, impartial analysis, this paper makes no recommendations.

Noelia Duchovny and Lyle Nelson of CBO's Health and Human Resources Division prepared the report under the supervision of James Baumgardner and Bruce Vavrichek. Carol Frost provided assistance with the data analysis. Tom Bradley, Jeanne De Sa, Tim Gronniger, Arlene Holen, Donald Marron, Eric Rollins, and Sven Sinclair, all of CBO, provided comments on drafts, as did Jeanne Lambrew of the George Washington University, Anthony T. Lo Sasso of the University of Illinois at Chicago, and Kosali I. Simon of Cornell University. (The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.)

John Skeen edited the paper, and Christine Bogusz proofread it. Maureen Costantino designed the cover and prepared the report for publication. Lenny Skutnik produced the printed copies, Linda Schimmel coordinated the print distribution, and Simone Thomas prepared the electronic versions for CBO's Web site (www.cbo.gov).

Peter R. Orszag
Director

May 2007

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Summary

The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 to expand health insurance coverage to uninsured children in families with income that is modest but too high to qualify for Medicaid. SCHIP is financed jointly by the federal government and the states, and it is administered by the states within broad federal guidelines. Since the program's inception, the Congress has provided nearly $40 billion for it. Approximately 6.6 million children were enrolled in SCHIP at some time during 2006, as were about 670,000 adults through waivers of statutory provisions. Under current law, SCHIP is not authorized to continue beyond 2007, and the Congress is considering reauthorization of the program this year.

Overview of SCHIP

States have considerable flexibility in designing their eligibility requirements and policies for SCHIP.[1] In 2006, 26 states set their eligibility thresholds at 200 percent of the federal poverty level, 15 states had thresholds above 200 percent of the poverty level, and 9 had thresholds below.[2] (The federal poverty level for a family of three in 2007 is $17,170.) The lowest eligibility threshold in a state was 140 percent of the poverty level and the highest was 350 percent. Most states subtract a portion of the family's earnings and certain expenses to compute a measure of net income that is used to determine a child's eligibility for SCHIP.

States can provide SCHIP coverage by expanding Medicaid to children not eligible for that program, creating a separate program under SCHIP, or using a combination of the two approaches.[3] In 2006, 11 states expanded Medicaid, 18 states operated a separate program under SCHIP, and 21 states used a combination approach.[4] States that provide SCHIP coverage by expanding Medicaid must provide the same benefits that are available under their Medicaid program and follow all other requirements of that program. States that create a separate program under SCHIP are subject to certain minimum standards, including providing a benefit package that is based on one of several specified "benchmark" insurance plans or an alternative that is actuarially equivalent or otherwise approved by the federal government.

Each year, the federal funding for SCHIP is allocated among states on the basis of a formula that takes into account the number of children in low-income families in each state, the number of such children who are uninsured, and wages in the health services sector in the state relative to the national average. States must provide matching funds for expenditures from their federal allotments and have up to three years to spend those allotments. Funds that are not spent within three years are redistributed to states that have exhausted their allotments and are made available to those states for an additional year.

1. This paper focuses primarily on the 50 states and the District of Columbia (which, for the purpose here is counted as a "state"). The five U.S. territories—Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands—also have programs under SCHIP. Tennessee did not have any enrollment in SCHIP between 2002 and 2006.

2. Elicia J. Herz and Chris L. Peterson, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, CRS Report for Congress RL30473 (Congressional Research Service, October 12, 2006; updated January 30, 2007).

3. In some states that use a combination approach, children at the lower end of the income range of eligibility are enrolled under the expansion of Medicaid, while children at the upper end of the range are enrolled in the separate program under SCHIP. Using a different approach, other states cover children below a certain age under the Medicaid expansion and older children under the separate program.

4. Herz and Peterson, *State Children's Health Insurance Program*.

To encourage states to participate in SCHIP, the federal government pays a higher share of their spending on SCHIP than it pays for Medicaid. The federal government's matching rate for SCHIP varies among states from 65 percent to 83 percent, while the federal matching rate for Medicaid varies from 50 percent to 76 percent. Although federal spending is made available on a matching basis for both programs, the nature of the programs differs significantly because SCHIP is a grant program in which federal spending is capped in advance whereas Medicaid is an entitlement program with no predetermined limit on spending.

Because the implementation of SCHIP occurred over several years, federal spending on the program was lower in its initial years. As the states' programs matured, federal spending exceeded current-year allotments starting in 2002. Some states have been able to spend more federal dollars than their allotment in a particular year by drawing on unspent funds from previous years and funds redistributed from other states. Yet a great deal of variation exists among states in their spending relative to their allotments: Federal spending falls short of the allotments in some states and exceeds it in others. In recent years, some states have projected that they will exhaust their federal funds. As a result, the Congress has acted twice to provide additional funding. The Deficit Reduction Act of 2005 appropriated an additional $283 million for SCHIP in 2006, and the National Institutes of Health Reform Act of 2006 included provisions modifying the redistribution of unspent funds from previous years to provide additional funds in 2007.

The implications of exhausting the available SCHIP funds vary among states. States that provide coverage by expanding Medicaid automatically receive federal matching payments under the Medicaid program once their SCHIP funds have been exhausted, but at the lower matching rate for Medicaid. Similarly, states that operate a combination program receive federal matching payments under Medicaid for beneficiaries who are enrolled in the Medicaid component of their program. In contrast, states that operate a separate program under SCHIP receive no additional federal matching payments once their available SCHIP funds have been exhausted. However, those states can constrain their expenditures through measures such as capping enrollment or increasing premiums, which are not allowed in states that provide SCHIP coverage through an expansion of Medicaid. In addition, states that operate a separate program have the option of converting some or all of their program into an expansion of Medicaid, which would provide access to additional federal matching funds under that program.

The Effect of SCHIP on Children's Health Insurance Coverage

SCHIP has significantly reduced the number of low-income children who are uninsured. According to the Congressional Budget Office's (CBO's) analysis, among children living in families with income between 100 percent and 200 percent of the poverty level (the group with the greatest increase in eligibility for public coverage under SCHIP), the uninsurance rate fell from 22.5 percent in 1996 (the year before SCHIP was enacted) to 16.9 percent in 2005, a reduction of 25 percent. In contrast, the uninsurance rate among higher-income children remained relatively stable during that period. SCHIP has also apparently contributed to an increase in insurance coverage among children below the poverty level, as states' outreach efforts and simplified enrollment procedures for SCHIP appear to have increased the percentage of eligible children who participate in Medicaid.[5]

Although SCHIP has significantly reduced the number of uninsured children in low-income families, the net effect on the extent of coverage is smaller than the number of children who have been enrolled in public coverage as a result of SCHIP because the increase in public coverage has been partially offset by a reduction in private coverage.[6] SCHIP provides an alternative source of coverage that is less expensive and that often provides a broader range of benefits than private insurance. As a result, some parents who otherwise would have enrolled their children in private coverage may prefer instead to switch their coverage to SCHIP.[7] In addition, to the extent that SCHIP

5. Most children below the poverty level are eligible for Medicaid. Children who apply for SCHIP must be enrolled in Medicaid if they are eligible for that program.

6. For the purpose of this paper, private coverage is insurance that is privately financed; it includes employer-sponsored insurance and private nongroup insurance. Public coverage is publicly financed, although some states use private health plans to deliver care to enrollees in SCHIP.

7. Such a change in coverage need not result from the parents of previously insured children dropping their coverage to enroll them in SCHIP, although that is one possibility. Another possibility, for example, is for parents who lost their coverage to decline coverage at a new job if their children are eligible for (or already enrolled in) SCHIP.

makes private coverage less important for some low-income families, parents might be more inclined to take jobs that offer higher cash wages rather than health insurance. Moreover, if employers of low-wage workers believe that SCHIP reduces the value of private health insurance in attracting employees, some might reduce their contribution to the premiums for family coverage, reduce the benefits offered, stop offering family coverage, or stop offering insurance altogether.

Considerable potential thus exists for increases in SCHIP coverage to be partially offset by a reduction in private coverage. For example, about 60 percent of the children who were eligible for the program were covered by private insurance in the year before the program was enacted.[8] But measuring the extent to which enrollment in SCHIP has actually been offset by a reduction in private coverage is difficult. Estimates vary depending on the measure that is used. Moreover, studies have obtained widely varying estimates depending on the data sources and methods used.

On the basis of a review of the research literature, CBO concludes that the most reliable estimates currently available suggest that the reduction in private coverage among children is between a quarter and a half of the increase in public coverage resulting from SCHIP. In other words, for every 100 children who enroll as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.[9] The available evidence, which is quite limited, suggests that the bulk of the reduction in private coverage occurs because parents choose to forgo private coverage and enroll their children in SCHIP (because of better benefits, lower costs, or some combination thereof), rather than employers deciding to drop coverage for such children. No studies have estimated the extent to which SCHIP reduces private coverage among parents, so the available estimates probably understate the total reduction in private coverage associated with the introduction of SCHIP.

Changes to the program may generate different effects on private coverage than those estimates suggest; in general, expanding the program to children in higher-income families is likely to generate more of an offsetting reduction in private coverage (and therefore less of a net reduction in uninsurance) than expanding the program to more children in low-income families. (Over the course of 2005, an average of nearly 2 million children were apparently eligible for SCHIP but remained uninsured.)[10] As discussed below, policymakers are exploring options to increase participation among eligible children.

Key Issues for Reauthorizing SCHIP

The process of reauthorizing SCHIP gives the Congress an opportunity to reexamine the program's design and reassess budgetary priorities. A key issue is the level of federal funding for the program and whether funding levels will be adjusted to account for growth in enrollment and health care costs and for possible changes in the design of the program, including eligibility rules and benefit packages. Until recently, the level of federal funding has not been an issue because states generally could cover their SCHIP spending through a combination of annual allotments; unspent funds from earlier years; and, if eligible, redistributed funds from other states. In addition, the Congress has provided additional money to prevent states from exhausting their federal funds. If federal funding for the program in the future did not keep pace with increases in health care spending per beneficiary and the number of enrollees, an increasing number of states would exhaust their federal funds. As a result, states would have to pay an increasing share of costs to maintain their current programs, modify their programs to lower spending, or both.

8. Julie L. Hudson, Thomas M. Selden, and Jessica S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry*, vol. 42, no. 3 (Fall 2005), pp. 232–254.

9. That range includes estimates obtained under various approaches. For example, one approach seeks to estimate the reduction in private coverage associated with both the increase in enrollment in SCHIP and the increase in enrollment in Medicaid that is attributable to SCHIP. Another approach seeks to estimate the reduction in private coverage associated just with the increase in enrollment in SCHIP. A final approach examines the share of SCHIP enrollees who had private coverage before enrolling.

10. Genevieve Kenney and Allison Cook, *Coverage Patterns Among SCHIP-Eligible Children and Their Parents* (Washington, D.C.: Urban Institute, Health Policy Online, no. 15, February 2007).

A number of options to modify the program have been suggested:

- Intensifying efforts to enroll uninsured children who are eligible for SCHIP or Medicaid.
- Redefining the target population—either broadening it or narrowing it—by changing the income levels determining eligibility; changing the rules regarding the eligibility of adults; or expanding eligibility to new groups, such as pregnant women, legal immigrants, and children of state employees.
- Changing the formula that determines the distribution of federal SCHIP funding among states.
- Modifying the rules for the redistribution of unspent funds.
- Changing the matching rates for SCHIP.
- Modifying the benefits that states are required to provide—for example, by requiring that states provide services covered under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program.

The State Children's Health Insurance Program

The Design of the State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) was created by the Balanced Budget Act of 1997 (Public Law 105-33), under title XXI of the Social Security Act. The program provides federal funding that states can use to expand health insurance coverage to uninsured children living in families with income that is low but too high to be eligible for Medicaid. Under broad federal guidelines, the program grants states flexibility in how they design their programs, including eligibility, benefits, and cost-sharing provisions. (See Box 1 for a comparison with Medicaid.)

Eligibility Criteria for Children

SCHIP was designed for uninsured children under age 19 living in families with income that is low but above Medicaid's threshold.[1] According to the SCHIP statute, states may cover children living in families with income up to 200 percent of the federal poverty level or 50 percentage points above their Medicaid threshold.[2] States are also allowed to disregard certain types of income and expenses in determining eligibility for the program. Eligibility criteria vary among the states. As of 2006, 26 states had a threshold of 200 percent of the poverty level, 15 states set the limit above 200 percent of the poverty level, and 9 states set it below 200 percent of the poverty level. North Dakota had the lowest threshold, at 140 percent of the poverty level, while New Jersey had the highest, at 350 percent of the poverty level.[3] In addition, variation among states in their Medicaid thresholds means that programs under SCHIP with equal thresholds may cover different segments of the population. For example, both Colorado and Kentucky have thresholds for SCHIP of 200 percent of the poverty level, but Kentucky's program covers a narrower range of people because its Medicaid program covers children in families with income up to 150 percent of the poverty level, whereas for Colorado's Medicaid program, the threshold is the poverty level.[4]

States with a separate program under SCHIP (as opposed to implementing SCHIP through an expansion of Medicaid) have some flexibility to control enrollment. For example, such states can cap or freeze enrollment. They can also impose waiting periods, typically lasting three to six months, during which children must be uninsured—a provision originally intended to discourage people from dropping private health insurance coverage for children in order to enroll them in SCHIP.

Eligibility Criteria for Adults

A number of states have used waiver authority to expand coverage under SCHIP to adults. Covering parents may help to increase participation among children, because parents who are eligible may be more likely to enroll their children also. In particular, section 1115 of the Social Security Act gives the Secretary of Health and Human Services the authority to waive certain statutory and regulatory requirements of Medicaid and SCHIP. The Secretary has used that authority to allow states to expand

1. Children of state employees cannot be covered under a separate program under SCHIP if they are eligible for coverage under a state health benefits plan. In addition, SCHIP is generally limited to citizens and to legal immigrants who have resided in the United States for five or more years.

2. States are required to maintain the Medicaid threshold that was in place just before SCHIP was enacted. That requirement, known as "maintenance of effort," prevents states from lowering their Medicaid threshold in order to receive a higher matching rate under SCHIP for children who would have otherwise been covered by Medicaid.

3. New Jersey, for example, has effectively expanded its threshold to 350 percent of the poverty level by disregarding all income between 200 percent and 350 percent of the poverty level.

4. Those Medicaid thresholds apply for children between the ages of 6 and 19.

Box 1.

A Brief Overview of Medicaid and the State Children's Health Insurance Program

Medicaid, enacted under title XIX of the Social Security Act in 1965, offers health insurance coverage to a variety of low-income individuals, including children and their parents, pregnant women, the disabled, and the elderly. In 2006, about 30 million nondisabled children were enrolled in Medicaid, accounting for roughly $31 billion in federal expenditures. (Medicaid also provides coverage to about 1 million disabled children, primarily recipients of Supplemental Security Income benefits.)

The State Children's Health Insurance Program (SCHIP) was enacted as part of the Balanced Budget Act of 1997, under title XXI of the Social Security Act, to provide health insurance coverage to uninsured children living in families with income that is low but too high to qualify for Medicaid. Over the course of 2006, 6.7 million children were enrolled in SCHIP, at a total cost to the federal government of $4.8 billion.

Both Medicaid and SCHIP are financed by the federal government and the states. The federal government matches spending according to a formula that determines the matching rate. Medicaid is an open-ended entitlement program, with no predetermined limit on federal spending. Annual federal funding for SCHIP, by contrast, is set at a fixed level ($5 billion for 2007), and each state receives an allotment based on the number of children in low-income families, the number of such children who are uninsured, and health care costs.

Under Medicaid, the federal government matches states' spending using a matching rate, known as the federal medical assistance percentage, or FMAP, that is based on each state's per capita income relative to the national average. In 2007, the FMAP ranges from 50 percent to 76 percent. Under SCHIP, the federal government matches states' spending using a higher rate that, in 2007, ranges from 65 percent to 83 percent.

eligibility for SCHIP to low-income parents, pregnant women, and adults without children.[5] As a condition for those waivers, states are required to cover those populations with funds not used to cover children. Section 1115 waivers also provide states additional flexibility to use SCHIP funds to subsidize the purchase of private health insurance through premium assistance programs. Of the 18 states that have obtained section 1115 waivers, 13 have expanded coverage to parents, related caretakers, and legal guardians, as well as pregnant women. Adults without children are currently covered in four states; however, the Deficit Reduction Act of 2005 (P.L. 109-171) prohibits the approval of such waivers in the future.

The Design of Benefits

States have the option of enrolling children by expanding their existing Medicaid program, creating a separate program under SCHIP, or implementing a combination of the two approaches. As of 2006, 11 states used an expansion under Medicaid, 18 states used a separate program, and 21 states used a combination of the two approaches.

States that implement SCHIP by expanding Medicaid must provide all of the benefits that are covered in their Medicaid plan. States that choose a separate program must provide a benefit package that is based on one of

5. In addition to waivers, the SCHIP statute allows states to purchase family coverage with SCHIP funds if such coverage is deemed cost-effective and does not displace private coverage. (Family coverage is considered to be cost-effective when the cost does not exceed that of coverage for children only.) That statutory test has seldom, if ever, been passed.

Box 2.

Overview of the Financing Structure for the State Children's Health Insurance Program

Federal Funding Levels. Legislation provided the State Children's Health Insurance Program (SCHIP) federal funding for 1998 to 2007.

Annual State Allotments. For each fiscal year, federal funding is allocated among states on the basis of the number of children in low-income households, the number of such children who are uninsured, and a geographic cost factor for health care wages. Floors or ceilings may result in adjusted annual allotments.

Federal Matching Rates. The federal government matches states' SCHIP spending using an enhanced matching rate (relative to that of Medicaid) that ranges from 65 percent to 83 percent.

Availability of Allotments. In general, states have three years to spend their original allotments. For instance, in 2006 a state had SCHIP funds from its 2006 allotment plus any unspent funds from 2004 and 2005.

Redistribution of Unspent Funds. In general, any funds that are not spent within three years are redistributed to states that have spent all of their funds. Recently, the Centers for Medicare & Medicaid Services has redistributed funds only to those states that are projected to exhaust all of their available funds. Redistributed funds that remain unused after one year expire.

Total Funds Available to States. Total available funds for states in any given year are equal to the sum of their annual allotment plus any unspent funds from previous years plus any funding redistributed from other states.

Note: Different procedures apply to the U.S. territories' programs under SCHIP.

several "benchmark" insurance plans, [6] a package that is actuarially equivalent to a benchmark plan, an existing state-funded plan,[7] or any other benefit plan approved by the federal government. Some states with a separate program have gone beyond the minimum federal requirements for a benefit package. For example, many states cover dental and vision services, even though those services are normally not covered by private health insurance.[8]

Cost Sharing and Premiums

States that have chosen to participate in SCHIP by expanding their Medicaid program are required to follow Medicaid's guidelines for cost sharing and premiums. Historically, children in the Medicaid program were exempt from cost sharing or premiums. However, as of March 31, 2006 (with the enactment of the Deficit Reduction Act of 2005), states have the option of imposing cost sharing for some children under their Medicaid program (except for preventive services), including a program under SCHIP that expands Medicaid. For children living in families with income below the poverty level, premiums are prohibited but nominal cost sharing is allowed for certain services—namely, prescription drugs and nonemergency care provided in a hospital. For children living in families with income between 100 percent

6. A state may choose one of three benchmark plans: the Blue Cross/Blue Shield Standard Option Service Benefit Plan offered under the Federal Employees Health Benefits program, a health benefit plan that is available to the state's employees, or a plan offered by the HMO (health maintenance organization) with the largest enrollment outside of Medicaid in the state.

7. Florida, New York, and Pennsylvania had state-funded programs prior to the enactment of SCHIP. The benefits provided under those programs were deemed to meet SCHIP's requirements.

8. Margo Rosenbach and others, *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations* (report submitted by Mathematica Policy Research, Inc., to the Centers for Medicare & Medicaid Services, March 2003).

and 150 percent of the poverty level, states cannot charge premiums, and coinsurance is capped at 10 percent of the charge for a given service. For children living in families with higher income levels, premiums are allowed, and copayments can be as high as 20 percent. For all income levels, the sum of cost sharing and premiums cannot exceed 5 percent of family income.

In separate programs under SCHIP, cost sharing is allowed for certain populations and services. However, as in the Medicaid program, states are prohibited from imposing cost-sharing requirements for preventive services. For children living in families with income below 150 percent of the poverty level, premiums cannot exceed Medicaid's limits, and cost sharing is limited to nominal amounts. For families with income above 150 percent of the poverty level, states can impose premiums and cost sharing of up to 20 percent. For all income levels, expenses for cost sharing and premiums cannot exceed 5 percent of annual income.

As of 2005, 39 states had cost-sharing requirements under SCHIP.[9] States with a program expanding Medicaid have been less likely to require cost sharing, but they could expand the use of it under new Medicaid rules.

The Financing of SCHIP

As part of the implementation of SCHIP, national funding levels were specified for 1998 to 2007. In addition, the SCHIP statute established a formula for determining each state's share of the federal funding, a matching rate for federal reimbursement of SCHIP spending, and a mechanism for redistributing states' unused SCHIP funds. (See Box 2 for an overview of the program's financing structure.)

Federal Funding for SCHIP

Unlike Medicaid, SCHIP is not an open-ended entitlement program: SCHIP is a matching grant program with a fixed nationwide cap on federal spending. The Congress provided roughly $40 billion for 1998 to 2007.

Annual funding levels were specified in the original SCHIP legislation as follows: for 1998 through 2001, roughly $4.2 billion annually; for 2002 through 2004, about $3.2 billion per year; for 2005 and 2006, $4 billion per year; and for 2007, $5 billion.

The State Allocation Formula

Each state receives an annual SCHIP allotment based on two factors: an estimate of the target population and an adjustment reflecting the cost of providing medical services there.[10]

Estimate of Target Population. The target population is based on the number of children under the age of 19 living in low-income families (families with income below 200 percent of the poverty level) in that state and the number of such children who are uninsured.

When SCHIP was first implemented, the allotment formula was solely based on the number of uninsured children in low-income families. In 2000, the number of such children was given a weight of 75 percent, and the number of low-income children received a weight of 25 percent.[11] Since 2001, each factor has received an equal weight of 50 percent.

Estimates of the total number of children in low-income families and the number of such children who are uninsured are derived using the Annual Social and Economic Supplement to the Current Population Survey (formerly known as the March Supplement) conducted by the Bureau of the Census. Because of a lack of precision in estimating the figures for some of the states with data from a single year, the formula is based on the average of the most recent three surveys.[12]

9. Statement of Kathryn G. Allen, Director, Health Care, Government Accountability Office, before the Subcommittee on Health of the House Committee on Energy and Commerce, published as Government Accountability Office, *Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization*, GAO-07-558T (March 1, 2007).

10. SCHIP funding for the five territories is not based on that formula; in aggregate, they receive 0.25 percent of the total funding; additional funding has been appropriated to the territories starting in 1999.

11. That change was introduced by the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 with the purpose of limiting the reduction in the share of federal SCHIP funding among states that were successful in enrolling children in the program.

12. The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 provided new funding to increase the sample size of the survey in order to improve the reliability of the estimates.

Table 1.

Enrollment in the State Children's Health Insurance Program, 1998 to 2006

Fiscal Year	Number of Children (Thousands)	Percentage Change from Previous Year	Number of Adults (Thousands)	Percentage Change from Previous Year
1998	660	n.a.	0	n.a.
1999	2,014	205	0	n.a.
2000	3,358	67	0	n.a.
2001	4,603	37	234	n.a.
2002	5,354	16	374	60
2003	5,985	12	484	29
2004	6,103	2	646	33
2005	6,114	0	639	-1
2006[a]	6,622	9	671	5

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Notes: n.a. = not applicable.

The figures for the number of people enrolled reflect enrollment at any time during the year. The number of people enrolled in an average month would be about 60 percent of the above totals.

There was a change in reporting between 2004 and 2005. Prior to 2005, in states with a combination program, children enrolled in both the Medicaid expansion and the separate program during a given year were counted twice. Starting in 2005, however, those children were counted only in the program where they were last enrolled.

a. Preliminary.

Geographic Cost Adjustment. SCHIP allotments for states are also adjusted to account for differences in health care costs. The formula includes a so-called state cost factor that is based on the ratio of wages in the health services industry in the state relative to the national average.[13] Estimates of wages in the health care industry in states are calculated using data from the Bureau of Labor Statistics. As with the estimates of the number of children, wage data are averaged across three years.

States' Annual Allotment of Federal SCHIP Funds. To compute each state's annual allotment, the above two factors (the target population and the geographic cost adjustment) are multiplied, and the products for each state are summed. Each state's percentage of that total is multiplied by the annual federal funding level, yielding the state's allotted amount for that year. Annual allotments are also subject to floors and ceilings. A $2 million floor has been in effect since the beginning of the program but has never been constraining because all states have qualified for funds in excess of that amount. The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (incorporated in the Consolidated Appropriations Act for Fiscal Year 2000, P.L. 106-113) instituted two new floors effective as of 2000: A state's share of the annual funding could be no lower than 90 percent of the previous year's share and no lower than 70 percent of the 1999 share. The law also introduced a ceiling such that a state's annual allotment could not exceed 145 percent of the 1999 share.[14]

Each state is paid a matching rate for SCHIP expenditures up to its available funds. The "enhanced" federal matching rate for SCHIP is higher than that for Medicaid. In 2007, the matching rate for SCHIP ranges from 65 percent to 83 percent, whereas for Medicaid, it ranges from 50 percent to 76 percent.[15] The national average matching rate for SCHIP is 69 percent and for Medicaid, 57 percent.

Both Medicaid and SCHIP include federal funds for administrative expenses. For Medicaid, the federal matching rate for that purpose is set at 50 percent, with the exception of certain expenses matched at higher rates. For SCHIP, the federal matching rate for administrative expenses is the same as the enhanced matching rate for the program, with a limit of 10 percent of the annual SCHIP expenditures.

Redistribution of Unspent SCHIP Funds. In general, states are given three years to spend their allotments. Then, the federal government redistributes unspent funds to states that spent all of their funds within the three-year period.

13. Specifically, the state cost factor is the result of the following formula: $0.15 + 0.85 * (\text{wages}_{\text{state}}/\text{wages}_{\text{national average}})$.

14. For more detail, see John L. Czajka and Thomas B. Jabine, "Using Survey Data to Allocate Federal Funds for the State Children's Health Insurance Program (SCHIP)," *Journal of Official Statistics*, vol. 18, no. 3 (2002), pp. 417–418.

15. SCHIP's formula for the matching rate is based on the state's federal medical assistance percentage (FMAP), as used in the Medicaid program, and equals FMAP + 0.3 * (100 - FMAP), with an upper limit of 85 percent. The enhanced rate was originally adopted to encourage states' participation in SCHIP.

Table 2.

Allotments and Spending Under the State Children's Health Insurance Program, 1998 to 2007

(Millions of dollars)

Fiscal Year	SCHIP Allotments[a]	Allotments Unspent After 3 Years[b]	Federal Spending	Funds Expiring
1998	4,235	n.a.	122	0
1999	4,247	n.a.	922	0
2000	4,249	n.a.	1,929	0
2001	4,249	2,034	2,672	0
2002	3,115	2,819	3,776	0
2003	3,175	2,206	4,276	0
2004	3,175	1,749	4,645	1,281
2005	4,082	643	5,089	128
2006	4,365 [c]	173	5,452	0
2007	5,040	147	5,656 [d]	0

Sources: Congressional Budget Office, Congressional Research Service, the Balanced Budget Act of 1997, the Deficit Reduction Act of 2005, and the Centers for Medicare & Medicaid Services.

Note: n.a. = not applicable.

a. For both states and the five territories.

b. In general, states' annual allotments are available for three fiscal years. Any funds unspent after three years become available to other states with projected spending in excess of their allocation plus any available funds from previous years.

c. Includes additional funding from the Deficit Reduction Act of 2005.

d. Projection by the Congressional Budget Office.

Most recently, the redistribution of funds has been a way to provide funding to states with projected spending in excess of available funds. (Redistributed funds that remain unused after one year expire, a phenomenon that occurred at the end of 2004 and 2005.) Therefore, the total funding available to states is equal to the sum of their original allotment plus any unspent funds from previous years plus any funding redistributed from other states.

Redistribution rules have been amended a number of times, both by extending and shortening the periods during which unspent funds are available. Because states were initially slow in spending their allotments, the Congress allowed the states to retain some of their allotments longer than three years. In contrast, because recent spending has outpaced federal funds, the National Institutes of Health Reform Act of 2006 (P.L. 109-482) required that a portion of unspent 2005 allotments be redistributed in 2007 instead of 2008.

Funding Interactions Between Medicaid and SCHIP. The type of program that a state operates under SCHIP has distinct implications for funding levels. States choosing to implement SCHIP by expanding Medicaid may continue receiving federal matching funds at that program's lower federal matching rate once their SCHIP spending exceeds their available funds. In contrast, states operating a separate program receive federal matching funds (at the enhanced rate) only for their available funds (unless they convert their program to a Medicaid expansion).[16]

Enrollment in and Expenditures for SCHIP

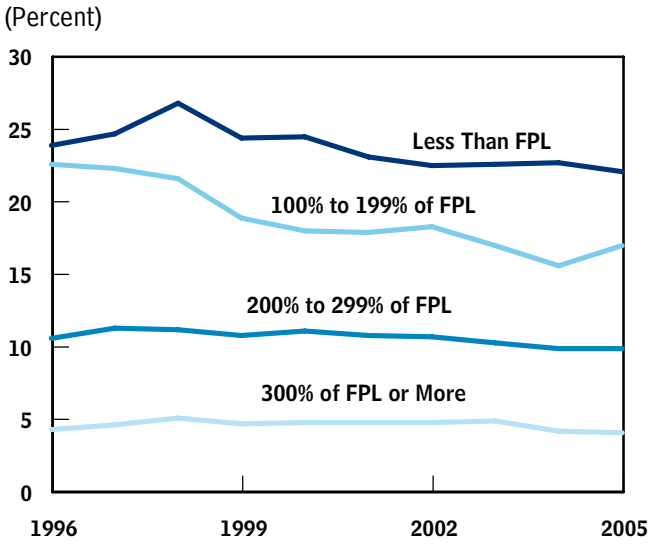
The number of children enrolled in SCHIP at any time during the year increased from 660,000 in 1998 to 6.6 million in 2006 (see Table 1). Enrollment grew very rapidly as states first implemented their programs, reaching almost 6 million children by 2003. Since then, enrollment has slowed as states' programs have matured and as some states have enacted policies to restrict enrollment in response to budgetary pressures. About 670,000 adults were enrolled at some time during the year in 2006.

Initially, federal spending on SCHIP was well below the allotments, as states implemented their programs (see Table 2). However, since 2002, federal spending has exceeded the annual allotments every year. Because unspent funds from previous years and the redistribution of unspent funds provide additional funding for some states, the exhaustion of funding in those states has been forestalled. Recently, however, some states have had insufficient federal funds available to fully match their desired level of SCHIP spending. As a result, the Congress has acted twice to provide additional funding. The Deficit Reduction Act of 2005 appropriated an extra $283 million in federal funding to support states' SCHIP spending in 2006. The National Institutes of Health Reform

16. As previously discussed, those states have other options that allow them to control their SCHIP expenditures, including charging limited premiums and cost sharing, capping enrollment, or establishing waiting lists.

Figure 1.

Percentage of Children Who Were Uninsured, by Family Income as a Percentage of the Federal Poverty Level, 1996 to 2005



Source: Congressional Budget Office based on data from the Current Population Survey for 1996 to 2005.

Note: FPL = federal poverty level.

Act of 2006 included provisions modifying the redistribution of unspent funds from previous years to provide additional funds in 2007. [17]

According to the Congressional Budget Office's (CBO's) estimates, 35 states have projected spending in 2007 above their allotment for the year, and 11 of those states will exhaust their available funds. CBO estimates that those states would require $646 million in 2007 to maintain their existing programs. Without that funding, some states will turn to Medicaid to fund coverage for children no longer funded under SCHIP, and, by CBO's estimates, therefore increase Medicaid spending by $250 million.

The Effect of SCHIP on Children's Health Insurance Coverage

SCHIP has significantly increased the number of children in low-income families who have health insurance, but the increase has not been one for one with the number of children enrolled in public coverage as a result of the program. SCHIP provides an alternative source of coverage that is less expensive to enrollees and often provides a broader range of benefits than private coverage; as a result, the program "crowds out" private coverage to some extent. Estimates of the extent to which private coverage has declined in response to the program vary; the available evidence, however, strongly suggests the net effect of the program has been to reduce the number of uninsured children.

Changes in the Number of Uninsured Children

Information on changes in the number of children who are uninsured comes from self-reported data collected in household surveys. This paper used data from the Annual Social and Economic Supplements to the Current Population Survey, conducted by the Census Bureau, which is the most widely cited source of information on insurance coverage. Although the survey is intended to measure the number of people who were uninsured throughout the calendar year, it is widely believed that the survey's estimates more closely approximate the number of people who were uninsured at a particular point in time.[18]

SCHIP should be expected to have had the greatest effect on uninsurance rates among children in families with income between 100 percent and 200 percent of the poverty level because that was the group that had the greatest

17. The National Institutes of Health Reform Act of 2006 reduced the availability of 2005 allotments in some states from three years to two and a half. Specifically, states forfeited half of their unspent 2005 funds (not exceeding $20 million) if their total available funds as of March 31, 2007, were at least twice their projected spending in 2007. The law also specified that spending in 2007 from redistributed funds on adults who are not pregnant will be reimbursed at Medicaid's lower matching rate.

18. For a discussion of the strengths and limitations of the Current Population Survey and other household surveys for measuring insurance coverage, see Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003); and Genevieve Kenney, John Holahan, and Len Nichols, "Toward a More Reliable Federal Survey for Tracking Health Insurance Coverage and Access," *Health Services Research*, vol. 41, no. 3 (June 2006), pp. 918–945.

increase in eligibility for public coverage.[19] According to CBO's analysis, the percentage of children in that income range who were uninsured fell from 22.5 percent in 1996 (the year before SCHIP was created) to 16.9 percent in 2005, a reduction of 5.6 percentage points (see Figure 1). The uninsurance rate was relatively stable among children in families with income over 200 percent of the poverty level. For example, among children whose families had income between 200 percent and 300 percent of the poverty level, the uninsurance rate fell from 10.5 percent in 1996 to 9.8 percent in 2005.[20]

Among children below the poverty level, the uninsurance rate rose from 23.8 percent in 1996 to 26.7 percent in 1998 and then fell to 22.0 percent in 2005. The increase from 1996 to 1998 in the percentage of poor children who were uninsured was accompanied by a drop in Medicaid coverage, which some analysts have cited as an unintended consequence of the welfare reform law that was passed in 1996.[21]

The decline in the percentage of poor children who were uninsured after 1998 was accompanied by an increase in Medicaid coverage. SCHIP did not in general make more poor children eligible for public coverage, since most were already eligible for Medicaid. However, the percentage of children eligible for Medicaid who participated in that program increased, which some analysts have attributed partly to states' outreach efforts for SCHIP (as applicants for SCHIP were enrolled in Medicaid if they were found eligible for that program) and the simplified application procedures that states adopted for both SCHIP and Medicaid.[22]

Those changes in the percentage of children who were uninsured do not yield an estimate of the impact of SCHIP because there are many other factors—such as changes in employment levels, family income, and health insurance premiums—that affect children's health insurance coverage. Nevertheless, the fact that the greatest reduction in the percentage of children who were uninsured occurred among those who had the greatest increase in eligibility for public coverage after SCHIP was established strongly suggests that the program has reduced the number of children in low-income families who are uninsured. As discussed below, however, estimating the effect of SCHIP on children's health insurance coverage requires a more sophisticated analysis that controls for other factors that influence such coverage and accounts for the program's effects on the number of people with private insurance.

Children's Participation in SCHIP

The number of children who participate in SCHIP depends in part on low-income parents' awareness and understanding of the program, their attitudes toward public insurance programs and health insurance generally, and the ease of the application process. Nearly all states have promoted SCHIP through mass media campaigns, and most have used community-based efforts such as educational sessions and home visits.[23] States have also implemented simpler enrollment procedures for SCHIP than what is in place for Medicaid (although some have also adopted simpler enrollment procedures for Medicaid). For example, most states do not require a face-to-face interview to apply for SCHIP or to renew coverage but instead use simple mail-in application

19. One recent study found that children between 100 percent and 200 percent of the poverty level had a 70 percentage-point increase in their rate of eligibility for public coverage from 1996 to 2002—compared with an increase of about 30 percentage points among children between 200 percent and 300 percent of the poverty level, an increase of 10 percentage points among children below the poverty level, and an increase of 8 percentage points among those between 300 percent and 400 percent of the poverty level. See Jonathan Gruber and Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* Working Paper No. 12858 (Cambridge, Mass.: National Bureau of Economic Research, January 2007).

20. In its analysis, CBO accounted for the fact that a "confirmation" question was added to the Current Population Survey beginning with the interviews that collected data for 1999. The new question asked people who did not report having any of several types of insurance coverage whether, in fact, they were uninsured. CBO compared estimates of uninsurance rates with and without the data from the confirmation question and used those two sets of estimates to create an adjustment factor (separately for each income group) that it applied to the estimates for years prior to 1999 to make them comparable with estimates for later years.

21. See, for example, Karl Kronebusch, "Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding," *Health Affairs*, vol. 20, no. 1 (January/February 2001), pp. 97–111.

22. See Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996–2002," *Health Affairs*, vol. 23, no. 5 (September/October 2004), pp. 39–50.

23. Rosenbach and others, *Implementation of the State Children's Health Insurance Program*.

forms, and most do not impose an asset test. Most states have a 12-month renewal period, which enables children to remain enrolled in SCHIP for a year unless their family reports a change in income or other circumstances.[24] Since 2001, though, some states have reduced their outreach efforts and retracted certain simplified enrollment procedures in response to fiscal pressures.[25]

According to one study, 29 percent of the children who appeared to be eligible for SCHIP in 2005 on the basis of their family's income participated in the program.[26] Half of the children who were eligible for SCHIP had employer-sponsored insurance, 6 percent had other coverage, and 15 percent were uninsured. By that study's estimates, the uninsured children who were eligible for SCHIP accounted for over a fifth of all uninsured children in 2005. Other studies have estimated that between 60 percent and 75 percent of all uninsured children are eligible for either Medicaid or SCHIP.[27] The wide range of estimates obtained in those studies is due to differences in the data sources and methods used.

Although all of those studies were based on rigorous statistical methods, they have important limitations because they relied on data collected in household surveys to determine children's health insurance coverage and to identify children who were eligible for SCHIP or Medicaid. Coverage in public programs such as Medicaid is underreported in such surveys, but the implications of that underreporting for the estimated number of people who are uninsured is unclear. There is some evidence that many people who are enrolled in Medicaid but who do not report having coverage under the program may report having private coverage instead.[28] There is also evidence that some SCHIP enrollees report having private nongroup insurance, which is not surprising given that many states design their programs to resemble private insurance.[29] Additional research is needed to fully understand the implications of the underreporting.

Another potential problem is that survey data on such things as types of income and expenses that may be disregarded for determining eligibility are also subject to misreporting. In addition, some major surveys (such as the Current Population Survey) collect data on annual income, and no information on fluctuations during the year, which would be relevant for determining eligibility for SCHIP.

The Effect of SCHIP on Private Coverage

Determining the extent to which enrollment in SCHIP is offset by reductions in private coverage is important for evaluating the overall effects of the program and for assessing the extent to which government spending on the program has reduced the number of children who are uninsured. The crowd-out of private coverage can occur through various mechanisms. For example, some parents who would have otherwise had family coverage through their employer might decline it for their children—or might decline coverage altogether—if their children are eligible for SCHIP. In addition, previously unemployed parents might be more likely to decline coverage at a new job if their children are enrolled in SCHIP. To the extent that SCHIP makes private coverage less important for some families, the program might also increase the likelihood that low-income parents take jobs that offer higher cash wages rather than health insurance. Thus, even in the majority of states where SCHIP covers only children, the program could reduce private coverage among adults as well as children.

SCHIP can also reduce private coverage by influencing the actions of employers. If employers of low-wage work-

24. Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP* in 2006 (January 9, 2007), available at www.kff.org/medicaid/7608a.cfm.

25. Ibid.

26. Genevieve Kenney and Allison Cook, *Coverage Patterns Among SCHIP-Eligible Children and Their Parents* (Washington, D.C.: Urban Institute, Health Policy Online, no. 15, February 2007).

27. See Selden, Hudson, and Banthin, "Tracking Changes in Eligibility"; and Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, Web Exclusive, November 30, 2006.

28. See Kathleen Thiede Call and others, "Uncovering the Missing Medicaid Cases and Assessing Their Bias for Estimates of the Uninsured," *Inquiry*, vol. 38, no. 4 (Winter 2001/2002), pp. 396–408.

29. See Joel C. Cantor and others, "The Adequacy of Household Survey Data for Evaluating the Nongroup Health Insurance Market," *Health Services Research* (forthcoming); and Anthony T. Lo Sasso and Thomas C. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics*, vol. 23, no. 5 (2004), pp. 1059–1082.

ers believe that SCHIP makes health insurance less important in attracting high-quality employees, some might reduce their contribution to the premiums for family coverage, reduce the level of benefits offered, stop offering family coverage, or stop offering insurance altogether. Those actions could lead to less private coverage among families that are eligible for SCHIP as well as ones that are not.

Families that substitute SCHIP for private coverage are generally better off as a result of switching to an alternative source of coverage that is not only lower in cost (to the enrollee) but may also have a more extensive package of benefits. However, to the extent that employers respond to SCHIP by increasing premiums, reducing benefits, or declining to offer coverage, other families could be worse off.

Little is known about how employers have responded to SCHIP. As discussed below, the limited evidence that is available suggests that SCHIP has not affected employers' decisions on whether to offer coverage but may have caused them to modestly raise employees' premiums for family coverage relative to the premiums for individual coverage. The implication is that most of the reduction in private coverage associated with SCHIP's existence appears to result from parents choosing to forgo private insurance for their children and instead enroll them in SCHIP, presumably because the parents believe the program offers better benefits or lower costs than private insurance.

As noted previously, the outreach that states have conducted for SCHIP and the simplified application procedures that many have adopted (in some cases, for Medicaid as well as for SCHIP) appear to have increased enrollment in Medicaid. That increased enrollment in Medicaid has probably been offset to some extent by a reduction in private coverage, for the same reasons that enrollment in SCHIP has probably been partly offset by a reduction in private coverage. The reduction in private coverage associated with the increase in Medicaid coverage is probably smaller than that associated with enrollment in SCHIP, however, because people eligible for Medicaid have lower income and less access to private insurance than people eligible for SCHIP do.

Measuring the Effect of SCHIP on Private Coverage. Studies typically define the crowd-out associated with SCHIP as the reduction in private coverage due to SCHIP expressed as a percentage of the increase in public coverage due to the program:

Crowd-out = $-100 * \Delta \text{private} / \Delta \text{public}$.[30]

Defined that way, the effect can range from zero (if SCHIP causes no change in the number of people with private coverage) to 100 percent (if the reduction in private coverage is equal to the increase in public coverage).

There are several possible variants of the measure, depending on how the changes in public and private coverage are defined. Two common measures are these:

- A broader measure, which captures the total increase in public coverage due to SCHIP (including the impact on Medicaid) as well as the total reduction in private coverage attributable to the program. The reduction in private coverage under this measure includes all those who would have had private coverage if the program did not exist.

- A narrower measure, which captures the substitution of SCHIP for private coverage, includes only those individuals who are covered by SCHIP under current law but who would have had private coverage if the program did not exist or, in some studies, had such coverage before enrolling in SCHIP.

The broader measure is the most useful for assessing the net effect of SCHIP on the insurance coverage of children and adults. It accounts for the fact that some people who would have otherwise had private coverage might be uninsured as a result of families' or employers' reactions to SCHIP. The narrower measure focuses strictly on people enrolled in SCHIP and on the insurance coverage they would have had without the program. That measure includes people who switched directly from private coverage to SCHIP as well as those who were uninsured or covered by Medicaid before they enrolled in SCHIP but who would have gained private coverage if SCHIP did not exist. Both of those measures should include changes in private coverage among both children and adults, but

30. The ratio of the change in private coverage (Δ private) to the change in public coverage (Δ public) is multiplied by 100 to convert the proportion to a percentage. That value is typically multiplied by -1 to express crowd-out as a positive number rather than a negative number.

the existing studies have estimated only changes among children.[31]

Efforts to Limit the Substitution of SCHIP for Employer-Sponsored Insurance. Federal law requires that the states have procedures in place to prevent people from substituting SCHIP for employer-sponsored insurance. The Congress included that provision in the authorizing legislation because of concern about substitution, in part resulting from a study that estimated that an expansion of Medicaid in the late 1980s and early 1990s caused a decline in private coverage that was about half the size of the increase in Medicaid coverage.[32] Subsequent studies obtained much lower estimates for the effects of Medicaid on private coverage.[33]

The potential for SCHIP to displace employer-sponsored insurance is greater than it was for the expansion of Medicaid because the children eligible for SCHIP are from families with higher income and greater access to private coverage. According to one study, 60 percent of the children who became eligible for SCHIP had private coverage in the year before the program was established.[34]

States have included a variety of features in their programs to try to prevent SCHIP from displacing employer-sponsored insurance. A widely used approach is to impose a waiting period—that is, a specified length of time that children must be uninsured before becoming eligible for SCHIP. In 2006, 35 states had a waiting period, the two most common being six months (imposed by 16 states) and three months (imposed by 11).[35] Only one state had a waiting period that was longer than six months. Many states allow exceptions to the waiting period—when a parent loses private coverage for reasons considered involuntary (by losing his or her job, switching to a job that does not offer family coverage, or becoming disabled, for instance) or when the available insurance is considered too expensive (if the employee's premiums would exceed a specified percentage of income or if the employer contributes less than 50 percent to the cost of coverage, for example).[36] Most states collect insurance information on the application for SCHIP, and some verify that information with employers. Some states try to limit the displacement of employer-sponsored insurance by requiring premiums and copayments within SCHIP.

Estimates of the Effects of SCHIP on Private Coverage. Estimates vary about the extent to which SCHIP has resulted in less private coverage. The available studies, which have focused on the effects of SCHIP on children, use various data sources and methods. On the basis of a review of the available studies, CBO concludes that the reduction in private coverage among children is most probably between a quarter and a half of the increase in public coverage resulting from SCHIP.[37] That is, for every 100 children who gain coverage as a result of

31. As defined under the narrower measure, SCHIP could influence the private coverage of adults only in states that cover adults under the program. Under the broader measure, however, the program could affect the private coverage of adults in all states through the mechanisms described previously.

32. That estimate includes changes in coverage among children, women of childbearing age, and other adults (who were not eligible for Medicaid). Among children, the study found, the reduction in private coverage was equal to 40 percent of the increase in public coverage. See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *The Quarterly Journal of Economics*, vol. 111, no. 2 (May 1996), pp. 391–430.

33. See, for example, Linda J. Blumberg, Lisa Dubay, and Stephen A. Norton, "Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP," *Journal of Health Economics*, vol. 19, no. 1 (2000), pp. 33–60.

34. See Julie L. Hudson, Thomas M. Selden, and Jessica S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry*, vol. 42, no. 3 (Fall 2005), pp. 232–254.

35. Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Coverage for Children and Parents*.

36. Rosenbach and others, *Implementation of the State Children's Health Insurance Program*.

37. That range includes estimates obtained under various approaches. Estimates differ under alternative specifications of the statistical models that analysts have used; some specifications yield estimates that are below or above the range cited. That range encompasses the estimates from specifications in the studies that CBO reviewed and considered most reliable (listed in the appendix).

SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children.[38]

Measuring the extent to which SCHIP is associated with a decline in private coverage is difficult because it requires comparing the insurance coverage of people under current law with an estimate of the coverage they would have had if the program did not exist. Analysts have estimated the reduction in private coverage attributable to SCHIP by using various statistical models to try to remove the effects of other factors that affect private coverage. All studies that have been conducted to date have estimated the reduction in private coverage among children only; they do not capture any possible reduction in private coverage among parents or other adults. Consequently, the available estimates probably understate the total extent to which SCHIP has reduced private coverage.

The estimates reported in the research literature measure average changes in private coverage since SCHIP has been implemented, which may differ from what would occur if policies were adopted to increase enrollment. For example, policies designed to increase enrollment among children who are currently eligible would involve less reduction in private coverage than would expanding the program to cover children in families with higher income. Such an expansion to higher income would probably involve greater crowd-out of private coverage than has occurred to date because such children have greater access to private insurance.[39]

Some studies have estimated crowd-out using the narrower measure defined above by obtaining survey data on the insurance coverage of enrollees before they were in the program. Such studies classify enrollees who had private insurance prior to being in SCHIP as having potentially substituted SCHIP for private coverage, and they classify those who were uninsured or covered by Medicaid as not having substituted SCHIP for private coverage. One such study found that 28 percent of children enrolled in SCHIP in 10 states had private coverage at some time during the six months before they enrolled in the program. [40] Such studies probably understate the full extent to which SCHIP reduces private coverage because they do not account for the fact that some of the children who were uninsured or enrolled in Medicaid prior to enrolling in SCHIP may have obtained private coverage if SCHIP had not been established.[41] Moreover, such studies do not account for the possibility that some of the children who were uninsured prior to enrolling in SCHIP may have lost coverage as a result of parents' or employers' response to the program (such as a decision by employers to drop family coverage or raise the premiums). In addition, in the surveys that are conducted for such studies, some parents might have underreported their children's private coverage before they enrolled in SCHIP out of fear that their children could be dropped from the program if the state authorities learned that their children had private coverage.

There is limited evidence on whether SCHIP has affected the health insurance decisions of employers. Only one study has examined that issue, and it analyzed employers'

38. Nearly all studies have estimated the effect of SCHIP on private coverage generally (including both employer-sponsored insurance and private nongroup coverage). Some might argue that studies should focus on the effects of the program on employer-sponsored insurance, because federal law requires states to have procedures in place to prevent the substitution of SCHIP for employer-sponsored insurance. However, estimates of the effects of SCHIP are not likely to be affected measurably by whether or not private nongroup insurance is included. According to CBO's analysis of data from the Current Population Survey, only about 6 percent of children with family income between 100 percent and 200 percent of the poverty level had private nongroup insurance in the year before SCHIP was enacted, while about half had employer-sponsored insurance. Moreover, a recent study found that, although SCHIP reduced coverage of children by employer-sponsored insurance, it had no effect on private nongroup coverage of them. See Lisa Dubay and Genevieve Kenney, *The Impact of SCHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families* (working paper, Washington, D.C.: Urban Institute, May 2007).

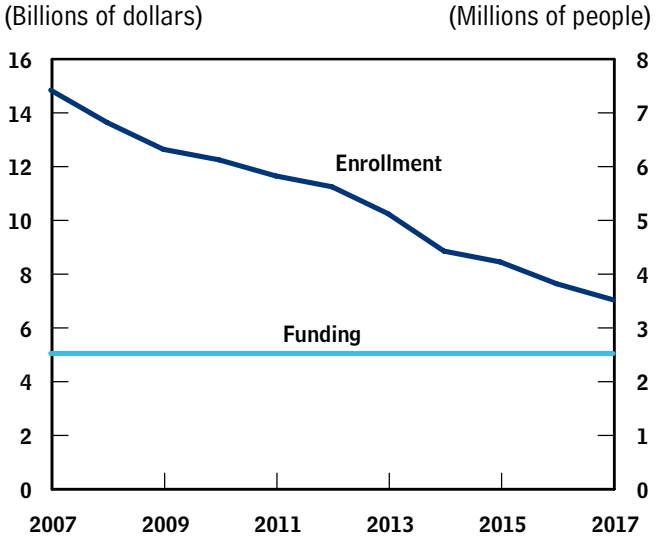
39. According to CBO's analysis of data from the Current Population Survey, 50 percent of children in families with income between 100 percent and 200 percent of the poverty level had private coverage in 2005. The rate of private coverage rose to 77 percent among children between 200 percent and 300 percent of the poverty level, 89 percent among those between 300 percent and 400 percent of the poverty level, and 95 percent among those over 400 percent of the poverty level.

40. See Anna Sommers and others, "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs*, vol. 26, no. 2 (March/April 2007), pp. 529–537.

41. The uninsured population is not a static group but is constantly changing. Some people are uninsured for long periods, while others are uninsured for shorter periods, such as between jobs. See Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?*

Figure 2.

CBO's Baseline Projections of Funding and Enrollment in SCHIP, 2007 to 2017



Source: Congressional Budget Office, *Fact Sheet for CBO's March 2007 Baseline: State Children's Health Insurance Program* (February 23, 2007).

responses to SCHIP only through 2001.[42] It found no evidence that employers stopped offering single or family coverage in response to SCHIP but did find evidence suggesting that employers of low-wage workers reacted to the program by increasing the marginal cost of family coverage (which was defined as the difference between employees' premiums for family coverage and single coverage). For example, the study estimated, a hypothetical employer with 20 percent of its workforce with children eligible for public coverage would increase employees' marginal cost of family coverage by about $120 per year (in 2001 dollars). The estimated increase was larger in states that experienced a higher-than-average increase in eligibility for public coverage following the establishment of SCHIP and larger for employers with a higher percentage of the workforce with children eligible for public coverage.

The study also examined the extent to which employees accepted private insurance that was offered. It found evidence suggesting that SCHIP reduced the percentage of employees who accepted any private coverage, generally, and family coverage, specifically. For example, at a hypothetical employer at which 20 percent of the workforce had children eligible for public coverage, the estimated percentage of employees who accepted any offer of insurance fell by an average of 1 percentage point. Among employees who accepted any coverage, a similar decline occurred in the percentage of workers who accepted family coverage. The estimated declines were greater at employers that had a higher percentage of workers with children eligible for public coverage. Such findings suggest that SCHIP can reduce private coverage of adults as well as children; in other words, the study suggests that some workers responded to SCHIP by declining coverage altogether, not merely declining coverage for their children.

Issues in Reauthorizing SCHIP

SCHIP, which is authorized to continue through the end of 2007, faces significant funding issues that are expected to shape its reauthorization. Reauthorization is occurring at a time of substantial budgetary pressures as lawmakers contend with growing federal spending on health care and competing priorities. An additional challenge is posed by the reintroduction of "pay-as-you-go" financing rules, which require offsets for any increases in mandatory federal spending.

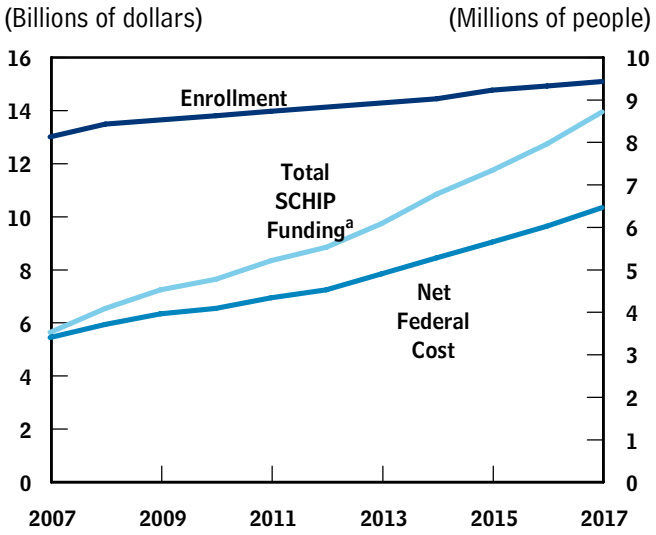
Funding levels for SCHIP have not been a concern until recently, when some states exhausted their available funds. In 2007, CBO estimates, 11 states will require a total of $646 million in additional funds to maintain their existing programs. If annual funding for the program continued at $5 billion (the level incorporated in CBO's baseline spending projections) and current eligibility rules and benefits were unchanged, by 2017, 43 states would have projected spending outstrip available funds by $8.9 billion. With that level of funding, enrollment would fall from 7.4 million in 2007 to 3.5 million in 2017, CBO estimates (see Figure 2).

A key issue to be addressed in reauthorizing SCHIP is whether the program will continue to operate as a capped grant program with predetermined spending limits or whether federal funding will be open-ended. If SCHIP continues to operate as a capped grant program, a basic question is how funding levels will be adjusted to account for growth in enrollment and health care costs and for possible changes in the design of the program, including eligibility rules and benefit packages.

42. Thomas Buchmueller and others, "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry*, vol. 42, no. 3 (Fall 2005), pp. 218–231.

Figure 3.

CBO's Projections of Funding and Enrollment to Maintain States' Current Programs Under SCHIP, 2007 to 2017



Source: Congressional Budget Office, *Fact Sheet for CBO's March 2007 Baseline: State Children's Health Insurance Program* (February 23, 2007).

Notes: Following statutory guidelines, CBO's baseline spending projections for the State Children's Health Insurance Program (SCHIP) assume that annual funding after 2007 continues at the current level of $5 billion. CBO's estimates were obtained by taking states' projections of spending for 2007 and 2008, adjusting them in later years to account for increases in both health spending per enrollee and the projected number of enrollees (due to both population growth and increases in the number of people who are uninsured). The calculations assume no change in eligibility rules or benefit packages after 2008.

Current funding rules for SCHIP do not allow specifically targeting funds to states whose spending exceeds available funding. Without such targeting, a greater increase in funding than the one projected in the figure would be needed.

The net federal cost of maintaining states' current programs under SCHIP incorporates savings that would arise in the Medicaid program, as additional SCHIP funding would reduce the states' need for Medicaid funds.

a. Includes the $5 billion funding level used in CBO's baseline spending projections.

The Cost of Maintaining the States' Current Programs

By CBO's estimates, maintaining the states' current programs under SCHIP would require funding of $39 billion for the 2007–2012 period and $98 billion over the 2007–2017 period—increases of $14 billion and $48 billion, respectively, over the baseline spending levels. Those estimates account for projected increases in health spending per enrollee and the number of enrollees but assume no changes in the design and operation of the states' programs—for example, no changes in eligibility rules, benefit packages, or outreach activities. The availability of additional federal funds for SCHIP would reduce the states' need for some Medicaid funds, so the net cost to the federal government would be smaller. On balance, CBO estimates, the net additional federal cost to maintain current programs under SCHIP would be $8 billion over the 2007–2012 period and $28 billion over the 2007–2017 period, relative to baseline spending levels. With those additional funds, enrollment (at any time during the year) would grow from the 8.1 million people in 2007 to 8.8 million in 2012 and 9.4 million in 2017 (see Figure 3).

Those estimates assume that the additional funds could be targeted to states whose projected spending exceeded their available funds—though current rules for the program do not allow such targeting. Without effective targeting, however, a greater increase in funding would be needed to maintain states' current programs.

Options for Modifying SCHIP

Reauthorization presents the Congress with an opportunity to consider changes in SCHIP, including encouraging or requiring efforts by the states to enroll eligible children who are uninsured, redefining the target population, changing the formula that allocates funds to individual states, modifying the rules for the redistribution of unspent funds, reexamining the matching rate for the program, and modifying the benefits that states are required to provide.

Intensify Efforts to Enroll Eligible Children Who Are Uninsured. According to one study, there were about 2 million children who were eligible for SCHIP but uninsured in 2005, accounting for 20 percent of all uninsured children in that year.[43] One option for policymakers is to maintain the current program but encourage or require states to undertake activities to enroll such children. For example, the federal government could require or provide incentives for states to conduct greater outreach and simplify their enrollment procedures, prohibit states from using waiting lists to limit enrollment, and require that all states grant 12 months of continuous eligibility. Such efforts could not be perfectly targeted to children who would have otherwise been uninsured, however, so they would reduce private coverage to some extent. The amount of any such reduction would depend on the nature of the policy and how it was implemented. Moreover, greater outreach for SCHIP would lead to greater enrollment in Medicaid as well.

The federal government would be limited in its ability to evaluate states' performance at enrolling children who would have otherwise been uninsured because timely state-level data are not available for most states. The Current Population Survey is the only source of state-level data on insurance coverage, but sample sizes for most states are too small to yield reliable estimates for a single year.[44] Moreover, sophisticated statistical analysis would be required to distinguish changes in uninsurance rates that result from efforts to enroll uninsured children in SCHIP from changes that result from other factors, such as changes in employment levels and family income. Consequently, if the federal government provided financial incentives to the states to undertake activities to enroll eligible but uninsured children, those incentives would most likely need to take the form of giving the states additional funds for conducting certain activities (such as outreach) rather than bonuses for meeting certain performance targets.

Redefine SCHIP's Target Population. One approach to changing the target population for SCHIP is to modify the income thresholds that states use to determine eligibility. For example, the target population could be expanded by requiring states to increase their thresholds to 300 percent of the poverty level.[45] Alternatively, the thresholds could be reduced—or the matching rate could be reduced for children and adults above a certain threshold, such as 200 percent of the poverty level—to focus federal funds on children in low-income families. The latter approach would disproportionately affect states that had already expanded Medicaid before the establishment of SCHIP and had used SCHIP funds to expand eligibility to children in families with higher income and to adults. Policymakers considering changes to the requirements for thresholds may want to take into account the fact that states vary in how they define income for determining eligibility. Many states subtract certain expenses or a portion of the family's income to obtain a measure of net income.

Another approach to modifying SCHIP's target population is to change the rules regarding parents. For example, making parents eligible would not only extend coverage to them but would probably boost participation among children currently eligible but not enrolled—as parents and their children could be covered under the same insurance.[46] Disadvantages of this approach are that it would would probably result in greater crowd-out of private coverage and would draw funds that could be used to cover children.

Other possibilities for changing SCHIP's target population are to expand eligibility to pregnant women, legal immigrants, and children of state employees. Coverage could also be extended to people with private insurance—for example, by dropping the requirement that people be uninsured in order to qualify for SCHIP, which would permit people to directly switch from employer-sponsored insurance to SCHIP. Such a policy might also allow the greater use of SCHIP funds in premium assistance programs.

43. Kenney and Cook, *Coverage Patterns Among SCHIP-Eligible Children and Their Parents.*

44. As mentioned previously, the formula that allocates federal funds to individual states uses an estimate of the average number of uninsured children in each state computed over a three-year period.

45. Current rules allow states to effectively expand coverage to families with income above 200 percent of the poverty level by disregarding certain expenses or a portion of their income. Therefore, merely permitting states to increase their thresholds (as opposed to requiring them to do so) could have little effect.

46. Lisa Dubay and Genevieve Kenney, "Expanding Public Health Insurance to Parents: Effects on Children's Coverage Under Medicaid," *Health Services Research,* vol. 38, no. 5 (October 2003), pp. 1283–1302.

Change the Formula that Allocates Funding to Individual States. Each year, federal funding for SCHIP is allocated to states on the basis of a formula that takes into account the number of children in low-income families (with income less than 200 percent of the poverty level) in each state, the number of such children who are uninsured, and wages in the health services sector. An important and unintended limitation of the formula is that it reduces allotments for states that enroll more children in SCHIP. One possible solution is to include the number of children enrolled in SCHIP in the formula. For example, the formula could be modified to allocate funds to states on the basis of the sum of the number of children who are enrolled in SCHIP and the number of children who are in low-income families and who are uninsured.[47] The number of children enrolled in SCHIP would be determined from administrative data, while the number of children who are in low-income families and who are uninsured would continue to be estimated from survey data.[48] A potential problem with including SCHIP's enrollment in the allocation formula is that it could reward states that had higher levels of substitution of SCHIP for private coverage.

Another possible approach is to allocate funds to states on the basis of their historical spending on SCHIP. For example, each state's share of the national funding for a particular year could be determined from its share of federal spending for SCHIP in a specified base year (or perhaps its share of funding averaged over several base years). Alternatively, state-specific allotments could be determined by a statutory formula that would adjust each state's spending from a specified base year to account for factors such as projected growth in costs per enrollee and population growth. Although using historical data on spending would be intended to align states' future allotments more closely with their funding requirements, such an approach would make it more difficult for states that have operated limited programs in the past to expand their programs. In addition, if the base year for determining funding allocations was updated periodically, this approach could reduce states' incentive to spend money efficiently, because greater spending in the base year could increase states' share of federal funds in the future.

Finally, some of the floors and the ceilings that are used to calculate a state's share of federal SCHIP funding utilize 1999 as the base year—raising some issues because, at that time, some states' programs had been in place for only a short period. Therefore, an option would be to use a more recent year as the base year for calculating floors and ceilings so that all programs will have been operational for longer periods of time. In addition, more recent state shares are based on expanded Current Population Surveys, yielding more precise estimates.

Modify the Rules for the Redistribution of Unspent Funds. In altering SCHIP, another option is to shorten the length of time that states have to spend their allotments (as the National Institutes of Health Reform Act of 2006 did for allotments that were unspent in 2005). Shortening the length of time that states can spend their allotments would increase the amount of funds available for redistribution and more effectively target funds to states with higher spending.

Reexamine the Matching Rate. The enhanced matching rate was originally put in place to encourage states' participation in SCHIP. At the time, the incentive was perceived as necessary because only a few states had taken advantage of the existing flexibility to expand their Medicaid programs. Reducing the matching rate for SCHIP would increase the states' share of spending for the program and could cause some states to reduce the size of their program. But having a uniform matching rate—for both SCHIP and Medicaid—may be more equitable, especially for states that expanded their Medicaid programs before the establishment of SCHIP and are reimbursed at the lower Medicaid rate for children who would otherwise qualify for the higher SCHIP rate. In addition, a uniform matching rate would overcome the criticism that the current enhanced matching formula for SCHIP disproportionately favors states with the lowest Medicaid

47. Under that approach, the total number of low-income children in the state would no longer appear in the formula. See Czajka and Jabine, "Using Survey Data to Allocate Federal Funds for the State Children's Health Insurance Program (SCHIP)," pp. 409–427.

48. States could be required to include in the administrative data submitted to the federal government information on family income and family size that could be used to compute the number of children enrolled in SCHIP whose family income was less than 200 percent of the poverty level, which would make that measure more comparable with the measures used in the current allocation formula.

matching rates.[49] Still, the federal government could make use of an enhanced matching rate as a financial incentive in order to elicit certain behavior from states.

Augment Required Benefits. States that expanded Medicaid are required to provide a wide range of services under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. That program includes various screening services and mandates treatment for diagnosed conditions. States with a separate program under SCHIP must cover some basic benefits. Some of them have included optional benefits, but the generosity of those benefits varies. One option, then, to even out the benefits provided under SCHIP, and perhaps attract more enrollees, would be to require states to provide the services in the EPSDT program. Alternatively, requirements could target specific benefits, such as dental services.

49. A state with the lowest Medicaid matching rate of 50 percent receives SCHIP's enhanced matching rate of 65 percent (a gain of 15 percentage points), whereas a state with a Medicaid matching rate of 76 percent receives an enhanced matching rate of 83 percent (a gain of 7 percentage points).

Appendix: Studies Reviewed by the Congressional Budget Office for This Analysis

Cynthia Bansak and Steven Raphael, "The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children's Health Insurance Program," *Journal of Policy Analysis and Management*, vol. 26, no. 1 (2006), pp. 149–175.

Thomas Buchmueller and others, "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry*, vol. 42, no. 3 (Fall 2005), pp. 218–231.

Peter J. Cunningham, Jack Hadley, and James Reschovsky, "The Effects of SCHIP on Children's Health Insurance Coverage: Early Evidence from the Community Tracking Study," *Medical Care Research and Review*, vol. 59, no. 4 (December 2002), pp. 359–383; and an update on the Web site of the Center for Studying Health System Change, available at www.hschange.com.

Lisa Dubay and Genevieve Kenney, *The Impact of SCHIP on Children's Insurance Coverage: An Analysis Using the National Survey of America's Families* (working paper, Washington, D.C.: Urban Institute, May 2007).

Lisa Dubay and Linda Blumberg, "The Impact of SCHIP on Insurance Coverage of Children in Its Infancy: An Analysis Using the SIPP" (draft working paper, Washington, D.C.: Urban Institute, April 2007).

Jonathan Gruber and Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* Working Paper No. 12858 (Cambridge, Mass.: National Bureau of Economic Research, January 2007).

Julie L. Hudson, Thomas M. Selden, and Jessica S. Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry*, vol. 42, no. 3 (Fall 2005), pp. 232–254.

Anthony T. Lo Sasso and Thomas C. Buchmueller, "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics*, vol. 23, no. 5 (2004), pp. 1059–1082.

Anna Sommers and others, "Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States," *Health Affairs*, vol. 26, no. 2 (March/April 2007), pp. 529–537.

Judith Wooldridge and others, *Congressionally Mandated Evaluation of the State Children's Health Insurance Program* (report submitted by Mathematica Policy Research, Inc., and the Urban Institute to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, October 26, 2005).