# STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The Balanced Budget Act of 1997 (BBA 97; Public Law 105-33) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. In general, the program offers Federal matching funds to States and territories to provide health insurance to certain low-income children.

## ELIGIBILITY

Under SCHIP, States may cover children under 19 years of age in families with incomes that are above the State's Medicaid eligibility standard but less than 200 percent of the Federal poverty level (FPL).[1] However, States in which the maximum Medicaid income level for children was at or above 200 percent FPL prior to the enactment of SCHIP may increase the SCHIP income level by an additional 50 percentage points above the prior level used under the State's Medicaid program.

Not all targeted low-income children necessarily will receive medical assistance under SCHIP for two reasons. First, unlike Medicaid, Federal law does not establish an individual entitlement[2] to benefits under SCHIP. Instead, it entitles States with approved SCHIP plans to pre-determined Federal allotments based on a distribution formula set in the law. Second, each State can define the group of targeted low-income children who may enroll in SCHIP. Title XXI allows States to use the following factors in determining eligibility: geography (e.g., sub-State areas or statewide), age (e.g., subgroups under 19), income and resources, residency, disability status (so long as any standard relating to that status does not restrict eligibility), access to other health insurance, and duration of SCHIP enrollment. Title XXI funds cannot be used for children who would have been eligible for the State's Medicaid plan under the eligibility standards that were in effect prior to March 31, 1997 or for children covered by a group health plan or other insurance.

As of fiscal year 2002, the upper income eligibility limit under SCHIP had reached 350 percent FPL (in one State; see Table 15-SCHIP-1).[3] Twenty-four States and the District of Columbia had established upper income limits at 200 percent FPL. Another 13 States exceeded 200 percent FPL. The remaining

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[1] For example, in 2002, the poverty guideline in the 48 contiguous States and the District of Columbia was $18,100 for a family of four (*Federal Register*, v. 67, no. 31, February 14, 2002. p. 6931-6933.) In 2003, the comparable poverty guideline for a family of four is $18,400 (*Federal Register*, v. 68, no. 26, February 7, 2003, p. 6456-6458).

[2] The one exception to this rule is when a State chooses to implement a Medicaid expansion under SCHIP. Children who qualify for SCHIP through a Medicaid expansion are entitled to Medicaid benefits as long as they continue to meet these specific eligibility criteria (even if SCHIP itself terminates) or until the State is granted approval to eliminate such coverage.

[3] For determining income eligibility for SCHIP and Medicaid, some States apply "income disregards." These are specified dollar amounts subtracted from gross income to compute net income, which is then compared to the applicable income criterion. Such disregards may increase the effective income level above the stated standard.

13 States set maximum income levels below 200 percent FPL.[4]

## BENEFITS

States may choose from three options when designing their SCHIP programs. They may expand their current Medicaid program, create a new "separate State" insurance program, or devise a combination of both approaches. Under limited circumstances, States have the option to purchase a health benefits plan that is provided by a community-based health delivery system or to purchase family coverage under a group health plan that may cover adults as long as it is cost-effective to do so.

States that choose to expand Medicaid to new eligibles under SCHIP must provide the full range of mandatory Medicaid benefits, as well as all optional services specified in their State Medicaid plans. States that choose to create separate SCHIP programs may elect any of three benefit options: (1) a benchmark benefit package, (2) benchmark equivalent coverage, or (3) any other health benefits plan that the Secretary determines will provide appropriate coverage to the targeted population of uninsured children.[5]

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

Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A State choosing to provide benchmark-equivalent coverage must cover each of the benefits in the "basic benefits category." The benefits in the basic benefits category are inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. Benchmark-equivalent coverage also must include at least 75 percent of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category." These additional services include prescription drugs, mental health services, vision services, and hearing services. States are encouraged to cover other categories of service not listed above. Abortions may not be covered, except in the case of a pregnancy resulting from rape or incest, or when an abortion is necessary to save the mother's life.

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[4] States may apply resource or asset tests in determining financial eligibility, but are not required to do so. Individuals must have resources for which the dollar value is less than a specified standard amount in order to qualify for coverage. States determine what items constitute countable resources and the dollar value assigned to those countable resources. Assets may include, for example, cars, savings accounts, real estate, trust funds, and tax credits.

[5] When the law establishing SCHIP was enacted, existing State programs in Florida, New York, and Pennsylvania were designated as meeting the minimum benefit requirements under this program.

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TABLE-SCHIP-1--PRELIMINARY SCHIP ENROLLMENT DATA FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEAR 2002

| State and Program Type | Date enrollment began | SCHIP upper income eligibility standard (% FPL) | FFY2002 enrollment (number of children ever enrolled during year) | | | Adults Ever Enrolled in SCHIP Demonstrations |
|---|---|---|---|---|---|---|
| | | | Medicaid expansion | Separate Child Health Program | Total | |
| Alabama (C) | 2/1/1998 | 200% | 17,332 | 66,027 | 83,359 | NA |
| Alaska (M) | 3/1/1999 | 200% | 22,291 | NA | 22,291 | NA |
| Arizona (S) | 11/1/1998 | 200% | NA | 92,705 | 92,705 | 30,382 |
| Arkansas (M) | 10/1/1998 | 100% | 1,912 | NA | 1,912 | NA |
| California (C) | 3/1/1998 | 250% | 81,089 | 775,905 | 856,994 | NA |
| Colorado (S) | 4/22/1998 | 185% | NA | 51,826 | 51,826 | NA |
| Connecticut (C) | 7/1/1998 | 300% | 3,216 | 18,130 | 21,346 | NA |
| Delaware (S) | 2/1/1999 | 200% | NA | 9,691 | 9,691 | NA |
| District of Columbia (M) | 10/1/1998 | 200% | 5,060 | NA | 5,060 | NA |
| Florida (C) | 4/1/1998 | 200% | 4,706 | 363,474 | 368,180 | NA |
| Georgia (S) | 11/1/1998 | 235% | NA | 221,005 | 221,005 | NA |
| Hawaii (M) | 7/1/2000 | 200% | 8,474 | NA | 8,474 | NA |
| Idaho (M) | 10/1/1997 | 150% | 16,895 | NA | 16,895 | NA |
| Illinois (C) | 1/5/1998 | 185% | 42,992 | 25,040 | 68,032 | NA |
| Indiana (C) | 10/1/1997 | 200% | 50,423 | 15,802 | 66,225 | NA |
| Iowa (C) | 7/1/1998 | 200% | 13,373 | 21,133 | 34,506 | NA |
| Kansas (S) | 1/1/1999 | 200% | NA | 40,783 | 40,783 | NA |
| Kentucky (C) | 7/1/1998 | 200% | 59,642 | 34,299 | 93,941 | NA |
| Louisiana (M) | 11/1/1998 | 200% | 87,675 | NA | 87,675 | NA |
| Maine (C) | 7/1/1998 | 200% | 15,033 | 7,553 | 22,586 | NA |
| Maryland (C) | 7/1/1998 | 300% | 121,305 | 3,875 | 125,180 | NA |
| Massachusetts (C) | 10/1/1997 | 200% | 77,788 | 38,911 | 116,699 | NA |
| Michigan (C) | 5/1/1998 | 200% | 26,777 | 45,105 | 71,882 | NA |
| Minnesota (M) | 10/1/1998 | 280% | NR | NA | NR | 40,008 |
| Mississippi (C) | 7/1/1998 | 200% | 1,180 | 63,625 | 64,805 | NA |
| Missouri (M) | 9/1/1998 | 300% | 112,004 | NA | 112,004 | NA |
| Montana (S) | 1/1/1999 | 150% | NA | 13,875 | 13,875 | NA |
| Nebraska (M) | 5/1/1998 | 185% | 16,227 | NA | 16,227 | NA |
| Nevada (S) | 10/1/1998 | 200% | NA | 37,878 | 37,878 | NA |
| New Hampshire (C) | 5/1/1998 | 300% | 438 | 7,700 | 8,138 | NA |
| New Jersey (C) | 3/1/1998 | 350% | 42,017 | 75,036 | 117,053 | 142,427 |
| New Mexico (M) | 3/31/1999 | 235% | 19,940 | NA | 19,940 | NA |
| New York (C) | 4/15/1998 | 250% | NR | 807,145 | 807,145 | NA |

TABLE-SCHIP-1-- PRELIMINARY SCHIP ENROLLMENT DATA FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEAR 2002 -continued

| State and Program Type | Date enrollment began | SCHIP upper income eligibility standard (% FPL) | FFY2002 enrollment (number of children ever enrolled during year) | | | Adults Ever Enrolled in SCHIP Demonstrations |
|---|---|---|---|---|---|---|
| | | | Medicaid expansion | Separate Child Health Program | Total | |
| North Carolina (S) | 10/1/1998 | 200% | NA | 120,090 | 120,090 | NA |
| North Dakota (C) | 10/1/1998 | 140% | 892 | 3,571 | 4,463 | NA |
| Ohio (M) | 1/1/1998 | 200% | 183,034 | NA | 183,034 | NA |
| Oklahoma (M) | 12/1/1997 | 185% | 84,490 | NA | 84,490 | NA |
| Oregon (S) | 7/1/1998 | 170% | NA | 42,976 | 42,976 | NA |
| Pennsylvania (S) | 5/28/1998 | 200% | NA | 148,689 | 148,689 | NA |
| Rhode Island (M) | 10/1/1997 | 250% | 19,515 | NA | 19,515 | 22,459 |
| South Carolina (M) | 10/1/1997 | 150% | 68,928 | NA | 68,928 | NA |
| South Dakota (C) | 7/1/1998 | 200% | 8,893 | 2,290 | 11,183 | NA |
| Tennessee (M) | 10/1/1997 | 100% | NR | NA | NR | NA |
| Texas (C) | 7/1/1998 | 200% | 10,491 | 716,961 | 727,452 | NA |
| Utah (S) | 8/3/1998 | 200% | NA | 33,808 | 33,808 | NA |
| Vermont (S) | 10/1/1998 | 300% | NA | 6,162 | 6,162 | NA |
| Virginia (C) | 10/22/1998 | 200% | 11,484 | 56,490 | 67,974 | NA |
| Washington (S) | 2/1/2000 | 250% | NA | 8,754 | 8,754 | NA |
| West Virginia (S) | 7/1/1998 | 200% | NA | 35,949 | 35,949 | NA |
| Wisconsin (M) | 4/1/1999 | 185% | 62,391 | NA | 62,391 | 113,842 |
| Wyoming (S) | 12/1/1999 | 133% | NA | 5,059 | 5,059 | NA |
| Total | – | – | 1,297,907 | 4,017,322 | 5,315,229 | 349,118 |

S – Separate child health programs

M – Medicaid expansion program

C – Combination programs

NR – Indicates that State has not reported data via the Statistical Enrollment Data System (SEDS)

FPL - Poverty level

NA - Not applicable

Note- For States with combination programs, the "total" column shows the sum of the unduplicated number of children ever enrolled in the SCHIP Medicaid expansion program during the year and the unduplicated number of children ever enrolled in the separate SCHIP program during the year. Because a child may be enrolled in both programs during the year, there may be some double counting of children enrolled in these States.

Source: Data on date enrollment began and the SCHIP upper income eligibility standard are taken from the Centers for Medicare and Medicaid Services, The State Children's Health Insurance Program, Annual Enrollment Report Federal Fiscal Year 2001: October 1, 2000 – September 30, 2001, February 6, 2002. When applicable, these FY2001 upper income limit data were updated by CRS to reflect effective thresholds during FY2002. The State-reported SCHIP enrollment figures are taken from Centers for Medicare and Medicaid Services, Fiscal Year 2002 Number of Children Ever Enrolled in SCHIP – Preliminary Data Summary, January 31, 2003.

## COST SHARING

Cost-sharing refers to the out-of-pocket payments made by beneficiaries of a health insurance plan. Cost-sharing may include, for example, monthly premiums, enrollment fees, deductibles, copayments, coinsurance and other similar charges.

Federal law permits States to impose cost-sharing for some beneficiaries and some services under SCHIP. States that choose to implement SCHIP as a Medicaid expansion must follow the nominal cost-sharing rules of the Medicaid program.

If a State implements SCHIP through a separate State program, premiums or enrollment fees for program participation may be imposed, but the maximum allowable amount is dependent on family income. For all families with incomes under 150 percent FPL and enrolled in separate State programs, premiums may not exceed the amounts set forth in Federal Medicaid regulations.

Additionally, these families may be charged service-related cost-sharing, but such cost-sharing is limited to (1) nominal amounts defined in Federal Medicaid regulations for the subgroup with income below 100 percent FPL, and (2) slightly higher amounts defined in SCHIP regulations for families with income between 101-150 percent FPL. For families with income above 150 percent FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher income children is not less than cost-sharing for lower income children.

Most importantly, the total annual aggregate cost-sharing (including premiums, deductibles, copayments and any other charges) for all children in any SCHIP family may not exceed 5 percent of total family income for the year. In addition, States must inform families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.

Preventive services are exempt from cost-sharing for all families regardless of income. The Centers for Medicare and Medicaid Services (CMS) defines preventive services to include the following: all healthy newborn inpatient physician visits, including routine screening (inpatient and outpatient); routine physical examinations; laboratory tests; immunizations and related office visits; and routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays).

## FINANCING

The Balanced Budget Act of 1997 appropriated a total of $39.7 billion for SCHIP for fiscal years 1998 through 2007.[6] The funding level by fiscal year varies across time. The total annual appropriation for each of fiscal years 1998 through 2001 is about $4.3 billion. This annual total drops to about $3.2 billion for fiscal years 2002 through 2004, then rises to $4.1 billion for fiscal years 2005 and 2006, with a further increase to $5.0 billion in fiscal year 2007. The drop in funding for

[6] The law set aside 0.25 percent of SCHIP funds for five territories and commonwealths (Puerto Rico, Guam, Virgin Islands, American Samoa, and the Northern Mariana Islands). It also set aside $60 million annually for Special Diabetes Grants for fiscal year 1998 through fiscal year 2002 only.

fiscal years 2002 through 2004, sometimes referred to as the "SCHIP dip," was written into SCHIP's authorizing legislation due to budgetary constraints applicable at the time the legislation was drafted.

Allotment of funds among the States is determined by a formula set in law. This formula is based on a combination of the number of low-income children and low-income, uninsured children in the State, and includes a cost factor that represents average health service industry wages in the State compared to the national average. A State must draw down its entire allotment for a given fiscal year before it can access the next year's funding.

States have three fiscal years in which to draw down a given year's allotment. For example, fiscal year 2002 allotments are available until the end of fiscal year 2004. At the end of the applicable three-year period, unspent allotments are subject to redistribution among only those States that fully expend their allotments, by a method to be determined by the Secretary.

In 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established special redistribution rules for unspent fiscal years 1998 and 1999 allotments. The reallocation process is the same for each of these two fiscal years and is applied to each year separately. From those States that did not fully expend their original allotments for a given year within the applicable three-year time frame, a pool of unused funds was formed. From this pool, 1.05% was set aside for redistribution among the 5 territories that exceeded their original allotments for that year based on each territory's designated proportion of the original total appropriation established for the territories. Then the States that fully expended (exceeded) their original allotments for that year received redistributed funds equal to their excess spending–12 States for fiscal year 1998 redistributions and 13 States for fiscal year 1999 redistributions. Finally, the remaining States that did not use all their original allotments for these years retained a portion of the remaining unused funds in the pool, equal to the ratio of such a State's unspent original allotment to the total amount of unspent funds for that fiscal year. The deadline for spending all fiscal year 1998 and 1999 reallocated funds was September 30, 2002.

In August 2003, the State Children's Health Insurance Program Allotments Extension Act (Public Law 108-74) extended the availability of fiscal year 1998 and 1999 reallocated funds through the end of fiscal year 2004. This law also created a special redistribution rule for unspent fiscal year 2000 and 2001 SCHIP allotments that differs from the approach used for the fiscal year 1998 and 1999 reallocation process. The fiscal year 2000 and 2001 methodology is identical for each of these two years and is applied to each year separately. For example, for fiscal year 2000, each State that did not spend its full original allotment by the 3-year deadline will retain 50 percent of its unspent funds. The remaining unspent funds across such States will form a pool for redistribution among the territories and remaining States that did fully expend (and exceeded) their original fiscal year 2000 allotments by the 3-year deadline. Of the total redistribution pool, 1.05 percent is earmarked for the territories, each of which will receive an amount from this earmark that is equal to its designated proportion of the total fiscal year

2000 funds originally allotted to the territories. The remaining redistribution pool is divided among those States that exceeded their original fiscal year 2000 allotments. Each such State will receive an amount that is based on the proportion of its excess spending relative to the total amount of excess spending for all such States. Reallocated fiscal year 2000 and 2001 funds are available until the end of fiscal years 2004 and 2005, respectively. Finally, this new law also permits certain States to use up to 20 percent of their reallocated fiscal year 1998 through 2001 SCHIP funds for Medicaid expenditures for services delivered to Medicaid beneficiaries under age 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150 percent of the FPL. (See the Legislative History section for more details.)

Like Medicaid, SCHIP is a Federal-State matching program. For each dollar of State spending, the Federal government makes a matching payment drawn from SCHIP allotments. A State's share of program spending for Medicaid is equal to 100 percent minus the Federal medical assistance percentage (FMAP). The enhanced SCHIP FMAP is equal to a State's Medicaid FMAP increased by the number of percentage points that is equal to 30 percent multiplied by the number of percentage points by which the FMAP is less than 100 percent.[7] For example, in States with a Medicaid FMAP of 60 percent, the enhanced FMAP equals the Medicaid FMAP increased by 12 percentage points (60 percent + [30 percent multiplied by 40 percentage points] = 72 percent). In this example, the State share is 100 percent - 72 percent = 28 percent.

Compared with the Medicaid FMAP, which ranges from 50 percent to 76.62 percent in fiscal year 2003, the enhanced FMAP for SCHIP ranges from 65 percent to 83.63 percent. All SCHIP assistance for targeted low-income children, including child health coverage provided through a Medicaid expansion, is eligible for the enhanced FMAP. The Medicaid FMAP and the enhanced SCHIP FMAP are subject to a ceiling of 83 percent and 85 percent, respectively.

There is a limit on Federal spending for SCHIP administrative expenses, which include activities such as data collection and reporting, as well as outreach and education. For Federal matching purposes, a 10 percent cap applies to State administrative expenses. This cap is tied to the dollar amount that a State draws down from its annual allotment to cover benefits under SCHIP, as opposed to 10 percent of a State's total annual allotment.

## GENERAL PROGRAM CHARACTERISTICS

The 50 States, the District of Columbia and 5 territories operate 56 SCHIP programs. As of May 2002, 21 had Medicaid expansions, 16 had separate State programs, and 19 provided health insurance coverage through a combination

[7] The Federal medical assistance percentage (FMAP) and the enhanced Federal medical assistance percentage (enhanced FMAP) are calculated and published annually by the Secretary of HHS. FMAP is a measure of the average income per person in each State, squared, compared to that of the nation as a whole. This formula is designed to provide a higher FMAP to States with lower per capita income.

approach. Because some States had multiple plans for different SCHIP subgroups, in total the 35 States with separate SCHIP programs (SSPs) actually had 42 distinct programs identified by CRS. For example, some States have created more than one SSP for children at different income levels with different benefit packages. As of May 2002, among these 42 SSPs, 15 were benchmark plans (10 based on the State employees' health plan, 4 based on the largest commercial HMO and 1 based on FEHBP). Another 14 SSPs were Secretary-approved programs (11 modeled after Medicaid, 2 modeled after the State employees' health plan and 1 that built upon a comprehensive Medicaid waiver demonstration financed through SCHIP). Ten SSPs were classified as benchmark-equivalent (six equivalent to the State employees' health plan, two equivalent to FEHBP, one equivalent to the largest commercial HMO, and one exceeding the actuarial value of all three types of benchmark plan options). Finally, three SSPs were unique comprehensive State-based plans that were deemed to meet SCHIP requirements under the Balanced Budget Act of 1997.

SCHIP programs across States are evolving rapidly as evidenced by the numerous changes States have made to their original State plans over time. As of February 2003, 150 amendments to original State plans had been approved and 17 more were in review. Several States have multiple amendments. The content of the plan amendments varies among States. For example, some States use amendments to extend coverage beyond income levels defined in their original State plans. Others define new copayment standards for program participants. Still others modify benefit packages.

In addition to the amendment process, States that want to make changes to their SCHIP programs that go beyond what the law will allow may do so through what is called an 1115 waiver (named for the section of the Social Security Act that defines the circumstances under which such waivers may be granted). The Secretary may waive certain statutory requirements for conducting research and demonstration projects under SCHIP that allow States to adapt their programs to specific needs. On August 4, 2001, the Bush Administration announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. Using 1115 waiver authority, this initiative is designed to encourage States to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on Statewide approaches that maximize private health insurance coverage options and target populations with income below 200 percent FPL.

As of March 2003, CMS had approved 12 SCHIP 1115 waivers in 10 States.[8] Four additional 1115 waiver proposals were under review at that time. Five of the twelve approved waivers are HIFA demonstrations in Arizona, California, Colorado, New Jersey, and New Mexico. In eight of the ten States with approved 1115 waivers (excluding Maryland and Ohio), SCHIP coverage is expanded to include one or more categories of adults[9] with children, typically

[8] The 10 States are Arizona, California, Colorado, Maryland, Minnesota, New Jersey, New Mexico, Ohio, Rhode Island, and Wisconsin. New Jersey and New Mexico each have two approved 1115 waivers. The remaining States have one waiver each.

[9] As noted above, States have the option to purchase family coverage under a group health plan that may

parents of Medicaid/SCHIP children, caretaker relatives, legal guardians, and/or pregnant women. Two States (Arizona and New Mexico) also cover childless adults under their HIFA demonstrations. In addition to expanding coverage to new populations under waivers, some States have used this authority for other purposes. Rhode Island will use redistributed SCHIP funds to finance coverage of adults with children in its waiver program. Through HIFA, New Jersey will offer the same (SCHIP) benefit package to adults covered under its SCHIP and Medicaid waiver demonstrations. Using 1115 waiver authority, both Maryland and New Mexico require a 6-month period of no insurance prior to enrollment under their waivers.[10] New Mexico also has modified its cost-sharing rules for SCHIP Medicaid expansion participants. Finally, Ohio received approval to implement an annual enrollment fee and to give 12 months of continuous eligibility for certain beneficiaries in its Medicaid expansion.[11]

## TRENDS IN ENROLLMENT AND EXPENDITURES

Nearly 1 million children (982,000) were enrolled in SCHIP under 43 operational State programs as of December 1998.[12] Nearly 2 million children (1,979,450) were enrolled in SCHIP during fiscal year 1999 under 53 operational State programs.[13] The latest official numbers show that SCHIP enrollment reached a total of 5.3 million children in fiscal year 2002 (see Table 15-SCHIP-1). Of this total, 4.0 million were covered in separate State programs, and 1.3 million participated in SCHIP Medicaid expansions. In addition, five States also reported enrollment of nearly 350,000 adults in fiscal year 2002. Two of these States (New Jersey and Wisconsin) accounted for nearly three-fourths of adult enrollment in SCHIP. Adult enrollment exceeded child enrollment in three of these States (New Jersey, Rhode Island, and Wisconsin).

To date, SCHIP spending has fallen well below allotment levels for a variety of reasons. Despite the fact that 42 States began enrolling children in their SCHIP programs in late 1997 or 1998 (see Table 15-SCHIP-1), new programs take time to get off the ground and participation rates rose more slowly than expected. Table 15-SCHIP-2 shows total available funds and cumulative spending by State for fiscal year 1998 through fiscal year 2002, as of the end of fiscal year 2002.

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cover adults as long as it is cost-effective to do so (relative to the amount paid for comparable coverage for the children only), and it must not substitute for health insurance that otherwise would be provided to the children. For States seeking greater flexibility both in selecting which adults to cover and in the benefit package offered to those adults, a waiver is required.

[10] In general, for Medicaid expansions under SCHIP, all Medicaid rules apply. Thus, when States with SCHIP Medicaid expansions want to implement other rules (e.g., establish waiting periods before enrollment, implement enrollment fees, etc.), a waiver is required.

[11] Due to a variety of budget and resource constraints, in May 2002, Ohio decided not to pursue implementation of its waiver.

[12] U.S. Health Care Financing Administration. *A Preliminary Estimate of the Children's Health Insurance Program Aggregate Enrollment Numbers Through December 31, 1998* (background only). April 20, 1999.

[13] U.S. Health Care Financing Administration. *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999* (no date).

During this period, States had access to fiscal years 1998 and 1999 redistributed funds as well as their original allotments for fiscal years 2000, 2001 and 2002. By the end of fiscal year 2002, eight States had spent less than 25 percent of their available allotments. Of these eight States, two had spent less than 10 percent of these funds. Another 21 States had used between one-fourth and one-half of their allotments. The remaining 22 States had expended more than 50 percent of available funds. Of these 22 States, 2 had spent more than 75 percent of their allotments. As SCHIP enrollment across States grows over time, expenditures under the program are likely to account for an ever increasing share of available allotments.

TABLE 15-SCHIP-2--SCHIP PROGRAM ALLOTMENTS AND EXPENDITURES BY STATE, FISCAL YEARS 1998-2002

[In Thousands of Dollars]

| | Total available (Adjusted)[1] allotments for fiscal years 1998-2002 | Total expenditures applied against allotments | Percent of available (adjusted)[1] allotments spent | Allotment balance at end of fiscal year 2002[2] |
|---|---|---|---|---|
| Alabama | $320,043 | $153,953 | 48.1 | $166,090 |
| Alaska | $91,051 | $66,482 | 73.0 | $24,569 |
| Arizona | $479,610 | $213,005 | 44.4 | $266,605 |
| Arkansas | $195,714 | $6,213 | 3.2 | $189,501 |
| California | $2,998,522 | $1,022,659 | 34.1 | $1,975,864 |
| Colorado | $184,182 | $76,067 | 41.3 | $108,115 |
| Connecticut | $154,601 | $54,410 | 35.2 | $100,191 |
| Delaware | $37,435 | $7,190 | 19.2 | $30,245 |
| District of Columbia | $46,358 | $17,008 | 36.7 | $29,349 |
| Florida | $1,059,194 | $648,261 | 61.2 | $410,933 |
| Georgia | $543,921 | $239,137 | 44.0 | $304,784 |
| Hawaii | $40,828 | $7,363 | 18.0 | $33,465 |
| Idaho | $83,117 | $40,113 | 48.3 | $43,005 |
| Illinois | $573,738 | $128,896 | 22.5 | $444,842 |
| Indiana | $461,019 | $235,787 | 51.1 | $225,232 |
| Iowa | $143,700 | $79,904 | 55.6 | $63,797 |
| Kansas | $132,745 | $82,104 | 61.9 | $50,641 |
| Kentucky | $374,247 | $217,915 | 58.2 | $156,333 |
| Louisiana | $351,625 | $140,437 | 39.9 | $211,188 |
| Maine | $85,592 | $48,956 | 57.2 | $36,636 |
| Maryland | $446,975 | $318,362 | 71.2 | $128,613 |
| Massachusetts | $358,621 | $189,717 | 52.9 | $168,904 |
| Michigan | $441,650 | $128,810 | 29.2 | $312,840 |
| Minnesota | $129,139 | $65,423 | 50.7 | $63,716 |
| Mississippi | $240,217 | $147,912 | 61.6 | $92,305 |
| Missouri | $343,483 | $175,404 | 51.1 | $168,080 |
| Montana | $58,964 | $30,839 | 52.3 | $28,125 |
| Nebraska | $72,741 | $31,138 | 42.8 | $41,603 |
| Nevada | $128,342 | $47,977 | 37.4 | $80,365 |

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TABLE 15-SCHIP-2--SCHIP PROGRAM ALLOTMENTS AND EXPENDITURES BY STATE, FISCAL YEARS 1998-2002-continued

[In Thousands of Dollars]

| | Total available (adjusted)[1] allotments for fiscal years 1998-2002 | Total expenditures applied against allotments | Percent of available (adjusted)[1] allotments spent | Allotment balance at end of fiscal year 2002[2] |
|---|---|---|---|---|
| New Hampshire | $44,369 | $9,413 | 21.2 | $34,956 |
| New Jersey | $542,408 | $451,398 | 83.2 | $91,009 |
| New Mexico | $209,107 | $26,128 | 12.5 | $182,979 |
| New York | $2,517,549 | $1,405,833 | 55.8 | $1,111,716 |
| North Carolina | $545,750 | $257,313 | 47.1 | $288,437 |
| North Dakota | $23,829 | $8,164 | 34.3 | $15,664 |
| New Hampshire | $44,369 | $9,413 | 21.2 | $34,956 |
| New Jersey | $542,408 | $451,398 | 83.2 | $91,009 |
| Ohio | $589,150 | $326,767 | 55.5 | $262,383 |
| Oklahoma | $302,822 | $107,317 | 35.4 | $195,505 |
| Oregon | $181,828 | $51,227 | 28.2 | $130,601 |
| Pennsylvania | $588,656 | $317,709 | 54.0 | $270,947 |
| Rhode Island | $70,031 | $65,522 | 93.6 | $4,510 |
| South Carolina | $437,593 | $206,138 | 47.1 | $231,455 |
| South Dakota | $34,379 | $18,542 | 53.9 | $15,836 |
| Tennessee | $307,585 | $60,139 | 19.6 | $247,446 |
| Texas | $1,882,714 | $881,015 | 46.8 | $1,001,700 |
| Utah | $125,376 | $69,232 | 55.2 | $56,143 |
| Vermont | $17,536 | $6,848 | 39.0 | $10,688 |
| Virginia | $284,710 | $92,210 | 32.4 | $192,500 |
| Washington | $205,491 | $14,180 | 6.9 | $191,310 |
| West Virginia | $95,929 | $59,860 | 62.4 | $36,069 |
| Wisconsin | $248,170 | $159,327 | 64.2 | $88,843 |
| Wyoming | $28,126 | $7,160 | 25.5 | $20,966 |
| MOE[3] | $7,894 | NA | NA | $7,894 |
| Puerto Rico | $208,136 | $178,424 | 85.7 | $29,711 |
| Guam | $7,953 | $5,550 | 69.8 | $2,403 |
| Virgin Islands | $5,908 | $4,079 | 69.1 | $1,828 |
| American Samoa | $2,598 | $4,128 | 158.9 | -$1,530 |
| Northern Mariana Islands | $2,499 | $5,203 | 208.2 | -$2,704 |
| Total | $20,095,471 | $9,420,272 | 46.9 | $10,675,199 |

[1] "Adjusted" refers to increases or decreases to the amounts provided through the redistribution of unspent FYs 1998 and 1999 funds. For States that received redistributions of other States' unspent funds, this amount is greater than what was provided by original allotments. For States that contributed unspent funds to the pool for redistribution to other States, this amount is less than what was provided by original allotments.

[2] Figures in this column do not show the exact amount of funds available to States in FY2003. Some States lost access to unspent reallocated money from FYs 1998 and 1999, and unspent FY2000 original allotments, all of which expired on September 30, 2002. In addition, some States will gain additional funds through the redistribution of unspent FY2000 allotments that CMS will make available in the spring of 2003. Also new FY2003 allotments became available on October 1, 2002.

TABLE 15-SCHIP-2--SCHIP PROGRAM ALLOTMENTS AND EXPENDITURES BY STATE, FISCAL YEARS 1998-2002-continued

[In Thousands of Dollars]

[3] MOE refers to one of the maintenance of effort provisions in SCHIP statute. When SCHIP was created, three States – Florida, New York and Pennsylvania – had existing comprehensive State-based health benefit programs for children that were deemed to meet SCHIP requirements. These States are required to maintain their prior level of spending under SCHIP. Specifically, beginning in FY1999, the allotment for a given fiscal year will be reduced by the difference between the States' spending in the prior fiscal year versus fiscal year 1996 (before SCHIP began). The $7.9 million shown for MOE in this table reflects spending patterns in Pennsylvania for FY1999, in which Pennsylvania's share of SCHIP costs was $7.9 million less than FY1996 spending, so its allotment for FY2000 has been reduced by $7.9 million. This amount will be included in the redistribution process for FY2000. (Pennsylvania's share of FY1998 SCHIP costs was $2.2 million less than FY1996 spending, and its SCHIP allotment for FY1999 was reduced by $2.2 million. This amount is not shown in the MOE cell because it has already been redistributed to other States in the FY1999 redistribution process.)

NA-Not applicable

Source: Centers for Medicare and Medicaid Services, last updated November 20, 2002.

Nationally, through September 2002, $9.4 billion or 47 percent of available funds had been expended, leaving an unspent balance of approximately $10.7 billion from the fiscal years 1998 through 2002 allotments. As of October 2003, several SCHIP allotment accounts are available to the States and territories. (Accessing each account is subject to specific rules.) These "open accounts" include fiscal years 1998 and 1999 reallocated funds (available through the end of fiscal year 2004), unspent fiscal years 2000 and 2001 allotments to be reallocated among all of the States and territories based on a special redistribution formula (available through the end of fiscal years 2004 and 2005, respectively), and the three original allotment accounts for fiscal years 2002, 2003, and 2004, not yet subject to redistribution (available through the end of fiscal years 2004, 2005, and 2006 respectively).

## LEGISLATIVE HISTORY

Below is a summary of major SCHIP changes enacted in public laws beginning with the legislation authorizing the program in 1997:

Balanced Budget Act of 1997 (BBA 1997), Public Law 105-33:

*Creation of SCHIP*—Under BBA 1997, the State Children's Health Insurance Program was established, effective August 5, 1997. A number of provisions specified eligibility criteria; coverage requirements for health insurance; Federal allotments and the State allocation formula; payments to States and the enhanced FMAP formula; the process for submission, approval and amendment of State SCHIP plans; strategic objectives and performance goals, and plan administration; annual reports and evaluations; options for expanding coverage of children under Medicaid; and diabetes grant programs.

District of Columbia Appropriations Act of 1998, Public Law 105-100:

*Increased appropriation*—This law increased the fiscal year 1998 SCHIP appropriation from $4.275 billion to $4.295 billion.

Omnibus Consolidated and Emergency Supplemental Appropriation Act, fiscal year 1999, Public Law 105-277:

*Increased appropriation for territories*—For fiscal year 1999, an additional appropriation of $32 million for the territories was provided, bringing the fiscal year 1999 total appropriation to $4.307 billion.

*Change in allotment formula affecting some Native American children.*—For fiscal year 1998 and fiscal year 1999, the law changed the annual State allotment formula by stipulating that children with access to health care funded by the Indian Health Service and no other health insurance would be counted as uninsured (rather than as insured as required under the previously existing law).

The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999), incorporated by reference in the Consolidated Appropriations Act for Fiscal Year 2000, Public Law 106-113:

*Stabilizing the SCHIP allotment formula*—Annual Federal allotments to each State are determined in part by States' success in covering previously uninsured low-income children under SCHIP. Under prior law, the more successful a State was in enrolling children in SCHIP, especially early in the program, the greater the potential reduction in subsequent annual allotments. To limit the amount a State's allocation can fluctuate from one year to the next, BBRA 99 modified the allotment distribution formula and established new floors and ceilings.

*Targeted, increased allotments*—Additional allotments for the commonwealths and territories were provided for fiscal years 2000 through 2007.

*Improved data collection*—The law provided new funding for the collection of data to produce reliable, annual State-level estimates of the number of uninsured children. These data changes will improve research and evaluation efforts. They also will affect State-specific counts of the number of low-income children and the number of such children who are uninsured that feed into the formula that determines annual State-specific allotments from Federal SCHIP appropriations.

*Federal evaluation*—New funding also was provided for a Federal evaluation[14] to identify effective outreach and enrollment practices for both SCHIP and Medicaid, barriers to enrollment, and factors influencing beneficiary dropout.

*Additional reports and a clearinghouse*—The law also required: (a) an inspector general audit[15] and GAO report on enrollment of Medicaid-eligible

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[14] *Implementation of the State Children's Health Insurance Program: Momentum is Increasing After a Modest Start*, First Annual Report, Cambridge, MA: Mathematica Policy Research, Inc., January 2001. Additional reports describing results from other components of the national evaluation of SCHIP are available from the U.S. Department of Health and Human Services.

[15] The OIG has issued two audit reports: Department of Health and Human Services, Office of Inspector General: *State Children's Health Insurance Program: Assessment of State Evaluations Reports*, OEI-05-00-00240, February 2001, and Department of Health and Human Services, Office of Inspector

children in SCHIP,[16] (b) States to report annually the number of deliveries to pregnant women and the number of infants who receive services under the Maternal and Child Health Services Block Grant or who are entitled to SCHIP benefits, and (c) the Secretary of Health and Human Services to establish a clearinghouse for the consolidation and coordination of all Federal databases and reports regarding children's health.

Agriculture Risk Protection Act of 2000, Public Law 106-224:
See the description of this law in the *Medicaid* subsection.

Children's Health Act of 2000, Public Law 106-310:

*Rights of institutionalized children*—The law requires that general hospitals, nursing facilities, intermediate care facilities and other health care facilities receiving Federal funds, including SCHIP, protect the rights of each resident, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for the purposes of discipline or convenience. Restraints and seclusion may be imposed in such facilities only to ensure the physical safety of the resident, a staff member or others. Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

*Children's rights in community-based settings*—The law also includes requirements for protecting the rights of residents of certain non-medical, community-based facilities for children and adolescents, when that facility receives funding under this Act or under Medicaid. (Forthcoming regulations are expected to clarify if and how these rights apply to such facilities funded by SCHIP.) For such individuals and facilities, restraints and seclusion may be imposed only in emergency circumstances and only to ensure the physical safety of the resident, a staff member, or others, and only when less restrictive interventions have been determined to be ineffective. Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), incorporated by reference into the Consolidated Appropriations Act 2001, Public Law 106-554:

*Special redistribution rules for unspent fiscal year 1998 and 1999 allotments*—For each of these years separately, a pool of unspent funds is created from the unused allotment amounts of those States that did not fully expend their original allotments within the applicable 3-year time frame. From this pool, 1.05 percent is set aside for the territories that exceeded their original allotments for

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General: *State Children's Health Insurance Program: Ensuring Medicaid Eligibles are not Enrolled in SCHIP*, OEI-05-00-00241, February 2001.

[16] U.S. General Accounting Office: *Children's Health Insurance: Inspector General Reviews Should Be Expanded to Further Inform the Congress*, GAO-02-512, March 2002.

that year, based on each territory's designated proportion of the original total appropriation allotted to the territories. Then the States that fully expended (exceeded) their original allotments for that year receive redistributed funds from the remaining pool equal to their excess spending. The remaining States that did not use all their original allotments for the year retain a portion of the remaining funds in the pool, equal to the ratio of such a State's unspent original allotment to the total amount of unspent funds for that fiscal year. These latter States are permitted to use up to 10 percent of their retained fiscal year 1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap described above. The deadline for spending all redistributed and retained funds from fiscal years 1998 and 1999 is September 30, 2002. (See the text for additional information on redistribution of unspent SCHIP funds.)

*Presumptive eligibility*—Under Medicaid presumptive eligibility rules States are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards, until a final formal determination of eligibility is made. BIPA clarified States' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

*Authority to pay SCHIP Medicaid expansion costs from Title XXI appropriation*—Under prior law, States' allotments under SCHIP paid only the Federal share of costs associated with separate (non-Medicaid) SCHIP programs. The Federal share of costs associated with SCHIP Medicaid expansions was paid for under Medicaid. State SCHIP allotments were reduced by the amounts paid under Medicaid for SCHIP Medicaid expansion costs. BIPA authorized the payment of the costs of SCHIP Medicaid expansions and the costs of benefits provided during periods of presumptive eligibility from the SCHIP appropriation rather than the Medicaid appropriation, and as a conforming amendment, eliminated the requirement that State SCHIP allotments be reduced by these (former) Medicaid payments. Also, for fiscal years 1998 through 2000 only, BIPA authorized the transfer of unexpended SCHIP appropriations to the Medicaid appropriation account for the purpose of reimbursing payments associated with SCHIP Medicaid expansion programs.

Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Public Law 107-188:

See the description of this law in the *Medicaid* subsection.

Health Care Safety Net Amendments of 2002, Public Law 107-251:

See the description of this law in the *Medicaid* subsection.

State Children's Health Insurance Program Allotments Extension Act, Public Law 108-74:

*Extension of available SCHIP reallocated funds from fiscal years 1998 and 1999*—This law extends the availability of fiscal year 1998 and 1999 reallocated

funds through the end of fiscal year 2004 (rather than the end of fiscal year 2002).

*Revision of methods for reallocation of unspent fiscal years 2000 and FY2001, and extension of the availability of such funds*—The law also establishes a new method for reallocating unspent funds from fiscal years 2000 and 2001 allotments. For fiscal year 2000, each State (and territory) that did *not* spend its full original allotment by the 3-year deadline retains 50% of its unspent funds. The remaining 50 percent from each such State forms a pool of unspent funds for redistribution among the territories and other States that did fully expend (and exceeded) their fiscal year 2000 allotments by the 3-year deadline. First, 1.05 percent of the total redistribution pool is set aside for allocation among the territories, from which each of the territories receives an amount equal to its designated proportion of the total fiscal year 2000 funds originally allotted to the territories. Then the remaining redistribution pool is allocated to each State that fully expended (exceeded) its fiscal year 2000 original allotment by the 3-year deadline. The redistribution amount for each such State is based on the proportion of its excess spending relative to the total amount of excess spending for all such States. The same methodology is applied to reallocation of unspent fiscal year 2001 original allotments. Reallocated funds for fiscal years 2000 and 2001 are available until the end of fiscal years 2004 and FY2005, respectively.

*Authority for qualifying States to use certain funds for Medicaid expenditures*—The law permits certain States to use not more than 20 percent of reallocated fiscal year 1998 through 2001 SCHIP funds for Medicaid expenditures for services delivered to Medicaid beneficiaries under age 19 whose family income exceeds 150 percent of the federal poverty level (FPL) and who otherwise are not eligible for SCHIP. For such services, the additional payments due are based on the SCHIP enhanced federal matching rate (up to the 20 percent cap on the use of reallocated funds for this purpose). Qualifying States include those that on or after April 15, 1997 had an income eligibility standard of at least 185 percent of the FPL for at least one category of children, other than infants. (Other qualifications apply to States with Statewide waivers under Section 1115 of the Social Security Act.)