



Highlights of [GAO-07-501T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

## Why GAO Did This Study

In August 1997, Congress created the State Children's Health Insurance Program (SCHIP) with the goal of significantly reducing the number of low-income uninsured children, especially those who lived in families with incomes exceeding Medicaid eligibility requirements. Unlike Medicaid, SCHIP is not an entitlement to services for beneficiaries but a capped allotment to states. Congress provided a fixed amount—approximately \$40 billion from fiscal years 1998 through 2007—to states with approved SCHIP plans. Funds are allocated to states annually. Subject to certain exceptions, states have 3 years to use each year's allocation, after which unspent funds may be redistributed to states that have already spent all of that year's allocation.

GAO's testimony addresses trends in SCHIP enrollment and the current composition of SCHIP programs across the states, states' spending experiences under SCHIP, and considerations GAO has identified for SCHIP reauthorization.

GAO's testimony is based on its prior work, particularly testimony before the Senate Finance Committee on February 1, 2007 (see [GAO-07-447T](#)). GAO updated this work with the Centers for Medicare & Medicaid Services' (CMS) January 2007 approval of Tennessee's SCHIP program.

[www.gao.gov/cgi-bin/getrpt?GAO-07-501T](http://www.gao.gov/cgi-bin/getrpt?GAO-07-501T).

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or [allenk@gao.gov](mailto:allenk@gao.gov).

# CHILDREN'S HEALTH INSURANCE

## States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization

### What GAO Found

SCHIP enrollment increased rapidly during the program's early years but has stabilized over the past several years. As of fiscal year 2005, the latest year for which data are available, SCHIP covered approximately 6 million enrollees, including about 639,000 adults, with about 4 million enrollees in June of that year. Many states adopted innovative outreach strategies and simplified and streamlined their enrollment processes in order to reach as many eligible children as possible. States' SCHIP programs reflect the flexibility federal law allows in structuring approaches to providing health care coverage. As of July 2006, states had opted for the following from among their choices of program structures allowed: a separate child health program (18 states), an expansion of a state's Medicaid program (11), or a combination of the two (21). In addition, 41 states opted to cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher, with 7 of these states covering children in families with incomes at 300 percent of FPL or higher. Thirty-nine states required families to contribute to the cost of their children's care in SCHIP programs through a cost-sharing requirement, such as a premium or copayment; 11 states charged no cost-sharing. As of January 2007, GAO identified 15 states that had waivers in place to cover adults in their programs; these included parents and caretaker relatives of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

SCHIP spending was initially low, but now threatens to exceed available funding. Since 1998, some states have consistently spent more than their allotments, while others spent consistently less. States that earlier overspent their annual allotments over the 3-year period of availability could rely on other states' unspent SCHIP funds, a portion of which were redistributed to cover other states' excess expenditures. By fiscal year 2002, however, states' aggregate annual spending began to exceed annual allotments. As spending has grown, the pool of funds available for redistribution has shrunk. As a result, 18 states were projected to have "shortfalls" of SCHIP funds—meaning they had exhausted all available funds—in at least one of the final 3 years of the program. To cover projected shortfalls faced by several states, Congress appropriated an additional \$283 million for fiscal year 2006.

SCHIP reauthorization occurs in the context of debate on broader national health care reform and competing budgetary priorities, highlighting the tension between the desire to provide affordable health insurance coverage to uninsured individuals, including low-income children, and the recognition of the growing strain of health care coverage on federal and state budgets. As Congress addresses reauthorization, issues to consider include (1) maintaining flexibility within the program without compromising the primary goal to cover children, (2) considering the program's financing strategy, including the financial sustainability of public commitments, and (3) assessing issues associated with equity, including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.