

The State Children's Health Insurance Program: Let the Discussions Begin

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Roadmap

- Summary of SCHIP Record: Experiences to Date
- Reauthorization: Key Issues
- Competing Visions For SCHIP

Summary of SCHIP's Record: Experiences to Date

- Though optional, resulted in coverage expansions in all states, with eligibility at 200% FPL or higher in all but about 10 states
- Produced diverse set of programs in terms of program structure, eligibility, cost sharing, and benefits
- Prompted new outreach efforts and enrollment/renewal simplification, much of which spilled over onto Medicaid
- Is a key source of insurance, providing coverage to over 4 million children at a point in time and more than 6 million children over the course of a year

Summary of SCHIP's Record: Experiences to Date

- Contributed to declines in uninsurance among poor and near-poor children
- Econometric evidence is inconclusive on extent of crowd-out, but most SCHIP enrollees lack access to employer coverage
- Contributed to improvements in access to care among low-income children; improvements found for different program types and subgroups of children
- Narrowed race/ethnic gaps in coverage and access

Summary of SCHIP's Record: Experiences to Date

- Though enrollment is still growing in some states, enrollment and coverage gains have stalled nationally in recent years
- An estimated 2 million children are uninsured despite being eligible for SCHIP (Kenney and Cook 2007)
- To date, there have been only limited, ongoing efforts to monitor quality and access in a uniform way across all SCHIP programs
- Perennial issues with federal funding level and structure (formula, redistribution process, etc.)

Near-term Funding Shortfalls in SCHIP

- Partial fix in December 2006 (H.R. 6164) addressed some of the \$745 million in shortfalls projected in 14 states in FY2007
- 14 to 17 states projected to face shortfalls starting in May 2007 (Peterson 2006; Park and Broaddus 2006)
- Georgia is slated to run out of SCHIP funds even sooner which could affect 270,000 children
- At the same time that states are facing shortfalls, about \$4 billion in unspent SCHIP funds have accumulated in other states, with 25 percent of unspent funds in Texas

SCHIP Reauthorization: Key Issues

- How much flexibility to maintain and where?
- How much federal funding to provide and how to allocate across states? Redistribution process?
- Whether/How to promote higher enrollment among SCHIP- (and Medicaid-) eligible children?
 - DRA documentation requirements
 - Barriers to automatic/express lane eligibility
 - Outreach grants/providing performance incentives
 - Coverage gaps among parents
- Whether/How to improve monitoring quality and access to care under SCHIP (and Medicaid)?
 - Funding, structure, demonstrations

While We Await the Specifics of Legislative Proposals, It's Clear that There are Competing Visions for SCHIP...

- Status Quo: Maintain programs in their current form
- Reduce scope of SCHIP to cover just low-income children in existing programs
- Expand SCHIP to provide coverage for more uninsured children
- Expand SCHIP to provide coverage for more low-income families and other low-income groups

Maintaining the Status Quo

- Requires addressing near-term funding shortfalls
- Requires addressing longer-term funding shortfalls
 - CBO baseline includes an annual federal funding level of \$5.0 billion. At that funding level, SCHIP enrollment is projected to fall from 4.4 to 3.1 million over five years (HHS 2006)
 - An estimated \$12.7 to \$14.6 billion in additional funds would be needed to maintain programs at current levels through 2012 (Peterson 2006; Park and Broaddus 2006)
- Any additional funds beyond the CBO baseline require offsetting savings elsewhere in the budget

Administration's SCHIP Proposal (Based on President's Budget, Public Statements of Secretary Leavitt, etc.)

- Funds FY2007 shortfalls out of unspent funds from other states
- Adds about \$5 billion new funds to SCHIP over the next 5 years; seems to assume automatic redistribution of unspent funds
- Limits use of federal SCHIP funds to “low-income” children
 - Definition of low-income?
 - Treatment of “qualifying states”?
 - Use of SCHIP funds for adults?
- Indicates that SCHIP enrollment would decline, according to available evidence

Building on SCHIP to Cover More Children (Many Variants on This)

- SCHIP expansions part of proposals/plans in a growing number of states aimed at achieving universal coverage for children (California, Illinois, Pennsylvania, etc.)
- Use SCHIP reauthorization as a vehicle to fund coverage for more uninsured children, to support state policies to increase participation in Medicaid and SCHIP, and to improve quality under SCHIP (Coalition of groups focused on children's health issues; Sen. Baucus's statement 2/7/07)

Reauthorization: SCHIP at a Crossroads

- Preserving progress achieved to date and helping programs better fulfill basic mission
 - Cover current enrollees and more children who are uninsured
 - Provide access to high quality care
- Reducing scope of SCHIP
 - Focus on low-income children in existing programs
- Addressing broader health care needs of low-income children and their families
 - Low-income parents
 - Low-income adolescents aging out of coverage
 - Wrap around coverage for those with private insurance

Supplemental Materials

Background on the State Children's Health Insurance Program

- SCHIP was created in August 1997
- SCHIP allows states to extend public health insurance coverage to uninsured children not eligible for Medicaid
- SCHIP is a block grant not an entitlement program, funded with \$40 billion over the first 10 years
- States receive a higher federal match for SCHIP
- States can expand Medicaid, create a separate program, or use a combination approach
- States with separate programs have more flexibility than under Medicaid in the areas of benefits, cost sharing, crowd-out prevention, and enrollment limits

State SCHIP Programs are Diverse

- All states expanded eligibility for children under SCHIP: Eligibility thresholds vary from 140% in North Dakota to 350% in New Jersey, but most states set eligibility levels at 200% FPL.
- Over two-thirds of states adopted separate programs, either alone or in combination with smaller Medicaid expansions
- Separate programs' benefits approach breadth of Medicaid and are broader than most private insurance, covering:
 - Preventive services in accordance w/ AAP guidelines
 - Dental, hearing, and vision screening
 - Benefit gaps in some areas for CSHCN
- Around one-fifth of states are covering pregnant women or other adults under SCHIP
- Nearly all separate programs adopted sliding scale monthly premiums or annual enrollment fees, and copayments on selected services and majority use “waiting periods” to deter crowd-out

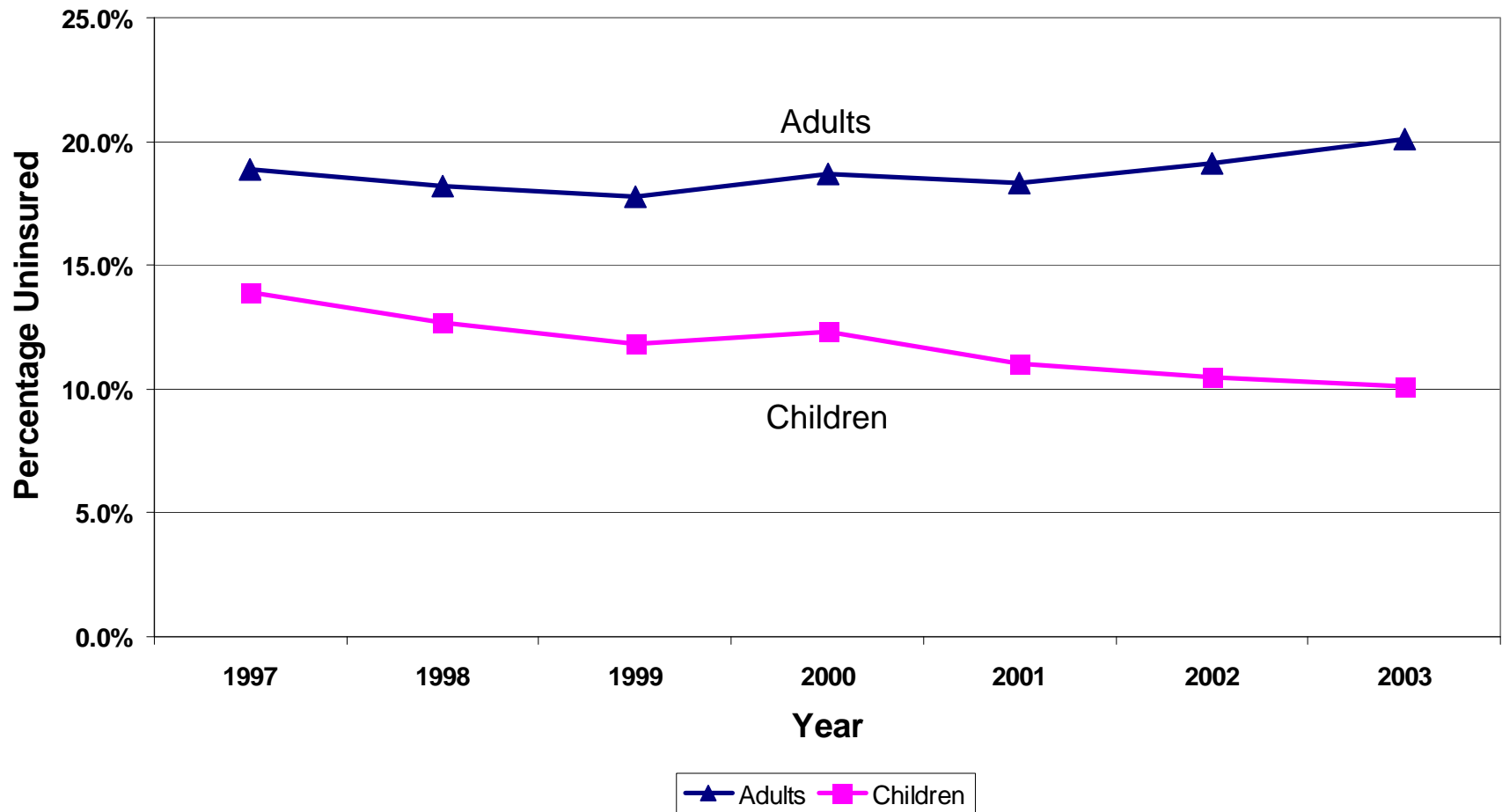
While Medicaid is far larger, SCHIP is now an important source of coverage for children

- SCHIP covers over 4 million children at a point in time and over 6 million children over the course of a year.
- Around 5 to 8 percent of all children and 29% of children who meet the income requirements for the program rely on SCHIP for coverage.

Findings on Insurance Impacts

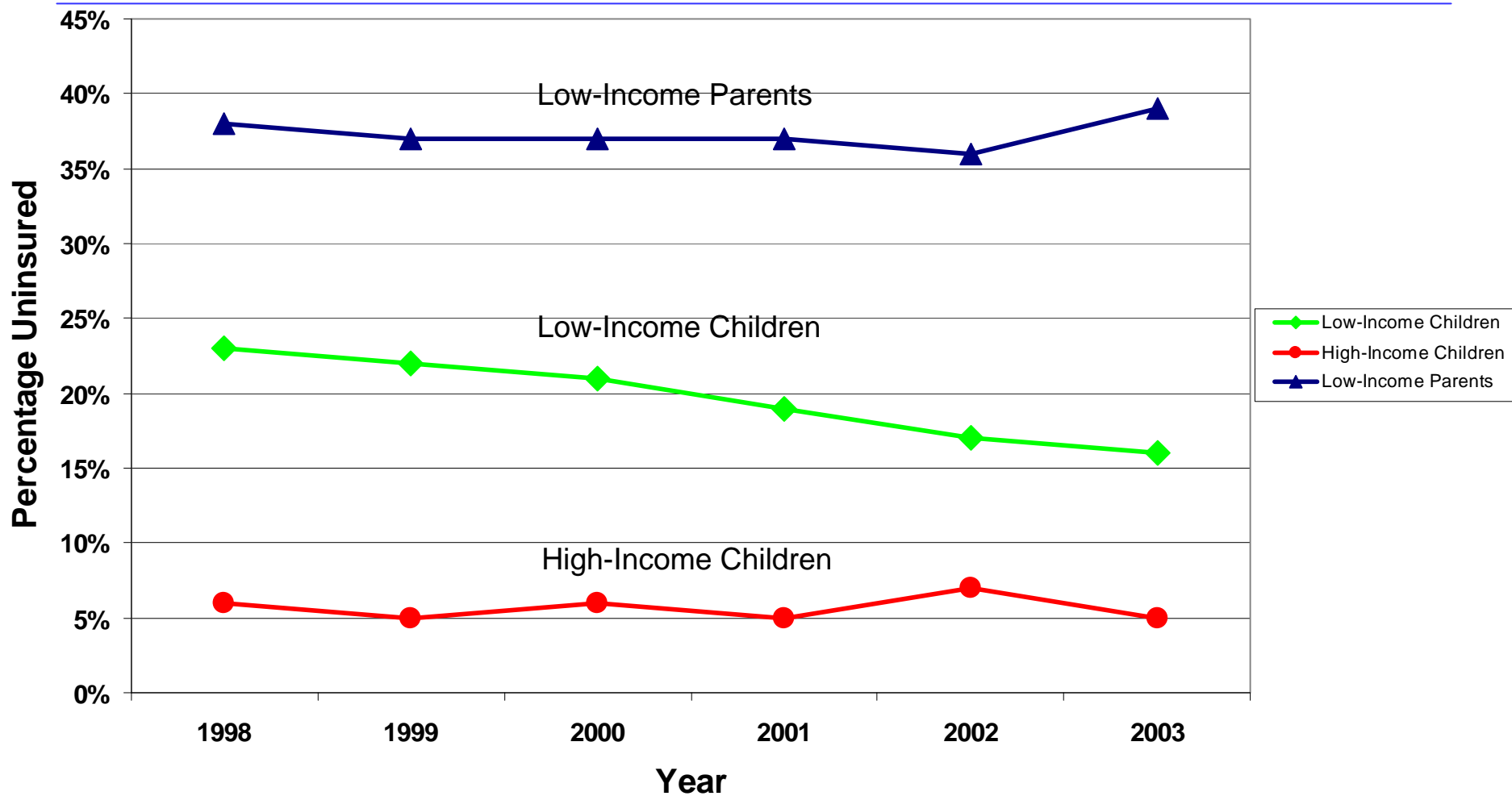
- Every available household survey documents declines in uninsured rates for children in the last decade, in contrast to experiences of adults and higher-income children; gains were concentrated among low-income and minority children; coverage gains were driven by increased participation in Medicaid and SCHIP
- Econometric studies provide inconclusive evidence on the extent of crowd out under SCHIP, with estimates that range from 10 to 70 percent; some evidence that SCHIP lowered employer contributions to family coverage.
- However, access to ESI appears low among SCHIP enrollees--most do not have access to employer-sponsored coverage and few transfer directly from employer-sponsored coverage.
- Direct evidence suggests crowd out lower than what was assumed in CBO baseline estimates for SCHIP.

Share without Health Insurance Coverage at the Time of Interview, by Age Group: 1997-2003



Source: Schiller JS, Martinez M, Barnes P. Early release of selected estimates based on data from the 2005 National Health Interview Survey. National Center for Health Statistics. <http://www.cdc.gov/nchs/nhis.htm>. June 2006.

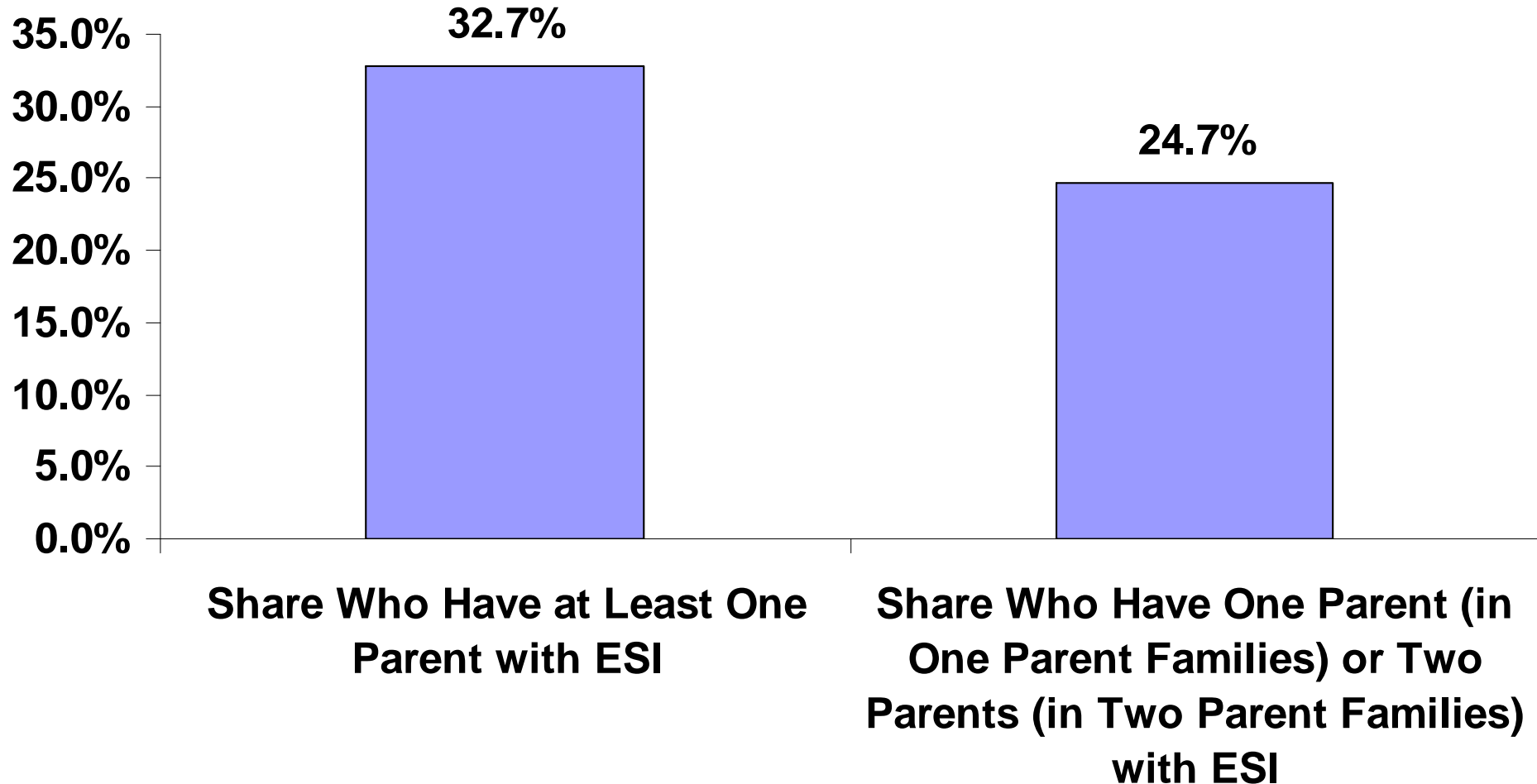
Trends in Uninsurance Among Children by Income and Among Low-Income Parents, 1998-2003



Source: Urban Institute tabulations of the 1998 to 2003 National Health Interview Survey

Note: Low-income families are defined as those with incomes at or below 200% of the Federal Poverty Level.

Most SCHIP Enrollees Do Not Have Access to ESI



SCHIP Contributed to Health Care Gains

- SCHIP enrollees were more likely to receive preventive dental care, to have a usual source of medical care and less likely to have unmet needs for physician services, prescription drugs, dental care, or specialty care (Kenney forthcoming)
- Similar patterns found in different states and for different program types (non-Medicaid and Medicaid SCHIP programs alike) and for children in different race/ethnicity, age, health status categories (Kenney forthcoming)
- Improved functioning and reduced the incidence and frequency of asthma attacks among enrollees with asthma (Szilagyi et al. 2006)
- Reduced hospital admissions for ambulatory care sensitive conditions (Bermudez and Baker 2005)
- Reduced unmet needs and out-of-pocket spending for low-income children who have chronic health problems (Davidoff et al. 2005)
- But no effects found on immunization levels (Joyce and Racine 2005) and mixed effects found on health status and functioning (Seid et al. 2006; Szilagyi et al. 2004; Szilagyi et al. 2006; Damiano et al. 2003)

SCHIP is Meeting the Primary Health Care Needs of Most Enrollees

- Case studies and focus groups with parents of enrollees find benefits to be largely affordable and meeting children's needs
- Nearly half had received a well-child visit in the 6 months prior to the survey
- More than 90% had a usual source of medical care and more than 80% had a usual source of dental care
- More than 80% of parents were very confident they could meet their child's health care needs

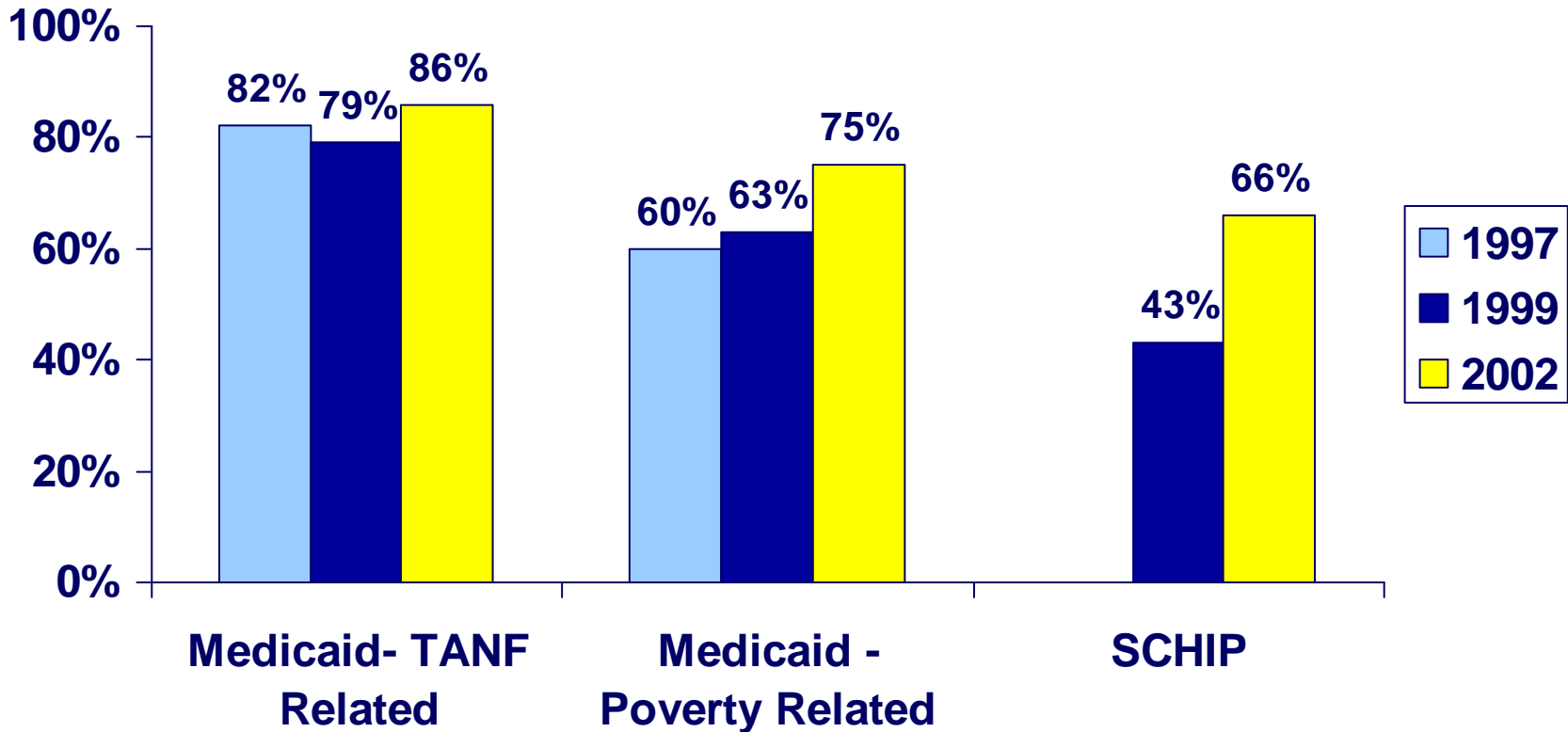
Source: 2002 Congressionally Mandated Survey of SCHIP Enrollees in Ten States.

Some Subgroups of Children Have Lower Access in SCHIP than Others

- Parents with less education and parents who do not speak English were less confident they could meet their child's health care needs
- Children with greater health care needs were more likely to have unmet health care needs and their parents were less confident they could address their child's health care needs

Source: 2002 Congressionally Mandated Survey of SCHIP Enrollees in Ten States.

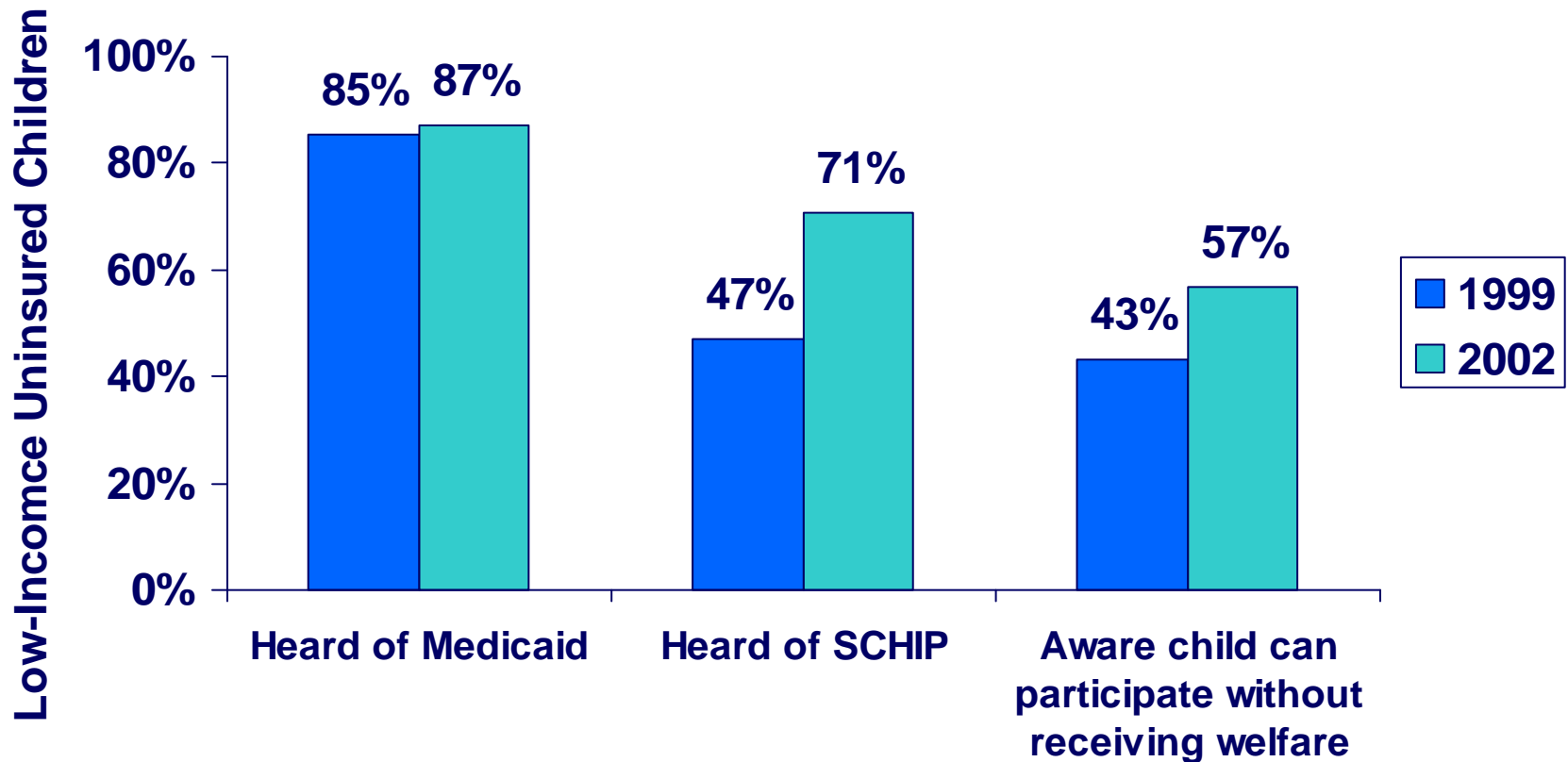
Participation in Both Medicaid and SCHIP Increased After 1999



Source: Urban Institute tabulations of 1997, 1999, and 2002 National Survey of America's Families

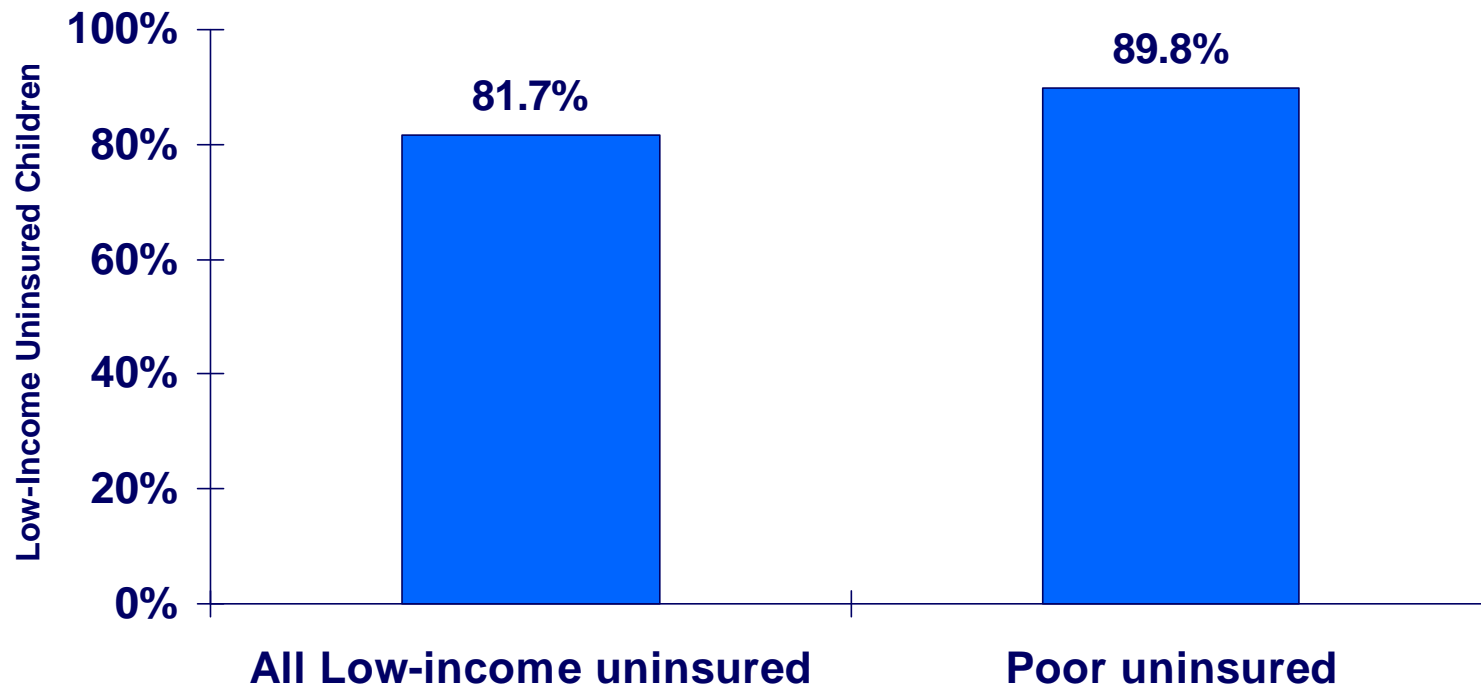
Note: Excludes children with private coverage and defined for citizen children ages 0 to 17.

Familiarity with Public Health Insurance Programs Increased between 1999 and 2002



Source: Kenney, Haley and Tebay (2003)

Interest in Enrolling in Medicaid and SCHIP is High



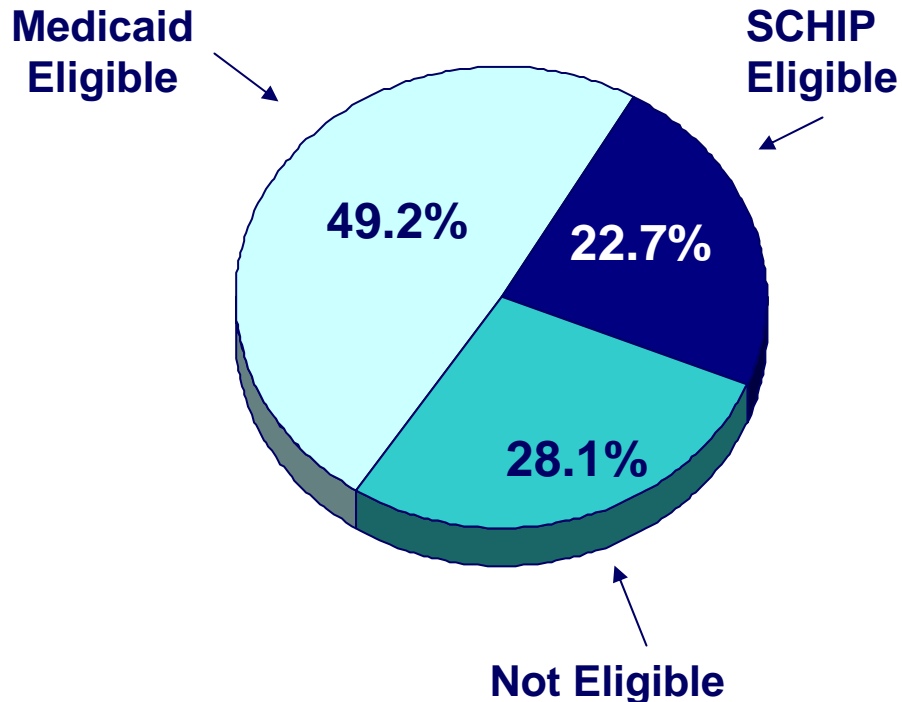
Source: Kenney, Haley and Tebay (2003)

But Barriers to Enrollment Persist

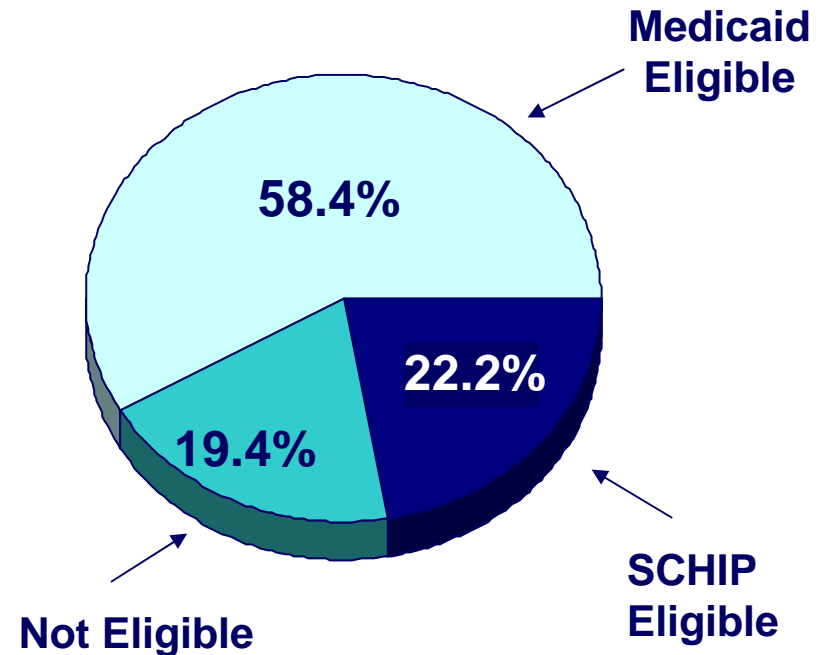
- Many low-income parents with uninsured children
 - Do not know that their child is eligible for Medicaid or SCHIP,
 - Have not heard of the Medicaid and SCHIP programs in their state, and/or
 - Do not believe that the enrollment processes are easy
- Source: Kenney, Haley, and Tebay 2005

Most Uninsured Children are Eligible for Public Insurance Coverage

Uninsured Children



Low-Income Uninsured Children

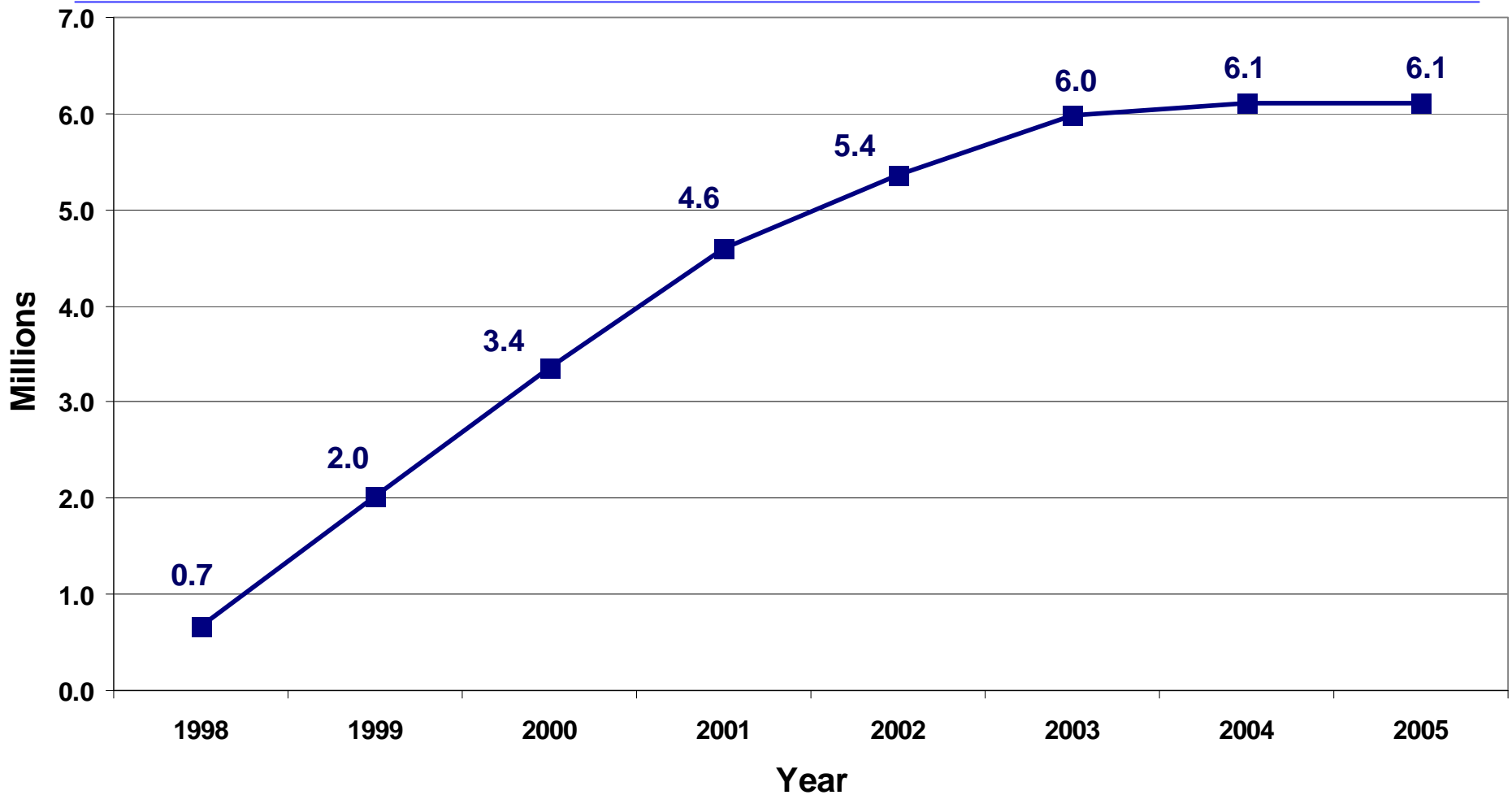


Source: 2002 National Survey of America's Families using July 2002 eligibility rules.

Recent SCHIP Enrollment and Coverage Patterns

- Since 2003, it appears that coverage improvements have slowed for children and the most recent Current Population Survey found an increase in uninsurance among children, particularly in the 100 to 200% FPL income group (Holahan and Cook 2006)
- SCHIP enrollment growth has stalled nationally over the last several years (CMS 2006; Smith, Rousseau, and Marks 2006)
- Recent slower enrollment growth driven in part by state responses to the economic recession earlier this decade and by increasing uncertainty around federal funding levels
- Recent research indicates that close to two million children are uninsured despite being eligible for SCHIP (Kenney and Cook 2007)

SCHIP Enrollment by Fiscal Year



Source: Centers for Medicare & Medicaid Services

Note: These figures reflect the number of children enrolled in SCHIP at any point during the year.

Persistent Uninsured Problem Among SCHIP-eligible Children

- SCHIP participation rates are around 66 percent and close to two million uninsured children appear to be eligible for SCHIP, with about twice that many qualifying for Medicaid
- Research indicates that willingness to enroll in Medicaid and SCHIP is very high, but that knowledge and enrollment barriers persist; uninsurance among parents may be a barrier
- Studies show that premiums, waiting periods, Medicaid/SCHIP coordination, parental coverage, community-based outreach, and reenrollment procedures affect coverage
- Federal policies (e.g. DRA documentation requirements, low federal matching rates on Medicaid/SCHIP IT investments) may adversely affect enrollment

Absence of Ongoing Information on Quality and Access to Care

- Routine, ongoing efforts to monitor quality and access have been limited to date, though there has been an increased focus on bringing uniformity to reporting and measurement.
- There is no regular public reporting on access and quality measures for different subgroups (e.g., children with special health care needs.)
- Improvements in this area would require greater federal resources, more technical support to states, and the imposition of a mandatory, standardized reporting system with a broad set of quality measures; may also involve testing incentives and innovative payment strategies.

Insurance Gaps Among Low-Income Parents

- Over a third (38%) of SCHIP enrollees have an uninsured parent (Kenney and Cook 2007)
- Expanded public eligibility for parents leads to greater public coverage among children (Dubay and Kenney 2003; Summers (2006)
- Lack of coverage raises unmet health needs among parents, which can have adverse effects on children and raise their treatment costs (Ku and Broaddus 2006, Perry 2006)

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