California HealthCare Foundation

Funding California's SCHIP Coverage: What Will It Cost?

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Prepared for:

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About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at **www.chcf.org**.

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I. Introduction

The federal State Children's Health Insurance Program (SCHIP) is a basic source of funding for children's health coverage programs in California. Created in 1997, the program is a federal-state partnership: The federal government sets broad program standards and offers financial support to states, which use the money to create and operate children's coverage programs that best meet the states' goals and needs.

California's SCHIP program is the largest in the country, providing coverage to more than one million children and women each month. Over the past decade, California spent about $5.3 billion in federal dollars through SCHIP toward the provision of children's health insurance. However, the program's funding is set to expire this year.

Without congressional action, no additional federal dollars would be available to California or any other state after September 30, 2007.[1] With the reauthorization debate already under way, two key questions must be answered: (1) How much federal money is needed for California to fund both those children now enrolled and those who might be added due to proposed expansions in eligibility? (2) How many California children are at risk of losing insurance coverage should federal funding end or fall short of projected needs?

To address these questions, the California HealthCare Foundation commissioned Harbage Consulting to develop a five-year budget forecasting model for spending on California programs supported by SCHIP.

The analysis found that an additional $60 billion over five years, as is being sought from Congress by key stakeholder groups, would probably be sufficient for California to meet the needs of its programs.[2,3] California will need between $6.7 billion and $8.1 billion in federal funding over the next five years to meet and sustain the existing state programs funded by SCHIP. This is $2.8 billion to $4.2 billion above the baseline set by the Congressional Budget Office (CBO).[4] The health insurance coverage of over 1.5 million Californians is at issue.[5]

When possible eligibility expansions are included, the funding estimate rises to between $7.4 billion and $8.8 billion, amounts that are $3.5 billion to $4.9 billion above the CBO baseline. Given California's high enrollment numbers, the state is counting upon federal funding significantly above its current allocation to simply maintain these programs.

II. Background

SCHIP HAS BEEN SUCCESSFUL IN DECREASING the ranks of uninsured children in the United States. Within six years of its 1997 inception, the estimated percentage of uninsured children nationwide had dropped from nearly 23 percent to 15 percent, despite an economic recession that resulted in many families losing access to employer-based health insurance.[6] By 2005, the proportion of uninsured children fell to 12 percent. Census figures show that California had a similar experience, with the number falling from 21 percent in 1998 to 14 percent in 2005.[7] The California Health Interview Survey, which began collecting data in 2001, estimated that the proportion of uninsured children fell from 15.2 percent in 2001 to 10.9 percent in 2005.[8]

The Creation of SCHIP

SCHIP, authorized under Title XXI of the Social Security Act, was created in the Balanced Budget Act of 1997 to serve "targeted low-income children," defined as uninsured children under the age of 19 in families with incomes below 200 percent of the federal poverty level (FPL).[9] At that time, Congress allocated $39.6 billion over 10 years to the program, making it the largest expansion of public health insurance since the creation of Medicare and Medicaid in 1965. To implement SCHIP, states could choose to expand their existing Medicaid programs (called Medi-Cal in California), create new children's insurance programs, or opt for a combination of both.[10]

California chose a combination expansion: It initiated a small expansion of coverage under Medicaid, increasing eligibility under Medi-Cal for children ages 6 to 18 from 85 percent to 100 percent FPL, and created a separate program for children in families with incomes above Medi-Cal levels. California designated the Managed Risk Medical Insurance Board (MRMIB) to oversee the state's new SCHIP program, called the Healthy Families Program (HFP).

Federal Funding Formula

Federal SCHIP dollars are awarded at what is called an "enhanced matching rate." Like Medicaid, SCHIP reimburses state program costs at a set percentage. For SCHIP, the reimbursement is 30 percent above a state's Medicaid (or regular) matching rate. In California's case, the enhanced matching rate is 65 percent, meaning that the federal government reimburses 65 cents to California for every dollar spent on Title XXI programs.

Unlike Medicaid and Medicare, SCHIP is not an entitlement program. Instead, SCHIP has a capped allotment amount and uses a formula to determine each state's annual funding level. The formula is based on each state's number of low-income children—regardless of insurance status—and share of uninsured low-income children. Both factors are determined by the U.S. Current Population Survey. The resulting number, which is calculated on a rolling basis, is then multiplied by a state cost factor based on wages of the state's health service industry employees. Ultimately, this calculation determines each state's share of the total funds available from the federal government, which is $5 billion for the current fiscal year.[11]

California received its first allotment, worth $855 million, in 1998. Subsequent annual allotments have varied because of changes in the amount of available federal funding. Federal law requires that allotments must be used within three years. Funds used in a year other than the current year are called carry-over funds. Any funds left unused after three years are returned to the federal treasury and reallocated to states that spent their entire allotment.[12]

Generally, the allotments do not accurately reflect a state's needs for a given year. For example, the amount California received in its first year was larger than the $791 million received in fiscal year 2007,[13] even though California had no children enrolled the first year. Until 2002, California—and several other states—had to return funds to the federal government for reallocation. From 1997 to 2007, California's total allotment was $6.9 billion, and the state was able to spend about $5.3 billion.[14] The chart in Appendix A provides detailed information on federal spending through SCHIP.

Despite its initial status as a "donor" state that consistently returned unused SCHIP dollars to the federal treasury, California has spent its entire allocation since Federal Fiscal Year (FFY) 2002.[15] This year, the large number of children receiving services means the state will overspend its FFY 2007 allotment by approximately $274 million, forcing it to rely on available carry-over funding to cover the shortfall.[16]

California's SCHIP Programs

California runs the largest SCHIP program in the country, using Title XXI dollars to support a wide range of programs to help uninsured children, as shown in Table 1. Although the state uses the bulk of its SCHIP money for the Healthy Families Program, California also funds several programs created and approved by the federal government to achieve a number of goals, including: (1) helping smooth the HFP and Medi-Cal enrollment process; (2) helping enrollees move between Medi-Cal and HFP without a break in coverage; and (3) supporting certain prenatal programs under Medi-Cal and Access for Infants and Mothers (AIM). Appendix B highlights important changes in the Healthy Families Program since its 1998 inception.

Table 1: California Programs Funded by Title XXI

Healthy Families Program
Severely Emotionally Disturbed Children
California Children's Services
Medi-Cal Associated Programs
Access for Infants and Mothers

Impact on Health Care

California's SCHIP programs have significantly increased timely access to needed care.[17] Uninsured children who gained coverage through SCHIP received more preventive care, and their parents reported better access and improved communication with providers.[18] Racial disparities in access were reduced.[19]

A comprehensive study of the Healthy Families Program, published in the *Journal of American Pediatrics* in September 2006, found that the program improved access and significantly improved children's health outcomes.[20] The study also found that California's SCHIP enrollees experienced the same benefits.

III. SCHIP Cost Projections and Financial Analysis

This section discusses the methodology used to project the future federal contributions for California's SCHIP programs over the next five years. Future funding estimates from the federal perspective are approached systematically. For each major Title XXI component—Healthy Families, associated Medi-Cal programs and Access for Infants and Mothers—the analysis starts with baseline spending and rates and then projects five-year costs using assumptions about future payment and enrollment growth rates, as well as other factors where necessary. The estimates also include possible eligibility expansions. Given the challenge of accurate forecasting, low to high estimates are provided and the midpoint is used for the overall analysis. Because the analysis is complex and involves several variables, the chart in Appendix C summarizes the relevant assumptions.

Healthy Families Program

Major variables that affect the cost projection for the Healthy Families Program are: (1) annual cost of health benefits per child; (2) administrative costs; and (3) caseload.

Per-Child Costs

Virtually all Healthy Families Program services are provided through managed care plans, allowing for the use of a per capita rate in calculating the cost of covering children.

Base payment rate. This analysis assumes a base rate for all children in the program at $1,186 per child per year. This is a blended rate, based on data showing an average annual cost for infants of $2,835 across health plans, and a non-infant rate of $1,153.[21] The infant rate is weighted to the infant portion of the HFP population at 2 percent.[22] While this amount includes basic mental health costs offered through the health plans, it does not include services offered by counties for severely emotionally disturbed (SED) children, nor does it include spending through California Children's Services (CCS). Although they are an essential part of the core Healthy Families Program, SED and CCS costs are more appropriately calculated with their own methodology, as described below.

Growth in payment rates. Using past annual rate increases as an indicator, this analysis assumes the annual per-child health benefit cost will increase 3.65 percent a year for the midpoint estimate. This rate is varied by plus or minus 15 percent annually to reflect a possible range of spending due to several variables, such as utilization, medical inflation, and changes in national trends (for a range of 3.1 percent to 4.2 percent). For instance, while the growth rate in overall health care expenditures is expected to slow over the next several years, there is no way to know what impact (if any) that may have on rate negotiations.[23]

The 3.65 percent figure is based on the historical pattern of rate increases, with the understanding that some of the rate increases in various years are outliers. In the past, the Healthy Families Program negotiated relatively low year-over-year rate increases with health plans. Since 2000, HFP premiums have increased at rates substantially lower than the average growth in health spending as defined by National Health Expenditure data.[24]

Other adjustments. These per-child costs require two adjustments:

- **Administrative costs.** The current HFP administrative vendor is MAXIMUS, a national health consulting firm, which is paid by the state at a rate of $4.10 per child per month to maintain enrollment operations, a total of $49.20 per person per year.[25] For purposes of this analysis, the administrative vendor costs are considered to be flat over time.[26]
- **Patient contribution.** The Healthy Families Program requires families to contribute to the cost of coverage by paying premiums determined by income and family size, up to a cap of $45 per month. There is an average $5 copayment for doctor's visits (preventive services are carved out). A family's total out-of-pocket costs are capped at $250 per year. For State Fiscal Year (SFY) 2007, the average cost-sharing per child is estimated to be $7.67 per child per month, or $92.04 per child per year.[27] (This amount is held flat for the analysis since a change in state law would be needed to increase it.) These contributions offset program costs and, by federal law, cannot be matched.

Annual per-child cost. The forecasting model estimates that the Healthy Families Program total cost per child (not including SED and California Children's Services) is between $1,431 and $1,506 during Year 5 of the reauthorization. This amount reflects only federal dollars, based on the projected growth in per capita payment rates, administrative costs, and patient contribution amounts discussed above.

Enrollment Growth

Given existing program rules and state outreach efforts, Healthy Families Program enrollment is expected to increase over the next decade. This was incorporated into the analysis in two steps, first for the eligible and enrolled population, and then for the eligible-but-not-enrolled population. Finally, the potential impact of declining employer-sponsored insurance (ESI) coverage and its implications for the Healthy Families Program is also considered.

To determine the number of children eligible for Title XXI programs over time, this analysis first anticipates the growth in California's child population. It is estimated that the number of children in California will increase about 15 percent from 2000 to 2020, from about 10.3 million to 11.8 million.[28] Based on this projection, it is reasonable to assume that California's child population will grow at a rate of 0.69 percent annually through the end of the decade. At that point, the California Department of Finance projects a growth rate of 0.75 percent annually for the remainder of the budget window.

There are limitations to this growth rate analysis. In particular, the data do not allow for growth rates by income, which would provide a more accurate picture. Also, these rates are based on average annual growth and do not account for periods when growth may be slower or faster. To reflect a possible range of spending, low and high growth ranges were developed based on a plus or minus 15 percent of the midrange (for a range of 0.59 percent to 0.79 percent until 2010 and a range of 0.69 percent to 0.86 percent subsequently).

Base population 1: eligible and enrolled. Assuming that growth in the eligible and enrolled population will occur at the same rate as growth in the general population, this analysis applied the child population growth rates to the existing population of eligible and enrolled children. It is projected that at the end of FFY 2007, about 786,000 children will be enrolled in the Healthy Families Program.[29] This serves as the base for calculating future enrollment. By the end of FFY 2012, the forecasting model estimates that this population is likely to be as large as 819,000.

Base population 2: eligible but not enrolled. This analysis assumes that 228,000 children are eligible but not enrolled in the Healthy Families Program.[30] It also assumes that this population will grow at the same rate over the budget window, meaning it could number as many as 238,000 children by FFY 2012.

The model then applies an enrollment rate to the eligible but not enrolled population to determine how many children would enroll. A range was developed based on possible enrollment scenarios:

- **Low.** This assumes an enrollment rate based on a 2006 Lewin Group report, estimating the percentage of the eligible population that would be enrolled due to outreach activities recently undertaken in California.[31] This also assumes that the enrollment due to SB 437—the California Healthy Kids Insurance Program—will occur as budgeted by the Department of Health Services (DHS).[32] It then assumes that only small annual improvements in outreach would take place, with enrollment reaching a maximum of 53 percent at the close of the five-year window.
- **Midrange.** This assumes a midrange enrollment estimate based on the mathematical average between the low and high estimates, reaching a maximum 76 percent enrollment rate at the end of the five-year window.
- **High.** This approach assumes that an individual mandate is in effect in California, and that 99 percent of all eligible but not enrolled children will be enrolled in the Healthy Families Program. The remaining children are captured as part of Medi-Cal or are assumed to be transitioning between coverage providers in the system.

Base population 3: declining employer coverage. One of the most difficult aspects of this analysis is the potential impact of declining employer coverage rates on Healthy Families Program enrollment. Historically, California has lower employer coverage rates than most states,[33] and these rates continue to fall. A 2005 report by the UCLA Health Policy Center called employer-based insurance the "crumbling" foundation of the health care insurance system.[34] From 2001 to 2005, the rate of employment-based insurance for low-income children fell from 38.9 percent to 28.7 percent, meaning 1.5 million low-income children lost coverage provided through a parent's employer in that time period.[35]

Given a range of confounding factors, it is difficult to predict where this trend will lead. From 2001 to 2003, California experienced a recession,[36] which could mean this drop is temporary. Also, it is possible that some employers are dropping their coverage in favor of state-subsidized coverage under the Healthy Families Program. Some analysts view the failure of the employer-based health insurance system as inevitable.[37] In contrast, the health care reform efforts being discussed in California could bolster the employer-sponsored system, should they come to pass.

Using 2005 data, the model estimates that 1.2 million children eligible for the Healthy Families Program are currently enrolled in employer-sponsored coverage. It then assumes that this number will fall at a uniform rate for the period of this analysis. The rates used are:

- **Low.** Annual 0.75 percent drop in the number of children with employer-sponsored insurance who are otherwise eligible for HFP.
- **Midrange.** Annual 1 percent drop in the number of children with employer-sponsored insurance who are otherwise eligible for HFP.
- **High.** Annual 1.25 percent drop in the number of children with employer-sponsored insurance who are otherwise eligible for HFP.

The analysis projects that the weakening employer-based insurance market could add as many as 75,000 children to the Healthy Families Program's annual rolls by FFY 2012.[38]

Severely Emotionally Disturbed Children

The Healthy Families Program relies on the Department of Health Services to offer SED mental health services to its enrollees. Spending on these programs is projected to total $21.5 million in federal money for SFY 2007. In recent years, program growth has been as high as 30 percent. The forecasting model projects growth will continue at 30 percent, with 25 percent and 35 percent as the low- and high-range estimates.[39]

Children in the Healthy Families Program typically receive basic mental health services through their health plans, while those with more severe needs receive care through the county. Children with basic mental health needs are given up to 30 inpatient and 20 outpatient visits each through their health plans. In addition, plans must provide unlimited inpatient and outpatient visits to children with severe mental illnesses, such as bipolar disorder and schizophrenia. This benefit is given as part of the per capita plan (the $1,186 cited earlier). Children who may qualify as severely emotionally disturbed are referred to the county mental health department for an assessment. If the county finds that a child is severely emotionally disturbed, then the county, with HFP support, provides services.[40]

Program growth. These programs are anticipated to expand quickly. Over the next five years, the forecasting model estimates federal spending for the program will be between $220 million and $289 million.

California Children's Services

The CCS program, administered by the Family Health Division at the Department of Health Services, provides specialized services for children in the Healthy Families Program with specific disability or chronic conditions. HFP pays California Children's Services for providing these services on their behalf. In SFY 2007, CCS services for children in the Healthy Families Program amounted to $78 million of federal Title XXI dollars, an increase of almost 70 percent since SFY 2004. California Children's Services also provides services to AIM infants linked to the Healthy Families Program, with federal spending on this program more than doubling from $5.5 million to $13.2 million from 2004 to 2007.

Growth rate. With a base of $102 million, the total spending for this category is relatively small. However, for SFY 2006, it increased 44 percent, followed by an estimated 18 percent the following year. Although volatile, the midpoint growth rate for this category is anticipated to be 16 percent in the first year of reauthorization, with growth slowing over time. The low- and high-end estimates are set at a plus or minus 15 percent of the midpoint for a first-year range of 13.6 percent to 18.4 percent with growth slowing over time. This estimate accounts for the influx of new eligible children in the forecasting model.

Program growth. These programs are expected to grow quickly. Over the next five years, federal spending for California Children's Services is projected to be between $716 million and $803 million.

Estimated Federal Contribution for the Healthy Families Program

This analysis estimates that the Healthy Families Program alone would need $4.7 billion to $5.7 billion in federal funding over the next five years. This amount reflects the federal dollars only, based on HFP costs per child, the growth in enrollment, and the costs for severely emotionally disturbed children and California Children's Services.

Medi-Cal Associated Programs

To help serve all of California's children, there is a suite of smaller, targeted programs that operate under several federal authorities, including waivers, operated by the Department of Health Services. Many of these programs are newly established within the past few years and some are still to be implemented. California Children's Services and severely emotionally disturbed children have already been discussed. The remainder is related to the Medi-Cal program.

Using available flexibility under federal law and in compliance with federal rules, several programs have been created in California to help expand coverage using Title XXI dollars outside of the Healthy Families Program. The programs in this category operate at a current federal cost of $262 million.[41] These associated programs include:

- Prenatal care through Medi-Cal, an explicit option under federal law, which will use an estimated $97 million in SCHIP allotment funding;
- The Child Health Development Program Gateway, which provides temporary coverage through HFP or Medi-Cal with an automated pre-enrollment process at a cost of $69.7 million; and
- Those other programs that generally fall under the categories of outreach programs and operations that smooth the transition for children moving between Medi-Cal and the Healthy Families Program (called Accelerated Enrollment).[42]

Growth Rate

Given the small size of these programs, it is difficult to assess their true costs. In some cases, programs have yet to be implemented, so there is no history upon which to base increases. One obvious approach would be to project cost increases of 8 percent a year, the Medi-Cal growth rate. However, such a rate would be significantly higher than that calculated for the Healthy Families Program. In fact, the Legislative Analyst's Office assumes that at least some of these measures will not be fully implemented until SFY 2009-2010.[43] Given the lack of more specific information on these programs, the model used here sets a range of estimates, with growth rates of 6 percent, 8 percent, and 10 percent.

Estimated Federal Contribution for Med-Cal Associated Programs

The forecasting model estimates that the DHS-operated SCHIP programs would need $1.6 billion to $1.8 billion in federal dollars over the next five years. This amount is based on the growth in the Medi-Cal associated programs.

Access for Infants and Mothers

California has exercised its option under federal law to provide prenatal care to pregnant women through Access for Infants and Mothers using Title XXI funds. This section provides a cost estimate for this population by using the same basic methodology applied in the Healthy Families Program cost section.

Per-Person Cost

Base payment rate. This analysis assumes a base rate for AIM enrollees of $9,541 per person per year. Of this amount, the federal government matches $8,587.[44]

Growth in payment rates. In recent years, Access for Infants and Mothers costs have grown faster than those for the Healthy Families Program. For the past four years, AIM payment rates have consistently increased between 7 percent and 8 percent. Using past annual rate increases as an indicator, this analysis assumes the annual per child health benefit costs will increase 7.5 percent a year for the midpoint estimate. This rate is varied by plus or minus 15 percent annually to account for changes in factors such as utilization, medical inflation, and changes in national trends (for a range of 6.34 percent to 8.63 percent).

Other adjustments. There are three necessary adjustments to these costs:

- **Administrative costs.** AIM administrative costs are slightly higher than for the Healthy Families Program at $4.19 per person per month for enrollment operations, a total of $50.28 per person per year.[45] For purposes of this analysis, administrative vendor costs are considered to be flat over time.

- **Crowd-out adjustment.** Under an agreement with the federal government, there is a 10 percent reduction in the per capita amount that is matchable to reflect that some program participants may have private insurance and are enrolled in Access for Infants and Mothers based on the high deductible in the private plan.
- **Patient contribution.** Like the Healthy Families Program, AIM requires some cost sharing. (The amount, equivalent to $593 per woman per year,[46] is held flat for this analysis since any increase would require a change in state law.) These contributions offset program costs and, by federal law, cannot be matched.

Annual per-person cost. The model used here estimates the total cost per person is between $11,746 and $13,037 during Year 5 of the reauthorization.

Enrollment Growth

The enrollment projection for Access for Infants and Mothers is not as complex as that used for the Healthy Families Program. This is because information is not available to guide an analysis of the eligible-but-not-enrolled population, nor of the loss of employer-sponsored coverage that may occur in favor of AIM.

The AIM population has been highly variable over recent years. In SFY 2005, AIM enrollment increased 10 percent, and it spiked 23 percent during SFY 2006. It is projected that at the end of FFY 2007, about 12,100 women will be enrolled in Access for Infants and Mothers.[47] This serves as the base for calculating future enrollment. This model estimates that by the end of FFY 2012, this population is likely to number as many as 25,755.

Estimated Federal Contribution for AIM

The forecasting model estimates that Access for Infants and Mothers would need a total of $566 million to $695 million in federal funding over the next five years. This amount is based on the growth in payment rates and enrollment.

Possible Healthy Families Program Expansions

California will very likely undertake expansions of the HFP-eligible population. Any SCHIP reauthorization would need to account for these expansions.

Expansion From 250 Percent to 300 Percent FPL

The governor and others in California have proposed expanding the Healthy Families Program to 300 percent of the federal poverty level. According to the Lewin Group, this would increase enrollment by 117,000 children, assuming no other changes in current law.[48] The analysis presented here assumes that some employers who offer coverage for children will drop it in favor of SCHIP coverage.

Using the midpoint assumptions for per-child cost and population growth, as well as assuming full implementation in Year 1 of the reauthorization, expanding coverage to this population would require $497 million in federal funding over the next five years.

Elimination of the Five-Year Ban for Immigrants

Under federal law, federal matching funds cannot be used for coverage of otherwise eligible immigrant children if they have been in the United States for less than five years. The authors estimate about 48,000 California children in this population would be eligible for the Healthy Families Program, assuming no other changes in current law.[49] The program now uses state funds to cover about 15,000 children who would be eligible but for the five-year ban. A policy change here would involve the federal government rescinding the ban.

Using the midpoint assumptions for per-child costs and population growth, as well as assuming full implementation in Year 1 of the reauthorization, eliminating the five-year ban would require $203 million in federal funding over the next five years.

Estimated Federal Contribution for Possible HFP Expansions

The forecasting model estimates that proposed expansions would require a total of $701 million over the next five years. This amount reflects federal dollars only, and is based on the projected growth in payment rates and enrollment, both for the expansion to 300 percent FPL and the five-year ban on immigrant children.

How SCHIP Reauthorization Could Affect Children

About 1.5 million children could lose health care coverage under SCHIP reauthorization, based on the number of children who are projected to rely on all of California's SCHIP-funded programs at the end of the five-year reauthorization process (in FFY 2012).[50] This projection includes:

- The base enrollment;
- The entire number of children projected as eligible but not enrolled;
- Those likely to enroll due to loss of employer-based coverage; and
- Those who could be enrolled under the expansions proposed here.

This projection also assumes a takeup rate at the upper end of the trend to capture the maximum possible impact. For all these children, reauthorization will determine whether they have health care coverage.[51]

California's Funding Needs

Over the next five years, not counting possible eligibility expansions, California will need between $6.7 billion and $8.1 billion to fund existing SCHIP programs. As shown in Table 2, this is $2.8 billion and $4.1 billion, respectively, above the baseline set by the Congressional Budget Office.[52]

Beyond the five-year analysis, it is also important to understand the projected federal need year-by-year, which is given in Table 3.

Table 2: Projected Five-Year Federal Costs for California's SCHIP Programs, Current Eligibility Rules

Numbers in Millions; May Not Add Due to Rounding

	Five-Year Projected Cost		
	Low-Cost Range	**Mid-Cost Range**	**High-Cost Range**
Healthy Families Program	$4,591	$5,109	$5,673
Health Coverage Costs			
Eligible and Enrolled	$3,274	$3,341	$3,409
Eligible but Not Enrolled	$338	$652	$979
Declining ESI Rates	$42	$105	$194
Severely Emotionally Disturbed Children	$220	$252	$289
California Children's Services	$716	$759	$803
Other Title XXI Programs	$2,134	$2,290	$2,458
Medi-Cal Associated Programs	$1,568	$1,663	$1,763
Access for Infants and Mothers	$566	$627	$695
Projected Spending	*$6,726*	*$7,399*	*$8,130*
Projected Spending Above Baseline	*$2,771*	*$3,444*	*$4,175*

Source: Harbage Consulting

Table 3: Projected Year-by-Year Federal Costs for California's SCHIP Programs, Current Eligibility Rules

Numbers in Millions; May Not Add Due to Rounding

	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	Total
High						
Total	$1,323	$1,457	$1,607	$1,778	$1,965	**$8,130**
Above Baseline	$532	$666	$816	$987	$1,174	**$4,175**
Mid						
Total	$1,240	$1,348	$1,467	$1,601	$1,744	**$7,399**
Above Baseline	$449	$557	$676	$810	$953	**$3,444**
Low						
Total	$1,159	$1,245	$1,337	$1,439	$1,546	**$6,726**
Above Baseline	$368	$454	$546	$648	$755	**$2,771**

Source: Harbage Consulting

This analysis also addresses the possible costs of expanded eligibility. As shown in Table 4, the proposed expansions would add about $701 million over five years in federal contributions. This means that the total federal funding requirement for California would be between $7.4 billion and $8.8 billion—$3.5 billion and $4.9 billion above the baseline assumed by the Congressional Budget Office.

Considering the possible expansions discussed here, the need for federal dollars increases by $701 million over the first five years. The cost to the federal government of adding groups to the Healthy Families Program, such as parents of enrolled children, which is not addressed here, would be significantly higher.

The baseline concept is vital to understanding how much is needed from the federal government to cover its equal share of the SCHIP program. The Congressional Budget Office is responsible for determining the cost of government programs for Congress. The budget baseline is the amount of money that is already assumed to be spent by the federal government. Under current CBO rules, SCHIP, as a mandatory program, is assumed to be reauthorized and to have a baseline set at the final year of its spending, or $5 billion. This means, for a five-year reauthorization, $25 billion ($5 billion each year for five years) is assumed to be included in the baseline.

As such, the total SCHIP payment needed from the federal government would be the total projected spending over five years, less $25 billion. It is worth noting that baseline levels are typically referred to as assumptions and subject to change. This analysis consistently presents an estimate of total required spending, which is followed by an estimate of additional federal dollars that would be needed above the baseline, as determined under current rules. It is common practice at the federal level to state only new budget spending because baseline spending is assumed to occur.

Table 4: Projected Five-Year Federal Costs for California's SCHIP Programs, Expanded Eligibility Rules

Numbers in Millions; May Not Add Due to Rounding

	Five-Year Projected Cost		
	Low-Cost Range	**Mid-Cost Range**	**High-Cost Range**
Projected Spending On Existing Program (From Table 2)	$6,726	$7,399	$8,130
Possible Expansions	$701	$701	$701
Expansion from 250% to 300% FPL	$498	$498	$498
Elimination of Five-Year Ban for Immigrants	$203	$203	$203
Projected Spending For Base and Expansion Programs	*$7,427*	*$8,100*	*$8,832*
Projected Spending For Base and Program Expansions Above Baseline	*$3,472*	*$4,145*	*$4,877*

Source: Harbage Consulting

Policy Implications

Among policymakers in Washington, D.C., a wide range of funding levels is under discussion. President Bush has proposed expanding SCHIP funding by $4.8 billion over five years,[53] while others have discussed adding $60 billion in federal spending over five years (again, above the baseline).[54] This most likely represents the full range of outcomes that could occur under reauthorization.

The additional $60 billion over five years sought by national stakeholders represents new spending on both SCHIP and Title XXI Medicaid expansions that occurred in other states.[55] At least $35 billion over five years (an additional $7 billion per year) of the additional $60 billion requested by national advocates would need to be dedicated to SCHIP. At lower levels of federal spending, it is more likely that California would have to pursue a greater share (more than the current 16 percent) of the total SCHIP allotment to fund its existing programs. This would require changes to the funding formula.

Impact on expanded eligibility. Under this analysis, an additional $60 billion probably would make it possible to expand coverage for children, including legal immigrants, to 300 percent of the federal poverty level. Again, at lower levels of spending, it is more likely that California would have to pursue a greater share (more than the current 16 percent) of the total SCHIP allotment to fund its existing programs.

The president's plan. The proposal outlined in the president's budget could force California to disenroll children in the Healthy Families Program by setting a cap on eligibility at 200 percent FPL.[56] California is one of 16 states with an income cap at 250 percent FPL.[57] California is also one of five states where prenatal care is offered to women through SCHIP funds under federal option.[58] This coverage is clearly at risk under the president's plan.

In addition, the president has called for $4.8 billion in additional SCHIP spending starting in FFY 2009 and for a faster redirection of allotment dollars held by states.[59] Not all of

Table 5: Projected California SCHIP Funding Shortfall Under President's Budget

	FFY 2008[62]	FFY 2009	FFY 2010	FFY 2011	FFY 2012
High					
Shortfall	$391,572,600	$621,839,426	$574,222,097	$745,413,066	$932,339,203
Children Affected	382,308	715,477	635,016	792,252	952,310
Mid					
Shortfall	$239,007,652	$519,051,033	$445,662,885	$586,946,150	$739,179,724
Children Affected	287,552	603,302	500,415	636,652	774,490
Low					
Shortfall	$160,893,095	$421,728,321	$326,345,650	$442,491,158	$566,093,391
Children Affected	194,560	495,206	372,094	489,877	608,505

Source: Harbage Consulting

the details of the president's plan have been released—including whether the $4.8 billion would simply be targeted to states with funding shortfalls.[60] According to the assumptions in this model, 609,000 to 952,000 children could be denied Healthy Families Program coverage in FFY 2012 due to federal underfunding, as shown in Table 5.[61]

Comparison to Other Estimates

Several other analysts have released estimates of the SCHIP shortfall nationally and in California. The findings presented in this paper are slightly higher than, but consentient with, those of other analysts.

The Congressional Research Service has found that the funding shortfall nationally would be about $12.1 billion over five years.[63] Similarly, the Center for Budget and Policy Priorities (CBPP) found a shortfall of $12.3 billion to $13.4 billion over five years.[64] The primary difference between the two approaches is that the Congressional Research Service assumes an annual growth rate of about 6 percent to 7 percent while CBPP uses states-specific growth rates based on historical growth, which then converge on an annual growth rate of 5 percent to 7.5 percent. There are also California-specific estimates from CBPP and the California Budget Project (CBP). As shown in Table 6, the analysis presented in this paper projects a higher need than does the Center for Budget and Policy Priorities.

The difference in 2008 is primarily because this estimate does not take into account the possibility of redistributed funds from other states. Such analysis is beyond the scope of this report because it requires several assumptions about the spending in all states and how much of allotments may be left available for redistribution. If redistribution funds are available from other states, those dollars would reduce the need for new federal funding.

In addition, growth in need for the CBPP analysis regresses toward a national mean, whereas this report is based on specific events in California and uses assumptions that go beyond historical growth. While other approaches, as published, use flat rates of growth to project costs over time, this analysis adopts a more dynamic model of program growth, especially around program enrollment. The more specific approach to budget analysis given here allows for factors to be evaluated on their specific spending patterns. For example, the approach in this report reflects that some items, such as spending on severely emotionally disturbed children, are growing two and three

Table 6: Comparison of CBPP and CHCF Projections for California's Federal Need

Numbers in Millions

	FFY 2008	FFY 2012
CBPP Annual Need, Moderate Estimate	$213	$781
CHCF Annual Need, Moderate Estimate	$449	$953
Difference	**$236**	**$172**
Percent Difference	**111%**	**22%**

Source: Harbage Consulting

times faster than the baseline program. And changes such as SB 437 mean that growth in California will occur faster than historical trends would indicate.

The differences in methodology can also be seen in the differences between this analysis and that of the the California Budget Project, as shown in Table 7.

For comparable trends, the CHCF estimate has a slightly higher overall federal funding requirement than the California Budget Project. A final methodological difference is that the analysis assumes a high level of growth based on full enrollment of children in the Healthy Families Program, something not done in other analyses.

Given the health reform discussion taking place in California, it seems appropriate to understand the maximum enrollment level possible and the associated costs. The CBP paper uses an approach very similar to CBPP in that it considers very low, low, and moderate rates of growth. As a result, this report has a significantly higher upper bound than the other analyses.

Overall, the budget forecast here would seem consistent with, but higher than, both CBPP and CBP. Further analysis would be useful to understand specific differences.

Table 7: Comparison of CBP and CHCF Projections for California's Federal Need Five-Year Estimate

Numbers in Millions

	Very Low	Low	Moderate	High
CBP Estimate	$2,011	$2,484	$2,988	Not Given
CHCF Estimate	Not Given	$2,771	$3,444	$4,175
Difference	—	$287	$456	—
Percent Difference	—	12%	15%	—

Source: Harbage Consulting

IV. Conclusion

THE FEDERAL SCHIP PROGRAM AND THE FUTURE of children's health coverage are at a crossroads. Nearly two-thirds of the funds supporting California's Healthy Families program, as well as several other health programs for low-income and vulnerable children and women, come from SCHIP. The reauthorization of this program, currently under debate in Congress, may have far-reaching consequences for California's ability to provide coverage to children.

This report concludes that an additional $60 billion in federal dollars over five years, as is being sought by key stakeholder groups from Congress for SCHIP reauthorization, probably would be sufficient for California to meet the needs of its programs. More specifically, it finds that California will need between $6.7 billion and $8.1 billion in federal dollars over the next five years to maintain existing state programs funded by SCHIP. This is $2.8 billion to $4.2 billion above the baseline set by the Congressional Budget Office. In total, the health insurance coverage of over 1.5 million Californians is at issue during this debate.

Over the next five years, funding California's existing SCHIP programs—including possible expansions—will require an additional $700 million in support (between $7.4 billion and $8.8 billion over five years). These amounts are $3.5 billion to $4.9 billion above the Congressional Budget Office baseline. The budget request for an additional $60 billion in federal funding over five years probably would support these expansions.

This federal partnership in SCHIP funding has allowed California to significantly reduce the percentage of uninsured children over the past nine years. This analysis, like those by others examining this issue, illuminates the important federal funding needed to sustain these programs and continue California's notable success.

Appendix A:

SCHIP Funding and Healthy Families Program Spending Projections

Actual Allotments and Expenditures

Dollars in Millions

	FFY 1998	FFY 1999	FFY 2000	FFY 2001	FFY 2002
Nationwide Title XII Allotment	**$4,295**	**$4,275**	**$4,275**	**$4,275**	**$3,150**
CA Title XXI Allotment[1]	$855	$851	$766	$705	$528
Carry over Funding	—	$853	$1,636	$2,003	$1,903
Total Federal Funds Available	**$855**	**$1,704**	**$2,402**	**$2,708**	**$2,431**
Child Benefit Costs	– $2	– $62	– $169	– $278	– $406
Child Administration Costs	—	– $6	– $18	– $19	– $48
Subtotal Child Costs[2]	**– $2**	**– $68**	**– $187**	**– $297**	**– $454**
Presumptive Eligibility Claiming Prenatal Care Option Retained FFY 98 for Outreach	—	—	—	-$14	—
Total Expenditures	**– $2**	**– $68**	**– $187**	**– $311**	**– $454**
Balance of Available Funds	$853	$1,636	$2,215	$2,397	$1,977
Federal Allotment Unspent/Redistributed	—	—	– $212	– $494	– $372
Final Balance—Carried Forward	**$853**	**$1,636**	**$2,003**	**$1,903**	**$1,605**
FFY 98 Allotment	– $853	– $785	– $386	– $75	—
FFY 99 Allotment		– $851	– $851	– $357	—
FFY 00 Allotment			– $766	– $766	– $372
FFY 01 Allotment				– $705	– $705
FFY 02 Allotment					– $528
FFY 03 Allotment					
FFY 04 Allotment					
FFY 05 Allotment					
FFY 06 Allotment					
FFY 07 Allotment					

Estimate is for Illustrative Purposes Only

	FFY 1998	FFY 1999	FFY 2000	FFY 2001	FFY 2002	TOTAL
Unspent California Allotment	$598	$851	$744	$512	$122	$2,827
Unspent Allotment Redistributed to Other States	– $212	– $494	– $372	– $256	– $122	– $1,456
Unspent Allotment Retained by California	$386	$357	$372	$256	—	$1,371
Percentage of Allotment Retained by California	65%	42%	50%	50%		49%

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Projected Allotments and Expenditures

Actual Allotments and Expenditures

	FFY 2003	FFY 2004	FFY 2005	FFY 2006	FFY 2007
Nationwide Title XII Allotment	$3,150	$3,150	$4,050	$4,050	$5,000
CA Title XXI Allotment[1]	$549	$534	$667	$647	$791
Carry over Funding	$1,605	$1,333	$1,083	$990	$486
Total Federal Funds Available	$2,154	$1,867	$1,750	$1,637	$1,277
Child Benefit Costs	– $519	– $559	– $650	– $1,036	– $772
Child Administration Costs	– $46	– $36	– $40	– $49	– $75
Subtotal Child Costs[2]	– $565	– $595	– $690	– $1,085[3]	– $847[4]
Presumptive Eligibility Claiming		– $67	– $70	– $66	– $82[5]
Prenatal Care Option				[6]	– $136
Retained FFY 98 for Outreach	—	—	—	—	
Total Expenditures	– $565	– $662	– $760	– $1,151	– $1,065
Balance of Available Funds	$1,589	$1,205	$990	$486	$212
Federal Allotment Unspent/Redistributed	– $256	– $122	—	—	—
Final Balance—Carried Forward	$1,333	$1,083	$990	$486	$212
FFY 98 Allotment	—	—	—	—	—
FFY 99 Allotment	—	—	—	—	—
FFY 00 Allotment	—	—	—	—	—
FFY 01 Allotment	– $256	—	—	—	—
FFY 02 Allotment	– $528	—	—	—	—
FFY 03 Allotment	– $549	– $549	—	—	—
FFY 04 Allotment		– $534	– $323	—	—
FFY 05 Allotment			– $667	—	—
FFY 06 Allotment				– $486	—
FFY 07 Allotment					– $212

Dollars in Millions

Source: Managed Risk Medical Insurance Board (www.mrmib.ca.gov/MRMIB/HFP/FedFundChart0611.pdf), based on November 2006 estimate

1. California Title XXI allotments through FFY 07 are actuals. Actual California allotments are not available until each year's Title XXI appropriation is available.
2. California HFP Expenditure Projections are limited to federal funding costs.
3. FFY 06 expenditures were updated to reflect actual data. The actual expenditures include Prenatal and AB 495 actual expenditures.
4. FFY 07 expenditures were updated to reflect the 2006 November estimate. These estimated expenditures do not include expenditures for the Prenatal Care Option, which are reflected.
5. Per CMS claiming instructions, reflects 50% Medicaid FMAP applied to SCHIP allotment for those children who are not Title XXI eligible. Reflects 65% Medicaid FMAP applied to SCHIP allotment for those children who are Title XXI eligible.
6. Actual FFY 2006 prenatal expenditures are included in the Child Benefit/Child Admin Actual expenditures.

Appendix B:

Timeline of Critical Changes in the Healthy Families Program

The Healthy Families Program provides comprehensive health care coverage, including medical, dental and vision care, to California's uninsured children. Over the years, California has implemented a number of innovations designed to increase enrollment or improve the quality of coverage.

- **1998:** The Healthy Families Program is implemented in July. HFP and Medi-Cal establish a fee to pay community-based organizations to provide application assistance to families whose children might be eligible for the programs. By year end, Healthy Families Program enrollment is at 56,000 children.
- **1999:** California receives federal approval to extend enrollment to children in families with incomes up to 250 percent FPL. HFP and Medi-Cal reduce the size of the joint application to four pages and establish a single point of entry to review applications and to forward them to the appropriate program. By year end, enrollment is at 200,000 children.
- **2000:** The Healthy Families Program issues the results of its first consumer satisfaction survey, the Consumer Assessment Health Plan Survey, which was conducted in five languages. The survey found high satisfaction levels with participating plans. By year end, enrollment is over 362,000 children.
- **2001:** California develops one of the first Web-based applications in the country. Health-e-App immediately determines preliminary eligibility for Medi-Cal and Healthy Families.[65] HFP, in conjunction with the RAND Corporation, develops the first consumer satisfaction survey for dental services. HFP also issues its first report on HEDIS scores for the program, presenting scores for 1999, 2000, and 2001 by plan and for the program as a whole. By year end, enrollment is over 506,000 children.
- **2002:** At year end, enrollment is over 621,000 children.
- **2003:** California creates a coverage gateway under which the state provides presumptive eligibility in Medi-Cal or the Healthy Families Program for two months to potentially eligible children who see a provider in the state health screening program, Child Health Development Program. In addition, the federal government allows four counties to use SCHIP funds to cover children up to 300 percent FPL. Despite major fiscal problems, the state maintains eligibility levels for the Healthy Families Program. Outreach funds, however, are eliminated. SB 24 is signed into law, establishing an electronic Prenatal Gateway and presumptive eligibility guidelines to simplify enrollment of pregnant women and certain newborn infants into Medi-Cal. By year end, enrollment is over 683,000 children.

- **2004:** Infants born to mothers in AIM are automatically enrolled in the Healthy Families Program up to age 2 and 300 percent FPL. HFP again procures its administrative vendor contract and achieves significant savings, as well as major customer service improvements. By year end, enrollment is over 697,000 children.
- **2005:** California receives permission to use SCHIP funds to cover pregnant women in AIM and undocumented pregnant women in Medi-Cal. Even with continuing state fiscal problems, the state reestablishes part of its outreach program and maintains eligibility levels. By year end, enrollment is over 742,000 children.
- **2006:** Outreach funding is fully restored. SB 437 is signed into law, establishing self-certifying simplifications, presumptive eligibility, and an accelerated enrollment process. By year end, enrollment is over 770,000 children.

Appendix C:

Assumptions Made in Cost Projections

Healthy Families

		Rate of Growth			Projected Range in Year Five		
	Current Year	Low	Mid	High	Low	Mid	High
Cost Per Child	$1,186	3.1%	3.7%	4.2%	$1,431	$1,468	$1,506
Administrative Cost	$49	Held Flat				$49	
Client Premium Offset*	$92	Held Flat				$92	
Federal Spending for HFP Children Enrolled in Severely Emotionally Disturbed (SED) Children	$21,469,000	25%	30%	35%	$65,518,188	$79,712,894	$96,267,714
Federal Spending for HFP Children Enrolled in California Children's Services	$102,382,000	14%	16%	19%	$169,933,135	$184,859,267	$200,809,575
Number of Children in HFP Core Program†	786,000	0.7%	0.8%	0.9%	810,242	814,570	818,918
Eligible and Not Enrolled†	228,000	0.7%	0.8%	0.9%	235,035	236,291	237,552
Enrollment Increase from ESI‡	Unknown	0.8%	1.0%	1.3%	45,000	60,000	75,000
Total HFP Enrollment		30%	65%	99%	1,090,277	1,110,861	1,131,469

Source: Harbage Consulting

* Spending here is aggregate and not per child.

† Rates vary over the five-year window. These are first-year rates.

‡ From a base of 1.2 million.

Other Title XXI Programs

		Rate of Growth			Projected Range in Year Five		
	Current Year	Low	Mid	High	Low	Mid	High
Med-Cal Associated Programs Federal Program Spending*	$262,455,600	6%	8%	10%	$470,018,007	$566,621,956	$680,742,234
Access for Infants and Mothers Cost Per Participant Per Year	$8,637	6.3%	7.5%	8.6%	$11,746	$12,378	$13,037
Total Administrative Costs	$50	Held Flat				$50	
Premium Offset	$593	Held Flat				$593	
Number of Program Participants	12,097	13%	15%	17%	21,378	23,485	25,755

Source: Harbage Consulting

* Spending here is aggregate and not per child.

† Rates vary over the five-year window. These are first-year rates.

‡ From a base of 1.2 million.

Program Expansions	Rate of Growth				Projected Range in Year Five		
	Current Year	Low	Mid	High	Low	Mid	High
Expansions from 250% to 300% FPL							
Total Cost Per Child	$1,186		3.7%			$1,458	
Number of Children in Base Program	117,000		0.8%			121,314	
Take-up Rate			100%				
Elimination of Five-Year Ban for Immigrants							
Cost Per Child Per Year	$1,186		3.7%			$1,458	
Number of Children in Base Program	48,000		0.8%			49,617	
Take-up Rate			100%				

Source: Harbage Consulting

* Spending here is aggregate and not per child.

† Rates vary over the five-year window. These are first-year rates.

‡ From a base of 1.2 million.

Endnotes

1. As explained later in the paper, failure to reauthorize would mean that existing carry-over funds would remain available to states, but no new allotment dollars would be awarded.
2. Through letters to the Congressional Budget Committee, many stakeholder groups have called for an additional $60 billion over five years above the federal funding baseline for SCHIP reauthorization, including the Georgetown University Center for Children and Families, the Congressional Hispanic Caucus, and a coalition of over 60 stakeholder groups such as the American Academy of Pediatrics, the National Health Law Program, and Families USA. For more information, see the Georgetown University Health Policy Institute's Center for Children and Families SCHIP portal at ccf.georgetown.edu/schip.html.
3. The $60 billion includes funding through both SCHIP and Medicaid programs. To be certain that the $60 billion is adequate, stakeholders need to clarify how much would be dedicated to SCHIP versus Medicaid.
4. "Baseline funding" is a technical term for the amount of money that is assumed will be allocated to SCHIP over the next five years. Currently, the Congressional Budget Office assumes SCHIP will be reauthorized at baseline funding levels—$25 billion over the next five years. This means that only funding above this $25 billion level would count against federal pay-as-you-go budget requirements.
5. A recent California Budget Project report estimated that maintenance of SCHIP baseline funding only (with no increase) would mean a shortfall that "could result in more than 700,000 California children losing health coverage in FFY 2012." The estimate presented here considers the full extent of all children who could be affected by a failure to reauthorize Title XXI funding for FFY 2012.
6. Holahan, John, and Arunabh Ghosh. *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003*. Washington, D.C.: The Urban Institute, September 2004 (www.urban.org/UploadedPDF/411089_HealthInsCoverage.pdf). See also: Mann, Cindy, Jocelyn Guyer, and Joan Alker. *A Success Story: Closing the Insurance Gap for America's Children Through Medicaid and SCHIP*. Washington, D.C.: Georgetown University Health Policy Institute, Center for Children and Families, July 2005 (ccf.georgetown.edu/pdfs/success.pdf).
7. Statehealthfacts.org based on the U.S. Census Bureau's Current Population Survey, March 2005 and 2006. Viewed January 19, 2007.
8. The California Health Information Survey was conducted by UCLA's Center for Health Policy in 2001, 2003, and 2005. This data represents children ages 0 to 18 under 300 percent FPL.
9. States that had already expanded coverage had the option to expand coverage to the higher of 200 percent FPL or to 50 percentage points above their pre-SCHIP coverage levels. States also have the authority to use "income disregards" to expand coverage levels.
10. National Health Policy Forum. *SCHIP: The Basics*. Washington, D.C.: April 27, 2004.
11. Federal law provides $400 million to U.S. territories for SCHIP in the current year.
12. In 2000, Congress approved a measure to allow states to retain part of their unspent funds from the beginning of the program until September 30, 2002.
13. Congressional Research Service. *SCHIP Original Allotments: Description and Analysis*. Washington, D.C.: October 31, 2006 (updated); 8-9.
14. More specifically, from FFY 1998 to FFY 2007, California will have lost $1.5 billion in unspent federal SCHIP funds to other states. Numbers here do not add due to rounding.
15. Since FFY 2002, California has overspent its allotment and has needed to use accumulated carry-over funds.
16. The state's FFY 2007 SCHIP allotment was $791 million, as stated in *SCHIP Title XXI Funds: Total Healthy Families Spending Projection based on November 2006 Estimate,* MRMIB, May 2006.
17. Lambrew, Jeanne M. *The State Children's Health Insurance Program: Past, Present, and Future*. New York, N.Y.: The Commonwealth Fund, February 2007 (www.cmwf.org/publications/publications_show.htm?doc_id=449518).
18. Woolridge, Judith, et al. *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress*. Washington, D.C.: Mathematica Policy Research and the Urban Institute, 2005.
19. Shone, Laura P., et al. 2005. "Reduction in Racial and Ethnic Disparities after Enrollment in the State Children's Health Insurance Program." *Pediatrics* 115 (6); e697-e705.

20. Seid, Michael, et al. 2006. "The Impact of Realized Access to Care on Health-Related Quality of Life: A Two-Year Prospective Cohort Study of Children in the California State Children's Health Insurance Program." *Journal of Pediatrics* 149 (3); 354-361.
21. State of California. *2006 November Estimate for the Healthy Families Program and Access for Infants and Mothers Program and the County Health Initiative Matching Fund Program for Fiscal Years 2006-2007.*
22. Ibid.
23. National growth rate discussion is based on National Health Expenditure data (www.cms.gov).
24. HFP data is based on the average statewide premium increase across all managed care providers. The National Health Expenditure data is based on an analysis of national cost trends conducted by the Centers for Medicare & Medicaid Services Office of the Actuary.
25. State of California. *2006 November Estimate.*
26. The administrative vendor contract expires in December 2008, with an option for two one-year extensions.
27. State of California. *2006 November Estimate.*
28. Authors' analysis based on population growth statistics from the California Department of Finance.
29. Authors' conversation, MRMIB Budget Office, January 2007. This analysis accepts the assumptions used by MRMIB. Others, including the Legislative Analyst's Office, have suggested that MRMIB sometimes overstates enrollment projections. For the current year, we have concluded that MRMIB's enrollment projections appear to be on track.
30. The Lewin Group. *Estimated Cost and Coverage Impacts of Four Proposals to Expand Health Insurance Coverage for Children in California.* Falls Church, VA: April 20, 2006. These findings are consistent with those of other analysts. For more information, see UCLA Center for Health Policy Research, *More than Half of California's Uninsured Children Eligible for Public Programs But Not Enrolled,* October 2006.
31. The Lewin Group. *Estimated Cost and Coverage Impacts.*
32. The Schwarzenegger administration released an analysis of SB 437, signed into law in 2006, which shows that the bill will increase HFP program enrollment by 94,700 children.
33. California Department of Insurance. *Priced-Out: The State of California Health Care.* 2005.
34. Brown, E.R., S.A. Lavarreda, T. Rice, J.R. Kincheloe, and M.S. Gatchell. *The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey.* Los Angeles, CA: UCLA Center for Health Policy Research, 2005.
35. Authors' analysis of California Health Interview Survey data for children ages 0 to 18 and under 300 percent FPL. Results statistically significant at the 95 percent level. The rate of employer-sponsored coverage fell each survey year (2001, 2003, and 2005).
36. From 2001 to 2003, California's unemployment rate increased from 5.4 percent to 6.8 percent, according to the California Department of Labor.
37. The president of the Service Employees International Union, Andy Stern, has referred to America's employer-based system as "dead" (for more information, see transcript of the Brookings Institution-New America Foundation Forum, "Employment-Based Health Insurance: A Prominent Past, but Does it Have a Future?" held June 16, 2006). Others, including Len Nichols of the New America Foundation, have said the employer system will continue to operate under strain with more employers dropping in the future (for more information, see Len M. Nichols, *Outline of the New America Foundation Vision for a 21st Century Health Care System,* New America Foundation, January 2006).
38. This is based on applying the take-up rate for the eligible but not enrolled population to this population.
39. Based on authors' conclusion of technical assistance provided by the California Department of Health Services.
40. All information in this paragraph is taken from: California Managed Risk Medical Insurance Board. *2004 Healthy Families Program Mental Health Utilization Report.* MRMIB Board Meeting Agenda Item 8.j, 7/19/06.
41. Based on authors' conclusion of technical assistance provided by the California Department of Health Services; number is less SED costs, which were already discussed.
42. Advocates have expressed concerns that enrollment innovations like Accelerated Enrollment should not be applied to the SCHIP allotment for children ultimately enrolled in Medi-Cal. A discussion of this matter is beyond the scope of this paper.
43. Legislative Analyst's Office. *California's Fiscal Outlook, Projections 2006-07 Through 2011-12.* November 2006.

44. State of California. *2006 November Estimate.*
45. Ibid.
46. Ibid.
47. Ibid.
48. The Lewin Group. *Estimated Cost and Coverage Impacts.*
49. This is based on the Lewin Group estimate that there are 79,000 legal immigrant children in California. The authors assume that 60 percent of these children are otherwise eligible for HFP.
50. Based on monthly eligibles who could be enrolled in the program in five years. Obtaining a count of unduplicated program enrollees is difficult for several reasons, particularly since existing state data systems are not conducive for this type of analysis.
51. If SCHIP is not reauthorized, California would still have the option to cover these children through Medicaid at the regular match rate. However, given that California did not choose to expand coverage through Medicaid when given the option originally, and given that California's budget situation may make it difficult to fund SCHIP at the regular match rate, it seems reasonable to assume that all currently covered children are at risk of losing coverage.
52. There is no state baseline set by the Congressional Budget Office. In order to discuss California's need compared with federal need, this paper assumes that California's baseline is 16 percent of the $5 billion in annual baseline spending.
53. Budget of the United States Government. *Analytical Perspectives: Aid to State and Local Governments, Fiscal Year 2008.* 103-104. More specifically, the president's budget calls for $277 million in new spending in FFY 2009, with $1.512 billion in new spending in each of FFY 2010, FFY 2011, and FFY 2012. The president's budget also calls for redistributing unspent funds by limiting the availability of annual allotments to one year, instead of three years.
54. See Endnote 2.
55. For a discussion of the budget being sought by national groups, see ccf.georgetown.edu/schipdocs/chgletter.pdf. At least some of the $60 billion in additional funding is for Title XXI Medicaid spending that occurs in other states. The analysis in this report shows that at least $35 billion over five years in additional funding is needed for California to have sufficient funding.
56. As discussed earlier in the paper, the state would continue to have the option to use income disregards to cover higher-income children in Medicaid at the regular match rate in the president's budget.
57. Georgetown University Health Policy Institute, Center for Children and Families. S*tates Affected by Proposals to Reduce SCHIP Coverage Options.* Washington, D.C.: February 7, 2006.
58. Ibid.
59. White House Office of Management and Budget. *Just the Facts, State Children's Health Insurance Program (SCHIP).* 2007 (www.whitehouse.gov/omb/pubpress/2007/factsheet_schip.pdf).
60. Park, Edwin, and Matthew Broaddus. *SCHIP Reauthorization: President's Budget Would Provide Less than Half the Funds That States Need to Maintain SCHIP Enrollment.* Center on Budget and Policy Priorities, February 22, 2007 (www.cbpp.org/2-22-07health.htm).
61. Assumptions used with reference to the president's budget are the same as those given in the beginning of this section. Under the president's plan, California could still convert to a Medicaid program or could use state funds only for health coverage. This assumes that AIM would always provide prenatal care using Title XXI funds. The rapid growth in AIM prenatal spending is one reason so many children would be affected by the president's budget; spending on AIM dollars helps to crowd out dollars on HFP spending.
62. As discussed in the next section, other analyses have included the impact of re-allotment from other states. In fact, the Center on Budget and Policy Priorities has found that for FFY 2008 there should be sufficient reallotment dollars under the president's policy to hold states harmless. Such an analysis is beyond the scope of this paper.
63. Chris Peterson. *SCHIP Original Allotments: Description and Analysis.* Congressional Research Service, October 31, 2006 (updated).
64. Broaddus, Matt, and Edwin Park. Freezing SCHIP Funding in Coming Years Would Reverse Recent Gains in Children's Health Coverage. Center on Budget and Policy Priorities, February 22, 2007 (www.cbpp.org/6-5-06health.htm).
65. Presently, the electronic application is only used by trained community-based organizations and counties. In 2008, the state will make it available to the public.