California HealthCare Foundation

The Future of California's SCHIP Program:
Analyzing the Proposed Federal Legislation

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Prepared for

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by

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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

Reauthorization of the State Children's Health Insurance Program (SCHIP) is a major health policy topic this year. During its ten-year history, SCHIP has played an integral role in facilitating access to health coverage for six million children nationally and helped sustain states' commitment to children's health coverage, even during difficult economic times.

California has the largest SCHIP program in the nation, known as Healthy Families. In 2006 alone, the state spent $1.8 billion in combined federal and state funds to operate its SCHIP program. Over the past ten years, California has spent more than $5 billion to provide health insurance coverage for children with family incomes up to 250 percent of the federal poverty level (FPL).[1] Federal contributions through SCHIP provide about 65 percent of the funding needed to operate Healthy Families, which today covers roughly 800,000 children. In addition, the state's Medi-Cal program covers more than 4 million children at a combined state-federal cost of nearly $10 billion.[2]

This report is part of the California HealthCare Foundation's body of work examining California's stake in the SCHIP reauthorization debate.[3] It details the issues that are likely to arise as policymakers determine the future of the program, including possible changes to eligibility and benefits rules, as well as the financing structure, with a specific focus on the factors that could have a significant impact in California. It also offers an overview of the SCHIP allotment formulas in two proposed federal bills that address SCHIP reauthorization and an analysis of what they might mean to California.

II. Background

SCHIP was enacted as part of the Balanced Budget Act of 1997 and provided states an opportunity to expand publicly funded health care coverage for children. SCHIP offered a $40 billion block grant of federal funding to states over ten years. There is no new funding for the program after September 30, 2007.

The SCHIP statute (Title XXI of the Social Security Act) gives states significant flexibility in designing their programs. To implement SCHIP, states could choose to expand their existing Medicaid programs (called Medi-Cal in California), create a new children's health insurance program, or opt for a combination of both.[4] California chose a combination approach. In creating Healthy Families, the state initiated a small coverage expansion under Medicaid by increasing Medi-Cal eligibility for children ages 6 to 18 from 85 to 100 percent of the FPL, and it created a separate program for children in families with incomes above Medi-Cal levels. Healthy Families covers children with family incomes up to 250 percent of the FPL ($43,380 for a family of three in 2007). California also uses SCHIP funds to enhance and support improvements to Medi-Cal, such as presumptive eligibility, that promote children's health insurance, and specifically to support prenatal care.[5] The Managed Risk Medical Insurance Board (MRMIB) oversees Healthy Families and the Department of Health Services operates the Medi-Cal program.

In 2006, California spent its entire allotment of $647 million, roughly 16 percent of the national allotment of SCHIP funds. This has not always been the case; a variety of factors inhibited the state from spending all of its SCHIP funds in the early years of the program. While specific financial mechanisms were created to support states that exceeded their allotment, the system has not adequately responded to such needs at the appropriate time. As a result, nearly $1.5 billion of California's SCHIP funds were redistributed to other states. Today, Healthy Families is serving more than 800,000 children and is spending at rates that exceed the state's allotment. In FY 2007, California will spend an estimated $300 million over its allotment, making Healthy Families the largest SCHIP program in the nation.[6]

Importance of the SCHIP Program

In the United States, health insurance coverage promotes access to care and improves a child's chances of reaching full physical and mental health potential.[7] To this end, the SCHIP and Medicaid programs have been successful in decreasing the number of uninsured children nationally. The estimated number of uninsured, low-income children nationwide decreased from nearly 23 percent in 1997 to 15 percent in 2003, despite a national economic recession that resulted in many families losing access to employer-based health insurance coverage.[8] By 2005, the national proportion of uninsured children had fallen to 12 percent. California had a similar experience, with the population of uninsured children falling from 21 percent in 1998 to 14 percent in 2005.[9] California's Healthy Families and Medi-Cal programs, and the federal funding that accompanies them, have also played a significant role in the states' efforts to provide health coverage to children.

Overview of Major Congressional Proposals

Congress is in the process of considering legislation to reauthorize SCHIP. The two bills attracting the most attention are:[10]

- **The Children's Health First Act** (HR 1535/SB 895) sponsored by Representative John D. Dingell (D-MI) and Senator Hillary Rodham Clinton (D-NY). Introduced in March 2007, the bill is designed as a comprehensive approach to children's health coverage.
- **The CHIP Reauthorization Act of 2007** (SB 1224) sponsored by Senators Jay Rockefeller (D-WV), Olympia Snowe (R-ME), and Edward Kennedy (D-MA). Introduced in April 2007, the bipartisan Rockefeller-Snowe bill is also intended to address SCHIP reauthorization and may be used to inform the Senate version of the final legislation.

The two bills approach SCHIP reauthorization quite differently, but both embrace several key principles for reform and the establishment of a more effective financing structure. They include several new optional eligibility groups (such as pregnant women and legal immigrant children), and encourage states to expand SCHIP coverage to families with higher incomes. It appears that either reauthorization proposal would benefit California by providing better targeting of funds and new areas of flexibility that would be helpful in advancing the state's goal of providing universal coverage for children.

The Children's Health First Act
(DINGELL–CLINTON)

The Dingell-Clinton bill would replace the existing SCHIP block grant structure with what is essentially an entitlement for states, meaning that states would be assured of receiving all the federal matching funds they need. The proposal does not include an aggregate upper limit to the national SCHIP allotment. The Dingell-Clinton formula uses a bottom-up approach to determine how much federal money each state needs to finance its SCHIP program in a given year, and then determine the amount of the national allotment.

Beginning in 2008, the formula would initially be based on a state's SCHIP spending in FY 2007. For future years, the amount would be indexed each year based on per capita increases in national health expenditures and the growth of the population of children in that state. The key difference from current law is that if a state increases its SCHIP enrollment to levels higher than ordinary population growth, the financing would be made available and would continue to be open-ended within certain parameters.

Dingell-Clinton expands the target population for SCHIP coverage to include families earning 400 percent of the federal poverty level, or nearly $70,000 for a family of three in 2007, up from the current 200 percent ceiling. States would have the option to enroll a number of new populations in their SCHIP programs including: children up to age 25, pregnant women, legal immigrant

children and pregnant women, and children of state employees. Dingell-Clinton also proposes to add new requirements to provide the Medicaid EPSDT benefit, including dental care, and coverage of services provided in community health centers. The bill provides financial incentives for states to expand their programs as long as certain conditions—such as providing 12 months of continuous eligibility and eliminating barriers to enrollment—are met. The Dingell-Clinton proposal also targets the employer-sponsored insurance system as a vehicle toward coverage, giving states broader options for providing premium assistance so that families can buy into, or stay enrolled in, private coverage.

The CHIP Reauthorization Act of 2007
(ROCKEFELLER-SNOWE)

The Rockefeller-Snowe bill expands the SCHIP target population from 200 percent of the federal poverty level to 300 percent, or $51,500 for a family of three in 2007. It maintains the existing block grant financing structure, but provides significant new federal resources for the program. The bill includes increased national allotment amounts totaling $58.4 billion over five years (FY 2008–12) and similarly revises the allotment formula that will be used to determine each state's share of federal SCHIP funds.[11] The Rockefeller-Snowe formula relies on three factors in determining state-specific allotments:

- **A coverage factor** that takes into account state SCHIP spending in FY 2007, indexed by the increase in national health expenditures and population growth. In some cases a projection for 2008 can be substituted.[12]
- **An uninsured-child factor** that takes into account the state's portion of uninsured children nationally with family incomes below 200 percent of the FPL (based on the most recent Current Population Survey data, with additional funding for sample size improvements).
- **A geographic cost adjustment** that takes into account variation in health care costs across states (based on the health care wage index, as used under current law).

The Rockefeller-Snowe proposal would automatically update states' allotments every two years based on spending levels in the prior year, as well as health care inflation and population growth. This is intended to make initial allotments more reflective of states' needs and to lessen their reliance on redistributed funds for the maintenance or expansion of SCHIP programs. This element would be important for California given the state's increasing population, particularly among children.

To increase the stability of the allotment structure, the Rockefeller-Snowe proposal also provides a guarantee that states receive (within the national capped allotment) at least the amount of their previous year's allotment or the amount of their previous year's spending (indexed for inflation), whichever is lower, each year. An estimate released by Senator Rockefeller's office on April 27, 2007 provided preliminary projections of states' 2008 CHIP allotments based on SB 1224. The estimates project that California would receive nearly $1.28 billion in federal funds for federal FY 2008, based on an estimated 835,000 low-income uninsured children in the state.[13]

The Rockefeller-Snowe bill likewise includes several new eligibility options for states including coverage of pregnant women, legal immigrant children and pregnant women, and children of state employees. It would require coverage of dental and mental health services and offers incentives that reward states for outreach efforts aimed at finding and enrolling the estimated 6 million children who are eligible for public health coverage programs but have not enrolled.[14] (See discussion of enrollment bonuses on page 18.)

III. Reauthorization Issues for California

There are many important issues related to SCHIP reauthorization that will affect California and could be addressed through either of these bills. The most basic is determining California's need for federal funds, which is estimated to be between $6.7 billion and $8.1 billion over the next five years in order to cover just those uninsured children already eligible for Healthy Families.[15] Assuming the federal allotment is increased beyond levels required to maintain existing coverage, policymakers will also face important questions about potential policy changes to the program.

The most important issue for SCHIP reauthorization is the size of the overall allotment. By funding SCHIP at the level specified in the Congressional Budget resolution, $50 billion over five years,[16] there is reason to believe that California and other states would be able to make significant strides in expanding coverage and reaching those children who are eligible but not enrolled. In addition, a large national allotment would make the details of the funding formula less important, an advantage in the political realm where a wide range of challenges will make creating a new funding formula difficult.

This chapter lays out the potential policy issues for California with respect to three broad areas: (1) eligibility rules, (2) benefits and cost sharing requirements, and (3) the financing structure.

Eligibility Rules: Who Gets Coverage?

There is debate on whether SCHIP eligibility rules should be changed. Some have called for SCHIP to be a vehicle for universal coverage for children, in the way that Medicare is for people 65 and over. Others believe that SCHIP funds should be focused only on lower-income children. This section discusses what impact eligibility changes at the federal level could have on California.

Eligibility Expansions

States, as well as children's health advocates, see SCHIP as a potential vehicle for further health coverage expansions. Health reform plans now being contemplated in many states, including bipartisan proposals in California, focus on using SCHIP as a step toward achieving universal coverage for children.[17]

Options include extending coverage to:

Children in higher-income families. While the SCHIP statute now targets families with incomes up to 200 percent of the federal poverty level, states have flexibility to set income eligibility levels as they see fit. Today, a majority of states cover children up to or above the 200 percent level, and eight states cover children with family income up to 300 percent and higher through the use of waivers and other methods (such as exempting or adjusting certain types of income when assessing eligibility). Many states would like to have a more explicit authority to receive SCHIP funds for such coverage.[18] Congress could streamline SCHIP's eligibility rules by changing the statute to include children at higher income levels.

The Dingell-Clinton bill defines the SCHIP target population as families with incomes up to 400 percent of the FPL (nearly $70,000 for a family of three in 2007); the Rockefeller-Snowe proposal takes a less-ambitious approach, targeting families with incomes up to 300 percent of the FPL ($51,500 for a family of three in 2007).[19]

Both proposals are consistent with California's efforts to use county programs to cover additional children. In 2001, the state legislature expanded the use of SCHIP funds by establishing the County Health Initiative Matching (CHIM) program. Through this program, three counties (Santa Clara, San Mateo, and San Francisco) use local funds to draw upon some of the unspent portion of California's federal SCHIP allotment according to the same 2-to-1 matching rate used by the state. On a county-by-county basis, the Healthy Families program is expanded to uninsured children living in families earning incomes between 250 percent and 300 percent of the FPL. If California covered children up to 300 percent of the FPL, the state could receive as much as $500 million in federal SCHIP funds over the next five years, if all newly eligible children were enrolled.[20]

Older children. Another possibility for expanding children's coverage would be to permit states to enroll people up to age 21 in SCHIP by continuing to define them as children, as is permitted in Medicaid. SCHIP eligibility rules under current law give states the opportunity to receive SCHIP funds to cover people up to age 19 whose family incomes are too high to qualify for Medicaid, but generally too low to afford private coverage. Coverage of older children is not included in either the Dingell-Clinton or the Rockefeller-Snowe proposals.

Pregnant women. California is one of six states that received a federal waiver to use SCHIP funds to cover pregnant women (in California's case, through the Access for Infants and Mothers program). This concept, and the importance of prenatal care, was envisioned under the original SCHIP statute, but Congress could go one step further and explicitly include pregnant women as an optional eligibility group under SCHIP. Both the Rockefeller-Snowe and the Dingell-Clinton proposals include such options. Such a step would eliminate administrative problems and guarantee future federal funding for this population.

Legal immigrants under the five-year ban. Under the 1996 welfare reform law, no legal immigrants are eligible for federal support until they have been in the country for at least five years. This lack of federal funds creates a barrier for states to provide coverage to this population. The Rockefeller-Snowe and Dingell-Clinton bills both include an explicit option for states to cover legal immigrant children and pregnant women in Medicaid and SCHIP. Like many states, California uses state-only funds to cover children who are otherwise eligible for Healthy Families but prohibited from using federal funds by the five-year ban, a population estimated at 15,300 people.[21] It is worth noting that any change to the five-year ban would have a much greater financial impact on Medicaid than SCHIP, as a larger number of previously ineligible children would qualify for Medicaid than SCHIP.

Parents. The original SCHIP law anticipated the possibility of covering parents of children enrolled in SCHIP,[22] and both the Clinton administration and the Bush administration granted waivers to cover adults under SCHIP. One justification for using SCHIP dollars for adult coverage is that covering parents has been shown to increase coverage and access to care for children.[23] The federal government has allowed 12 states to cover adults and six states to cover prenatal care. However, some policymakers say that using SCHIP funds to insure adults, especially those without SCHIP-eligible children at home, is at odds with the program's original legislative intent. In addition, Congress passed the Deficit Reduction Act of 2005, which prohibits new SCHIP waivers from covering childless adults.

California received permission from the federal government in 2002 to use SCHIP dollars to cover parents of children enrolled in the Healthy Families program. The state never implemented the waiver due to a lack of state funding,[24] and now the waiver option has expired. Though no current estimates exist on the impact of covering adults in California through SCHIP, federal flexibility on this issue could assist California in its efforts to extend health coverage to the uninsured.[25]

Possible Reductions in Eligibility Levels

An important issue being discussed is the possibility of placing an explicit income limit on the populations that can be covered with SCHIP funds. President Bush's budget and some members of Congress have called for SCHIP to "refocus" its funding on children with incomes at or below 200 percent of the FPL, the so-called "core population" named in law as the target group for SCHIP. While it seems unlikely that the Democratic Congress would accept the president's proposal, this change would be a significant point of contention for most states.

Eighteen states currently have income eligibility thresholds in SCHIP above 200 percent of the FPL, and an additional 16 states have income eligibility levels set at 200 percent of the FPL but apply income exemptions or deductions (for example, for work-related expenses) that allow them to effectively cover some children in families with incomes above 200 percent of the FPL.[26] As a result, more than half of the states, including California, would be required to modify their programs and potentially disenroll thousands of children.

Today, California covers about 190,000 children with family incomes between 200 percent and 250 percent of the FPL.[27] The president's preferred policy puts coverage of these children at risk. In California, 250 percent of the FPL may be a much more appropriate definition of "low-income," as shown in the cost of living comparison in Appendix C.

The federal government already recognizes that California has a high cost of living, as demonstrated by the fact that the federal Office of Personnel Management (OPM) adjusts salaries to a higher level in California than other states. Of the top ten "locality pay adjustments" offered by the office, three are in California, with the largest increase in pay for federal employees anywhere in the country going to those working in the Bay Area.[28]

Outreach Funding and Enrollment Incentives

One of the stated priorities of both the Bush administration and the policy community is to refocus efforts on reaching the 6 million children who are eligible for public programs but not enrolled. As part of SCHIP reauthorization, Congress has the opportunity to include additional funding specifically for outreach, as well as provide states with fiscal incentives to increase enrollment of eligible children.

Both the Rockefeller-Snowe and Dingell-Clinton bills address these issues. Under the Dingell-Clinton proposal, states that adopt eligibility simplification and outreach strategies can earn an increase in the Medicaid matching rate paid by the federal government. These new incentives would

undoubtedly assist California in reaching its goal of universal coverage for children, but counting those children who are eligible but not yet enrolled will be a key to the budgeting process.

Among its outreach options, the Rockefeller-Snowe bill creates federal authorization for California's own "express lane" eligibility, giving states the ability to expedite eligibility using the financial information gathered from other publicly funded programs, such as the school lunch program. For those states that make significant progress toward insuring all children, a higher Medicaid matching rate (enrollment bonus) would be available when states meet certain milestones.[29] (See discussion on page 18.)

California's funding for outreach was eliminated in 2003 due to state budgetary constraints, then restored in 2006. About half of the uninsured children in California are eligible for Medi-Cal or Healthy Families.[30] Given this, new incentives to cover additional children could be very important. California would benefit from dedicated outreach funding and additional state and federal support.

Citizenship Requirements

Under the Deficit Reduction Act, children applying for Medicaid (including SCHIP-funded Medicaid expansions), must provide documentation of citizenship and identity.[31] Although some policymakers argue that these rules are needed to prevent fraud, they run counter to state eligibility and enrollment simplification efforts. Evidence already exists that this new requirement is reducing and delaying Medicaid enrollment of citizens in some states.[32]

By expanding the use of the Deficit Reduction Act rules to non-Medicaid SCHIP programs, Congress would increase barriers to enrolling California children into the Healthy Families program.[33] For example, the use of the California Joint Application mail-in form for Medi-Cal and Healthy Families, as well as electronic enrollment processes, would become much less efficient under the Act. Also, requiring presentation of an original birth certificate may even be a de-facto requirement for a face-to-face interview of applicants' parents, if those parents are unwilling to send an original birth certificate through the mail. Both bills address this issue by giving states discretion on citizenship documentation issues.

Simplification of Crowd-Out Requirements

SCHIP requires states to establish rules that discourage parents and employers from dropping employer-sponsored insurance in favor of state-subsidized insurance (a process generally referred to as "crowd-out"). By simplifying federal crowd-out rules, the Healthy Families program could encourage enrollment of uninsured children. When crowd-out occurs in this context, the government pays the cost of covering children who previously had employer-sponsored insurance. As most of the specific rules governing crowd-out were developed through federal regulation, Congress could choose to simplify enrollment and give states more discretion to construct their own crowd-out prevention strategies.

Historically, the research as to whether or not crowd-out occurs in SCHIP has been mixed, ranging from as little as 1 or 2 percent to more than 25 percent, and the question of whether the private coverage that is considered available is actually affordable has not been addressed.[34] Additional state flexibility on crowd-out rules could ease barriers to enrolling more California children in Healthy Families.

California requires that children enrolling in the Healthy Families program do not have employer-sponsored health insurance for three months prior to enrollment.[35] There are few exceptions to this rule; it has been a barrier to enrollment and lengthens the Healthy Families application. Also, the crowd-out policy complicates the governor's individual mandate proposal that requires Californians to have health insurance. Families dropped from an employer's coverage would be required to purchase insurance immediately on the individual market

or through the purchasing pool, even though their children may be eligible for Healthy Families within three months. In this scenario, those children could potentially have three different health plans within a four-month period. The administrative costs alone, not to mention the burden of enrollment and disenrollment, warrant reconsideration of this policy at the federal level.

Benefits and Cost Sharing: Potential Changes

Under the SCHIP law, states must offer program enrollees health insurance that either meets a set standard or has been approved by the federal Department of Health and Human Services.[36] Throughout the program's existence, states have sought greater flexibility to establish benefits and cost-sharing rules. Because states have considerable control over SCHIP benefit design, policymakers will have the opportunity to revisit several of these issues during SCHIP reauthorization.

Premium Assistance and Preventing Crowd Out

Some low-income parents are offered employer-based insurance for their children that has a benefit package comparable to the SCHIP benchmark, but do not enroll because they find it unaffordable. One way to increase coverage of children and parents is to use SCHIP funds to create a premium assistance program to help working parents take advantage of employers' benefits. Under a premium assistance approach, states could provide funds to support the family contribution for children. This would both keep the family in the same health plan and help defray public costs by partnering with the employer.

Premium assistance was a key part of the bipartisan support for SCHIP in 1997. The Republican Caucus believed that the new program should not provide incentives for employers to drop health insurance coverage for their workers.

As part of its unimplemented waiver to cover parents under SCHIP, California was required to conduct a feasibility study to see whether premium assistance was a viable option in the state. California's study indicated several implementation barriers, including limited availability of employer sponsored insurance for low-wage workers, rapidly rising premium and cost-sharing requirements, and a variety of other administrative obstacles.[37]

Both of the SCHIP bills under discussion include some streamlining of rules regarding public-private interactions that are intended to strengthen ties to the private group health insurance market.[38]

Wrap-Around Services for the Underinsured

The SCHIP statute bars states with SCHIP programs that are separate from Medicaid from offering services to augment the coverage of children with private insurance on the grounds that children with "creditable coverage" (essentially any child enrolled in any other health insurance) are excluded from program enrollment.[39] At the same time, states with SCHIP expansions through Medicaid can provide wrap-around coverage to children with less-comprehensive private insurance.[40] The Medicaid statute does not bar children with creditable coverage and has provisions for how the program can wrap around other coverage.[41] By bringing the separate SCHIP rules in line with the Medicaid rules, states could improve the coverage provided to children while sharing the cost of child health insurance with employers. Allowing greater use of wrap-around services as proposed under both bills would give California (a state with a non-Medicaid SCHIP expansion) new flexibility to cover children. Under this approach, children with employer-sponsored insurance could continue to receive those benefits, and use certain services covered by Healthy Families that are lacking in the employer benefit plan, such as dental or vision insurance.

EPSDT in SCHIP

The current SCHIP benefit package rules allow flexibility for states to determine the benefits to offer SCHIP enrollees. In an attempt to make SCHIP

more like a commercial insurance plan, the law gives states four benefit package options to choose from. There has been some discussion of including Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) from Medicaid in the standard SCHIP benefits package.[42] EPSDT is a mandatory service for all individuals under age 21 who are enrolled in Medicaid and whose families meet the standard income requirements. Federal law defines EPSDT to cover certain screening, diagnostic, and treatment services, which must be furnished to eligible children both at age-appropriate periodic intervals and as needed.[43] EPSDT, however, is not required in SCHIP. Advocates have raised concerns over substandard benefits in SCHIP and out-of-pocket costs that limit access to care, particularly for vulnerable populations.[44] By requiring EPSDT in SCHIP as proposed in the Dingell-Clinton bill, the federal government would ensure that children have access to benefits that are more comprehensive than those offered today. However, this would conflict with the goal for SCHIP to be flexible and based on a private insurance model.

California has worked to offer a full benefit package. While a requirement to offer EPSDT services may improve the benefits of Healthy Families for California children, no analysis has been done to determine the cost impact of this proposal on the other states. One unintended consequence of creating a more expensive benefit package could be to force California to save money elsewhere in the program if state dollars are not available to cover the cost. Before taking a position on this policy, it is essential to assess the financial impact on the state.

Chronic Care Programs

Disease management and case management are approaches not specifically mentioned as part of the required SCHIP benefits. The federal government could allot funds for chronic care disease management programs to help families with chronically ill children better manage their health. For children with chronic conditions, such as the growing number with the twin conditions of obesity and diabetes, disease and case management services can be important for improving care and quality of life, and for containing costs.

In California, managed care plans serve as the primary care delivery system for the vast majority of children enrolled in Healthy Families, though it is unclear what chronic services may be offered. Also, the California Children's Services (CCS) program provides support to those children with long-term needs. Congress could choose to make additional resources available to states with the goal of promoting disease management tools that could reduce costs.

IV. Financing Issues for California

While the policy improvements being considered are extremely important for enabling states to move forward with their health coverage expansion efforts, all of the proposed eligibility and benefit expansions are predicated on the amount of federal funding that is allocated to the program. Without a large infusion of new funds, it is very unlikely that Congress will adopt additional eligibility options for SCHIP. However, reauthorization also provides an opportunity to improve on the financing structure of the program. Both bills attempt to offer a more stable and predictable funding stream so that states can more effectively budget and plan for programmatic changes in the future. The remainder of this report will provide an analysis of the financing elements of each proposed bill and consider how the proposals might affect California.

Financing Overview

When SCHIP was authorized as part of the Balanced Budget Act of 1997, there was significant debate over the program's financing structure. Many wanted SCHIP to be an entitlement program similar to Medicare and Medicaid, in which eligible individuals are guaranteed coverage. However, as part of the compromise struck by a Democratic president and a Republican-controlled Congress, SCHIP funding is provided primarily through block grants, although states that decided to use SCHIP funds to expand their Medicaid programs receive SCHIP's enhanced matching rate[45] for children entitled to Medicaid coverage.

The basic financing structure of SCHIP brought with it several challenges for states.[46] The SCHIP block grant formula has been criticized for being:

- **Unresponsive to economic cycles.** With a block grant, the total pool of resources available to states is independent of changes in the demand for coverage, which can make it difficult to address changing program needs. For example, during an economic downturn, states could see SCHIP enrollment spike, thereby putting enrolled children at risk if the state were to unexpectedly spend its entire allotment.[47]
- **Inconsistently funded over the ten years.** The funds provided to states for SCHIP in 1997 were not distributed equally over

the ten year period. Instead, Congress allocated almost $4.3 billion for each of the first four years of the program—1998 through 2001. In what is sometimes called the "CHIP Dip," Congress then decreased the funding by more than $1 billion to $3.15 billion for each of the following three years. It turned out that this dip occurred just at the point when state programs were maturing and enrollment was peaking. This was done solely to help ensure that the Balanced Budget Act could help balance the budget.[48] The amount of funding the formula provided was higher in the first year than the last, despite the fact that many states were starting new programs whose enrollment and expenditures would grow over time.

- **Inadequately targeted.** Initially, the SCHIP distribution formula relied primarily on calculating the number of low-income uninsured children in every state, using estimates generated by the Census Bureau's Current Population Survey. Over time, the formula was broadened to include a weighted average of the low-income uninsured children estimate and the number of low-income children in the state (also using Census data). However, the calculation has not reflected historical state spending patterns and enrollment levels. As SCHIP programs achieve the goal of insuring low-income children, uninsured rates decrease, thereby reducing state allotments. And while the Current Population Survey remains the best known and most comprehensive national survey of health insurance status, reliance on the state-specific data related to uninsured children has also proven problematic.[49]

As a result of these factors and other challenges, the federal SCHIP allotment formula led to a relatively poor distribution of funds across the states. Some states received significantly more than they could spend, while others received far too little funding to establish a significant program. In 2005, nine states were spending within 10 percent of their annual allotment for that year, as shown in Figure 1 on page 14.

Three-Year Allotments and the Redistribution Process

In recognition of the difficult challenge of estimating states' financing needs for the new program, the SCHIP statute gave states three years to spend their SCHIP funds. Funds from annual allotments that have not been spent after this period would then be "redistributed" among states that had spent their full allotments. According to the statute, the redistributed funds are available for one year, after which any remaining funds are to revert to the federal Treasury.

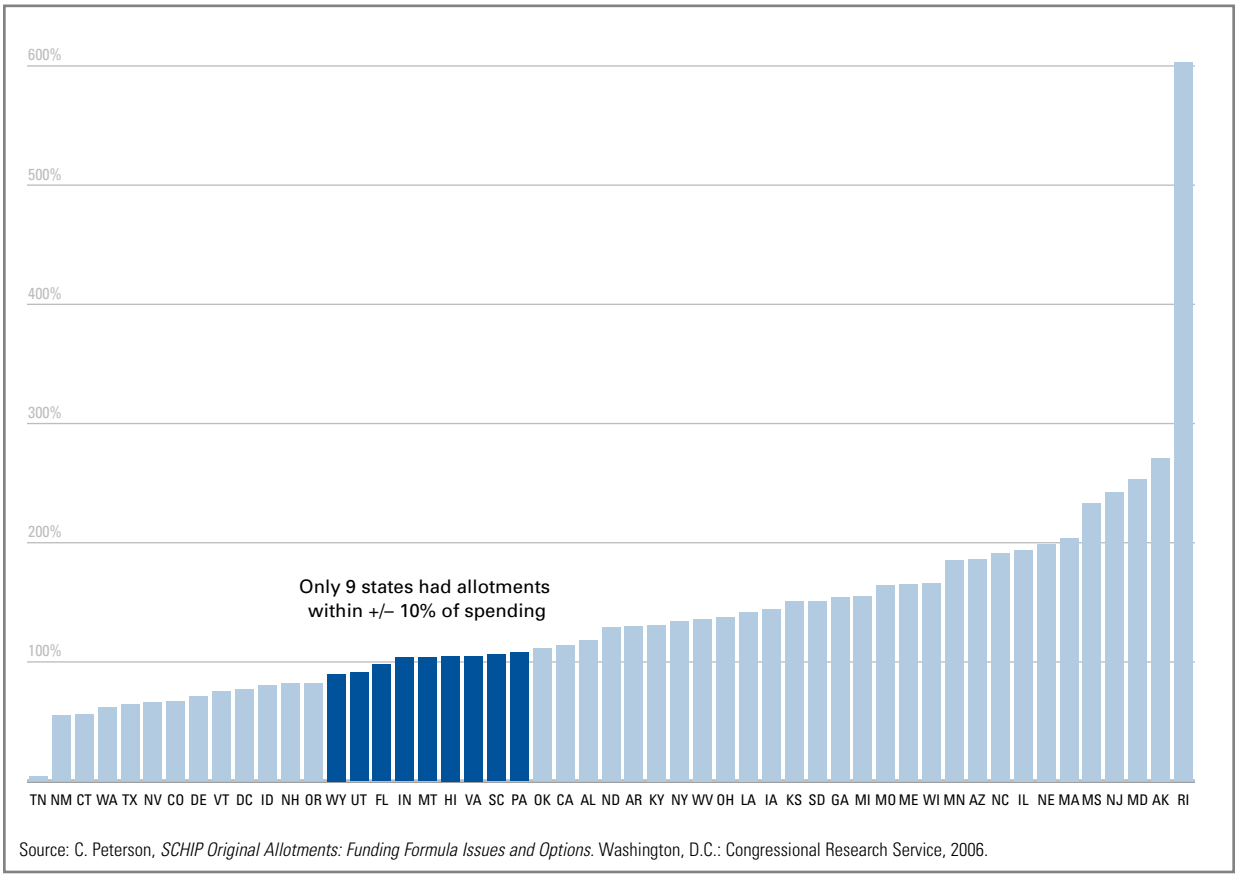
The rationale behind the redistribution process is that it increases the effectiveness of the SCHIP block grant by assuring that SCHIP funds eventually end up in the states where they will be used to cover children.[50] In the early years, however, most states, including California, did not spend their full allotments because setting up separate SCHIP programs took longer than Congress anticipated. State programs were never going to achieve full enrollment immediately.

By the end of 2000, only 11 states had spent all of the federal SCHIP funds they received in fiscal year 1998.[51] 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. Still, California lost $1.46 billion in federal SCHIP funding that was ultimately reallocated to other states.[52]

Short-term Fixes

To address these shortcomings, Congress has acted multiple times in SCHIP's history to temporarily modify the program's state funding allocation rules. In an effort to keep unspent money in the system, Congress has, at various points, allowed states to retain their allotments longer than three years, and has limited the amount redistributed. In 1999, Congress limited large annual changes in allotments. However, none of those temporary fixes has provided a permanent solution to the problem. In FY 2006, 38 states' annual spending exceeded annual

Figure 1. SCHIP Spending as Percent of Allotments, FY 2005



Source: C. Peterson, *SCHIP Original Allotments: Funding Formula Issues and Options.* Washington, D.C.: Congressional Research Service, 2006.

allotments (including California's);[53] in FY 2007, 12 states completely exhausted their federal funds. In addition, Congressional efforts to address limitations in the Current Population Survey, which could then yield better data for use in the allotment formula, have been slow in developing.[54]

Analysis of Proposed SCHIP Financing Reforms

The purpose of this section is to understand the specific factors behind the proposed SCHIP financing structures being considered in the reauthorization discussion and how they might relate to California. It is not intended to be a comprehensive explanation of the formulas; rather, the goal is to provide an overview of the proposed changes to the SCHIP financing structure and to offer an explanation as to how these key elements could potentially affect California.

Block Grant vs. Entitlement

While neither formula proposes making SCHIP an individual entitlement program like Medicaid, the Dingell-Clinton formula would effectively hold states harmless for the growth in covered children. Under this formula, the federal government would reimburse states for all eligible children enrolled, within certain parameters. The only limit on funds to states is a cap in the growth of medical inflation. This would eliminate the pressure on states to limit program growth and would send a clear signal that SCHIP children are as important as seniors in Medicare or children in Medicaid.

Issues for California. California, like all states, would likely benefit from a state SCHIP entitlement because it would relieve state budget pressures. Since California has been overspending its allotment in recent years, any such change (whether it is

elimination of the national cap or offering financial adjustments) would help state policymakers fund the program. However, the Dingell-Clinton proposal will clearly be seen as a new and significant cost to the federal budget, limiting its prospects for passage. On the other hand, the Rockefeller-Snowe proposal, while maintaining the existing capped grant structure, proposes nearly $60 billion in new SCHIP funding to the states over the next five years, which would also be beneficial to California. A capped grant structure holds much greater promise for Congressional approval.

Allotment Funds for the Coverage of Enrolled Children

As explained previously, both proposals rely on a determination of existing spending to establish future allotments. The fact that both bills base future state allotment amounts on existing spending levels for SCHIP is positive. For California, basing future allotments on fiscal 2007 spending would give the state more certainty to budget and plan for future expansions. In this process, a crucial step for both proposed formulas is determining the base year spending level, as that will affect spending in all future years.

Under the Rockefeller-Snowe proposal, there are four possible methodologies that can be used to determine the base year funding level for FY 2008, with the state receiving the highest of all four calculations. This is referred to in the bill as "the coverage factor."

The first methodology is tied to actual FY 2007 spending and the second is based on the FY 2007 allotment amount. Options three and four rely on state-developed projections for SCHIP spending previously reported to the secretary of the Department of Health and Human Services. This would account for some states that could be in the process of implementing major expansions, but which do not yet have the enrollment and spending levels to document that spending. At the same time, other states which rely on projections might be disadvantaged if their projections turn out to be inaccurate.

Options three and four could have adverse consequences. If states project spending that is higher than what occurs, there will be less money available when the uninsured child factor is calculated, which means that other states will receive lower allotments. The amount of money left over for the uninsured child factor depends on the amount of federal funds remaining after the coverage factor has been determined. The Dingell-Clinton bill relies exclusively on actual state spending for the prior year and does not allow for state projections to be used, so the issue does not appear to apply.

Issues for California. To help ensure that California receives sufficient funding to support Healthy Families, the state has a clear interest in ensuring the accuracy of other states' allotments. For states engaging in expansions, separate provisions could be made to hold them harmless for actual spending, versus the projection approach in Rockefeller-Snowe.

Allotment Funds for the Coverage of Uninsured Children

Both formulas make an effort to account for coverage of children who are currently uninsured. Under the Rockefeller-Snowe bill, the amount available for the uninsured child factor is uncertain because the amount of funding available for this adjustment would be based on how many dollars are left over after the coverage-factor allotments that are deducted from the national allotment. Given that there are proposals in the state to cover all children, the lack of predictability of this part of the allotment formula could make planning for such program expansions challenging.

In contrast, the Dingell-Clinton bill relies on state estimates of the number of uninsured children expected to be covered during the fiscal year. The initial allotment is based on that estimate, factored with an "enrollment bonus" that is equal to the state-specific per capita cost for covering an additional

child above the initial estimate. At the end of the year, the state's enrollment is reconciled and states are reimbursed for any additional children covered above the initial allotment amount. This open-ended financing structure is more favorable to states.

Issues for California. Any effort to cover all children will need to take into account the availability of supporting federal funds over time. It is likely that adoption of the Rockefeller-Snowe formula would mean that coverage of uninsured children under Healthy Families would need to be phased in. Careful planning will be needed to ensure that federal funding will be available for all children being enrolled in the Healthy Families program before a major expansion is executed. The Dingell-Clinton bill offers greater funding certainty for states than the Rockefeller-Snowe plan. However, if the Dingell-Clinton proposal were modified to include an aggregate cap on federal funds, this reconciliation process could cause uncertainty in the funding stream.

Adjustment for Medical Inflation

Once the base year allotments are established, both bills automatically increase the following year's allotment using a calculation of medical inflation (combined with other population-based growth factors). More specifically, both bills look at "per capita health care growth" projections of national health expenditures (NHE) as calculated by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS).

For the most part, California has successfully contained medical inflation in Healthy Families spending. While some other state programs that use Title XXI funds, such as Access for Infants and Mothers (AIM), have relatively high rates of inflation and spending for pregnant women, cost growth in the Healthy Families program has remained well below the national average.

The chart below illustrates the weighted average in growth of inflation for Title XXI programs.[55]

As shown in Table 1, the inflation estimates from low to high are based on a range of factors related to specific Title XXI-funded programs versus NHE growth estimates developed by the federal government.

Table 1. Annual Inflation Rates,[56]
California Title XXI vs. NHE, FY 2008–2012

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
High	4.83%	4.85%	4.87%	4.97%	5.07%
Mid	4.16%	4.16%	4.16%	4.24%	4.30%
Low	3.48%	3.46%	3.45%	3.50%	3.54%
NHE	6.10%	6.40%	6.10%	6.00%	6.10%

Issues for California. California would almost certainly benefit from this adjustment. As the analysis shows, the NHE growth rates probably exceed those of California's programs.

Accounting for Child Population Growth

Both of the proposed bills include an adjustment to the states' annual allotments based on the growth in the state's overall population of children. The Dingell-Clinton proposal includes a straightforward adjustment based on estimates of state-specific growth in the child population.[57]

Under the Rockefeller-Snowe proposal, the calculation would be based on the national (rather than a state-specific) average growth in the percentage of children, plus one percentage point. To determine the rate of growth in the child population, both formulas use the Current Population Survey. Although the survey is the most widely used and comprehensive source of health coverage information, its limitations are widely acknowledged and have added to the inaccuracies of SCHIP allotments under current law.[58]

In addition, there is a wide disparity across states with respect to growth in the population of children. Between 2000 and 2010, the United States growth rate for people under age 18 is estimated to be approximately 3 percent. However, using this average number hides the wide variation in

projected growth rates across states. For example, several states (including Michigan, West Virginia and New York) are expected to experience significant *decreases* in their populations of children. Conversely, other states (such as Nevada, North Carolina and Texas) will have even larger *increases* in their populations, making the use of the average even more problematic.[59] (See Appendix A.) Under the Rockefeller-Snowe formula, states with decreasing numbers of children will be rewarded.

By focusing on a national average calculation instead of state-specific data, the Rockefeller-Snowe allotment levels may end up being too high or too low for some states.[60] Directing funds to states with decreasing numbers of children would reduce the funds available to states with higher rates of growth. States receiving funds that exceed their child population growth rate would have a greater opportunity to cover adults and other populations with those SCHIP funds.

Issues for California. Conflicting data makes it difficult to assess the impact of the growth factor. According to CPS' near-term projections, California would most likely benefit from using the national average for the growth factor rather than state-specific data. In an uncharacteristic shift in projections, the survey has estimated that the national average growth in the number of children will be higher nationally than in California for the next several years.

Appendix B presents CPS data, as well as the California Department of Finance's (DOF) projections for the number of children in California. The state predicts a significantly higher rate of growth than CPS. If the state analysis is more accurate than the CPS national average projection, it appears the proposed formula could leave California at a disadvantage.

Population Growth: Coverage of Pregnant Women

A separate but important issue for population growth is related to pregnant women. The original statute did not authorize coverage of pregnant women, although the Centers for Medicare and Medicaid Services has granted approval for states to receive SCHIP funds for this group and, in some states, pregnant women are a significant part of total enrollment.[61] California is one of six states to use Title XXI funds to provide services to this group. Neither of the proposals takes into account pregnant women (or coverage of parents) in calculating population growth. This issue also applies in states that have been using state-only funds to provide health coverage to uninsured immigrant children.

Issues for California. Enrollment of pregnant women in AIM and Medi-Cal has been faster than that of children. Congress could offer a similar population growth adjustment to account for increases in enrollment of pregnant women over time. This would help California in its efforts to ensure access to prenatal care and better birth outcomes.

"Five Percent" Redistribution Set Aside

The Rockefeller-Snowe bill contains a number of provisions designed to prevent states from having funding shortfalls during the year. One such change is to the reallocation policy.[62] The proposal creates a set aside of 5 percent of the national allotment before the individual state allotments are calculated. After the two-year period of availability, any remaining funds would be combined with the 5 percent set aside to form the redistribution pool for that year. This ensures a particular amount of money will be available to be redistributed to states that need additional funds.

Issues for California. The implications of this change to the redistribution formula for California are unclear. Under the proposed policy, California's initial allotments will be 5 percent smaller than under the proposed law. Instead of holding these dollars in reserve, they might be more effectively

used to fund SCHIP programs on the front end. It is possible that the set-aside needlessly ties up funding. At the same time, the proposed withholding constitutes a safety valve that might enable the federal government to direct funds to states mid-year if the need arises. If this policy were in place today, California would most likely benefit given that the state has overspent its SCHIP allotment for the past several years. However, there is little quantitative data available that would allow for a definitive conclusion.

Enrollment Bonuses

Both bills contain a financial bonus for meeting certain enrollment goals. Evidence over the years has indicated that SCHIP outreach efforts have been extremely effective in encouraging parents to enroll their children in Medicaid as well.[63] Some states report two Medicaid children for every SCHIP child identified. Like SCHIP, Medicaid works on a matching principle. In general, California receives one federal dollar for every dollar it spends on health care services under the Medicaid law.[64] Both bills propose to offer additional assistance to states with costs associated with covering children through Medi-Cal. These bonuses are designed as incentive for states to renew or maintain existing outreach efforts and continue strategies for finding children who are eligible for Medicaid and SCHIP but have not enrolled.

Rockefeller-Snowe Enrollment Bonuses

The Rockefeller-Snowe proposal includes incentives for states to recommit to outreach efforts aimed at finding and enrolling the estimated 6 million children who are eligible for public health coverage programs but have not enrolled. The bill includes two possible bonuses:

- **Bonus for states significantly increasing enrollment of eligible children.** Under Section 304 of the bill, it is possible for states to earn enhanced matching payments for year-over-year growth in Medicaid enrollment for children. States must have enrollment growth for children in Medicaid that exceeds an established level in order to earn the SCHIP-financed bonus. The amount of the bonus is equal to the full percentage increase in enrollment over the prior year, so long as the benchmark is met or exceeded.

  Issues for California. The qualification requirements for the enrollment bonuses are very significant, and California seems unlikely to qualify at this point. For the 23 month period from January 2005 to November 2006, the number of children enrolled in Medi-Cal fell by 1.44 percent.[65] However, the implementation of SB 437 (Escutia), the state's latest effort to enroll children in health insurance, and other efforts may enable California to meet the proposed requirements. If full implementation could occur in fiscal 2008, the state could earn a bonus for that year.

- **Bonus for states that have achieved at least a high performing status.** It is also possible for states to receive a bonus based on the percentage of children without private insurance who are enrolled in some form of public insurance. To receive a bonus, states must have more than 90 percent of the children without private insurance whose family income is at or below 200 percent of the FPL enrolled in public insurance.[66]

  Once the 90 percent threshold is met, states must fulfill another round of requirements. For the bonus to be made available, states must meet all four of the following conditions: (1) offer 12-month continuous eligibility; (2) have no waiting list for Title XXI; (3) have no assets test for children; and (4) fulfill quality reporting requirements (to be determined). With the exception of the new reporting requirements, California meets all of these conditions.

  Issues for California. The thresholds set by this provision are so high as to make it unlikely that California would receive a bonus. An unpublished analysis developed by the Center on Budget and Policy Priorities measures the impact of this provision on all states. They estimate that

currently only one state, Vermont, would qualify for a bonus.[67]

Dingell-Clinton Enrollment Bonuses

The approach in the Dingell-Clinton bill rewards process improvements, rather than outcomes. To earn a bonus, states must first implement continuous eligibility. States must then implement three of five "model outreach and enrollment processes" intended to facilitate the enrollment process, with choices including the following:

- **Application outreach practices.** These include annual enrollment campaigns in schools, facilitating year-around availability of applications, and the training of outreach staff to initially process applications.
- **One-step application process.** Includes accepting a single application for multiple programs, such as food stamps (with similar income eligibility requirements); and implementing "express-lane" eligibility.
- **Administrative verification of income.** Permits self-declaration of income without requirement for unnecessary documentation.
- **Simplified, consistent application form and process.** Includes use of a joint Medicaid/SCHIP application and not requiring a face-to-face interview.
- **Administrative renewal.** Means renewal for SCHIP can be done on an ex parte basis to the extent that the state has the needed information.
- **Presumptive eligibility.** Allows children to access services while their application is being processed and eligibility is being determined.[68]

Issues for California. California already provides 12-month continuous eligibility; however, it is not clear whether the state would be able to satisfy the requirements for three of the five possible options specified in the Dingell-Clinton proposal. While California also seems to meet several elements of the other requirements, the complex legislative language makes a determination difficult. As noted previously, the state legislature has passed several proposals that would boost efforts in this area and many other enrollment streamlining initiatives, such as adoption of the One-E-App electronic application process, are well under way.

V. Conclusion

The challenges of expanding and improving children's health insurance are serious but surmountable, as proven by the original passage of SCHIP. Supporters and critics agree that SCHIP makes vital contributions to children's health care in the United States. Regardless of the outcome, the debate over SCHIP reauthorization provides Congress an opportunity to improve the system and renew its commitment to access to affordable, quality health care. The balance of federal and state governance, the relative roles of public and private insurers, the definition of coverage, and the public's willingness to pay for results will be reviewed, argued, and potentially resolved in SCHIP reauthorization. This will not only affect health insurance coverage for millions of low-income children, but will inform future debates over improving the coverage system for all Americans.

Both major SCHIP reauthorization proposals appear to do a better job than the current system of allocating resources to states in a manner that would be more responsive to state needs. There are important state-specific issues as outlined in this report and summarized in Appendix D. The California-specific issues described here are important, but they must be considered within a broader context. The proposed allocation formulas, overall funding levels, and policy changes under consideration would collectively provide a significant stepping stone along the path toward universal coverage for children in California and potentially across the nation.

Appendix A: State Population Projected Growth Rates, 2000–2010

STATE	POPULATION UNDER 18 2000	POPULATION UNDER 18 2010	GROWTH RATE
United States	**72,293,812**	**74,431,511**	**2.96%**
Alabama	1,123,422	1,092,184	–2.78%
Alaska	190,717	183,983	–3.53%
Arizona	1,366,947	1,688,464	23.52%
Arkansas	680,369	702,656	3.28%
California	9,249,829	9,496,978	2.67%
Colorado	1,100,795	1,188,583	7.97%
Connecticut	841,688	814,008	–3.29%
Delaware	194,587	202,208	3.92%
District of Columbia	114,992	114,064	–0.81%
Florida	3,646,340	4,086,123	12.06%
Georgia	2,169,234	2,502,386	15.36%
Hawaii	295,767	316,263	6.93%
Idaho	369,030	400,237	8.46%
Illinois	3,245,451	3,196,906	–1.50%
Indiana	1,574,396	1,596,185	1.38%
Iowa	733,638	711,056	–3.08%
Kansas	712,993	698,996	–1.96%
Kentucky	994,818	1,002,307	0.75%
Louisiana	1,219,799	1,171,502	–3.96%
Maine	301,238	269,232	–10.62%
Maryland	1,356,172	1,406,294	3.70%
Massachusetts	1,500,064	1,483,853	–1.08%
Michigan	2,595,767	2,487,058	–4.19%
Minnesota	1,286,894	1,289,963	0.24%
Mississippi	775,187	759,450	–2.03%
Missouri	1,427,692	1,411,394	–1.14%
Montana	230,062	212,312	–7.72%
Nebraska	450,242	446,256	–0.89%
Nevada	511,799	665,085	29.95%
New Hampshire	309,562	304,164	–1.74%
New Jersey	2,087,558	2,088,224	0.03%
New Mexico	508,574	479,405	–5.74%
New York	4,690,107	4,420,876	–5.74%
North Carolina	1,964,047	2,268,838	15.52%
North Dakota	160,849	141,964	–11.74%
Ohio	2,888,339	2,744,431	–4.98%
Oklahoma	892,360	895,073	0.30%
Oregon	846,526	863,166	1.97%
Pennsylvania	2,922,221	2,747,595	–5.98%
Rhode Island	247,822	249,273	0.59%
South Carolina	1,009,641	1,036,349	2.65%
South Dakota	202,649	194,152	–4.19%
Tennessee	1,398,521	1,478,915	5.75%
Texas	5,886,759	6,785,408	15.27%
Utah	718,698	818,985	13.95%
Vermont	147,523	132,372	–10.27%
Virginia	1,738,262	1,880,184	8.16%
Washington	1,513,843	1,488,423	–1.68%
West Virginia	402,393	382,311	–4.99%
Wisconsin	1,368,756	1,319,144	–3.62%
Wyoming	128,873	116,273	–9.78%

Appendix B: Child Population Demographic Comparison, CPS vs. CA DOF Projections

	PROJECTED CHILD POPULATION – 19 & UNDER					GROWTH RATE	
NATIONAL CPS DATA*	**2000**	**2005**	**2010**	**2015**	**2020**	**2000–2010**	**2010–2020**
Population	80,473,265	81,971,783	83,235,774	85,207,997	88,887,540		
Percent Increase		1.86%	1.54%	2.37%	4.32%	3.43%	6.79%
CALIFORNIA							
DOF Data†							
Population	10,256,862	10,621,542	10,986,221	11,414,699	11,843,177		
Percent Increase		3.56%	3.43%	3.90%	3.75%	7.11%	7.80%
CPS Data*							
Population	10,234,571	10,532,377	10,679,916	10,876,591	11,474,523		
Percent Increase		2.91%	1.40%	1.84%	5.50%	4.35%	7.44%

*U.S. Census Bureau, Current Population Survey (CPS) data:
File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July, 1 2004 to 2030
(www.census.gov/population/www/projections/projectionsagesex.html).

†State of California, Department of Finance (DOF) data:
Population Projections by Race/Ethnicity, Gender and Age for California and Its Counties 2000 to 2050, May 2004.
(www.dof.ca.gov/HTML/DEMOGRAP/ReportsPapers/Projections/P3/P3.asp).

Note: DOF growth rates for 2005 and 2015 are approximated. State projections are for 2000, 2010, and 2020 only.

Appendix C: How Does a 200 Percent FPL* in California Compare to Other States?

Large/Urban			
TO MAINTAIN THE SAME STANDARD OF LIVING FROM SAN FRANCISCO, CA TO:	**ATLANTA, GA**	**BOSTON, MA**	**WASHINGTON DC**
You need a salary of:	$ 23,969.62	$34,050.53	$ 34,245.80
Groceries will cost:	32.359% less	14.614% less	23.591% less
Housing will cost:	65.579% less	37.178% less	21.400% less
Health care will cost:	15.397% less	6.998% more	11.742% less
Mid-Sized			
TO MAINTAIN THE SAME STANDARD OF LIVING FROM SACRAMENTO, CA TO:	**DES MOINES, IA**	**AUSTIN, TX**	**DETROIT, MI**
You need a salary of:	$ 30,745.93	$33,189.32	$ 35,598.77
Groceries will cost:	33.151% less	26.833% less	20.515% less
Housing will cost:	44.523% less	42.473% less	25.432% less
Health care will cost:	17.254% less	10.479% less	10.93% less
Small/Rural			
TO MAINTAIN THE SAME STANDARD OF LIVING FROM BAKERSFIELD, CA TO:	**TUSCALOOSA, AL**	**ASHEVILLE, NC**	**BOISE, ID**
You need a salary of:	$ 37,109.04	$38,061.53	$ 36,385.15
Groceries will cost:	13.688% less	12.990% less	18.745% less
Housing will cost:	25.864% less	6.377% less	22.232% less
Health care will cost:	1.780% more	2.572% less	1.187% less

*For a family of four in 2007: $41,300.

Source: CNN.com, downloaded April 2007. http://cgi.money.cnn.com/tools/costofliving/costofliving.html?step=form&x=25&y=6

Appendix D: Key SCHIP Financing Issues

ISSUE	ROCKEFELLER-SNOWE (SB 1224)	DINGELL-CLINTON (HR 1535)	CONCERNS FOR CALIFORNIA
Eligibility Level	Expands target population to 300% FPL (or 50 percentage points above existing coverage level).	Expands target population to expand coverage to 400% FPL.	Both bills expand coverage options for California.
Calculation of Base Spending	Calculation of the coverage-factor amount is based on the highest of a state's: • FY 2007 spending; • FY 2007 allotment; • Spending projections for as reported to CMS under specified conditions.	Base state allotments are determined by actual state spending.	The Rockefeller-Snowe bill's use of spending projections raises some concerns about the accuracy of initial state allotments, which would then impact all future spending.
Uninsured-Child Factor	Based on CPS estimates of uninsured children in the state (bill includes funding to improve CPS). This portion of the federal allotment would be determined after the coverage factor has been calculated.	Relies on state estimates of uninsured children expected to be covered during the FY, factored with an "enrollment bonus" equal to the per capita cost of covering children above the initial estimate.	The Dingell-Clinton bill offers greater funding certainty for states compared with Rockefeller-Snowe, which creates uncertainty in allotment awards.
Medical Inflation Factor	Annual allotments indexed by increases in national health expenditures (NHE) as calculated by the Office of the Actuary at CMS.	Same as Rockefeller-Snowe.	Both bills seem to offer a methodology that benefits California since increase are based on national averages that California falls below.
Child Population-Growth Factor	Allotments adjusted to account for general growth in the states' populations of children. Calculation based on the national average growth (estimated by CPS) in the percentage of children, plus 1 percentage point.	Allotments adjusted based on estimates of state-specific growth in the child population, also by relying on CPS estimates (rather than state generated estimates).	Use of national average growth rate by Rockefeller-Snowe would benefit states with rates below the national average. Due to conflicting projections on California's growth, it is not clear if California would benefit under this approach. This is less of a factor for Dingell-Clinton because states are held harmless for growth above the projected level.
Enrollment Bonuses	Opportunity for states to receive: • "Enhanced" Medicaid matching rate when significant Medicaid enrollment growth is achieved. • High performance bonuses for demonstrating progress in reaching the uninsured and meeting a series of programmatic eligibility simplifications and quality assurance efforts.	Rewards programmatic improvements such as 12 months continuous eligibility, enrollment simplification practices, outreach and marketing activities, presumptive eligibility, and administrative renewals.	For both bills, the legislative language is sometimes vague and complex. It appears that California could have a difficult time meeting the bonus requirements of both bills.
5% Set Aside	Creates more stable redistribution "pool" made up of a 5% set aside of the national allotment supplemented by allotment funds that remain unspent after 2 years.	No specific system proposed, but indicates any unspent funds would be divided proportionately among states with the greatest need.	While Rockefeller-Snowe allotments would be smaller due to the 5%, the step provides insurance against unexpected financing shortfalls. The Dingell-Clinton approach eliminates the need for a 5% withhold.

Endnotes

1. California also receives federal SCHIP funds for children enrolled in the C-CHIP program (County Children's Health Insurance Program). This program expands coverage levels up to 300 percent of the FPL in Alameda, San Francisco, San Mateo, and Santa Clara counties. For more information on state and federal spending on SCHIP and Medicaid in California, see Kaiser Family Foundation's site www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=California&category=Medicaid+%26+SCHIP.
2. See note 1.
3. The first paper, "Funding California's SCHIP Coverage: What Will it Cost?," offered an analysis of California's SCHIP budget need over the next five years and is available at www.chcf.org/documents/policy/FundingCaliforniasSCHIPCoverage.pdf.
4. Jennifer Ryan, "SCHIP: The Basics." March 27, 2007, available at www.nhpf.org/pdfs_basics/Basics_SCHIP.pdf.
5. The Access for Infants and Mothers Program (AIM) receives SCHIP funds for coverage of children up to 2 years old whose mothers are enrolled in AIM and have incomes between 200 and 250 percent of the FPL.
6. "State Children's Health Insurance Program Title XXI Federal Funds, Total Healthy Families Spending Projections (Children) Based on the November 2006 Estimate," California Managed Risk Medical Insurance Board. Available at www.mrmib.ca.gov/MRMIB/HFP/FedFundChart0611.pdf.
7. Newacheck, P., J. Stoddard, D. Hughes, and M. Pearl, "Health Insurance and Access to Primary Care for Children," *New England Journal of Medicine,* 338:513–519 (1998); Olson, L.M.,S.F. Tang, and P.W. Newacheck, "Children in the United States with Discontinuous Health Insurance," *New England Journal of Medicine,* 353:382–391 (2005); and Stevens, G., M. Seid, and N. Halfon, "Enrolling Vulnerable, Uninsured, but Eligible Children in Public Health Insurance: Association with Health Status and Primary Care Access," *Pediatrics,* 117:751–759 (2006).
8. Holahan, John, and Arunabh Ghosh, *The Economic Downturn and Changes in Health Insurance Coverage, 2000–2003,* The Urban Institute, September 2004, available at 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,* Georgetown University Health Policy Institute, Center for Children and Families, Issue Brief, July 2005. Available at http://ccf.georgetown.edu/pdfs/success.pdf.
9. Statehealthfacts.org based on the Census Bureau's Current Population Survey, March 2005 and 2006, downloaded January 19, 2006. The California Health Interview Survey data have a higher figure for the number of uninsured.
10. Other bills have also been introduced that address SCHIP reauthorization, such as HR 2147, sponsored by Representative Rahm Emmanuel (D-IL) and HR 1013, sponsored by Representative Michael Burgess (R-TX).
11. SB 1224, section 101.
12. Or another calculation as specified in section 201 of the bill.
13. It should be noted that the state's calculations may differ from the projections offered by Senator Rockefeller, but the estimate is helpful for purposes of understanding the potential impact of the revised allotment formula. Office of Senator Jay Rockefeller, "Press Release Announcing Projections of States' 2008 CHIP Allotments under SB 1224," May 4, 2007. Available at www.senate.gov/~rockefeller/news/CHIP%20Reauthorization%20Act%202008%20State-By-State%20Projections.doc.
14. For a full summary of the bill, see Senators John D. Rockefeller IV and Olympia Snowe, "Summary of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007," April 26, 2007. Available at www.senate.gov/~rockefeller/news/Final%20Rockefeller-Snowe%20CHIP%20Reauthorization%20Bill%20Summary.doc.
15. Harbage, Peter, Lisa Chan-Sawin, and Clara Evans, *Funding California's SCHIP Coverage: What Will It Cost?* California HealthCare Foundation, Working Paper, February 2006.
16. Senate Congressional Budget Resolution (S.Con.Res 21), section 301.
17. Major healthcare reform plans in California have called for increased federal support. Of these plans, only Gov. Arnold Schwarzenegger has specified a plan for an immediate increase in Medi-Cal provider rates. For Speaker Fabian Núñez, Please See: Bill Ainsworth, "Boosting Medi-Cal viewed as first step," San Diego Union-Tribune, February 19, 2007. For Senate Republican Caucus, Please See: "The Cal-CARE Plan," January 2007. For Assembly Republican Caucus Plan, Please See: Assembly Republican Caucus Press

Release, "Assembly Republican Health Care Reforms Will Maximize Choice, Reduce Costs, and Increase Access," March 14, 2007. Gov. Schwarzenegger, Please See: Office of the Governor, "Governor's Health Care Reform Plan," January 2007. For Senate President Pro Tem Don Perata, Please See: "Health Care Q&A," December 2006. Also See: California Senate, Office of Research, "Comparison of Perata, Núñez, and Schwarzenegger Health Care Reform Proposals," January 11, 2007.

18. States can disregard portions of family income when determining Medicaid and SCHIP eligibility. For example, disregards might be applied for work expenses, child care costs, or child support payments. For more information, see Guyer, Jocelyn, Cindy Mann and Michael Odeh, Center for Children and Families, Georgetown University Health Policy Institute. States Affected by Proposals to Reduce SCHIP Coverage Options. February 2007. Available at: http://ccf.georgetown.edu/schipdocs/schippop2-7.pdf.

19. See note 14.

20. See note 15.

21. Projected enrollment as of September 2007. Please See: MRMIB, *2006 Estimate for the Healthy Families Program, Access for Infants and Mothers Program, and County Health Initiative Matching Fund Program for Fiscal Years 2006–2007 and 2007–2008,* November 2006.

22. Section 1115 of the Social Security Act applies to Title XXI, meaning that adults could be covered by Title XXI. In October 2005, Title XXI was changed to prohibit coverage of childless adults, per Title XXI, Sec. 2107(f). As originally envisioned under the original law, parents can still be covered under Title XXI.

23. Benjamin Sommers of Harvard examined Medicaid and SCHIP coverage retention over a year, and his analysis concluded that children enrolled in Medicaid or SCHIP were about 38 percent to 76 percent more likely to retain coverage when their parents also were covered. Please see: Benjamin Sommers, "Insuring children or insuring families: Do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP?" *Journal of Health Economics,* in press, 2006. Research has shown that insured children whose parents also are insured are more likely to retain their coverage longer and to receive needed preventative health care services than insured children whose parents lack coverage. Please See: Committee on the Consequences of Uninsurance, Institute of Medicine, Health Insurance Is a Family Matter, Washington, D.C.: National Academy Press, 2002.

24. CHCF, *Healthy Families, Facts and Figures 2006.* January 2006. Available at: www.chcf.org/documents/policy/HealthyFamiliesFactsAndFigures2006.pdf.

25. 2005 California Health Interview Survey; available at: www.chis.ucla.edu

26. Center for Children and Families, Georgetown University Health Policy Institute. *States Affected by Proposals to Reduce SCHIP Coverage Options.* April 2007; available at: http://ccf.georgetown.edu/schipdocs/schippop2-7.pdf

27. Projected enrollment as of June 30, 2007. Please See: MRMIB, *2006 Estimate for the Healthy Families Program, Access for Infants and Mothers Program, and County Health Initiative Matching Fund Program for Fiscal Years 2006–2007 and 2007–2008,* November 2006.

28. 2007 OPM Pay Tables, found at: www.opm.gov/oca/07tables/pdf/saltbl.pdf

29. See note 14.

30. UCLA Center for Health Policy Research "More than Half of California's Uninsured Children Eligible for Public Programs But Not Enrolled," October 2006.

31. Center for Children and Families, Georgetown University Health Policy Institute. *Children's Eligibility for SCHIP?* October 2006

32. Robert Pear. "Lacking Papers, Citizens Are Cut From Medicaid." *New York Times.* March 12, 2007.

33. California has always required a birth certificate to be filed with a Healthy Families application. However, while California will enroll a child in Healthy Families for up to two months before receiving a copy of a birth certificate, the Deficit Reduction Act rules prohibit enrollment until after an original birth certificate is received.

34. Gestur Davidson, et al, *Public program crowd-out of private coverage: What are the issues?* Robert Wood Johnson Foundation, June 2004. Westpfahl Lutzky, Amy, and Ian Hill, *Has the Jury Reached a Verdict? States Early Experiences with Crowd Out Under SCHIP,* Urban Institute, June 2001. Congressional Budget Office, "The State Children's Health Insurance Program," May 2007. The Congressional Budget Office recently found that 25 to 50 of every 100 children enrolled in SCHIP had given up private insurance, but the methodology used does not make clear why this may have happened.

35. Foundation for Taxpayer and Consumer Rights. *The California Patient Guide,* available at: www.calpatientguide.org/index.html. These rules do not apply to the non-group market, as the primary concern is the crowd-out of employer dollars.

36. For more information, see Jennifer Ryan, "SCHIP: The Basics", National Health Policy Forum, January 27, 2007.

37. Joan Alker, *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity,* Kaiser Commission on Medicaid and the Uninsured, October 2003, 4; available at www.kff.org/medicaid/upload/Serving-Low-Income-Families-Through-Premium-Assistance-A-Look-At-Recent-State-Activity-PDF.pdf.

38. *CHIP Reauthorization Act of 2007* (SB 1224), Section 701.

39. "Creditable coverage" is a very broad definition of health care coverage and generally encompasses most forms of health care. Section 2110(c) of the Social Security Act defines creditable coverage as, "(2) CREDITABLE HEALTH COVERAGE.—The term "creditable health coverage" has the meaning given the term "creditable coverage" under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver)."

40. Bergman, David, *Perspectives on Reauthorization: SCHIP Directors Weigh In.* National Academy for State Health Policy. June 2005. Available at: http://www.allhealth.org/briefingmaterials/PerspectivesonReauthorizationSCHIPDirectors-538.pdf.

41. Ibid.

42. The Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured. *SCHIP: Let the Discussions Begin.* Webcast of Capitol Hill Briefing. February 9, 2007. Available at: http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2045.

43. Please See: Sara Rosenbaum and Sonosky, Colleen, *Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts,* Prepared for the Health Care Financing Administration December, 2000. According to the report, EPSDT includes:
    - Screening services to detect physical and mental conditions. A screen is defined to consist of a comprehensive health and development history, an unclothed physical exam, appropriate immunizations in accordance with standards of the Advisory Committee on Immunization Practices, laboratory tests including lead blood level assessments, and health education.
    - Vision services, including eyeglasses;
    - Preventive, restorative and emergency dental services;
    - Hearing services, including hearing aids; and
    - Any 'other necessary health care, diagnostic services, treatment, and other Measures' that are described in §1905(a) of the Social Security Act (i.e., that fall within the federal definition of medical assistance) that are needed to 'correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.'

44. Lambrew, Jeanne M. *The State Children's Health Insurance Program: Past, Present, and Future,* The Commonwealth Fund, January 2007; available at: www.cmwf.org/publications/publications_show.htm?doc_id=449518.

45. The SCHIP statute provides financing to states using an "enhanced" federal matching rate that is based on the Medicaid program's matching structure and more broadly on per capita income in each state. The SCHIP enhanced matching rates range from 65 percent in wealthier states (including California) to 87 percent in lower-income states. See Jennifer Ryan, "The Basics: SCHIP Financing", National Health Policy Forum, March 28, 2007, available at www.nhpf.org/pdfs_basics/Basics_SCHIPFinancing.pdf.

46. The Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured. *SCHIP: Let the Discussions Begin.* Web cast of Capitol Hill Briefing. February 9, 2007. Available at: www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2045.

47. Historically, federal funds available through block grants tend to erode in real terms over time. Finegold, K., L. Sherry, and S. Schardin, "Block Grants: Historical Overview and Lessons Learned," Assessing the New Federalism Policy Brief A-63 (Washington: Urban Institute, April 2004).

48. Chris L. Peterson, "SCHIP Original Allotments," Congressional Research Service, CRS Report RL33666. Available at http://finance.senate.gov/hearings/testimony/2005test/072506cpattach1.pdf.

49. Many states have raised concerns that the state-level CPS data have significant limitations, such as insufficient sample sizes, which results in over- or under-estimating the numbers of uninsured children. The CPS has also been criticized for unstable estimates from year to year and for not including straightforward questions about health insurance status.

50. Jocelyn Guyer, "Maximizing Child Health Coverage Depends on Establishing an Effective system for Reallocating Unspent SCHIP Funds." Center on Budget and Policy Priorities. October 18, 2000, available at www.cbpp.org/10-18-00health.pdf.

51. Ibid.

52. Managed Risk Medical Insurance Board. SCHIP Title XXI Federal Funds Total Healthy Families Spending Projections based on the 2006 May Revision.

53. Chris L. Peterson, "SCHIP Original Allotments," Congressional Research Service, CRS Report RL33666. April 18, 2006, http://finance.senate.gov/hearings/testimony/2005test/072506cpattach1.pdf.

54. In 1999, Congress bolstered the sample size in the CPS survey to ameliorate criticism (P.L. 106–113); however results have been slow to come. The CPS estimate of uninsured, low-income children in California has a 13 percent margin of error. Jeanne M. Lambrew, "SCHIP: Past, Present and Future," The Commonwealth Fund, February 2007. Available at www.commonwealthfund.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf. And, Chris L. Peterson, "SCHIP Original Allotments," Congressional Research Service, CRS Report RL33666, Table 7. April 18, 2006. Estimates are for 2003–2005.

55. Harbage, Peter, Lisa Chan and Clara Evans, "Funding California's SCHIP Coverage: What Will it Cost?" California HealthCare Foundation, May 2007, available at http://www.chcf.org/documents/policy/FundingCaliforniasSCHIPCoverage.pdf.

56. Ibid.

57. A floor would prevent the growth rate from being negative.

58. As noted earlier, the CPS is not ideally suited for measuring major trends at the state level. Although the sample size has been improved over the last few years, states have continued to raise concerns about the CPS's accuracy in terms of estimating numbers of low-income uninsured children. North Carolina, for example, has consistently had more low-income children enrolled in the SCHIP program than CPS estimates indicated were eligible. As a result, the state has had a shortfall each year and was forced to take steps to control enrollment growth.

59. U.S. Census Bureau, Population Division, "Interim State Population Projections," 2005. Internet release date April 21, 2005. Available at www.census.gov.

60. This is similar to that used under the Clinton-Dingell bill. However, since states are ultimately held harmless for any additional children enrolled above the population growth rate, this factor is less important than under the Rockefeller-Snowe proposal.

61. Government Accountability Office, "State's SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization," GAO-07-558T, March 1, 2007, 24. Available at www.gao.gov/cgi-bin/getrpt?GAO-07-558T.

62. SB 1224, Section 203: Establishment of a Timely and Responsive Distribution Process.

63. Mathematica Policy Research, "The Santa Clara Healthy Kids Program: Impacts on Children's Medical Vision and Dental Care," July 2005. http://www.mathematica-mpr.com/publications/PDFs/santaclara.pdf

64. California receives a 50% Medicaid matching rate, known as the Federal Medical Assistance Percentage or FMAP. The state's matching rate for SCHIP is 65%. Supplemental federal payments to Medicaid effectively increase the matching rate.

65. Unpublished analysis, California Department of Health Services, Fiscal Forecasting.

66. There is a drafting error in the bill. Having checked with the author's office, the interpretation given here represents the intent of the language.

67. Unpublished analysis, Edwin Park and Matthew Broaddus, Center for Budget and Policy Priorities.

68. HR 1535, section 121, p27–29.

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