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Children's Health: SCHIP Should Not Become a Welfare Entitlement

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The State Children's Health Insurance Program (SCHIP) targets uninsured children in working families who earn too much to qualify for Medicaid. As such, Congress created SCHIP as a stand alone program with unique features that distinguish it from other health care programs. States have more flexibility in designing the program, can include private coverage options in benefit packages, can establish cost-sharing requirements for enrolled families, and can manage the program's growth and cost. To protect taxpayers and preserve private sector options for enrollees, Congress must stop the erosion of legal and structural distinctions that is turning SCHIP into an extension of Medicaid.

SCHIP Benefit Design Choices. States can choose from three basic SCHIP designs. States can expand the existing Medicaid program, set up a separate SCHIP program, or use a combination of the two. To date, 10 states and the District of Columbia have a Medicaid expansion, 18 states have a separate program, and 22 states use a combination of approaches.[1]

States that choose to expand Medicaid must adhere to Medicaid's rules and benefit requirements, whereas states that establish a separate SCHIP plan use benchmarks based on private sector coverage. Thirty-three states organize part or all of SCHIP as a Medicaid expansion, making the two programs almost indistinguishable in those states. Further eroding the differences are efforts to expand Medicaid benefit requirements like Early Periodic Screening, Diagnosis, and Treatment (EPSDT), which provides practically unlimited benefits to all SCHIP enrollees.[2]

Furthermore, excessive administrative and regulatory requirements have discouraged all but a handful of states from adopting one of SCHIP's most promising provisions—allowing states to enroll eligible children into private coverage.[3]

SCHIP Cost-Sharing Choices. Because SCHIP targets working families and not the truly poor, it is reasonable to require parents to bear some financial responsibility for their children's medical care. Although SCHIP allows states to establish cost-sharing requirements for its enrollees in some instances, the practice is not as common as many believe it to be.

States with a separate SCHIP plan can require premiums and cost-sharing so long as the total annual aggregate in cost-sharing does not exceed 5 percent of a family's annual income. The law forbids such cost-sharing standards in states that have a Medicaid expansion in place or for families with incomes below 150 percent of the federal poverty line (FPL). In these instances, Medicaid cost-sharing rules, which are minimal, must apply.[4] Unfortunately, even with these modest requirements, only 16 states require both a premium and a co-payment (and the range varies significantly by state) and 11 states require no cost-sharing at all.

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SCHIP Administrative Choices. SCHIP is based on a fixed block grant structure that is designed to keep federal and state spending in check. Some states have established waiting lists and enrollment caps to keep SCHIP spending within the fixed allotment of federal funds.

However, at both the state and federal level, momentum is building to discourage or prohibit states from limiting enrollment. Hidden behind the guise of "outreach" and/or "enrollment simplification" are efforts to streamline eligibility and expand access.[5] These trends would lead SCHIP away from a fixed funding structure based on fiscal prudence toward an open ended entitlement where the focus is on maximizing enrollment.[6]

What Congress Should Do. Congress should implement the following recommendations to prevent SCHIP from further morphing into an extension of Medicaid:

- **Remove Medicaid rules and regulations from SCHIP.** The replacement of SCHIP standards with Medicaid rules diminishes the distinction between the two programs and complicates administration. Congress should apply SCHIP rules across the full spectrum of the program and resist efforts to further expand Medicaid benefits or rules to SCHIP.
- **Reform the premium assistance option under SCHIP.** Congress should eliminate the administrative hurdles that make it difficult for states to use SCHIP funds to purchase private health care coverage for enrollees. Congress should also encourage the adoption of a premium assistance component in states that have not already done so.[7]
- **Establish firm cost-sharing requirements within SCHIP.** Congress should make cost-sharing a requirement applicable to all of SCHIP in order to help transition working families into private coverage, where cost-sharing is common.[8]
- **Protect the states' ability to manage SCHIP.** To preserve its block grant structure, Congress must ensure that federal funding remains fixed and that states are free to use techniques like waiting lists and enrollment caps to manage the growth of SCHIP. Moreover, Congress should not succumb to efforts focused on expanding and simplifying enrollment, which will ultimately result in further federal and state obligations.

Conclusion. The intended distinctions between SCHIP and Medicaid are diminishing. To protect taxpayers from yet another open ended entitlement or state funded mandate, Congress should reinforce the unique features of SCHIP that make it operate more like private coverage than a welfare program and better integrate private coverage into its basic structure.

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1. Allen, p. 18. See also Donna Cohen Ross, Laura Cox, and Caryn Marks, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," Henry J. Kaiser Family Foundation, January 2007, pp. 59–62, at *www.kff.org/medicaid/upload/7608.pdf*.
2. See leading SCHIP reauthorization proposals H.R. 1535/S. 895 and S. 1224.
3. For a discussion of the obstacles to premium assistance, see Cynthia Shirk and Jennifer Ryan, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum *Issue Brief* No. 812, July 17, 2006, at *www.nhpf.org/pdfs_ib/IB812_PremiumAssist_07-17-06.pdf*.
4. The co-pay for those children with family incomes between 101 and 150 percent of the FPL can be slightly higher than for traditional Medicaid. See Elicia J. Herz, Bernadette Fernandez, and Chris L. Petereson, "States Children's Health Insurance Program (SCHIP): A Brief Overview," Congressional Research Service *Report for Congress*, August 4, 2005, p.4.
5. See Ross, Cox, and Marks. See also H.R. 1535/S. 895 and S. 1224.
6. For purposes of this discussion, Tennessee is considered to have a combination approach. See Kathryn G. Allen, Director, Health Care, U.S. Government Accountability Office, "Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences in Implementing SCHIP and Considerations for Reauthorization," statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, February 15, 2007, GAO–07–447T, p. 13, at *www.gao.gov/new.items/d07501t.pdf*.
7. See Nina Owcharenko, "Reforming SCHIP: Using Premium Assistance to Expand Coverage," Heritage Foundation *WebMemo* No. 1465, May 22, 2007, at *www.heritage.org/Research/HealthCare/wm1466.cfm*.
8. These requirements are even more relevant since enactment of the Deficit Reduction Act, which allows states to apply SCHIP-style cost sharing on certain Medicaid enrollees.