The Idaho SCHIP[1] Experience

Background:

The State Children's Health Insurance Program (SCHIP) was created by Congress as part of the Balanced Budget Act of 1997. This legislation provided for an annual allotment (block grant) to states to provide health coverage to low-income, uninsured children whose family income was too high to qualify for Medicaid. States are allowed to implement SCHIP as a Medicaid-expansion program, a separate program or both (known as combination program).

Pursuant to then Governor Phil Batt's executive orders, in February 1998, Idaho submitted its first state plan to the Centers for Medicare & Medicaid Services (CMS) for approval. This request was to implement Idaho SCHIP as a Medicaid-expansion program for children with family income up to 160% of the Federal Poverty Guidelines (FPG). The 1998 Idaho legislature reduced the income limit to 150% of the FPG and this first state plan amendment for Idaho was approved.

In 2003, the Idaho legislature passed legislation to create three new programs: 1) a separate SCHIP for children with family incomes up to 185% FPG and a limited benefit package; 2) Children's Access Card, a premium assistance program to help pay for private insurance that families could opt in to instead of enrolling in the separate SCHIP program, and; 3) Access to Health Insurance (AHI), a premium assistance program for Idaho small business employees and their families. The first two of these programs were implemented in 2004 and AHI was implemented in 2005.

When Idaho implemented its Medicaid Modernization strategies in 2006, the separate SCHIP became a Medicaid look-alike program, with benefits the same for SCHIP kids as for those on Medicaid. The most recent use of SCHIP funding came about as part of Idaho Medicaid Modernization. Idaho Medicaid partnered with the Department of Education to provide funding for school districts to hire school nurses in districts with a high level of low-income students and a high student-to-nurse ratio. This child health initiative is funded with SCHIP administrative dollars which are capped at 10% of SCHIP benefits paid. Thirteen school districts are participating during the 2008-09 school year.

Eligibility Income Limits

When SCHIP was enacted, the federal statute directed that funding was for uninsured, low-income children with family income up to 200% of the FPG. This currently represents an annual income of about $42.5 thousand for a family of four. Over time, this "one size fits all" approach was seen as inadequate in states with a high cost of living or where the state has a higher

[1] State Children's Health Insurance Program (SCHIP), enacted as Title XXI of the Social Security Act.

median income than the national average. Most of these states had already raised Medicaid income limits above the minimum required and thus were challenged to spend their SCHIP allotments. This led to some creative financing approaches to handling family income.

Most states already had experience with applying income disregards to gross income and then using net income as the measure against the income limits. For example, North Dakota's program covers up to 140% of the FPG (net), but applies enough income disregards that the effective gross income is close to 200% of the FPG. So, states began submitting state plan amendments with provisions to disregard all income above 200% of the FPG. Many of these amendments were approved, with the highest being New Jersey at 350% of the FPG. Last year CMS took steps to stop this type of amendment and did not approve New York's request to take its program to 400% of the FPG. Now, the issue is in court. Twenty states currently have set their program's income limits above 200% of the FPG.

Idaho's Experience- Eligibility Income Limits

The eligibility income limit for Idaho SCHIP is 185% of the FPG. This is about $39 thousand for a family of four. Idaho is one of only seven states that currently have income limits set below 200% of the FPG.

Idaho's program does not use any income disregards. This means that gross income is used as the measure against the income limit. Approximately one-third of the children in Idaho are enrolled in either Medicaid or SCHIP at the current eligibility levels.

Crowd-Out

Crowd-out happens when private insurance is replaced with publicly funded health coverage. For each major public program, Medicaid and SCHIP, there are a number of children who would have been covered by private insurance if the public program was not available. Each time a public program is expanded, there is a resultant amount of crowd-out experienced. There is a higher rate of crowd-out at higher income levels than at lower income levels.

States are required to monitor the amount of crowd-out caused by SCHIP. As a deterrent to substitution, most states impose a waiting period for individuals who drop private coverage.

The Congressional Budget Office (CBO) is charged with estimating the amount of crowd-out for SCHIP at the national level. Recent testimony (April 2008) to the Senate Finance Committee by the CBO made the following major points[2]:

[2] Congressional Budget Office Testimony, *Covering Uninsured Children in the State Children's Health Insurance Program*, Statement of Peter R. Orszag, Director, before the Subcommittee on Health Care Committee on Finance, United States Senate, April 9, 2008, page 1, http://www.cbo.gov/ftpdocs/91xx/doc9105/04-09-SCHIP_Testimony.pdf , retrieved September 25, 2008.

- SCHIP has significantly reduced the number of low-income children who lack health insurance coverage. The percent of uninsured children in families below 200% FPG fell about 25% between 1996 and 2006.
- For every 100 children who gain public coverage as a result of SCHIP, there is a corresponding reduction in private coverage between 25 and 50 children.
- CBO estimated that of the 5.8 million children that would have gained coverage under last year's reauthorization attempt, 3.8 million of those children would otherwise be uninsured. In other words, approximately one-third of the children would have shifted from private coverage to public coverage.
- At this time, experts question the effectiveness of crowd-out policies such as waiting periods and increased cost-sharing.

Idaho's Experience- Crowd-out

A six month period of uninsurance is incorporated as an eligibility requirement for Idaho SCHIP. The application requires information on when the child was last covered by health insurance. Exceptions to the period of uninsurance are made if the applicant lost private insurance through no fault of their own (i.e., employer driven) or due to hardship.

The State also monitors the number of eligibility denials of children who have creditable insurance who subsequently become eligible within six months. Historically, Idaho has experienced a low incidence of crowd-out. Less than 1% of children applying for the program have private insurance at application and only a handful drop the insurance and subsequently become eligible within six months.

Adult Coverage

Although SCHIP has always allowed the purchase of cost-effective family health coverage[3], it wasn't until 2000 that other types of adult coverage using SCHIP funds began in earnest. This was when Health & Human Services (HHS) formally notified states it would begin considering §1115 waiver proposals for covering populations other than uninsured, low-income children[4]. States that still had excess allotments, began submitting §1115 waivers to test the theory that covering parents would result in coverage of more children. This in turn led to having childless adults covered using Health Insurance Flexibility & Accountability (HIFA) waivers for premium assistance.

In 2002, HHS promulgated a regulation to allow the coverage of unborn children using a state plan amendment. This meant that a pregnant woman could receive prenatal care on behalf of her unborn child.

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[3] See 42 CFR §457.1010, Purchase of family coverage.

[4] United States Government Accountability Office, Report to the Ranking Member, Committee on Finance, U.S. Senate, *STATE CHILDREN'S HEALTH INSURANCE PROGRAM- Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States That Cover Adults,* GAO-08-50, November 2007, page 10, http://www.gao.gov/new.items/d0850.pdf, retrieved September 26, 2008.

In 2007, the Government Accountability Office (GAO) published a report to the U.S. Senate Finance Committee regarding the issue of adult coverage under SCHIP. The GAO reviewed 10 of the 14 states providing adult coverage and found that adults comprised 41% of total enrollment and comprised 54% of total SCHIP expenditures (an average using 9 of the states experience). Also, 6 of the 10 states reviewed were shortfall states.[5,6]
During last year's attempt at SCHIP reauthorization, it became clear that in the future, adult coverage utilizing SCHIP funding will be curtailed.

Idaho's Experience- Adult Coverage
In 2003, the Idaho legislature considered a bill to implement the coverage of unborn children. After much analysis, the bill failed to gain enough support for passage since it was determined that the majority of the coverage would be provided to undocumented pregnant women.

However, also in 2003, House Bill 376 was passed to implement a premium assistance program to help pay the cost of private insurance for small business employees and their families. This program, Access to Health Insurance, was implemented in 2005.

This premium assistance program's enrollment is capped at 1000 adults and also capped at $100 per month per adult. To date, enrollment has never exceeded 400 adults and annual expenditures on the adult population have been less than $400 thousand dollars each year. Additionally, the GAO found that adults covered by Idaho SCHIP represented less than 1% of enrollment and less than 2% of expenditures[7]. In order to retain adult coverage under premium assistance, Idaho will need to evaluate the use of Medicaid funding at the time of waiver renewal in November 2009.

Allotments & Funding Formula

Each state receives an annual SCHIP allotment. The amount of each allotment is calculated based on a statutory funding formula. The state has 3 years to spend the funds. The oldest allotments are spent first. If after 3 years, a state fails to expend the funds, the monies revert to the treasury and are redistributed to states that have exhausted all their SCHIP funding.

During the first few years of SCHIP, states scrambled to implement programs to take advantage of this new funding stream. However, most states were not able to fully expend their allotments in the early years of SCHIP. Over time this situation changed as the states' programs grew. Currently, most states are expending more than their annual allotment on their program. There are many

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[5] A shortfall state is one that exhausts all its SCHIP allotments during a given year and receives redistributed funding when it becomes available.
[6] See United States Government Accountability Office, Report to the Ranking Member, Committee on Finance, U.S. Senate, *STATE CHILDREN'S HEALTH INSURANCE PROGRAM- Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States That Cover Adults,* GAO-08-50, November 2007, http://www.gao.gov/new.items/d0850.pdf.
[7] Ibid.

reasons this occurs, but one is related to the funding formula which has several nuances that make it difficult for states to develop reliable budgets for their program. These are:

1. The data source- the formula uses the Current Population Survey (CPS) data for the number of low-income, uninsured children. CPS data is not considered to provide an accurate estimate. For states with smaller populations, this becomes more problematic because these states are typically under-sampled. A report from the State Health Access Data Assistance Center indicated that between 1999 and 2002, states' SCHIP funding allocations fluctuated on average 22 percent per state[8].
2. The cost factor- the formula uses state wage data to estimate the cost of providing care. Therefore, poorer states with lower average incomes, will receive less funding. This does not take into account any other factors that may impact the cost of providing care, such as the cost of equipment or supplies or transportation[9].
3. Allocation- the formula is based on each state's share of low-income, uninsured children. Even if the number of these children increases in a state, the state will not receive a larger allocation unless the rate of increase is faster than the national average.[10]

Idaho's Experience- SCHIP Funding

Like most states, Idaho was unable to use all of the SCHIP funds available the first few years of the program. Idaho returned some funds each year until 2004, when the separate program was implemented. Since then Idaho has utilized more than its annual allotments and will become a shortfall state unless more funding than currently allotted becomes available through SCHIP reauthorization. Idaho's 2008 allotment was $23.8 million and the program's cost is about $35 million annually at current levels. Congress is scheduled to revisit reauthorization in March 2009.

[8] Bergman, David, *Perspectives on Reauthorization: SCHIP Directors Weigh In*, National Academy for State Health Policy CHIP 25, June 2005, http://www.nashp.org/Files/CHIP25_final.pdf, retrieved September 25, 2008.
[9] Ibid.
[10] Ibid.