

SCHIP REAUTHORIZATION: KEY QUESTIONS IN THE CURRENT DEBATE

The State Children's Health Insurance Program (SCHIP) was enacted with bi-partisan support a decade ago as part of the Balanced Budget Act of 1997 (BBA). Together with Medicaid, SCHIP has helped to reduce the number of low-income uninsured children by expanding eligibility levels and simplifying application procedures. Coverage gains helped to increase access to health services for millions of children, but about 9 million children remain uninsured. Congress is considering legislation to reauthorize the SCHIP program, which is scheduled to expire on September 30, 2007. This brief highlights some key questions underlying the debate over SCHIP reauthorization and provides a brief description of the bills under consideration in the House and Senate.

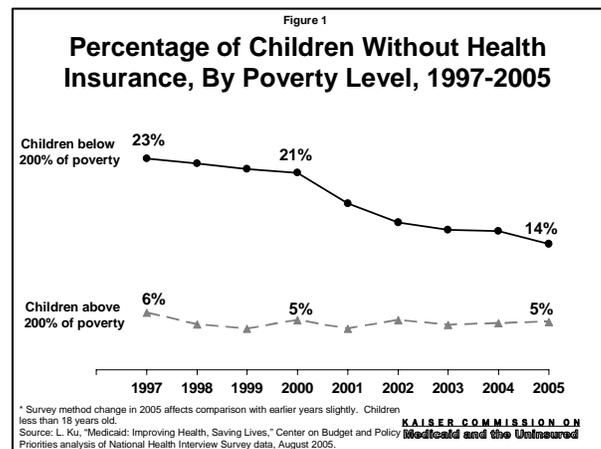
1. Who is covered now by Medicaid and SCHIP?

Medicaid and SCHIP together cover more than 30 million low-income children. Federal law requires states to cover infants and children under six with family incomes up to 133 percent of the federal poverty level and children under age 19 with family incomes up to 100 percent of the federal poverty level under Medicaid. Many states have opted to expand Medicaid coverage to children beyond these minimum levels. Medicaid also covers low-income pregnant women, about 14 million low-income parents, and 14 million elderly and people with disabilities. Federal law prohibits federal matching funds to be used to cover adults without dependent children through Medicaid without a waiver.

SCHIP was designed to build on Medicaid to provide insurance coverage to "targeted low-income children" who are uninsured and not eligible for Medicaid, typically from families with incomes up to 200 percent of the federal poverty level or about \$41,300 for a family of four in 2007. Currently, 20 states cover children in families with incomes up to 200 percent of poverty and 23 states cover children with family incomes above 200 percent of poverty. In 2006, 91 percent of children covered by the program have incomes that are at or below 200 percent of the federal poverty level.ⁱ Over the last decade, Medicaid and SCHIP together have helped to reduce the rate of low-income uninsured children by about one-third. Increased Medicaid coverage accounted for nearly 60 percent of the decrease in rates of uninsurance for low-income children.ⁱⁱ (Figure 1)

Coverage of groups beyond children under SCHIP is limited. The original SCHIP legislation permitted the Secretary of HHS to allow "Section 1115 Demonstration" waivers for alternative uses of SCHIP funds. Through waivers eleven

states use SCHIP funds to cover parents, four states cover childless adults and 11 states use SCHIP funds to cover pregnant women through the option to define a fetus as an unborn child. Approximately 600,000 adults were covered by SCHIP in FY 2005 compared to over 6 million children covered by the program. The Deficit Reduction Act (DRA) enacted in February 2006 prohibits any new SCHIP waivers to cover childless adults.



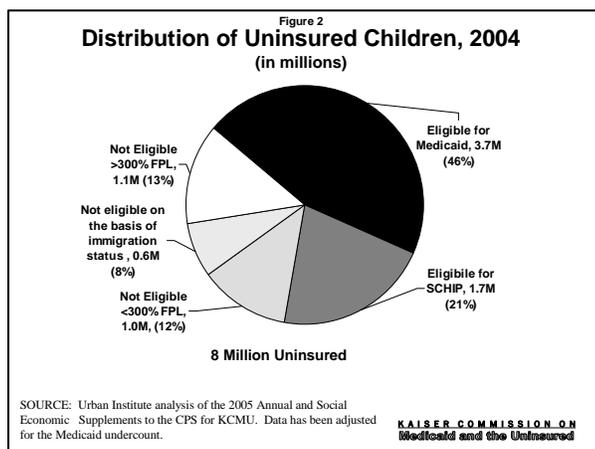
Legal immigrants in the country for less than five years are not covered under Medicaid and SCHIP even if they meet income eligibility requirements and undocumented immigrants are only eligible for emergency Medicaid.

2. How many children are uninsured?

Census data reports that there were approximately 9 million children under 18 without health insurance in 2005. Many researchers recognize that the census data under-estimates the number of individuals covered by Medicaid. Peer-reviewed literature suggests that after adjusting for the Medicaid under-count, there were about 8 million children without insurance at a point in time during 2004. Of the 8 million uninsured children, about two-thirds are estimated to be eligible but not enrolled in Medicaid and SCHIP. (Figure 2)ⁱⁱⁱ

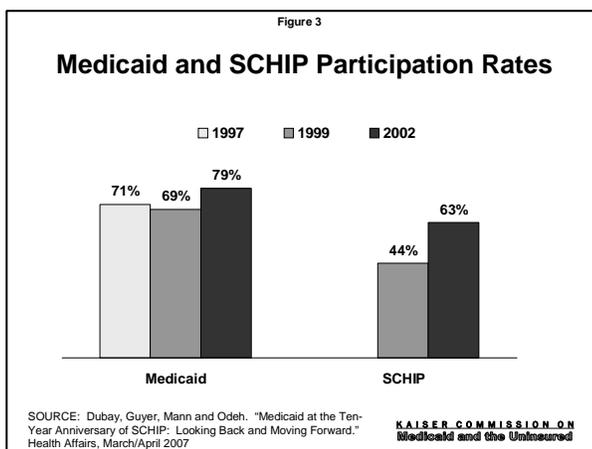
The Administration released estimates in June showing 4.9 million uninsured children. These figures are much lower than the 8 million estimate because they represent children who are uninsured for the entire year. Insurance coverage is not static and there may be more children without insurance over the course of the year than uninsured for the entire year. The methodology these estimates use to adjust for the

Medicaid undercount overstates Medicaid enrollment (resulting in participation rates over 100 percent in some states) and results in an undercount of the number of children remaining uninsured. Estimates of the coverage and cost impact of legislation that are prepared by the Congressional Budget Office (CBO) use the Census Bureau numbers as point-in-time, not full year uninsured estimates and thus show a higher number of uninsured children to be addressed.^{iv}



3. What are the Medicaid and SCHIP participation rates?

Medicaid and SCHIP are popular programs with high participation rates. On average, 3 out of 4 who are eligible for Medicaid and SCHIP currently participate. Participation is generally higher for Medicaid because SCHIP covers children with slightly higher income levels, so some of those eligible may not be aware that they might qualify for public coverage (especially if they are in working families) and others might have access to private health coverage. Research shows while large numbers of people have heard of the Medicaid and SCHIP programs, a significantly smaller number of people are aware that a child can participate in these programs without receiving welfare.^v (Figure 3)



4. Where do Medicaid and SCHIP enrollees get their care?

Most children enrolled in Medicaid and SCHIP are enrolled in private managed care plans. About 74 percent of all children on Medicaid and 77 percent of children in SCHIP are enrolled in some type of managed care plans.^{vi} States contract with managed care plans run by private companies to provide care for these children. Often families have a choice of plans. Only 18 of the 224 plans that were in Medicaid in 2004, were public plans operated by counties, the rest are private firms like Blue Cross Blue Shield, WellPoint, UnitedHealth, Amerigroup, Centene, and Molina.^{vii}

A smaller group of children receive care in fee-for-service delivery system. Even in these delivery systems, beneficiaries may choose to receive care from any number of private providers that participate in their state's Medicaid or SCHIP program.

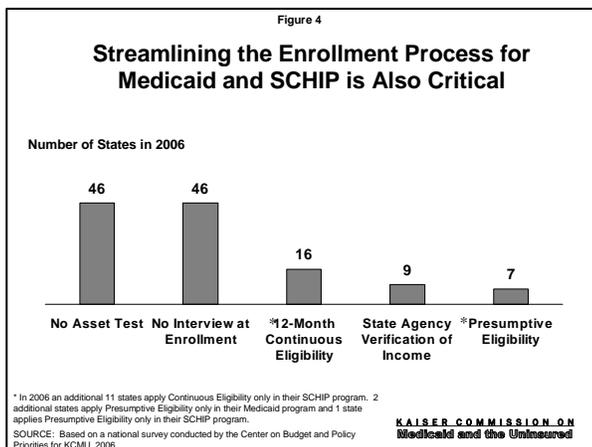
The government role in Medicaid and SCHIP is to help finance care for low-income individuals and contract with private providers and health plans to deliver care. Because Medicaid and SCHIP enrollees receive care primarily through private managed care plans or from private providers, their insurance coverage is much more similar to private insurance coverage than "government run" programs like the Veterans Administration (VA) where the government pays for and provides care. Additionally, like employer sponsored coverage enrollees may be required to pay a portion of the premiums or cost sharing in Medicaid or SCHIP.

5. How can more uninsured children be covered through Medicaid and SCHIP?

A decade of experience with SCHIP demonstrates that expanding eligibility levels, outreach and eligibility simplification in combination with adequate state and federal financing are the key ingredients to expanding coverage for children. Prior to the implementation of SCHIP, only 7 states had expanded coverage up to 200 percent of the federal poverty level.^{viii} States embraced the new SCHIP program and worked quickly to implement programs with eligibility levels that extended coverage beyond Medicaid levels to try to reach more uninsured children.

With outreach embodied into the SCHIP law, state and national campaigns sought to educate people about public programs and help to encourage enrollment in both SCHIP and Medicaid. To help families enroll, many states made efforts to streamline enrollment processes including the adoption of a joint application for Medicaid and SCHIP. Other simplification procedures such as the elimination of the asset test, elimination of the face-to-face application interview, 12-month continuous eligibility, and self-declaration of income were adopted for children applying for

both Medicaid and SCHIP. Some states are also using technology and data sharing across public programs to help facilitate enrollment. The citizenship documentation requirements included in the Deficit Reduction Act for Medicaid have complicated efforts by states to simplify enrollment procedures. (Figure 4)



Illinois was one of the early states to move forward with universal coverage for children. In their experience implementing the AllKids program, they have found that the simple message that “all kids” are eligible has been a powerful outreach campaign. The majority of children enrolling in AllKids were previously eligible for coverage under the state’s Medicaid and SCHIP programs but not enrolled.^{ix}

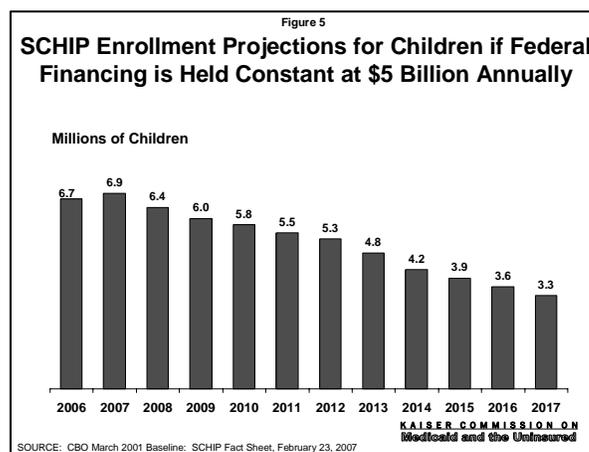
Research shows that in addition to outreach and simplified enrollment, covering parents in Medicaid and SCHIP leads to increases in enrollment and retention of children in Medicaid and SCHIP and helps to decrease uninsurance rates for children. In July 2006, former CMS director Dr. Mark McClellan testified that “extending coverage to parents and caretakers may also increase the likelihood that their children remain enrolled in SCHIP. For example, in New Jersey, which covers parents through a section 1115 demonstration, the State found that having one parent enrolled increased the likelihood that a child remains enrolled.”^x Covering parents also contributes to improvements in children’s access to and use of care.^{xi}

Adequate financing and fiscal incentives are central to boost state efforts to increase coverage. When SCHIP was implemented, states had federal financing available, an enhanced matching rate as an incentive for states to expand coverage and funds dedicated for outreach. As programs matured, enrollment grew and health costs continued to rise, more states began to spend more than their current year federal allotments. States relied on carry-over funds from prior years to fill the financing gaps. During the fiscal downturn from 2001 to 2004, many states implemented policies that dampened enrollment and funds for outreach dried up. In FY 2007, 14 states faced a federal funding

shortfall and Congress allocated supplemental funds to help these states maintain their programs. The amount of funding available in SCHIP reauthorization will determine how far states can go to reach more uninsured children.

6. What would it cost to maintain and expand coverage through Medicaid and SCHIP?

Current SCHIP financing is \$5 billion annually. While the program needs to be reauthorized for federal funds to be available after October 1, 2007, the CBO assumes that this level of funding would be continued in its “baseline”. CBO assumes that the SCHIP baseline will be \$25 billion over the next five years, but that these funding levels are not adequate to maintain current SCHIP programs. To maintain or expand SCHIP coverage, Congress must allocate new funds (above the baseline levels) for SCHIP. An estimated \$14 billion, in addition to the \$25 billion in the baseline over the next five years, would be necessary just to maintain current eligibility levels for SCHIP^{xii}. (Figure 5)



The costs of expanding coverage through Medicaid and SCHIP are a function of the medical costs of care in addition to the costs of the policies that would help increase enrollment (such as fiscal incentives to states or outreach grants) and other administrative costs. Medical costs refer to the per capita costs multiplied by the estimated number of children who would be covered. These per capita costs reflect estimates of either the costs of using medical services in a fee-for-service health delivery system or the capitation payment for services in a managed care arrangement which is usually the case for children enrolled in SCHIP.

These estimates take into account a variety of factors including the relative cost of additional coverage (currently eligible children that are not enrolled may be healthier and therefore less costly); how families would respond to paying premiums if they are imposed by states, and the number of individuals that will substitute private coverage for public coverage (which is typically modest for low-income families, but may increase as incomes go up).

The costs of new coverage are shared by the states and the federal government and in some states enrollees also pay for a portion of the care through premium or cost sharing payments. Given the current match rate for Medicaid and the enhanced match rate for SCHIP, the states pay a larger share of the costs to cover an individual through Medicaid. The federal government pays 57 percent of the costs for Medicaid and about 70 percent of the costs for SCHIP.

Because Medicaid is an entitlement program, projected increases in costs are based on enrollment and state spending and the federal financing is not capped. However, because of the lower match, states have less incentive to find and enroll lower income children eligible for Medicaid. Federal SCHIP funding is capped, so no federal financing is available once a state has drawn down its allocation of federal matching funds. States may have less incentive to enroll more children in SCHIP once they are reaching their capped financing levels.

7. If public coverage is expanded, would some families substitute public coverage for private coverage?

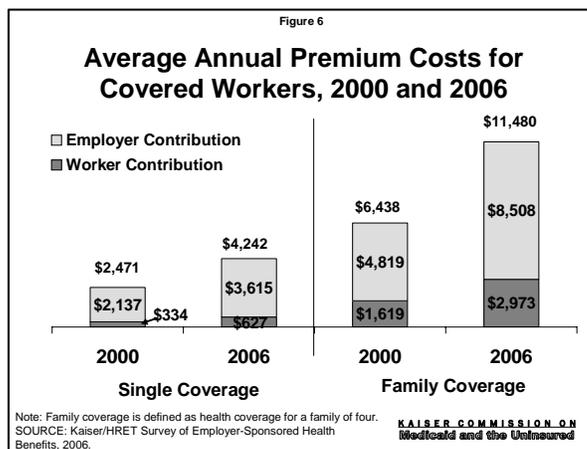
The extent to which individuals drop private coverage to enroll in public coverage is one of the central debates around SCHIP reauthorization. This substitution effect is often referred to as “crowd out”. It is impossible to perfectly target new policies to cover the uninsured without also reaching some individuals who currently have private insurance coverage. The question is how efficiently can the program be targeted to uninsured children.

Extensive research on this issue shows that substitution is very low for people with lower incomes. For example, for individuals with incomes below 200 percent of the poverty level private coverage is often not available or not affordable. Crowd-out estimates associated with efforts to enroll children who are currently eligible for Medicaid or SCHIP are low, about 14 percent or 24 percent respectively, because private insurance coverage is often not available. As eligibility levels are expanded up the income scale where private coverage is more available, the possibility for crowd-out increases. At 300 percent of the poverty level crowd-out could be as high as 50 percent. Expanding coverage to higher income levels often has the effect of increasing participation among lower-income groups already eligible for coverage.

An economist who has authored much of the research on crowd-out stated in March that, “public insurance expansions like SCHIP remain the most cost-effective means of expanding health insurance coverage...the public sector provides much more insurance coverage at a much lower cost than these [tax credits] alternatives. Tax subsidies mostly operate to buy out the base of insured without providing much new coverage.”^{xiii}

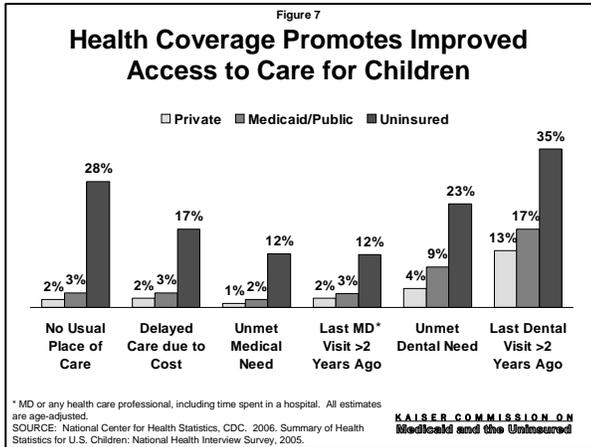
Under federal law, children must be uninsured to be eligible for SCHIP coverage. States have designed policies to comply with federal law and to deter people from dropping private coverage and to help minimize the substitution effect by imposing waiting periods. Children must be uninsured for a period of 3 or 6 months before they are eligible for SCHIP. In addition, states also are able to charge premiums and cost sharing amounts (similar to what they might face with private coverage) to make the program more consistent with employer-based coverage options.

While states do have policies to deter individuals from dropping private coverage that they may have, more generally private coverage has become less available for families because more employers do not offer coverage (especially small firms or those firms that employ a large number of low-wage workers) or because premiums are unaffordable. An average family premium of \$11,480 is more than a quarter of the annual income for a family at 200 percent of the poverty level. In addition to higher out of pocket expenses, some individuals are finding that their private insurance policies are not adequate to meet their health care needs. Due to all of these factors, many individuals have been left out of the private insurance market. Without Medicaid and SCHIP coverage, these individuals would most likely become uninsured. (Figure 6)



8. Does coverage matter?

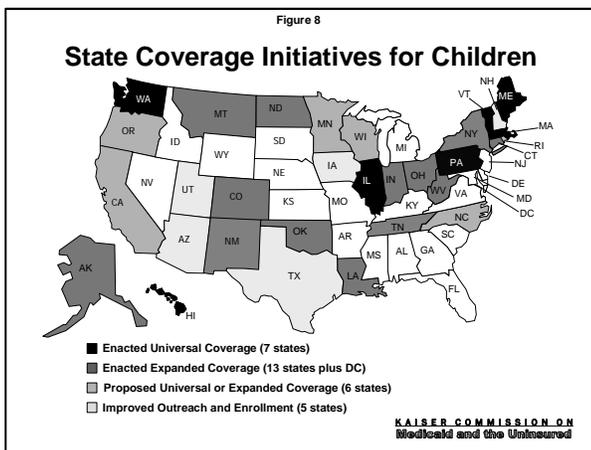
Children with Medicaid or SCHIP have access that is similar to private insurance coverage looking at measures of well-child visits, doctor visits and dental visits. Studies examining the effects of SCHIP show that children, even those with special health care needs, newly enrolled in SCHIP have improved access to care as measured by reductions in unmet health care needs, increased use of preventive care and an increased likelihood to have a regular source of care.^{xiv} (Figure 7)



Medicaid and SCHIP coverage have also helped to narrow ethnic and racial disparities in access to care, improve health care quality, result in improved health outcomes and improve school performance.^{xv}

9. How will state health reform efforts be affected by SCHIP reauthorization?

As of June 2007, 31 states plus the District of Columbia had enacted or announced coverage initiatives for children. Seven states have enacted proposals to provide universal health coverage for children and another 6 states have proposals to do so. Other states are moving forward to expand coverage to children by increasing eligibility levels or through improved outreach and enrollment efforts recognizing that many of the uninsured are currently eligible for Medicaid and SCHIP. (Figure 8)



Three states, Massachusetts, Maine and Vermont have passed legislation to implement universal coverage for their state residents. Several other states including Illinois, California and Pennsylvania have proposals for universal coverage. All of these plans include some type of public program expansion to cover low-income individuals. All of these plans also rely heavily on federal financing from

Medicaid and SCHIP. Therefore, the amount of funding available as a result of SCHIP reauthorization will have significant implications for state reform efforts.

10. What will happen if SCHIP is not reauthorized by September 30, 2007?

Both the Senate and House are considering legislation to reauthorize SCHIP. Congress will need to reach agreement on the policy options as well as the funding levels and funding offsets and send a bill to the President to sign into law by September 30, 2007. As the Senate and House move forward amid the threat of a presidential veto, the future of SCHIP is uncertain. If SCHIP is not reauthorized by the end of the fiscal year, the program will expire leaving states without federal funds to support coverage for the over 6 million children currently covered by the program and putting these kids at risk of being uninsured.

ⁱ Peterson and Herz, "Estimates of SCHIP Child Enrollees Up to 200% of Poverty Above 200% of Poverty and of SCHIP Adult Enrollees." Congressional Research Service, March 13, 2007

ⁱⁱ Dubay, Guyer, Mann and Odeh. "Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward." Health Affairs, March /April 2007.

ⁱⁱⁱ Urban Institute analysis of the 2005 Annual and Social Economic Supplements to the CPS for KCMU. Data has been adjusted for the Medicaid undercount. Poverty levels reflect income adjusted for income disregards used in determining eligibility for public coverage. Approximately 118,000 of the 5.4 million eligible uninsured children are legal non-citizens who have resided in the country for less than five years and are eligible for state-funded public coverage. 76,000 are covered in Medicaid and SCHIP with state only funds and the remaining 42,000 are income-eligible for coverage, but not eligible on the basis of immigration status.

^{iv} Congressional Budget Office, Memo to Health Staff, March 13, 2007 and "How Many People Lack Health Insurance and for How Long?" May 2003.

^v Kenney. Presentation for the Alliance for Health Reform. February 9, 2007.

^{vi} SCHIP data from SEDS (Statistical Enrollment Data System) for 2005 and Medicaid data from MSIS cube data for 2004. This data include PCCM arrangements.

^{vii} Felt-Lisk, "Trends in Plans Serving Medicaid" Paper Forthcoming from KCMU.

^{viii} National Governor's Association, MCH Update. September 1998. <http://www.nga.org/Files/pdf/MCHUPDATE0898.pdf>

^{ix} Coughlin. "A Race to the Top: Illinois's AllKids Initiative. KCMU Report Forthcoming

^x Testimony of Mark B. McClellan, MD, Ph.D. Administrator, Centers for Medicare & Medicaid Services Before the Senate Finance Subcommittee on Healthcare Hearing on State Children's Health Insurance Program July 25, 2006

^{xi} Artiga and Mann, "Family Coverage Under SCHIP Waivers," KCMU, May 2007.

^{xii} CBO assumed that increases in SCHIP funding would offset some projected Medicaid spending, so net federal costs over the period would be \$8.3 billion.

^{xiii} Letter from Jonathan Gruber to Representative John Dingell, March 1, 2007. http://energycommerce.house.gov/Press_110/110-ltr.022807.Gruber_ltr_to_Dingell.pdf

^{xiv} Genevieve Kenney and Debbie Chang. "The State Children's Health Insurance Program: Successes, Shortcomings and Challenges". Health Affairs. Volume 23, Number 5 (2004)

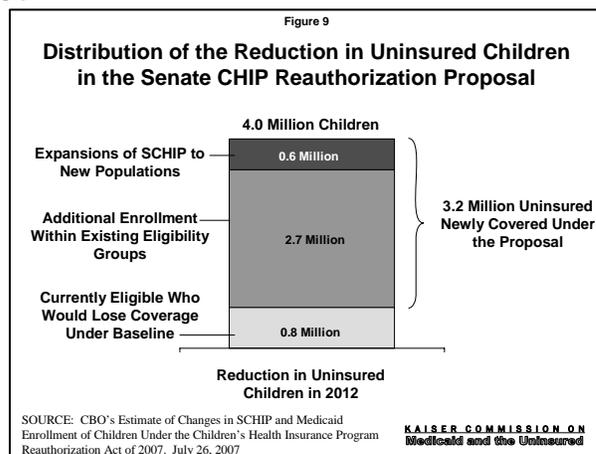
^{xv} KCMU, "Impacts of Medicaid and SCHIP on Low-Income Children's Health," May 2007

Senate Proposal: Children's Health Insurance Program Reauthorization Act of 2007, S. 1893

On July 19, 2007 the Senate Finance Committee approved a bi-partisan proposal to reauthorize the Children's Health Insurance Program. The Senate will consider S. 1893, The Children's Health Insurance Program Reauthorization Act of 2007 the week of July 30th. The Senate bill includes the following provisions:

Coverage. The Senate bill would extend coverage to 4.0 million children who otherwise would have been uninsured by maintaining coverage for the over six million children currently covered and by expanding coverage to another 3.2 million. Of the 3.2 million, 2.7 (over 80 percent) represent children who are currently eligible and not enrolled and the remaining .6 million are expected to enroll as a result of state efforts to expand to new populations. (Figure 9)

An estimated 6.1 million would be enrolled in SCHIP and Medicaid as a result of the proposal and the majority of them (66 percent or 4.1 million children) would have otherwise been uninsured.



The Senate bill would allow states to expand coverage up 300 percent of poverty; states that expand coverage beyond these levels in the future would receive the lower Medicaid match rate for these children. The bill would establish new options to cover pregnant women through CHIP, but would limit other coverage for adults. The Act would prohibit new waivers for parent coverage and limit funding for states that already cover parents by creating a set-aside for parent coverage that would be available to states at the Medicaid match. The bill would terminate coverage for childless adults in CHIP and allow states to transition this coverage to Medicaid within two years.

Financing. The bill would increase funding for children's coverage by about \$35 billion over baseline levels of \$25 billion over the next five years using an increase in tobacco taxes to finance the new spending.

Enrollment and Outreach. The bill creates fiscal incentives for states to enroll eligible children in Medicaid and SCHIP by paying a bonus for enrollment that exceeds established baseline levels and would provide outreach grant funding of \$100 million per year. The bill includes \$49 million to allow up to 10 states to implement "express lane" enrollment demonstrations. The bill also creates a contingency fund for states that face shortfalls, experience disasters or sustained high rates of unemployment. The bill would replace the current allocation formula with one that relies on state's actual and projected spending and allows states 2 years (instead of 3) to spend their allotments.

Benefits. The bill requires that there be parity between mental health services and medical and surgical services for states covering these services. The proposal also includes \$200 million in grants to help states improve access to dental coverage for children.

Quality. The bill requires HHS to develop child quality measures and would fund demonstration programs to improve quality and encourage the development of electronic health records for Medicaid and SCHIP.

Citizenship Documentation. The bill would extend the DRA citizenship documentation requirements to SCHIP, but would allow states new options to comply with these requirements by using Social Security Numbers instead of requiring original birth certificate or passports.

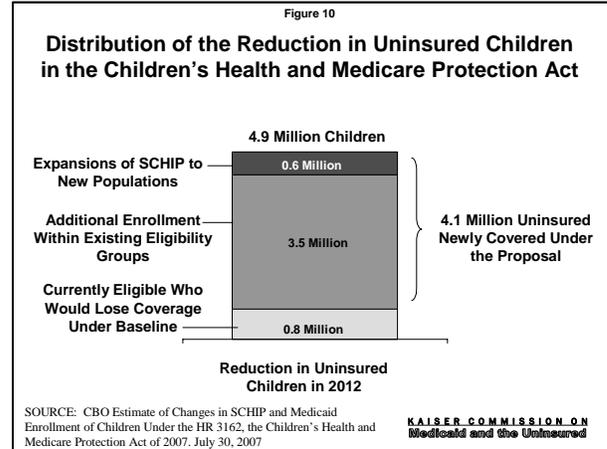
Premium Assistance. The bill allows states to offer subsidies to qualified, cost-effective employer-sponsored coverage, broadens how states use the cost-effectiveness test, makes it easier to share information between public and private plans and establishes a demonstration program to allow certain employers to buy-in to a pool that offers SCHIP benchmark coverage.

House Proposal: Children's Health and Medicare Protection Act (CHAMP Act) HR 3162

On July 26, 2007 the House Energy and Commerce Committee passed HR 3162, the Children's Health and Medicare Protection Act (CHAMP). The CHAMP Act includes the following Medicaid and SCHIP provisions:

Coverage. The CHAMP Act would extend coverage to 4.9 million children who otherwise would have been uninsured by maintaining coverage for the over six million children currently covered and by expanding coverage to another 4.1 million. Of the 4.1 million, 3.5 (or 85 percent) represent children who are currently eligible and not enrolled and the remaining .6 million are expected enroll as a result of state efforts to expand to new populations. (Figure 10)

An estimated 7.3 million would be enrolled in SCHIP and Medicaid as a result of the proposal and the majority of them (67 percent or 4.1 million children) would have otherwise been uninsured.



The House bill maintains flexibility for states to apply for waivers to cover parents and to cover children with incomes above 200 percent of the federal poverty level if states have enrollment and outreach efforts for children. The bill also adds new options for states to cover pregnant women through SCHIP and options to cover legal immigrant children and pregnant women and children through age 24 through Medicaid or SCHIP. The bill would extend Transitional Medicaid coverage through 2009.

Financing. The bill would increase funding for children's coverage by about \$50 billion over baseline levels of \$25 billion over the next five years primarily by using an increase of 45 cents per pack (compared to 61 cents per pack under the Senate Finance proposal) and reductions in payments for Medicare Advantage Plans. A much smaller share of financing would come from other Medicare provider rate cuts and an increase in the Medicaid drug rebate. New spending of \$50 billion over the next five years is the amount that was set aside in the budget resolution passed by Congress in May (more than the \$35 billion included in the Senate proposal and considerably more than the \$4.8 billion included in the President's budget proposal.)

Enrollment and Outreach. The bill includes bonus payments for states that enroll children above baseline levels and adopt four out of seven eligibility simplification efforts (12-month continuous eligibility, elimination or automatic verification of assets, presumptive eligibility, automatic renewal, use of joint applications for Medicaid and SCHIP, elimination of an in-person interview or express lane eligibility determinations). The bill would also increase the match rate for translation and interpretive services for families that do not speak English. The proposal also would replace the current allocation formula with one that relies primarily on state's projected spending, allows states 2 years (instead of 3) to spend their allotments, and re-bases the allotments every two years. Funds would be available for states that experience a shortfall in financing attributable to enrolling children who are currently eligible for SCHIP.

Benefits. The bill requires states to cover dental care, requires that there be parity in access to mental health and physical health care services, guarantees access to Federally Qualified Clinics and rural health clinics with Medicaid payment rules and limits the ability to approve Secretary-approved benchmark coverage under SCHIP. For Medicaid, the bill would allow states to offer coverage for family planning services without a waiver and would put a one year moratorium on the issuance of regulations that would limit payments for school-based administrative services, transportation or rehabilitation services. The bill prohibits the Secretary from approving new health opportunity account demonstrations that were authorized under the DRA.

Quality. The bill requires HHS to develop child quality measures and would establish the Children's Access, Payment and Equality Commission to monitor access and provider payment rates for Medicaid and SCHIP.

Citizenship Documentation. The bill allows for new options for individuals, newborns and tribal members to meet the citizenship documentation requirements imposed as part of the DRA. The bill would also allow states the option to return to pre-DRA requirements to document citizenship. The bill does not apply these requirements in SCHIP.

Premium Assistance. The bill would establish a demonstration program for up to 10 states to purchase family coverage through an employer buy-in program.

SIDE-BY-SIDE OF THE SENATE AND HOUSE SCHIP REAUTHORIZATION BILLS

	Children’s Health Insurance Program (CHIP) Reauthorization Act of 2007, S. 1893	Children’s Health and Medicare Protection Act (CHAMP), HR 3162
Enrollment Changes	<ul style="list-style-type: none"> • 4.1 million otherwise uninsured • 6.2 million enrollment increase 	<ul style="list-style-type: none"> • 4.9 million otherwise uninsured • 7.3 million enrollment increase
Coverage Options	<ul style="list-style-type: none"> • State option to cover children up to 300% FPL (above 300% FPL reimbursed at Medicaid match) • State option to cover pregnant women • No new parent waivers, establishes a set-aside fund for parents reimbursed at Medicaid match rate • Transitions coverage for childless adults to Medicaid 	<ul style="list-style-type: none"> • No upper income limit for children • State option to cover pregnant women under SCHIP; legal immigrant children and pregnant women under Medicaid or SCHIP • Waivers for parents allowed if states have outreach and enrollment efforts for children • No required transition of current childless adult waivers
Allotments	<ul style="list-style-type: none"> • Increase allotments by \$35 billion over 5 years over baseline • Distribution based on a combination of states’ actual spending, projections and allotments increased by population growth and per capita growth in national health expenditures • Allows states 2 years to spend allotments 	<ul style="list-style-type: none"> • Increase allotments by \$50 billion over 5 years over baseline • Distribution based primarily on states’ spending projections increased by population growth and per capita growth in national health expenditures • Allows states 2 years to spend allotments; re-base the allotments every 2 years
Outreach and Enrollment Incentives	<ul style="list-style-type: none"> • Bonuses for enrollment that exceeds baseline levels • \$100 million per year in grant funding • \$49 million for up to 10 states to implement “express lane” enrollment demonstrations • Contingency fund for states that face shortfalls, experience disasters, or sustained high unemployment rates 	<ul style="list-style-type: none"> • Bonus payments for states that enroll children above baseline levels and adopt seven eligibility simplification efforts • New option for Express Lane eligibility • 75% match for translation and interpretive services • Funds available for states with shortfalls in financing due to enrolling children who are currently eligible for SCHIP
Benefits	<ul style="list-style-type: none"> • Requires parity between mental health and medical and surgical services for states • \$200 million in grants to improve access to dental coverage 	<ul style="list-style-type: none"> • Requires states to cover dental care requires that there be parity in access to mental health and physical health care services under SCHIP • Guarantees access to FQHCs and RHCs with Medicaid payment rules • Limits Secretary-approved benchmark coverage under SCHIP.
Quality / Access	<ul style="list-style-type: none"> • Requires HHS to develop child quality measures • Funds demonstration programs to improve quality and encourage the development of electronic health records for Medicaid and SCHIP. 	<ul style="list-style-type: none"> • Requires HHS to develop child quality measures • Establishes the Children’s Access, Payment and Equality Commission to monitor access to care and provider payment rates for Medicaid and SCHIP.
Citizenship Documentation	<ul style="list-style-type: none"> • Extend the DRA citizenship documentation requirements to SCHIP, but would allow states new options to comply with these requirements by using Social Security Numbers instead of requiring original birth certificate or passports 	<ul style="list-style-type: none"> • Allows for new options for individuals, newborns and tribal members to meet the citizenship documentation requirements imposed as part of the DRA. • Allow states the option to return to pre-DRA requirements to document citizenship
Other	<ul style="list-style-type: none"> • Allows states to offer subsidies to qualified, cost-effective employer-sponsored coverage, broadens how states use the cost-effectiveness test, makes it easier to share information between public and private plans and establishes a demonstration program to allow certain employers to buy-in to a pool that offers SCHIP benchmark coverage. 	<ul style="list-style-type: none"> • Establishes a demonstration program for up to 10 states to purchase family coverage through an employer buy-in program • Allow states to offer coverage for family planning services without a waiver in Medicaid • Imposes a 1 year moratorium on regulations to limit payments for school-based administration, transportation or rehabilitation services • Prohibits approval of new DRA health opportunity account demonstrations
Offsets for New Spending on Children’s Health	<ul style="list-style-type: none"> • Financed by a 61 cent increase in the per pack federal tobacco tax 	<ul style="list-style-type: none"> • Financed primarily through a 45 cent increase in the per pack federal tobacco tax and reductions to Medicare Advantage Plans • Small amounts of financing from other Medicare provider cuts and increases in the Medicaid prescription drug rebate



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