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Eight important questions about SCHIP

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The State Children's Health Insurance Program (SCHIP) has been prominent in the news. Last week's attempt to overturn a presidential veto of SCHIP expansion marks the end of the first act in the SCHIP debate. There will be further acts to come.

Now is a good time to take a deep breath and look closer at SCHIP. While the program is provoking vigorous debate, much of the discussion has focused on polarizing talking points. So we've identified eight questions for people to consider about SCHIP. We're not suggesting definitive answers to these questions but will explain why they are important.

SCHIP is complicated, in part because it is flexibly used by states. What are the implications of this flexibility?

SCHIP has what's called an enhanced match rate. For example, in Indiana, if the state of Indiana spends a Medicaid dollar, the state will receive 63 cents of that dollar back from the federal government. However, if the state spends an SCHIP dollar, the state will receive 74 cents back from the federal government. The higher federal payment is referred to as the enhanced match rate. The range nationally for the enhanced match rate is between $0.65 and $0.83 for SCHIP, as compared with the standard federal medical assistance match rate, which ranges from $0.50 to $0.76. The SCHIP program was created with this enhanced match to encourage states to reach out to children and improve enrollment. States were also given the funds in block grants to allow for more flexibility and thereby to further encourage participation. The flexibility means states administer their programs differently, which is part of what makes the issue complex.

Most of the national discussion has focused on federal funding of SCHIP. What are the long-term prospects for state-level funding?

With the federal government paying for 65% to 83% of every dollar spent for the SCHIP program, where does the state get its money? Many states are using tobacco settlement money to pay for these programs. This is a finite pool of funds. These states will have to identify where they are going to receive their money once the tobacco settlement funds are no longer received. Alternative funding may come from general tax revenues, taxes on provider services, or insurance company premium taxes (among other sources). Alternatively, a state may decide to reduce the benefit levels for the SCHIP plans or require more cost sharing through higher premiums or copayments on the part of the insured based on family income level. Any solution is likely to put additional financial and political pressure on the state.

How do states reconcile their annual federal funding allocations and their actual spending?

The disparity between allocations and actual expenses has in many cases been overlooked. During its first year, SCHIP enrollment was understandably low. It was a new program and enrollment efforts had only begun. Rather than depriving states of these funds, the federal government allowed funds to roll over from year to year. The surplus funds will allow some states to maintain their SCHIP programs into the next six to 18 months even without additional federal fund allocations. However, other states have been fully spending their SCHIP funds. These states are in need of immediate federal funds to maintain their SCHIP programs. For all states, this surplus will eventually run out, just as the tobacco money on the state side will eventually run out. Based on how much the federal government allocated in federal fiscal year 2007, if states were only spending 2007 money, many would already have overspent their appropriation.

If federal funding of SCHIP were to expire without renewal or expansion, some states might shut down programs (as was the case with "Peach Care" in Georgia). What other alternatives are there to shutting down the program altogether?

From state to state the answer will differ. If SCHIP does not get reauthorized, states may have the opportunity to convert their SCHIP programs to Medicaid programs. The state will have to pay a greater percentage for the Medicaid program, but it could expand it to be Medicaid-eligible up to 200% of the federal poverty level (FPL). It really depends on the state's fiscal ability to cover the difference between the Medicaid match rate and the enhanced SCHIP match rate.

One of the concerns about SCHIP is the potential for "crowd out" of private insurers looking to provide children's health insurance. Crowd out occurs when a government-sponsored program overlaps a viable commercial option; in this case, the children's commercial health insurance market. Is it possible to quantify what percentage of the federal poverty level marks the SCHIP crowd-out tipping point?

In most states, SCHIP covers 150% to 200% of the FPL. Some states go up to 250%, and a few even as high as 300%. It is hard to index these levels to some kind of crowd-out threshold. Many employers offer single coverage or family coverage. A single working parent in that 150% to 200% range may choose single coverage instead of family coverage and have children covered through the state program. That is one kind of crowd out. Still, the statistics indicate that we have a smaller percentage of children uninsured. While it is possible that expanding SCHIP eligibility to slightly higher income levels may result in some children who are currently insured dropping that coverage to move to SCHIP, it may be a question of weighing the greater good if the expansion results in significantly fewer uninsured children overall.

How can states deal with crowd out?

Illinois recently adopted its "All Kids" program, which is a health insurance program available to all children in the state. The program offers guaranteed health insurance coverage for children with premium rates that vary based on the family income. To offset the crowd-out potential, Illinois included a waiting period for specific income levels that requires that the child not have other health insurance coverage for a 12-month period. Therefore, a parent would have to drop coverage for the child for a 12-month period prior to enrolling in the program. Due to the potential financial risk, a lot of parents are not willing to drop health insurance coverage on their child for that long, which may prevent those with the financial means to use the commercial market from using SCHIP. Meanwhile, some states are disqualifying families with availability to employer-based coverage from SCHIP.

If SCHIP is expanded, what kinds of strain might it place on primary-care providers? How might shifts in costs and care play out?

An expansion in SCHIP enrollment will result in a corollary increase in demand for primary-care providers. Some states are better equipped for this increase than others. As children are enrolled into SCHIP and move into a managed-care or other insured environment, the child will oftentimes be assigned to a primary-care physician. The children will stop relying on the emergency room and on other services that are not designed to meet day-to-day healthcare needs. Greater access to a primary-care physician may improve children's immunization and preventative healthcare coverage beyond current levels.

At the same time, an expansion of SCHIP—in some cases at income levels above 200% of FPL—will introduce new enrollees with expected reimbursement at Medicaid rates. With Medicaid reimbursement generally the lowest in the market, an expansion of SCHIP could strain providers by increasing the number of patients with the lowest reimbursement.

When do we reach the boiling point of the SCHIP debate?

The nationwide pressure has not started mounting yet because a lot of states still have SCHIP money left over that may last another six to 12 months. The states in trouble are the ones already using their current fiscal year's money. They're running day-to-day, as compared with other state programs, which may have enough federal funding to cover the program. It isn't a critical fiscal discussion. Yet. Future acts in the SCHIP debate are likely to possess a stronger sense of urgency.

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