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e-Health Policy News

September 2007

A Serious Debate Rages As SCHIP Deadline Looms

The State Children's Health Insurance Program (SCHIP) was enacted as a part of the Balanced Budget Act in 1997 to provide health insurance for children from working poor families that make too much to qualify for Medicaid. It was designed as a partnership between the federal government and the states. The federal government matches state spending for program beneficiaries according to an annually determined match rate. This rate varies based on a calculation of the percentage of low-income and uninsured children in each state as determined by estimates from the U.S. Census Bureau. The match rate must be at least 65%, but less than 85%. The federal government granted waivers to permit states to use SCHIP funds to cover parents and pregnant women and a few states use SCHIP funds to cover childless adults. States may use up to 10% of their annual allotment on outreach, administration, and other health-related activities. Congress allocated over $40 billion for SCHIP through 2007, and if it is not reauthorized by September 30, 2007, the program will expire.

There are currently 50 different federal-state health plans. Each state has the option of providing one of three plans: a Medicaid expansion plan, a state-designed plan, or a combination plan. Ten states and the District of Columbia use their SCHIP funds for Medicaid only, 18 states operate a separate SCHIP program, and 22 states use a combination plan. There is flexibility in design of benefits but certain standards must be met. All state programs must cover inpatient, outpatient, emergency care, and many kinds of specialist care. Most programs pay doctors at Medicaid rates. States are required to provide well-baby and well-child visits and immunizations, and many offer mental health and substance abuse services.

The Medicaid expansion plan is intended to broaden Medicaid to cover older children or children from families with incomes too high to qualify for regular Medicaid. Standard Medicaid rules for service delivery, benefits, and cost sharing apply, and states cannot cap enrollment after funds are exhausted. The federal reimbursement for this plan is at the regular Medicaid "match rate."

The state-designed plans are new programs designed to offer benefits consistent with the provisions outlined by SCHIP and must be approved by the Department of Health and Human Services. States have several benefit package options: benchmark coverage that is equivalent to either the Federal Employee's Health Benefit Package, the Blue Cross/Blue Shield plan in the state, the benefit package offered to state employees, or the package offered by the HMO in their state with the largest non-Medicaid enrollment; a benchmark-equivalent with the same actuarial value as one of the benchmark benefit packages that must include coverage for inpatient and outpatient hospital services, physicians' services, lab tests and x-rays, well-baby and well-child visits, and immunizations; or an existing state-based comprehensive coverage that is equivalent to other state subsidized non-Medicaid programs that existed before SCHIP.

Combination plans both expand Medicaid and create a separate private plan for different populations. In this plan, SCHIP is not an entitlement, and the program is not required to accept new enrollees if the capacity is reached or if all available funds are expended.

Both Medicaid and SCHIP provide health care coverage for more than 30 million people; however, there are still an estimated 8 million uninsured children in the United States, and approximately 70% of the uninsured are eligible but not enrolled. This program has reduced the rate of uninsured children by about 25% since its inception, but has also grown to cover the middle class and even many adults. Currently 20 states cover families with incomes up to 200% of the federal poverty level, and 23 states cover families with income above 200%. Utilizing waivers, 11 states use SCHIP funds to cover parents, 4 states cover childless adults, and 11 states cover pregnant women. Children's health insurance is increasingly covering adults. Minnesota spends 87% of its SCHIP funds on adults and Wisconsin spends 75%. Arizona ranks in the top 10 states with the highest rates of uninsured children, but 56% of their SCHIP enrollees are adults.

There are opposing visions of what children's health insurance should encompass. One side of the spectrum relies on government-run models to establish government control over health care decisions that affect children, a focus on enrolling more children in SCHIP, increased funding obligations to accommodate new enrollees, and a broader range of eligibility and services. Another vision of the program incorporates SCHIP into an even larger vision that addresses the fundamental problems of health care, focuses on maximizing existing SCHIP funds to cover low-income children, reforms federal tax treatment of health insurance to help families purchase private insurance, and provides states with greater flexibility to use federal funds to target assistance for those who need it. Regardless of the approach, it is obvious that the number of uninsured children continues to be a serious problem.

While SCHIP was originally designed to provide health care to uninsured children of low-income families, expansion would include children from families at 300% of the poverty level ($61,950 for a family of four), and in some cases children would be covered from families with even higher income. The Congressional Budget Office states that this expansion would shift billions of dollars for health insurance coverage from the private sector to the public sector with little actual gains in coverage for uninsured children. It is estimated that 33% of the total individuals who enroll in SCHIP will drop private insurance coverage in favor of the federal program. Opponents of the proposed bill also claim that the increased budget involves some "creative" cost accounting that actually requires states to cut millions of children from the program in the final year and assumes that the next Congress will provide additional funding to prevent such an event from occurring. These higher spending levels in the future will coincide with the increasing costs of retiring Baby Boomers. Also, the bill re-opens past Medicaid reforms in the Deficit Reduction Act that includes citizenship requirements and benefit mandates.

Various estimates indicate that at 300% of the federal poverty level, the "crowd-out" could be as high as 50%. Crowd-out occurs when the government raises income qualifications and individuals drop their private coverage to join an entitlement program that is perceived to be free. The Congressional Budget Office estimates that 25% to 50% of the new SCHIP funds would go to children from families who have private coverage. An estimated 50 to 75 cents spent on expanding government entitlement programs cover those who would drop private insurance. The Department of Health & Human Services estimates that an expanded SCHIP would encourage 1.6 million people with private insurance to drop coverage to enter the program. The National Board of Economic Research suggests that for every 100 children enrolled in publicly funded health insurance programs, 60 children lose private insurance, likely due in part to rising health insurance premiums and rising cost sharing. They also note that anti-crowd-out provisions, such as waiting periods and premium fees, have increased crowd-out because the number of those with private insurance will drop their coverage to sign up faster than the uninsured will enroll in the program.

To counter these criticisms, a broader reform of the health care system has been outlined to better meet the needs of lower-income families and their children with the intent to ensure that SCHIP remains a targeted safety net program for low-income families yet avoids displacement of private coverage. One recommendation toward this goal was to limit the current, unlimited tax preference for employer-based coverage in favor of a fairer system. For example, this strategy could give tax relief to low-income families for health care coverage without raising taxes for additional spending. Another recommendation was to provide premium assistance using SCHIP funds to help families enroll in private coverage, either through an employer or on their own. And finally, the strategy could promote overall health insurance reform. Several states are currently making efforts to enable individuals to own and control their own health insurance and promote portable policies that can be taken from job to job. Congress could assist by adopting legislation that would include grants for technical assistance to states that are willing to reform their health insurance markets, adopt pooling arrangements, or promote more affordable coverage.

Prior to the August recess, the U.S. House of Representatives passed legislation to reauthorize SCHIP with a 225-204 vote. This legislation provides $47.4 billion in new funding over five years. It also includes several state options that extends coverage to legal immigrant children, coverage through age 24, and establishes individual citizenship documentation requirements. In an effort to encourage states to improve and expand outreach, the House bill allows bonuses if the majority of "best practices," as outlined, are implemented. These "best practices" include continuous 12-month enrollment, elimination of face-to-face interviews and asset determinations, establishment of joint Medicaid/ SCHIP applications, and automatic renewals. The bill is funded through a 45-cent increase in federal tobacco tax and reductions in payments to Medicare Advantage plans.

The Senate passed, 68-31, a bill to provide $35.3 billion to SCHIP over the next five years. This plan would prohibit additional waivers to cover parents or childless adults and would begin phasing out coverage in states that currently have waivers, allowing an option to continue with a reduced match rate. The bill offers provisions to improve outreach and enrollment, incentives for increasing Medicaid enrollment, a method to use social security numbers to verify citizenship and identity, and allows for mental health parity and dental care. The legislation is offset under Senate pay-as-you-go rules by a 61-cent federal tobacco tax increase.

These two bills, HR 3162 and S183 (a bill that Democrats intend to substitute for the text of a House-passed tax bill HR976), must be reconciled before a bill can be sent to the President. The administration's Office of Management and Budget is recommending a veto of both bills as they currently stand. A statement released by the Secretary of Health & Human Services states, "This bill spends too much money with too little actual gain in insurance coverage for children—almost one-half of whom already have private insurance. It moves more than a million people with good incomes off private insurance and onto public assistance. Five years later, it cuts outlays for the program in half, causing any temporary gains in coverage for children to be lost." The President proposed an alternative that would result in government actuary estimates of 20 to 25 million Americans gaining insurance. Two steps the administration advocates are 1) to reform the tax code so that individuals who buy health insurance for themselves can get the same tax break that employer-provided health insurance get, and 2) to allow individuals to cross state lines to buy insurance, thus bypassing their own states' onerous mandates. Additionally, some health-care experts believe we should expand on these efforts to fix government health care policies by treating SCHIP and Medicaid the same as welfare. Congress could give a set amount of money to the states, similar to the way welfare was block-granted in 1996, to cover needy families and not reward the states for being more generous.

There is considerable debate on this issue and a great deal of compromise will be necessary to bridge the gap between the two bills. With the threat of a veto, the September deadline is fast approaching.

Hoosier Healthwise

Indiana's State Children's Health Insurance Program is Hoosier Healthwise, a combination program operating both a Medicaid expansion and separate SCHIP program. This plan covers eligible children, pregnant women, and low-income families with children under age 18. Hoosier

Healthwise requires premiums ranging from $11 to $24.75 a month, depending on family size and income. Managed Care Organizations are contracted to provide comprehensive preventive and primary care services. Benefits provided include: physician services; private duty nursing services; inpatient hospital services; home health services; inpatient and outpatient mental health services; pharmacy; dental preventive services; inpatient and outpatient substance abuse services; hearing aids; vision exams and eyeglasses; family planning services; and prosthetic appliances. The eligibility for coverage is 200% of the federal poverty level, or approximately $41,300 for a family of four. The federal match rate Indiana receives for SCHIP is 73.83% - this means that for every state dollar spent in Indiana, the state receives almost 74 cents from the federal government.

Children in Indiana are more likely than children in the rest of the country to have private health insurance coverage. Yet despite outreach programs that include distribution of applications and brochures in public schools, pre-printed reapplication information sent to families 30 days in advance of coverage renewal dates, and re-determination of eligibility every 12 months (if SCHIP is the only state program in which the child is enrolled), it is estimated that Indiana has more than 159,000 uninsured children. Roughly 9.5% of the state's 14.2% uninsured are children, compared with the national average of 11.7% children among the uninsured.

In Indiana, caseworkers perform all the activities for the cases to which they are assigned. This enables the caseworker to become knowledgeable about all phases of case management, thus increasing their ability to inform families of other programs for which they are eligible. This practice helps increase coverage for the uninsured. The growth rate in Indiana's SCHIP is more favorable than in most other states, but enrollment is beginning to level off. Indiana's program is the 14th largest in the country; however, it is unclear what the impact of the changes to SCHIP will mean for the state. Present estimates of available funding and allocations indicate that Hoosier Healthwise will be sustainable into 2008.

Project Update

A recent mental health and addictions needs assessment was conducted by the Center for Health Policy for North Central Health Services (NCHS). The goal of this study was to gain a better understanding of the mental health and addiction needs of the eight-county region served by NCHS. The final report and a summary of this project is now available at the Center for Health Policy Web site and may be viewed in its entirety at http://cl.exactt.net/?ju=fe5c15727d620079771c&ls=fe2911797c64077d771579&m=fefb1775766d04&l=ff011675746402&s=fe531376776701747c17&jb=ffcf14&t=. We also have created a blog for this project and invite your comments at http://cl.exactt.net/?ju=fe5b15727d620079771d&ls=fe2911797c64077d771579&m=fefb1775766d04&l=ff011675746402&s=fe531376776701747c17&jb=ffcf14&t=.

The Center for Health Policy is a partner center with the **Center for Urban Policy and the Environment** at the School of Public and Environment Affairs at Indiana University. The mission of the CHP is to collaborate with state and local government and public and private health care organizations in health policy and program development and to conduct high quality program evaluation and applied research on critical health policy-related issues.

FORWARD TO A FRIEND

This publication is sponsored in part by a grant from North Central Health Services.

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