April 27, 2004

NATIONAL HEALTH POLICY FORUM

The Basics

SCHIP

Created as part of the Balanced Budget Act of 1997, the State Children's Health Insurance Program (SCHIP) is the largest expansion of public health insurance coverage since the creation of Medicare and Medicaid in 1965. Although SCHIP, which served more than 5.8 million in 2003, is relatively small in size compared to the Medicaid and Medicare programs, it changed the focus of public programs by providing incentives for states to reach out to families by making it easier and more worthwhile to sign up for the program. These outreach activities in SCHIP simultaneously led to significant increases in children's enrollment in Medicaid.

Under the SCHIP statute, states could choose to expand the existing Medicaid program, create a separate child health insurance program, or use a combination of the two approaches. The majority of states are now using the combination approach.

WHO IS ELIGIBLE?

SCHIP was designed to serve "targeted low-income children," defined as uninsured children under age 19 in families with incomes below 200 percent of the federal poverty level (FPL) ($31,340 for a family of three in 2004). All states elected to expand children's coverage, and 40 states have expanded Medicaid/SCHIP up to at least 200 percent of the FPL.

Children who are otherwise eligible for Medicaid or have other insurance coverage are generally not eligible for SCHIP. Adults are also generally not eligible for SCHIP; however, several states have been granted special federal approval to receive enhanced matching funds for coverage of parents of children enrolled in SCHIP, pregnant women, and, in some cases, adults without children.

WHAT SERVICES ARE COVERED?

There are two distinct sets of benefit requirements, depending on the type of program a state has developed. States creating Medicaid expansion programs must provide the full Medicaid benefit package (see "The Basics: Medicaid" for a description). For separate SCHIP programs, states generally must cover primary and preventive benefits, including immunizations, well-baby and well-child care, and emergency services. In designing the benefit package, states may choose among four options:

- *Benchmark coverage* includes the BlueCross/BlueShield plan in the state, the state employees benefits plan, or the benefit package provided by the health maintenance organization (HMO) with the largest Medicaid enrollment in the state.

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- States may also offer *benchmark-equivalent coverage* that is approved based on an actuarial calculation of the value of the benchmark benefit package.
- States may elect to use the benefit package provided in one of three states that had existing child health insurance programs—Florida, New York, and Pennsylvania.
- States may propose another benefit package and request approval from the secretary of health and human services.

WHAT ABOUT COST SHARING?

Again, states with Medicaid expansion programs are required to follow the Medicaid cost-sharing rules, which generally prohibit all forms of cost sharing for children. (Although states may charge premiums for families enrolled in Medicaid.) For separate SCHIP programs:

- Cost sharing for families with incomes below 150 percent of the FPL ($22,890 for a family of three in 2003) is limited, and states may generally charge no more than a $5 copayment per visit.
- For families with incomes above 150 percent of the FPL, the total amount of cost sharing charges (including premiums, deductibles, enrollment fees, and co-payments) may not exceed 5 percent of the family's annual income.

HOW IS SCHIP FINANCED?

SCHIP made $39 billion in federal funds available over ten years to assist states in providing health care services to low-income children. This funding is distributed to the states in the form of individual "allotments" that are determined by calculations based on the Medicaid matching structure (see "*The Basics: Medicaid*"). The matching rates are higher than Medicaid. The "enhanced" payments are generally 15 percentage points more than under Medicaid and range from 65 percent in the wealthiest states to 83 percent in the poorest state.

Each state receives annual SCHIP allotments that can be spent over a three-year period. At the end of three years, any unspent funds are redistributed to those states that have spent all of their individual allotments. States generally have one year to spend the redistributed funds. If any funds remain unspent after the redistribution period expires, the statute requires those funds to be returned to the federal government.

For more information:

- Centers for Medicare and Medicaid Services, "State Children's Health Insurance Program (SCHIP)," http://www.cms.hhs.gov/schip/.