MMPI Massachusetts Medicaid Policy Institute

The State Children's Health Insurance Program in Massachusetts: Achievements, Challenges, and Implications for Health Reform

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The State Children's Health Insurance Program (SCHIP) was enacted nearly 10 years ago as part of the Balanced Budget Act of 1997. Created as Title XXI of the Social Security Act, SCHIP offers states enhanced federal match for providing coverage to low-income children who are not eligible for the Medicaid program. In addition to an enhanced match, SCHIP also offers states greater flexibility in the administration of the program, particularly in the area of benefit design and cost-sharing. Congress invested almost $40 billion in the program over a 10-year period. The enabling legislation is scheduled to expire on September 30, 2007.

SCHIP is seen as extremely successful — having insured over 6 million children nationwide — and reauthorization of the program is not in question; however, the debate in Washington on what SCHIP should look like going forward is already active and it is not clear whether there will be agreement on changes to the program by SCHIP's scheduled expiration date. The debate focuses on the appropriateness of the funding formula — many states, including Massachusetts, have begun experiencing significant shortfalls in federal funding — and on whether to use SCHIP reauthorization as a vehicle to further expand coverage options for the uninsured.

This issue brief provides an overview of SCHIP nationally and in Massachusetts, explores the state's funding shortfall and presents some opportunities and challenges for Massachusetts that come with the reauthorization of the program, particularly given the interconnectedness of SCHIP, the MassHealth waiver, and Chapter 58 of the Acts of 2006, the Commonwealth's Health Care Reform law.

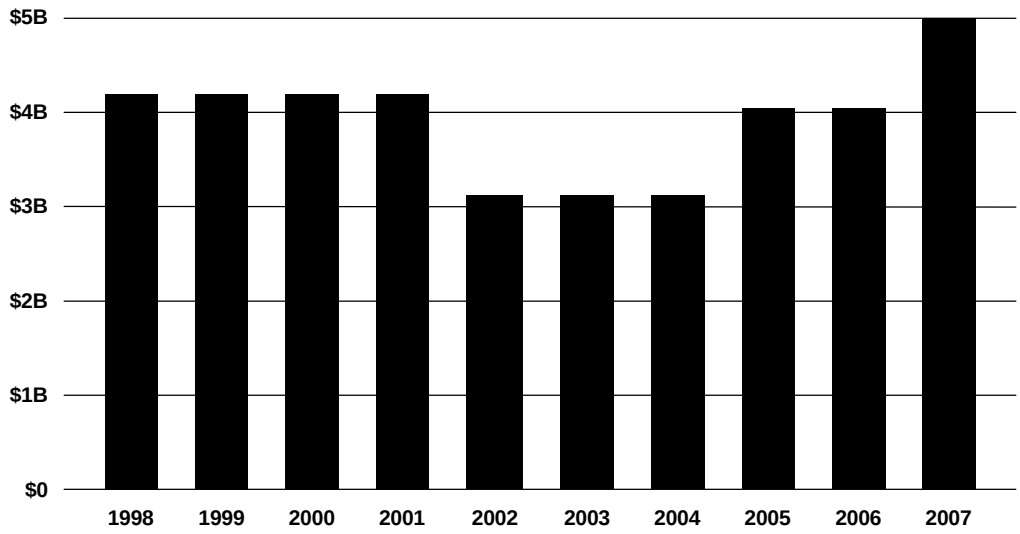
A Brief History of SCHIP

Following the failure of the Clinton Administration's bold attempt at a large-scale health care reform effort in the early 1990s, Congress and the Administration turned to an incremental step to improve coverage and access to health care. The State Children's Health Insurance Program gave states a vehicle to provide health coverage to uninsured children from families that had incomes too high to qualify for Medicaid. To entice states to increase income eligibility levels for children, SCHIP provides states with an enhanced federal financial participation rate.[1] In Massachusetts, the state receives 65 cents in federal reimbursement for each dollar it spends on SCHIP.

Availability of Federal Funds

Congress authorized the program for an initial period of 10 years and committed nearly 40 billion federal dollars to the program. Even with that level of commitment, the enabling statute included a planned reduction in funding, the "SCHIP-DIP", in order to meet federal budget targets (see Figure 1).

Figure 1: Total SCHIP Funding Allotments 1998-2007[2]



[1] See 42 U.S.C. 1397ee(b).

[2] The program began in FFY 98 with an annual allotment of $4.24 billion; annual allotments remained steady until 2002 when it dropped by 25% to $3.12 billion. This drop occurred just as many state programs were reaching full enrollment and using their annual allotment. The federal dollars remained at the lower levels until 2005 when the allotment rose to just over $4 billion. In 2007, the allotment totaled $5 billion. (See 42 U.S.C. 1397dd)

Although states receive a higher match rate for SCHIP than provided through the Medicaid program, SCHIP spending is limited by a capped federal allotment. If the allotment cap is reached, a state may discontinue its program, continue the program with state-only funding, or, if a state operates all or part of its program as a Medicaid expansion, may continue with that portion of the program and receive its lower Medicaid matching rate. Title XXI dictates a funding formula to determine each state's yearly allotment based on a number of factors including: the number of uninsured children in the state (as reported through Current Population Survey (CPS) data), the total number of low-income children in the state and the state's wage index.[3] States retain access to the annual allotment for a period of three years, allowing states the flexibility to retain an unspent allotment and use it in a future year.[4] The statute also provides for redistribution of unspent allotments to states that spend their full allotments.[5] In any year, a state may spend up to 10% of its annual spending on administrative expenses, including outreach.[6]

Enrollment and Program Design

States quickly took advantage of the SCHIP option. By September 30, 1999, every state had an approved SCHIP state plan and had implemented an SCHIP program.[7] In 2005, over 6 million children received coverage through the program.[8] In partnership with Medicaid, SCHIP has significantly helped reduce the number of uninsured children nationally over the past ten years. In so doing, SCHIP and Medicaid have helped to reduce the racial and ethnic disparities in access to health care. Moreover, children covered through these programs are as likely to utilize preventive and primary care as children with private insurance.[9]

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[3] For more detailed information on the allotment formula, see Chris L. Peterson, *SCHIP Original Allotments: Funding Formula Issues and Options*, Congressional Research Service (CRS), Report for Congress, April 18, 2006.

[4] In December 2006, Congress approved legislation that reduces the availability of FFY 2005 allotments. See H.R. 6164.

[5] 42 U.S.C. 1397dd (f).

[6] This limitation has proven especially burdensome for states that administer their SCHIP program separate from their Medicaid program. Because the 10% is based on annual spending, and not on the full allotment, separate programs had difficulty implementing programs and effectively outreaching to target populations.

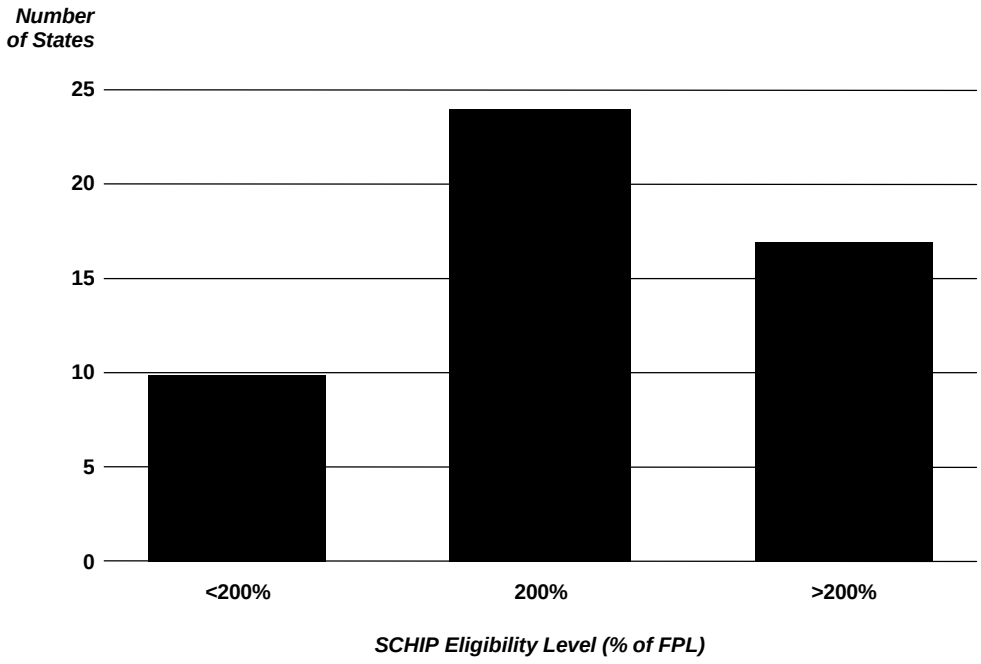
[7] *SCHIP Annual Enrollment Report*, October 1, 1998 — September 1, 1999; accessed at http://www.cms.gov/on March 19, 2007.

[8] *Enrolling Uninsured Low-Income Children in Medicaid and SCHIP*, Kaiser Commission on Medicaid and the Uninsured, January 2007.

[9] See Testimony of Barbara Lyons, Ph.D. before Senate Committee on Finance, April 4, 2007, accessed at http://www.kff.org/medicaid/7628.cfm.

Like Medicaid programs, no two SCHIP programs are the same. The statute allows for three types of programs: a Medicaid expansion[10], an SCHIP only, or a combination program[11]. Most states chose to implement SCHIP through their Medicaid agencies and chose to operate a Medicaid expansion or combination program. Only 18 states operate separate SCHIP programs.[12] As shown in Figure 2, a majority of states offers coverage to children in families at or below 200% of the federal poverty level ($34,344 per year for a family of three in 2007).[13]

Figure 2: SCHIP Eligibility Levels Nationally



Because SCHIP provides states with the opportunity to significantly increase eligibility levels for uninsured children, Title XXI specifically limits coverage under SCHIP to uninsured children and allows states to enact "crowd-out" provisions that, essentially, impose waiting

[10] A Medicaid expansion population is required to follow all Title XIX rules (or a state's 1115 demonstration waiver authority) but is eligible for the enhanced federal funding. Children served through a Medicaid expansion must receive Early and Periodic Screening, Diagnosis & Treatment (EPSDT) services.

[11] A combination state claims SCHIP dollars for coverage of children under both a Medicaid expansion option and an SCHIP-only program.

[12] See *A Decade of SCHIP Experience and Issues for Reauthorization*, The Kaiser Commission on Medicaid and the Uninsured, January 2007.

[13] Ibid. 24 states have income levels set at 200% of the FPL; 10 cover children at higher income levels. Currently, New Jersey has highest income level at 350% FPL. See New Jersey Title XXI Program and Title XXI Amendment Fact Sheet, accessed at http://www.cms.gov/ on March 20, 2007.

periods on children's ability to access the program if their parents were to drop private insurance.[14] Title XXI also attempts to limit crowd-out by providing states with the flexibility to create premium assistance programs to assist families of SCHIP eligible children in purchasing their employer-sponsored insurance. Nine states, including Massachusetts, have chosen this option, with varying success.[15]

In addition to an enhanced match rate, SCHIP also provides states with a greater amount of flexibility in benefit design and cost-sharing strategies than is allowed in the traditional Medicaid program.[16] States are required to offer enrollees a benchmark plan or a plan that is actuarially equivalent to one of the benchmark plans designated in Title XXI. Benchmark plans include the federal employees benefit plan, the plan offered by the largest commercial HMO in a state, the state employee benefit plan, or a different benefit that is approved by the Secretary of the U.S. Department of Health and Human Services. In Massachusetts, for direct services provided by MassHealth, the benchmark plan is the largest HMO in the state. The state's premium assistance program falls outside of the benchmark plans and operates with the Secretary's approval.

Unlike traditional Medicaid, coverage under a separate SCHIP program does not entitle children to the provisions of Early and Periodic Screening Diagnosis and Treatment (EPSDT), which requires that a state provide any medically necessary treatment or service to a child whether or not that treatment or service is generally covered by the state's Medicaid program.[17] SCHIP also allows higher levels of individual cost-sharing than is allowed in the Medicaid program. Families with incomes greater than 150% of the federal poverty level may be required to have out of pocket expenses in SCHIP, including premiums, co-payments and deductibles, at levels up to 5% of family income. No cost-sharing is allowed, however, for well-baby or well-child care.[18]

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[14] This is in contrast to Medicaid, where Title XIX requires that if a recipient has other insurance that Medicaid serve as the payor of last resort and provide additional benefits that "wrap" around the private insurance to bring the coverage to the same level as offered through Medicaid.

[15] For further information on premium assistance programs, see Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs*, pg. 17-20, National Academy of State Health Policy, September 2006.

[16] See 42 U.S.C. 1397cc. This is less true today given the passage of the Deficit Reduction Act of 2005 which allows states to create benchmark benefit levels and higher cost-sharing than previously allowed under Medicaid. However, due to the EPSDT requirement, which has not been altered, the ability of programs to make any significant reductions to benefits for children in Medicaid remains limited.

[17] In Massachusetts, this means that children covered with SCHIP funding that receive coverage through a "Medicaid expansion" under MassHealth Standard must receive EPSDT coverage, but children covered with SCHIP funding through a "separate SCHIP program" under MassHealth Family Assistance do not have the full protection of EPSDT.

[18] Well-baby and well-child care refer to preventive visits such as age-appropriate physician check-ups.

Waiver Authority

The Secretary of Health and Human Services is authorized to grant waivers of certain provisions of Title XXI. As many states struggled in the early years to spend their full allotments, the Centers for Medicare and Medicaid Services (CMS) began to allow states to use their SCHIP allotments to cover populations other than children. States that were spending their full allotments received access to redistributed funds from states that did not spend their full allotments and faced pressure from advocates and other stakeholders to leverage available SCHIP funding to expand access with their redistributed dollars. Through waivers, CMS approved use of SCHIP funding to cover parents in 8 states, childless adults in 5 states, and unborn children in 11 states.[19] Coverage of these populations through SCHIP has been controversial, particularly because some states with SCHIP funding shortfalls are covering populations other than children as part of their programs.[20]

The Massachusetts SCHIP program

In July 1997, Massachusetts implemented its original MassHealth waiver demonstration program to expand eligibility for the Massachusetts Medicaid program and leverage available federal funding. Under that expansion, families with incomes at or below 133% of the federal poverty level (FPL) were eligible for MassHealth. Just a few weeks after the implementation of the demonstration waiver, SCHIP was enacted at the federal level. Massachusetts officials quickly took steps to implement this new coverage option to take advantage of the enhanced match being offered by the federal government. The Commonwealth enacted legislation in November 1997 to expand coverage to children with family incomes at or below 200% of the FPL.[21] Following CMS approval of an SCHIP state plan, the coverage expansion was implemented in August 1998.

Massachusetts uses its SCHIP allotment as a financing mechanism that allows the state to leverage federal dollars to increase MassHealth coverage for children. Massachusetts technically operates its SCHIP program as a combination program, but a MassHealth member is not likely to know whether their coverage is funded through the state's Medicaid waiver or through Title XXI.[22] Figure 3 depicts the federal match rate for the MassHealth

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[19] *SCHIP at a Glance*, Kaiser Commission on Medicaid and the Uninsured; Fact Sheet; January 2007.

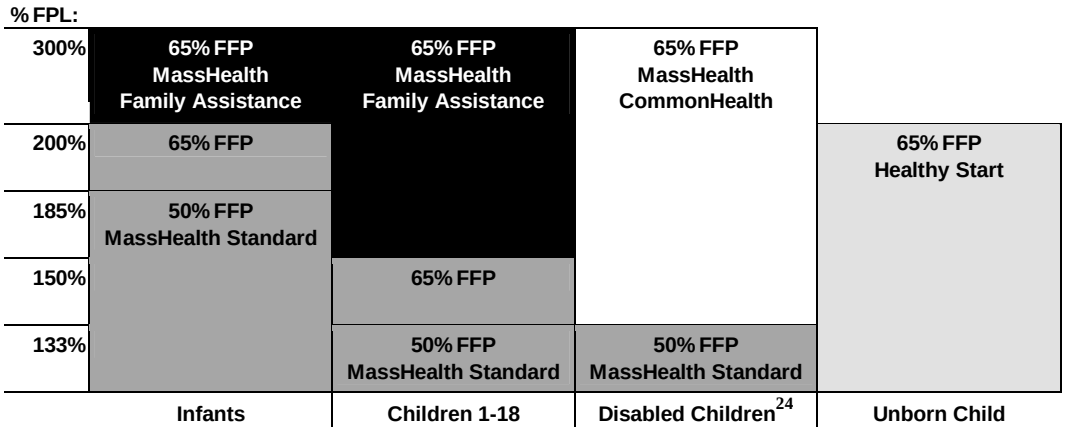
[20] Of the 14 shortfall states in FFY07, 6 states, including Massachusetts, cover populations other than children as part of their SCHIP programs.

[21] Chapter 170 of the Acts of 1997.

[22] Generally, a child whose family's income is greater than 133% of the federal poverty level will be claimed under SCHIP for an enhanced match if the family did not have health insurance at the time of enrollment in the MassHealth program. If a child was

coverage types, assuming a child is uninsured at the time of application. Match rates of 65% are funded through SCHIP and match rates of 50% are funded through Medicaid. Depending on income level, a child whose expenses are claimed to SCHIP may be covered through a variety of MassHealth coverage types: Standard, Family Assistance or CommonHealth. Pregnant women who are ineligible for MassHealth Standard due to their immigration status are covered through Healthy Start. Children at the same income levels who had insurance at the time of application to MassHealth are claimed for the lower Medicaid match rate (50%) through the MassHealth waiver.

Figure 3: Federal Funding of MassHealth Coverage Types[23]



In implementing the program, the state expanded MassHealth Standard coverage for children with family incomes to 150% FPL. In addition, MassHealth Family Assistance was created as a new coverage type for children with family incomes between 150% and 200% FPL. Coverage is provided in one of two ways:

1. If the child's family has access to employer-sponsored insurance, and purchasing the coverage is cost-effective for the state, the family receives a premium assistance payment on behalf of the eligible child towards the purchase of a family policy. This is a great advantage both to the state (which in the aggregate is paying less per child than if the

insured at the time of enrollment, or was not eligible for SCHIP due to a parent's employment with the state, then the child's expenses will be claimed under the MassHealth waiver. Additionally, a child with family income below 200% FPL who is eligible to be claimed under SCHIP may also be claimed at the state's regular federal match rate under the waiver if the state exhausts its SCHIP allotment.

[23] Due to the timing of the MassHealth expansion in July 1997, Massachusetts was also able to claim 65% federal match on some children below 133% of the federal poverty level in the early years of SCHIP.

[24] MassHealth CommonHealth is also available to children in families with incomes above 300% FPL as the state's Medicaid match of 50% FFP.

child were receiving benefits directly through MassHealth) and the family (which now receives family coverage that extends to the parents as well as the child); or

2. If the child's family does not have access to employer-sponsored insurance, or purchase of the employer-sponsored insurance is not cost-effective for the Commonwealth, the eligible children may enroll directly with MassHealth. Coverage in the direct benefit under MassHealth Family Assistance is similar to that offered under MassHealth Standard, though not quite as generous.[25]

Whether a family receives a premium assistance payment towards employer-sponsored insurance, or a direct benefit into a MassHealth coverage type, the family is responsible for a portion of the monthly cost. When the program launched in August 1998, the premiums were set at $10 per child per month, with a family maximum of $30 per month. The premiums have increased only once since that time, and are now set at $12 per child per month, with a family maximum of $36 per month.

The Commonwealth quickly began using most of its annual federal SCHIP allotments because of two main factors: First, Title XXI allowed states to begin claiming for services beginning in October, 1997, for expansions that had begun after June 1, 1997.[26] Because Massachusetts implemented an expansion in coverage for children in July 1997, the Commonwealth was eligible to access SCHIP funds for certain children with incomes below 133% FPL beginning in October 1997. Second, the state was able to quickly convert in August 1998 many of the existing members of the state-funded Children's Medical Security Plan[27] into the expanded MassHealth program. Because the Commonwealth used its full SCHIP allotments, it benefited from extra dollars in redistributed funds that had initially been allocated to states that were not able to use their full allotment.

For many years, the Commonwealth had funded with all state dollars Healthy Start, a program for pregnant women with incomes below 225% of the FPL who were not eligible for Medicaid. Because the Commonwealth provides MassHealth Standard to pregnant women to 200% FPL, the women in Healthy Start are generally undocumented immigrants. As a state-funded program, Healthy Start often was not able to serve all of the women who met the program's eligibility criteria. In November 2002, the Bush Administration signaled

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[25] See 130 CMR 450.105(A) and 130 CMR 450.105(H) for the full list of services offered under each coverage type. In general, the offered benefits are identical except that non-emergency transportation and long-term care services are not available through Family Assistance.

[26] 42 U.S.C. 1397ee(d).

[27] The Children's Medical Security Plan is a state-funded program that provides all children in the Commonwealth with access to preventive health coverage. Children with family incomes above 400% of the federal poverty level must pay the full premium. If a child needs access to other service, including hospital services, and the family's income is below 400% of the federal poverty level the child may receive available services through the uncompensated care pool through the free or partial free care programs. M.G.L. ch. 118E, section 10F.

that it would approve SCHIP state plan amendments that provided coverage to "unborn children" who were not otherwise eligible for Medicaid. Many were offended by this use of SCHIP as it appeared to be a strategy to further the Administration's anti-abortion views. However, the Commonwealth saw this as an opportunity to receive 65% match for a program that had been previously funded with state-only dollars. The Commonwealth received approval[28] from CMS to begin claiming Healthy Start spending[29] as part of the SCHIP program for services provided on or after November 1, 2002.

Since 2002, the Commonwealth has received more federal match for SCHIP than was available under the Commonwealth's yearly allotment. In other words, Massachusetts has been relying on redistributed unspent funds from other states in order to fund its program. Despite increased pressure on its SCHIP allotments as the dollars available for redistribution from other states became more limited, the Commonwealth's landmark health care reform legislation in 2006 included a provision expanding SCHIP coverage of children to 300% FPL. The state implemented the expansion in July 2006. Uninsured children with family incomes between 200% and 300% FPL now are eligible to receive MassHealth Family Assistance.[30] Premiums are set slightly higher due to higher family incomes — between 200-250% of FPL, the monthly premium is $20 per child with a family maximum of $60, and between 250-300% FPL, the premium is $28 per child with a family maximum of $84.[31]

Massachusetts's SCHIP Funding Allotment Shortfall

Over 88,000 children and pregnant women currently receive their MassHealth coverage with SCHIP funding. The majority of those covered by SCHIP are children between 133 and 150% FPL and receive benefits through MassHealth Standard. In total, SCHIP funding supports approximately 18% of all children enrolled in MassHealth.[32] Table 1 provides a breakdown of SCHIP enrollment for children based on income level and a total enrollment number for pregnant women through Healthy Start.

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[28] CMS approved federal funding for the Healthy Start program to 225% of the federal poverty level, however, the Commonwealth implemented the program up to 200% FPL.

[29] For SCHIP purposes, Healthy Start spending includes claims made through the Healthy Start program as well as claims made through MassHealth Limited to provide labor and delivery as an emergency service for Healthy Start members.

[30] Unlike the population below 200% of the FPL who may be eligible for MassHealth regardless of whether they are currently insured at the time of application, children at these higher income levels are only eligible for coverage if they did not have access to employer-sponsored insurance within the last 6 months. This difference in policy is the result of two major factors: 1) the threat of crowd-out increases as a family's income increases and 2) the cost to the Commonwealth of providing premium assistance to all children whose families have incomes between 200% and 300% of the federal poverty level is not affordable, either from a state funding perspective or within the state's SCHIP allotment.

[31] See 130 CMR 506.011(J).

[32] Information provided by Massachusetts Office of Medicaid, MassHealth Enrollment Snapshot Report, February 2007.

Table 1: SCHIP Enrollment, September 30, 2006[33]

Title XXI Category	Coverage Type	Number Enrolled as of 9/30/06
SCHIP Medicaid Expansion *(133-150% FPL)*	MassHealth Standard	51,640
SCHIP Only *(150-200% FPL)*	MassHealth Family Assistance	18,942
SCHIP Only *(200-300% FPL)*	MassHealth Family Assistance	12,155
Pregnant Women *(to 200% FPL)*	Healthy Start	5,596
Total SCHIP		**88,333**

With an enrollment of over 88,000 children and pregnant women, SCHIP has undoubtedly been a huge success in Massachusetts. However, Massachusetts currently faces a funding shortfall in its SCHIP allotment. This section of the issue brief will describe historical spending of the allotment, why the state currently faces a shortfall and the intersection between SCHIP, the MassHealth waiver and Chapter 58, the 2006 health reform law.

Table 2 shows SCHIP allotments, redistributions and spending for Massachusetts over the life of the SCHIP program by federal fiscal year.[34] As the table shows, Massachusetts has received redistributed dollars in each year that they have been available. For the most part, the state has made full use of these redistributed dollars to leverage the enhanced federal funding available through SCHIP.[35]

[33] Information provided by Massachusetts Office of Medicaid, March 2007.

[34] The Federal Fiscal Year runs from October 1st through September 30th.

[35] At the end of FFY 2004, the Commonwealth lost access to just over $31 million in redistributed dollars that the state was not able to spend in the allowable time frame.

Table 2: Allotments and Spending 1998 - 2007[36]

Federal Fiscal Year	Original Allotment	Remaining Prior Allotment	Redistributions	Spending	Available Funds at Year End
1998	$42,836,231	—	—	—	$42,836,231
1999	$42,633,928	$42,836,231	—	$35,385,895	$50,084,264
2000	$48,063,710	$50,084,264	—	$44,165,148	$53,982,826
2001	$55,879,946	$53,982,826	$36,714,812	$50,255,986	$96,321,598
2002	$45,318,822	$96,321,598	$87,173,101	$59,909,653	$168,903,868
2003	$46,201,047	$168,903,868	$53,096,780	$71,635,045	$196,566,650
2004	$46,201,047	$196,566,650	$27,707,902	$119,097,274	$120,109,996
2005	$59,401,346	$120,109,996	$11,757,911	$121,467,832	$69,801,421
2006	$59,401,346	$69,801,421	$21,905,233	$151,107,863	$137
2007	$73,334,995	$137	$55,900,000	$215,894,000	($86,658,868)

Because the state operates a combination SCHIP program, the Commonwealth can easily shift funding for its Medicaid expansion population to Title XIX (Medicaid) when its SCHIP allotment is exhausted. In addition, the MassHealth waiver permits the Commonwealth to shift children with incomes between 150-200% FPL to the waiver if the SCHIP allotment is exhausted. This provides the Commonwealth with an important cushion in case its SCHIP allotment is not sufficient to meet the demand for the program.

Using Title XIX funds impacts the MassHealth waiver, however. Waivers are required to be budget neutral to the federal government — that is, the federal government will not expend any more money on the MassHealth program than it would have if the Commonwealth had retained a traditional Medicaid program. The budget neutrality calculation is quite complicated and based on many assumptions and long-term projections.[37] With the passage and implementation of Chapter 58, the state has placed great pressure on the amount of total spending that impacts the budget neutrality calculation. In addition to expanding eligibility for children through SCHIP, Chapter 58 increases pressure on budget neutrality in the waiver by:

[36] Information provided by Massachusetts Office of Medicaid, March 2007. For 2007, the Office of Medicaid estimated the $215 million in spending based on the state's projections and used an estimate by the Congressional Research Service of $55.9 million in redistributed dollars.

[37] For more detailed information on budget neutrality, see the MMPI issue brief "The Role of MassHealth "Budget Neutrality" Requirements in Designing Policies to Expand Health Coverage" available at http://www.massmedicaid.org/pdfs/Issue-Brief-budget.pdf.

1. Providing significantly higher Medicaid rates to hospitals and physicians,
2. Providing actuarially "high" rate payments to certain Medicaid managed care organizations (MCO)[38],
3. Providing additional benefits for MassHealth members, including dental benefits for adults,
4. Increasing income eligibility for the Insurance Partnership to 300% FPL, and
5. Increasing the MassHealth Essential enrollment cap from 44,000 to 60,000.

These changes to the MassHealth program in Chapter 58, in addition to the creation of Commonwealth Care[39] and an individual mandate for insurance coverage (which is likely to increase take-up rates by those eligible for MassHealth programs), reduce available room in the waiver's budget neutrality calculation. In addition, the recent federal court decision in *Rosie D. v. Romney* may put further pressures on the budget neutrality calculation.[40] These factors result in the potential for a difficult waiver renewal negotiation with CMS over the next year.

Table 2 shows that the Commonwealth only had $137 in remaining allotment at the beginning of federal fiscal year 2007. In fact, the Commonwealth had a small shortfall in FFY 2006 and shifted $11.4 million in total spending to the MassHealth waiver in order to claim federal match on the entire SCHIP program in that year. As noted above, as a Medicaid expansion program, the Commonwealth is able to receive federal dollars at its Medicaid match rate if SCHIP dollars are unavailable.

Despite the infusion of $33.6 million in additional funds through Congressional action in December 2006[41] to push back the dates on which shortfall states would run out of SCHIP funding, the Commonwealth still has an approximately $87 million funding gap in FFY 2007

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[38] In addition to the creation of Title XXI, the Balanced Budget Act of 1997 also introduced a requirement that Medicaid payments to managed care organizations fall within an "actuarially sound" rate range. Chapter 58 includes language requiring the state to pay its MCOs at the high end of the range.

[39] Created as part of Chapter 58 and launched in October 2006, Commonwealth Care provides individuals with incomes at or below 300% FPL who are not eligible for MassHealth with access to health coverage. Eligible individuals receive coverage through a choice of the four Medicaid managed care organizations. Individuals with incomes above 100% FPL are required to pay a sliding-scale premium towards their coverage. Funding for Commonwealth Care comes from the waiver's Safety Net Care Pool.

[40] In *Rosie D v. Romney et al*, the federal court found that the Commonwealth was not providing medically necessary services to children with serious emotional disturbance. The Court recently entered an order incorporating the Commonwealth's remedial plan. It is likely that implementation of the Court's order will add significant dollars to the MassHealth budget.

[41] See H.R. 6164. Enacted January 15, 2007. In addition to redistributing unspent 2004 dollars, this provision also reduces the amount of time states have to spend their 2005 allotments. A state that has not used its 2005 allotment by March 31, 2007 will lose that funding to redistribution. See Edwin Park and Matthew Broaddus, *Fourteen States Face SCHIP Shortfalls This Year Totaling Over $700 Million*, Center on Budget and Policy Priorities, February 22, 2007.

between the amount of SCHIP funding it could claim based on current spending and the amount available in the state's allotment.[42]

Implications of This Year's Funding Shortfall

If Congress does not act to fill the funding shortfall for SCHIP, there will be financial implications for the Commonwealth and the potential need for programmatic changes. As described above, the Commonwealth may shift significant spending from SCHIP to Medicaid for purposes of claiming federal match if the SCHIP allotment is exhausted. In addition, Massachusetts could claim the emergency service expenditures for the Healthy Start population, including the cost of labor and delivery, to the Medicaid program. There are two downsides to such claiming:

1. Medicaid claiming is at a match rate of 50% rather than the enhanced SCHIP rate of 65%, which would result in a $20M revenue loss for the Commonwealth; and
2. Any claiming done through the Medicaid program is unexpected spending against the Commonwealth's already very tight budget neutrality cushion in the MassHealth Waiver. Though the Commonwealth likely has sufficient budget neutrality room in FFY07 to claim this spending and receive federal Medicaid match for these expenses under the waiver, it increases the Commonwealth's budget neutrality difficulties as part of the upcoming waiver renewal negotiations by an estimated $130 million.

A failure of Congress to act quickly on this year's shortfall will certainly complicate waiver renewal negotiations for the Commonwealth and raises questions about the Commonwealth's ability to sustain all of the coverage and benefit expansions gained through Chapter 58. Waiver renewal documents, including budget neutrality estimates, may be due to CMS as early as July 1, 2007. It is in the Commonwealth's interest to have the SCHIP funding shortfall for FY07 fully resolved prior to the start of those negotiations.

Despite the state budget and budget neutrality implications of a funding shortfall this year, it is unlikely that the Commonwealth would attempt to take any action to freeze enrollment at current levels or make significant changes to the populations and benefits served through the program. Coverage of children to 300% FPL is an essential part of the health care reform equation. But without benefit or payment cuts, or the imposition of an enrollment cap, the Commonwealth will need to move some spending to the MassHealth waiver or be fully

[42] The $87 million shortfall is based on an assumption of $55.9 million in redistribution monies in this fiscal year. The redistributed dollars are made up of the redistribution of FFY 2004 allotments that Congress made available in December to the seven states facing the greatest shortfall. Massachusetts received $33.6 million in federal allotment. The remainder of the $55.9 million is expected in the redistribution of unspent FFY05 allotments, which is expected to occur shortly.

responsible for all SCHIP expenditures in excess of the federal allotment cap. The Commonwealth may need to consider significant refinements to its overall coverage strategy, however, if the reauthorization of SCHIP for FFY 2008 and beyond does not result in sufficient funding to cover the Commonwealth's program as currently configured.[43]

The Reauthorization Debate is Underway

Since Congress convened in January, the dialog and debate has heated up on SCHIP reauthorization. Prior to dealing with SCHIP reauthorization, however, Congress is being pressed to deal with the SCHIP funding shortfalls of nearly $750 million that have been reported in 14 states[44] for this current federal fiscal year. At least one state, Georgia, has stopped new enrollment in its SCHIP program, PeachCare, due to its shortfall.[45] Most others are waiting to see if Congress will act — under the assumption that they won't be able to say no to children, especially when universal coverage is currently part of the political debate. As this issue brief goes to print, both branches of Congress have included a fix for the shortfall states in a supplemental appropriations bill for the Iraq war. Conference committee is working on a compromise bill that is expected in late April. However, it is not assured that this bill will become law.

The Bush Administration helped to ignite the SCHIP reauthorization debate by funding the program at $5 billion in its proposed FY08 budget. This is well short of the projected spending for coverage of all current enrollees during the next federal fiscal year.[46] The Administration contends that, as implemented, SCHIP has gone beyond the initial intent of the statute.[47] This position quickly focuses the reauthorization debate on two central issues:

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[43] Once the Commonwealth has a clear picture of what will be available annually for the SCHIP program, policymakers will need to determine whether there is sufficient funding in the state's SCHIP allotment to cover children to 300% of the federal poverty level and pregnant women who would otherwise qualify for Medicaid but for their immigration status. If there are not sufficient funds expected in the SCHIP allotment, and the state remains committed to covering children with incomes to 300%, the state may need to anticipate using greater portions of Title XIX funding to cover its Medicaid expansion population. With those children being funded through the waiver, the state, depending on how favorably CMS acts upon the state's waiver renewal request, may need to take steps to remain budget neutral — including reducing or eliminating special payments to safety net providers, reducing covered benefits, or capping eligible populations. The MassHealth waiver details what spending will be eliminated first in the event the waiver is not budget neutral and the state decides to curtail spending.

[44] The states facing funding shortfalls in this federal fiscal year include Alaska, Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, Rhode Island and Wisconsin.

[45] Georgia is one of four stand-alone SCHIP programs facing a funding shortfall. As a stand-alone program, Georgia cannot access federal funding to cover the shortfall through its Medicaid program.

[46] The Congressional Budget Office projects a $13 billion shortfall in SCHIP funding over the next five years if the annual total allotments remain constant. Congressional Budget Office, "Fact Sheet for CBO's March 2007 Baseline: State Children's Health Insurance Program," February 23, 2007.

[47] The Administration's FY08 budget would limit SCHIP coverage to children with family incomes at or below 200% FPL. See Kaiser Daily Health Policy Report, February 6, 2007; accessible at www.kaisernetwork.org/daily_reports.

1. whom should SCHIP be covering?
2. how should the funding be distributed to states?

There also is some potential for discussion of the type of coverage offered through SCHIP. In addition, many in Congress have proposed using SCHIP reauthorization as an opportunity to expand access to the uninsured generally. Following is a discussion of each of these potential issues.

Whom Should SCHIP Cover?

Title XXI was enacted with the clear purpose of providing a means of coverage for uninsured children with family incomes too high to qualify for Medicaid. Initial implementation by states of SCHIP programs focused solely on that goal. However, possibly due to the slow start-up nationally of drawing down SCHIP allotments and large redistributions to interested states, CMS began allowing SCHIP to be used to cover populations other than those for whom the program was initially intended. Eight states used SCHIP waivers to provide coverage to parents of Medicaid or SCHIP eligible children.[48] Five states used waivers to provide coverage through SCHIP for childless adults. CMS championed the use of SCHIP to provide coverage to the "unborn child". Massachusetts and ten additional states took advantage of that provision to receive federal match for existing state-funded programs covering undocumented pregnant women.

As more and more states use their full allotments, however, the ability for the SCHIP allotments to cover even those within the statute's original intent is strained, even before taking into account the additional populations. A key question in the reauthorization process is whether to continue to allow SCHIP spending for populations that do not fit squarely within the statute, and, if any such spending should continue, whether the statute should specify target groups for expansion.

The issue is an important one to Massachusetts. As discussed above, the Commonwealth began claiming SCHIP funding for its Healthy Start program in November 2002. In FY07, spending for this relatively small (nearly 5,600), but expensive, group of pregnant women is projected to account for nearly $72 million and 21.5% of the Commonwealth's total SCHIP spending.[49] If Congress limits SCHIP spending specifically to children and excludes coverage of the "unborn child" as part of that limitation, the Commonwealth stands to lose

[48] Some studies have shown that providing parents with the opportunity for coverage greatly enhances the chance that an eligible child will be enrolled in a publicly funded health program. See, e.g., Leighton Ku and Matthew Broaddus, *Coverage of Parents Helps Children, Too*, Center on Budget and Policy Priorities, October 2006.

[49] For purposes of SCHIP, Healthy Start includes both spending for coverage received under the Healthy Start program administered for the Commonwealth by Unicare and labor and delivery costs provided through MassHealth Limited.

approximately $47 million per year in enhanced match under SCHIP.[50] However, the Commonwealth would still be able to claim approximately $30 million in federal revenue for the labor and delivery costs that may be claimed as an emergency service under Title XIX. Given the Commonwealth's current allotment shortfall, using SCHIP as a source of federal revenue for the Healthy Start program may be an issue for the state going forward depending on the outcome of the funding discussion. As the Commonwealth previously provided Healthy Start at full state expense, there will be an expectation that this program continue whether or not federal funds remain available.

Alternatively, if Congress explicitly allows SCHIP to be used to expand coverage to include populations other than children, it is possible that CMS may allow Massachusetts to move some portion of its parent or childless adult populations and claim enhanced FFP for the costs of those members. In addition to giving the Commonwealth access to enhanced federal match for these populations, it would also decrease the budget neutrality pressures that the Commonwealth faces in the MassHealth waiver. However, given the current spending shortfall, the Commonwealth would only be able to take advantage of enhanced match for these populations to the extent that the funding formula is similarly revised to reflect such additional spending needs.

The Funding Dilemma

The SCHIP program faces a serious funding dilemma on two fronts — first, how much funding is available to states as a whole and, second, how will it be distributed to states on an annual basis.

In its initial design, federal funding for the SCHIP program, unlike Medicaid, was set at a specified dollar amount. As the reauthorization debate begins, there are differences of opinion as to what level of funding should be committed to SCHIP. President Bush proposed keeping SCHIP growth flat over the next 5 years at $5 billion per year. Congress, on the other hand, has included a $50 billion reserve fund for the program over the next five years in both the House and Senate budget resolutions. Once Congress settles on a number, it will be easier to determine how an appropriate funding formula could be designed. Though the parties may disagree on the level of funds available, it seems unlikely that Congress would remove the "block grant" feature of the SCHIP program despite the fact that each time there have been funding shortfalls, Congress and the Administration have jumped in to resolve the shortfall and continue coverage.

[50] Information provided by Massachusetts Office of Medicaid, March 2007.

Under the Title XXI funding formula, states are provided allotments based on a complicated formula that attempts to balance the number of uninsured children and total number of low-income children. However, state allotments can be increased by redistributions from states that do not spend their full allotments. For the most part, states are unhappy with the current allotment structure. Many believe that the Current Population Survey (CPS) data does not accurately reflect the number of uninsured in the state or the true costs to run an SCHIP program. In addition, as SCHIP matures, using a funding formula that is based on the state's number of uninsured children gets more complicated, as the number of uninsured children falls with the increasing success of SCHIP to cover children, and thereby reduce the number of uninsured children identified through CPS.

While there is general consensus on the need to revamp the funding formula as part of reauthorization, not surprisingly, there is little consensus on how to do so. Any change to the funding formula will create winners and losers. That makes it difficult for organizations such as the National Governors Association or the National Association for State Medicaid Directors to support specific proposals.

The outcomes of both of these funding discussions are of the utmost importance to all states. If there are no changes to the level of funding as part of reauthorization, then by 2012 the majority of states are projected to join Massachusetts and the other states now experiencing an SCHIP shortfall.[51] This may be true even if Congress limits coverage under SCHIP to children. If there is no fix to both the level of available funding and the annual allotment formula, many states will need to make difficult decisions about how to modify their current programs to live within the available allotments. A state may decide to contribute more state money, shift some SCHIP members to Medicaid and forego the enhanced rate, or reduce either the number of people served or the types of benefits offered, or both. Given that the allotment funding method is likely to remain, Massachusetts may want to attempt to build in room to cover some portion of the Medicaid expansion population under its MassHealth waiver renewal or make state-only funds available to allow for stability within the program over the long term.

On the other hand, if Congress makes the decision to devote more resources to the SCHIP program, because of the recently revived "pay-go" rules[52], it may still have a negative impact on states through cuts in other programs. It is important that any additional SCHIP funding increases not result in a decrease in federal spending on the Medicaid program. It is also

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[51] See Matthew Broaddus and Edwin Park, *Freezing SCHIP Funding In Coming Years Would Reverse Recent Gains In Children's Health Coverage*, Center for Budget and Policy Priorities, February 2007.

[52] Pay-go rules require that when adding spending to the budget, that an equal amount of savings must be found somewhere else within the budget in order to offset the increased costs.

important that other health and human service programs for which federal funds are available are not harmed. One item often mentioned as a potential trade-off for SCHIP spending is a decrease in payments to Medicare Advantage plans.[53]

Benefit Design Issues

Despite the concern that SCHIP be funded appropriately, there are some stakeholders that would like to expand available benefits in the program. Title XXI currently limits SCHIP programs to be used to provide comprehensive coverage plans only. SCHIP may not be used to provide limited service packages (e.g., dental benefits). Some have suggested that SCHIP be amended to allow states to offer such packages in addition to the comprehensive coverage plans.[54] If amended to allow limited service packages, Massachusetts would face enormous pressure to offer limited benefit packages, such as a dental benefit, to those who are not able to purchase such a plan through their employer. However, the cost of implementing such a benefit may be prohibitive, both based on availability of funding the state share of the cost as well as the available federal allotment to the state.

In addition, some stakeholders are advocating for SCHIP to include an EPSDT requirement like Medicaid. While it would provide a greater level of coverage for children than exists under SCHIP today, it would also place greater financial pressures on state SCHIP programs and could negatively affect the state legislature's willingness to expand coverage to higher income levels.

Missing from the debate to this point is a discussion of the potential need for specific quality standards and measurement within SCHIP. Over the past several years, various groups have focused on pursuing a specific quality agenda for coverage of children through public programs. States do measure quality within their programs to varying degrees and with differing measures. SCHIP reauthorization may be an opportunity for requiring the development of standard performance measures. [55]

SCHIP Expansion Potential

Following action in Massachusetts and several other states to take steps to provide access to health coverage for all residents, the universal health coverage debate is once again heating up

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[53] See Ricardo Alonso-Zaldivar, *Insuring children may squeeze seniors*, Los Angeles Times, March 26, 2007.

[54] Representative Dingell has introduced a bill that would amend SCHIP to require dental coverage as part of its benefit package and allow states to provide a limited dental package as a "wrap" to private insurance. See H. R. 1781.

[55] As this issue brief went to print, The Commonwealth Fund published a survey in which a majority of health care leaders expressed support for raising SCHIP quality standards. "Health Care Opinion Leaders' Views on Priorities for SCHIP Reauthorization." http://www.cmwf.org/publications/publications_show.htm?doc_id=479296.

in Washington. Many Democrats in Congress, and some Republicans, have signaled that SCHIP may be a vehicle for expansion action on the federal level. On the one hand, because the SCHIP reauthorization itself is practically guaranteed, it may seem like an easy vehicle to attach greater expansion legislation. However, there is risk in taking that route in that it may delay reauthorization of SCHIP beyond its statutory expiration date of September 2007, particularly since the White House has voiced its opinion that SCHIP coverage should be restricted to those with incomes at or below 200% FPL.

Prior to determining whether SCHIP reauthorization is the appropriate vehicle for congressional action on health care coverage, it is important first to determine the available funding for the program to gauge the amount of additional beneficiaries, if any, that may be added to the program. It is also important with any expansion for Congress to consider the sustainability of the program in the long run and consider potential cost containment requirements.

Conclusion

Congress must reauthorize SCHIP before it expires on September 30, 2007. The potential for changes to the program and uncertainty regarding the available funding makes it difficult for states to consider the shape of SCHIP programs going forward.

In Massachusetts, the SCHIP program is integrally linked with the MassHealth waiver and Chapter 58. Timely SCHIP reauthorization and sufficient funding for the program is essential. Without it, the Commonwealth will have a more complicated MassHealth waiver renewal negotiation with CMS and will face questions on its ability to continue to fund all aspects of the state's landmark health reform.

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