



**THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM:  
PAST, PRESENT, AND FUTURE**

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**ABSTRACT:** The reauthorization for the State Children's Health Insurance Program (SCHIP) is set to expire at the end of fiscal year (FY) 2007. SCHIP—broadly considered a success—has expanded health insurance for low-income children through federal–state and public–private partnerships. Reauthorization—which has historically been a chance to review, refine, and revamp programs—along with general concerns about the health system have put policy affecting children's health coverage at the top of the list of legislative priorities for the 110th Congress. This report reviews the program's history and design, describes its present challenges and successes, assesses issues Congress is likely to consider during reauthorization, and explores future policy options including potential changes in eligibility and financing.

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## EXECUTIVE SUMMARY

At the end of fiscal year (FY) 2007, congressional authorization for the State Children's Health Insurance Program (SCHIP)—widely considered a success for expanding health insurance for low-income children—is set to expire. The reauthorization process has historically been a chance to review, refine, and revamp programs. For SCHIP, the process will take place at a time when the uninsured rate for children is once again on the rise, budget pressures are leading to constraints on publicly financed coverage, and general concerns about the health system are growing.

This report examines the policy options that may be considered for SCHIP in 2007. It describes how eligibility, benefits, and financing might be modified in reauthorization. It also includes a review of the program's history, goals, and performance, and concludes with a discussion of the policy and political implications of change.

### **Past: History and Design of SCHIP**

SCHIP was created in 1997 to insure children in families with too much income to qualify for Medicaid and too little to afford private insurance. It emerged from a budget negotiation between a Democratic president and Republican Congress. As such, the program represents a fine balance, designed to maintain equilibrium between states and the federal government, as well as between political conservatives and liberals. It contains elements of both an entitlement program and a block-grant.

States have the option of providing child health assistance in SCHIP through Medicaid, a separate program, or a combination of the two. There is also flexibility in benefit design, though benefits must meet certain set standards. As in Medicaid, state payments for child health assistance under SCHIP qualify for federal matching payments. On average, the federal government pays 70 percent and state governments pay 30 percent of program costs. Unlike Medicaid, however, these enhanced federal matching payments are limited by national and state-specific "allotments," or annual limits on federal funding. SCHIP has a system to redistribute federal allotments from states that did not spend the full amount to others that may need higher amounts. States may use up to 10 percent of their annual allotments on outreach, administration, and other activities.

### **Present: Achievements and Challenges**

A federally funded evaluation found SCHIP to be successful in nearly all of the areas examined. Since inception in 1997, enrollment has increased steadily to 6.1 million children in FY 2005. This was complemented by a 6.8 million increase in children enrolled

in Medicaid from 1997 to 2004. As a result, between 1997 and 2005, the percentage of low-income, uninsured children dropped from 22.3 percent to 14.9 percent. Despite gains in coverage, about 9 million children under age 19 were uninsured in 2005, and many were eligible for public programs. Enrollment barriers and misunderstandings concerning eligibility are two of the major reasons for their lack of enrollment.

Relative to uninsured children, children enrolled in Medicaid or SCHIP reported much lower unmet health care needs (2% vs. 11%). Uninsured children who gained coverage through SCHIP received more preventive care; in addition, their parents reported better access to care and better communications with providers. One evaluation found that children who were uninsured and gained coverage through Medicaid or SCHIP had fewer asthma-related attacks after enrollment (3.8 versus 9.5 attacks), with significant improvements in quality of care.

The funding structure for SCHIP is both successful and flawed. It has succeeded in meeting its goal of encouraging state expansions while limiting federal liability, with a matching rate sufficient to encourage all states to expand coverage. However, the program's success in enrolling children has come up against its federal funding limits. Congress has acted six times in SCHIP's brief history to modify the program's rules.

### **Future: Major Issues in SCHIP Reauthorization**

Three major questions are likely to be contemplated by Congress.

*Who should SCHIP cover?* One option is to concentrate on enrolling those children who are already eligible for the program. While roughly two-thirds of eligible children participate, millions more could be signed up. The task of enrolling eligible children is made more difficult by concerns about “crowd out,” which occurs when public coverage substitutes for private coverage. To limit this, SCHIP requires that children be uninsured prior to joining SCHIP. Burdensome enrollment and re-enrollment policies have proven to be impediments. From a state's perspective, the most significant barrier to outreach may be cost.

Congress could also change who is eligible for SCHIP. It could eliminate the exclusion of children who are income-eligible but otherwise barred from participating in SCHIP, like immigrant children or children of state employees. It could also open SCHIP to all uninsured children, regardless of income. In fact, some children's health advocates believe Congress should use SCHIP as a means to achieve universal coverage for children.

*What coverage should children receive?* Currently, coverage must meet either the legislation’s benchmarks or the approval of the Secretary of Health and Human Services. State SCHIP directors have expressed a desire for greater flexibility to implement partial benefit packages. States would also like the option to design packages that wrap around other coverage and fill in gaps. The original SCHIP legislation included an option for states to subsidize employer-based family coverage for eligible children if such coverage meets certain rules. But these rules, which include minimums for benefits and the employer contribution, are considered onerous by states; consequently, few states have implemented premium-assistance programs.

There are also concerns over substandard benefits in SCHIP and out-of-pocket costs that limit access to care, particularly for special-needs children and other vulnerable populations. Concerns have also been raised that SCHIP has failed to address emerging health threats like childhood obesity. In terms of quality improvement, SCHIP and Medicaid have made progress, but more remains to be done.

*How should SCHIP be financed?* A number of options exist for extending, modifying, or overhauling SCHIP’s financing structure. Three options likely to be considered by Congress are:

- *Making better use of existing funding.* Congress could target or even restrict the use of SCHIP funding to low-income, uninsured children—the program’s core population. Limiting states’ use of allotments for higher-income children and other populations like low-income adults would increase the amount of the existing federal funding available to cover low-income children populations. However, this would create tension among states, since limited funds are redistributed; it would also run counter to the theme of state flexibility in SCHIP.
- *Making improvements within the current structure of SCHIP.* When it reauthorizes SCHIP, Congress could mitigate problems that have emerged, for example, by refining the formula for allocating and redistributing funds. Congress, alternatively, could raise the overall level of federal funding, increasing the total allotment to keep pace with medical inflation, projected enrollment growth, or national health expenditure growth. If the new federal funding is not sufficient for an allocation that meets all states’ needs, then the current allotment and redistribution formula concerns will persist.
- *Changing SCHIP’s financing structure.* The federal spending limit on SCHIP could be changed to accommodate enrollment increases, or it could be lifted altogether. In addition, creating one federal matching rate for Medicaid and SCHIP programs



would limit the incentive to enroll children into the program with the higher federal funding. It would also encourage states to encourage enrollment in Medicaid as well as SCHIP. Major changes in SCHIP's funding structure would likely raise concerns about the federal budget exposure as well as the elimination of SCHIP's block-grant feature.

### **Conclusions**

The challenges of expanding and improving children's health insurance are serious but surmountable, as proven by the original passage of SCHIP. Regardless of outcome, the debate over SCHIP reauthorization will offer an opportunity to reassess health coverage priorities and approaches. The balance of federal and state governance, the relative roles of public and private insurers, the definition of coverage, and the public's willingness to pay for results will be reviewed, argued, and potentially resolved in SCHIP reauthorization. This will not only affect the health insurance coverage for millions of low-income children, but will inform future debates over improving the coverage system for all Americans.



# **THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PAST, PRESENT, AND FUTURE**

## **INTRODUCTION**

Children's health insurance coverage has leapt to the top of the nation's policy agenda for several reasons. First, the authorization for the State Children's Health Insurance Program (SCHIP) is set to expire at the end of fiscal year (FY) 2007. SCHIP—broadly considered a success—has expanded health insurance for low-income children through federal–state and public–private partnerships. Reauthorization has historically been a chance to review, refine, and revamp programs. Second, the rate of uninsured children in 2005 rose for the first time since SCHIP's implementation, as several states have experienced shortfalls in federal funding and budget pressures have caused others to scale back coverage. Third, general concerns about the health system have spurred interest in major coverage expansions, with some attention focusing on populations like children.

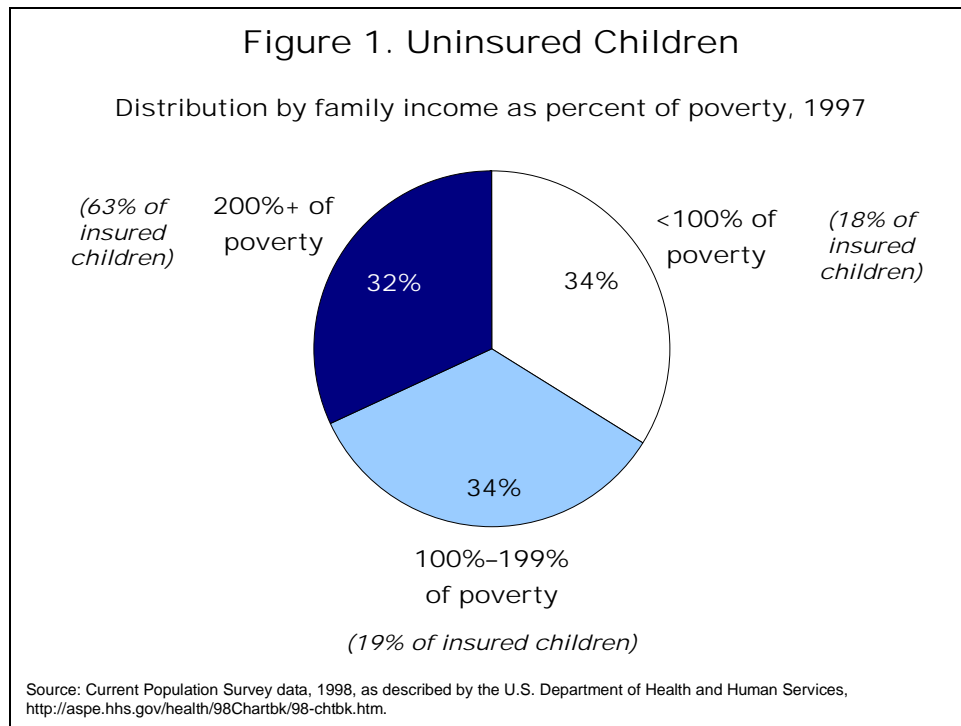
This report examines the policy options that may be considered for SCHIP in 2007. Specifically, it describes how eligibility, benefits, and financing of this popular program might be modified in reauthorization. These options are placed into context with a review of the program's history, goals, and performance. In concluding, the report discusses the policy and political implications of options regarding SCHIP reauthorization.

## **PAST: THE HISTORY AND DESIGN OF SCHIP**

Created in 1997, SCHIP symbolized both the end of years of effort to expand coverage and a new approach to insuring low-income children. Proposals to expand health insurance for children date back three decades. In 1977, President Carter announced the Child Health Assessment Program to increase federal funding and coverage for poor children.<sup>1</sup> Budget legislation in 1989 and 1990 phased in Medicaid coverage for all children in poverty, as well as children under age 6 whose family's income was below 133 percent of the federal poverty level (P.L. 101-239; P.L. 101-508).<sup>2</sup>

States were also given, and took advantage of, Medicaid options and demonstration waivers to extend coverage to children—and sometimes parents—at higher income levels. For example, Minnesota was insuring children up to 275 percent of the poverty level prior to the passage of SCHIP. In 1997, an estimated 21 million children were already enrolled in Medicaid.

SCHIP was shaped by the aspirations and compromises of its key authors. President Clinton made it a centerpiece of his second-term agenda. In so doing, he set his sights on children in families with too much income to qualify for Medicaid and too little to afford private insurance (roughly 100%–200% of poverty)—a group disproportionately uninsured in 1997 (Figure 1). His interest encouraged members of Congress to consider options to expand coverage. Most notably, Senators Orrin Hatch (R-Utah) and Ted Kennedy (D-Mass.) proposed a large block grant for comprehensive coverage (S. 525, 105th Congress), while Senators John Chafee (R-R.I.) and Jay Rockefeller (D-W. Va.) suggested expanding Medicaid (S. 674, 105th Congress). These proposals illustrate the disagreements among Democrats, as well as across the two parties, on the approach to coverage expansion—which made developing a consensus difficult.



The political balance of power was another critical force shaping the legislation. SCHIP was part of a larger negotiation between a Democratic president and Republican-led Congress over a bill to balance the budget (P.L. 105-33). Major Medicare, Medicaid, and tax policies were also at play. While President Clinton won certain of his priorities on children’s coverage through concessions on these other policies, the Republican Congress left a significant imprint on the program’s funding structure and benefit design. As such, the design of SCHIP that emerged in 1997 may be described as a fine balance—hard wrought but designed to maintain equilibrium between states and the federal government as well as political conservatives and liberals. (See Appendix for state-specific program information.)

## **Eligibility**

SCHIP's stated goal is to provide "child health assistance to uninsured, low-income children in an effective and efficient manner..." (42 U.S.C. 1397aa). Eligibility is based on a mix of federal targets and state flexibility. The statute allows federal funding for health assistance for children under age 19 in families with income below 200 percent of the federal poverty level (\$40,000 for a family of four in 2006). For states that had already expanded coverage to children as of enactment, this eligibility limit could be as much as 50 percentage points higher than their Medicaid limit.<sup>3</sup> States must have rules in place to target uninsured children rather than already-insured children to avoid "crowd out," which occurs when private coverage substitutes for public coverage. They must also screen children for eligibility under Medicaid and enroll them if they are determined to be eligible.<sup>4</sup>

Within these and other federal parameters, states may set their own eligibility rules, including income and, in some cases, assets levels that count toward eligibility. In 2006, 28 states set upper-income eligibility limits at 200 percent of the poverty level; eight states had lower eligibility limits while 15 states had higher eligibility limits.<sup>5</sup>

## **Structure**

A compromise was struck between those advocating for an entitlement program versus a block-grant structure. States have the option of providing child health assistance in SCHIP through Medicaid, a separate program, or a combination of the two. States opting for Medicaid extend their existing benefits and delivery systems to children in families with higher income. Because Medicaid guarantees coverage to children who are eligible, children in states that use Medicaid for SCHIP would remain eligible for coverage even if SCHIP funding runs out (Medicaid funding remains available at its lower matching rate). States opting for separate programs may adopt different benefits packages and delivery systems for targeted, low-income children, subject to standards (described below). Children in separate programs are not entitled to coverage; states may impose waiting lists if federal SCHIP funding is no longer available. In 2006, 11 states and the District of Columbia had Medicaid SCHIP programs, 18 states had separate programs, and 21 states had a combination of the two.<sup>6</sup>

## **Benefits**

While SCHIP offers flexibility in benefit design in separate, non-Medicaid programs, benefits must meet certain standards. States can offer: 1) "benchmark coverage," a package substantially equivalent to the Federal Employee Health Benefits Program (FEHBP)'s Blue Cross/Blue Shield Standard Option, a state health employees plan, or the most popular

HMO in the state; 2) “benchmark-equivalent coverage,” meaning a plan with an aggregate actuarial value no less than a benchmark plan; 3) existing comprehensive coverage, the option in place in states that had expanded coverage prior to SCHIP; or 4) Secretary-approved coverage, which could include the Medicaid package.

Certain services are required in states that opt for benchmark-equivalent coverage (e.g., well-child care and certain levels of drug coverage). All alternative benefits packages must limit cost-sharing and premiums. Specifically, cost-sharing for children in families with income below 150 percent of the poverty level must be nominal, while cost-sharing (including premiums) cannot exceed more than 5 percent of income for other families. Recent legislation gave states cost-sharing options for children optionally covered through Medicaid (P.L. 109-171). In 2003, 21 states had Secretary-approved plans (including Medicaid packages), 14 states used benchmark plans based on state employee plans, four used the largest HMO, and four used the federal employees’ plan.<sup>7</sup>

### **Financing**

The last major compromise in SCHIP is its financing structure. Like Medicaid, payments for child health assistance under SCHIP qualify for federal matching payments. To encourage states to participate in this voluntary program, policymakers set each state’s “enhanced” federal matching rates at 30 percentage points above 70 percent of their Medicaid matching rate, with an upper limit of 85 percent. On average, the federal government pays 70 percent and state governments pay 30 percent of program costs. This is higher than the federal matching rate for Medicaid, which average 57 percent. Unlike Medicaid, SCHIP matching payments are subject to annual, state-based caps. The law included specific limits for aggregate, annual federal program payments for FY 1998 through FY 2007, cumulating in \$39 billion over this period. The annual federal limit is divided into state allotments. The allotments limit all federal matching payments for SCHIP expenditures. For FY 2007, the total amount available for allocation to states is \$5 billion.

The annual federal limits for SCHIP are allocated to states based on two factors: each state’s “number of children” and “state cost factor.” The number of children is an equal blend of the number of uninsured children with the overall number of low-income children in the state. The state cost factor takes into account geographic variation in wages. The law includes floors and ceilings to limit variation in state-specific allotments from year to year.<sup>8</sup> Allotments may be used for the current fiscal year and two subsequent years if unspent. In FY 2005, the smallest state allotment was \$5 million (Vermont) and the largest was \$667 million (California).

SCHIP has a system to redistribute federal allotments from states that did not spend the full amount to others that may need higher amounts. Funds from annual allotments that have not been spent within three years qualify for redistribution. The original redistribution formula divides the total amount of unspent allotments among shortfall states or states that have spent their existing allotments. Redistributed funds are available for one year, and unspent redistribution funds revert to the Treasury.<sup>9</sup>

In certain years, Congress allowed states to retain their allotments longer than three years and limited the amount redistributed in an effort to keep unspent money in the system.<sup>10</sup> This recycling meant that, prior to FY 2006, states generally had sufficient funds to continue coverage even though some states' annual allotments were less than annual spending. However, because program spending growth has outstripped that of the total federal allotment, the amount available for redistribution has dropped. In FY 2006, 38 states' annual spending exceeded their annual allotments.<sup>11</sup> The amount available to redistribute from FY 2003 unspent funding was insufficient to continue federal funding for existing programs, causing Congress to include \$283 million in the Deficit Reduction Act of 2005 (P.L. 109-171) to fill in these shortfalls. In FY 2007, an estimated 17 states face shortfalls, some of which were filled by changes in the redistribution formula in legislation passed by Congress in December's lame-duck session (P.L. 109-432).<sup>12</sup>

### **Outreach**

SCHIP emphasizes outreach to raise awareness and enrollment in the program. States are allowed to use up to 10 percent of their annual allotments on outreach, administration, and other health-related activities. Through guidance and policies enacted in 1999 and 2000, the federal government has encouraged the simplification of the processes for eligibility determination (e.g., short, mail-in applications with no asset test) and redetermination (e.g., longer times between initial eligibility and redetermination). This was complemented by public and private efforts to raise awareness among parents of potentially eligible children. Both the Clinton and Bush Administrations have supported efforts to use social marketing, toll-free numbers, and other means of promoting enrollment. This has been augmented by private efforts, most notably that of the Robert Wood Johnson Foundation, which spent nearly \$150 million through its Covering Kids and Families initiative to promote enrollment of children and their parents.

The simplification and outreach efforts for SCHIP were also applied to Medicaid. Between 1997 and 2005, the number of state Medicaid programs with no required face-to-face interviews increased from 22 to 45 and the number that dropped asset tests rose from 36 to 47.<sup>13</sup>

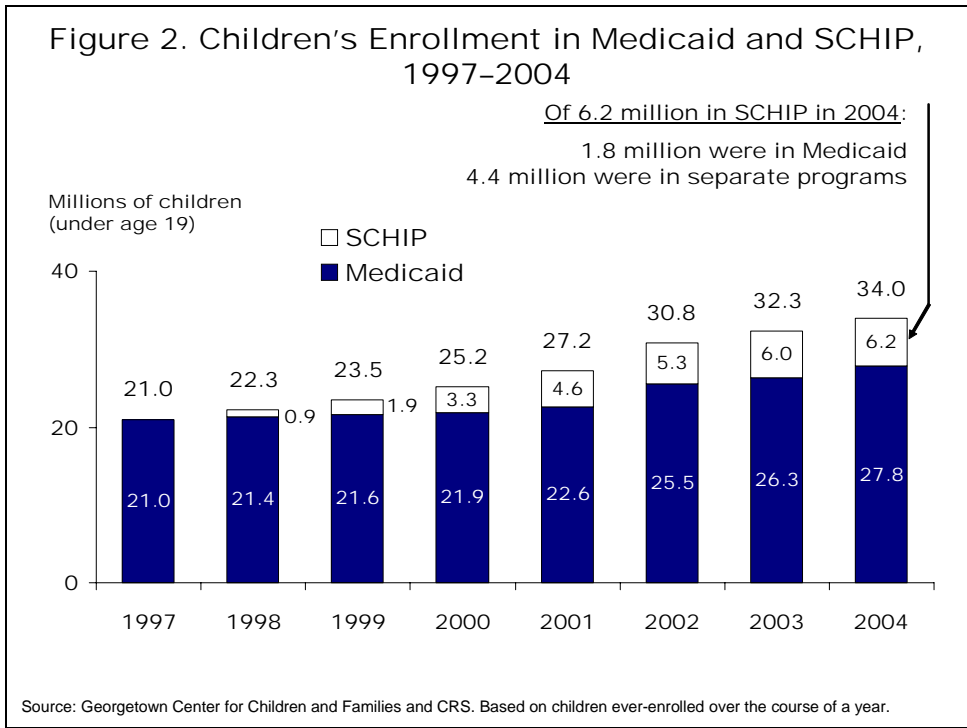
## **PRESENT: ACHIEVEMENTS AND CHALLENGES**

SCHIP, which is about to turn 10 years old, has undergone several assessments to measure how well it has been meeting its goals. A federally funded evaluation concluded: “This congressionally mandated evaluation found SCHIP to be successful in nearly all of the areas examined.”<sup>14</sup> The White House’s 2003 review found the program had high scores in purpose, design, and planning (exceeding 80%), with lower scores on program management and accountability.<sup>15</sup> State program directors generally have few concerns about the program<sup>16</sup> and political support in Congress is strong.<sup>17</sup> This section reviews SCHIP’s impact on coverage, access, and quality, and reviews its performance on financing.

### **Impact on Children’s Coverage**

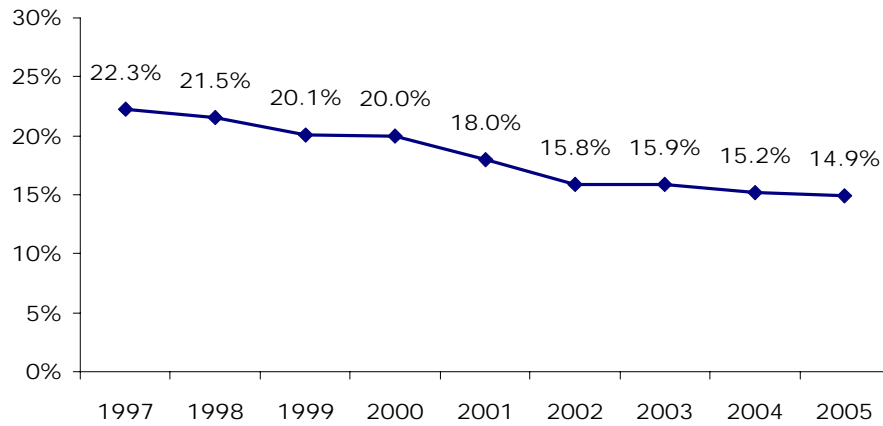
The primary goal of SCHIP is to expand health coverage to low-income children. Since the program began in the fall of 1997, enrollment increased steadily to 6.1 million children throughout FY 2005. Within total enrollment, 4.4 million children were enrolled in separate programs while 1.7 million were in Medicaid-based SCHIP.<sup>18</sup> The increase in SCHIP enrollment was complemented by a 6.8 million increase in Medicaid enrollment of children from 1997 to 2004 (Figure 2). A number of factors contributed to this rise. The same law that created SCHIP also allowed states to simplify and extend eligibility for children in Medicaid. Outreach for SCHIP had spillover effects on Medicaid. One study estimated that eligible children’s participation in Medicaid rose from 74 percent in 1997 to 82 percent in 2002.<sup>19</sup> In addition, during this period, an economic downturn in 2001–02 caused a decline in employer-sponsored insurance among low-income families, causing an increase in children eligible for SCHIP and Medicaid.





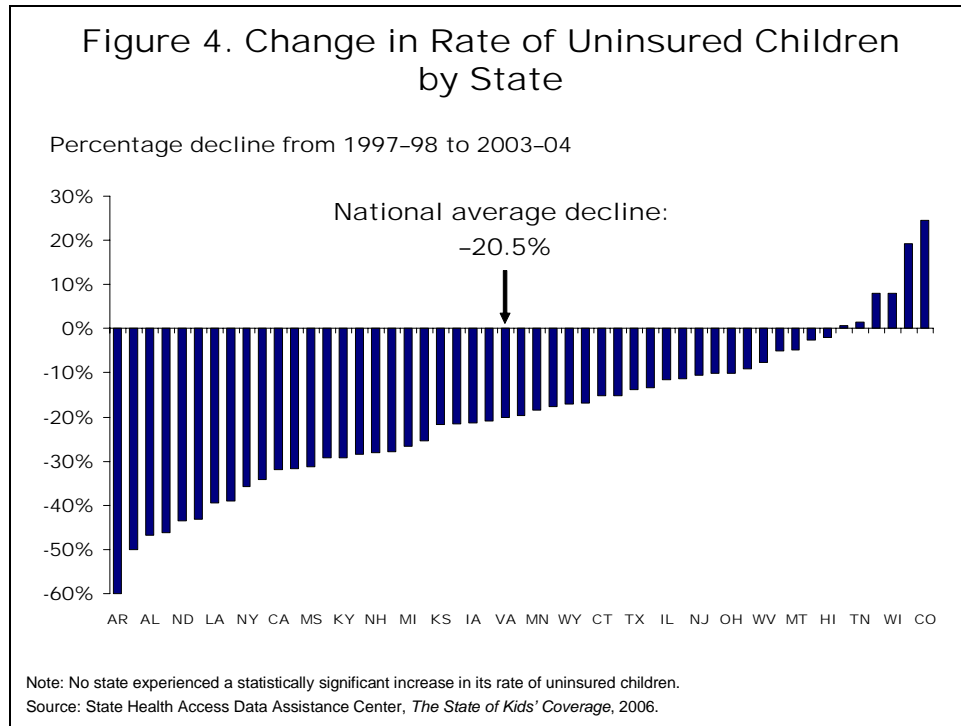
The enrollment increase in SCHIP and Medicaid contributed to a reduction in the rate of uninsured children. The percentage of low-income, uninsured children dropped by one-third, from 22.3 percent to 14.9 percent between 1997 and 2005 (Figure 3).<sup>20</sup> During the same period, the percent of higher-income, uninsured children rose slightly as private, employer-based coverage eroded. SCHIP and Medicaid largely defrayed what could have been large increases in uninsured low-income children. One analysis found that in states with small declines in employer coverage, there was a significant reduction in uninsured children; meanwhile, in states with large declines in employer coverage, coverage stabilized. As such, SCHIP and Medicaid helped prevent children from experiencing the types of coverage loss experienced by adults in recent years.<sup>21</sup>

Figure 3. Rate of Low-Income Uninsured Children, 1997–2005



Note: Beginning in 2004, the NHIS changed its methodology for counting the uninsured. This results in the data for 2004 and later years not being directly comparable to the data for 1997–2003.  
Source: Georgetown Center for Children and Families, L. Dubay analysis based on data from the National Health Interview Survey.

The impact of Medicaid and SCHIP on the rate of uninsured children varies by state (Figure 4). No state experienced a significant increase in the rate of uninsured children since SCHIP's implementation, and the average state decrease was 2.9 percentage points, or more than 20 percent. The greatest improvement was in Arkansas, where the rate of uninsured children dropped by nearly 13 percentage points, or 60 percent, from 1997–98 to 2003–04.<sup>22</sup> Louisiana, Mississippi, and Alabama, which also had some of the worst uninsured rates in the nation, also improved dramatically. States that showed the least change were those that began with generous programs (e.g., Wisconsin, Tennessee). Some states that had extensive programs prior to SCHIP maintained coverage despite declines in employer coverage. Although it experienced a significant decline in its rate of uninsured children, Texas remains the state with the highest rate: one of five children in the state is uninsured.



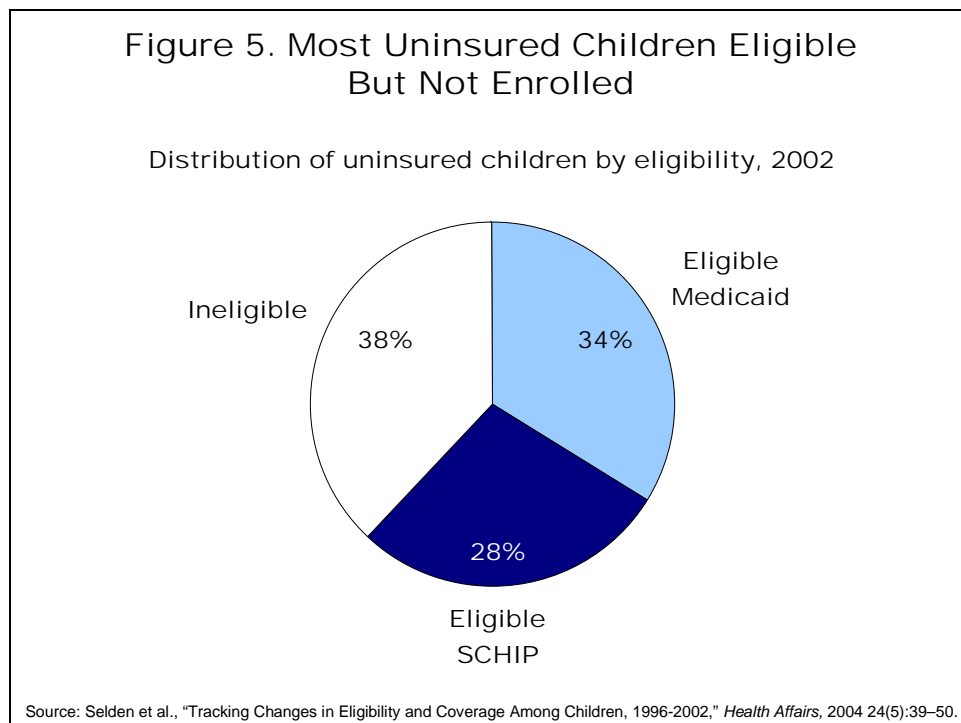
Other state policies have been linked to enrollment of low-income, uninsured children. Streamlined eligibility processes and eligibility linked to other programs like the school lunch program have led to increased enrollment of eligible children.<sup>23</sup> Simple eligibility redetermination rules also can facilitate coverage, as many eligible but uninsured children have previously been in the system. For example, a study in Rhode Island found that about 60 percent of children “disenrolled” from Medicaid were reenrolled within one year.<sup>24</sup>

Some practices limit enrollment. Waiting lists—which are allowed in non-Medicaid SCHIP programs—have proven to reduce enrollment beyond their intent. A study of North Carolina’s Medicaid program found that most children on its waiting list had been enrolled in Medicaid but were no longer eligible because they exceeded the age limit or their family’s income was too high. Nearly all families reported economic hardship as a trade-off for securing health care for their children.<sup>25</sup> Eight states implemented waiting lists for children in SCHIP at some point since its creation, with three states continuing these caps as of the fall of 2006.

A concern at the outset of SCHIP—and one that persists today—was that the expansion of eligibility for public programs would reduce private coverage. At the time of enactment, the Congressional Budget Office projected that about 40 percent of SCHIP enrollment would result from crowd-out of private coverage.<sup>26</sup> The federal evaluation

found that roughly 28 percent of recent enrollees in SCHIP had private coverage in the six months prior to enrollment, with half of these children having lost coverage involuntarily. Across state-specific studies, the percentage of enrollees who could have had employer coverage upon enrollment was less than 20 percent.<sup>27</sup> This level of crowd-out is lower than expected, especially given the unanticipated decline in employer-sponsored insurance in the last decade.

Despite gains in coverage for children, about 9 million children under age 19 were uninsured in 2005. In that year, the national rate of uninsured children increased for the first time since the implementation of SCHIP. Over 60 percent of uninsured children are eligible for either Medicaid or SCHIP (Figure 5). Two major reasons for the lack of enrollment are misunderstandings about eligibility and enrollment barriers. In 2002, a survey found that over 90 percent of parents of low-income, uninsured children knew about Medicaid and/or SCHIP, but only 57 percent understood that eligibility was not linked to receiving welfare.<sup>28</sup> Enrollment barriers also persist. When Washington increased income verification on its application and shortened its eligibility redetermination period to control enrollment growth, the result was the loss of 39,000 children from the program—twice as many as planned. A survey found that over half of this loss resulted from a failure to complete the new application. Among children losing coverage, 90 percent were eligible for public programs. Subsequent changes were made to the program to reverse these changes.



During the recent economic slowdown, 23 states reinstated or adopted procedural barriers to enrollment and redetermination as ways to reduce the number of children covered and cut costs.<sup>29</sup> In short, SCHIP is not immune to budget pressures, and trends suggest this pressure could worsen as employer-sponsored insurance declines.

### **Impact on Access, Quality, and Health Outcomes**

Studies of SCHIP have found that, just like having health insurance coverage generally, enrollment improves access to health care. Relative to uninsured children, children enrolled in Medicaid or SCHIP reported much lower unmet health care needs (2% vs. 11%).<sup>30</sup> According to a different study, unmet need among chronically ill low-income children who were uninsured and gained Medicaid or SCHIP coverage decreased by eight percentage points—exceeding the reduction among newly insured children without chronic illness.<sup>31</sup> Uninsured children who gained coverage through SCHIP received more preventive care, and their parents reported better access to providers and improved communications with their children’s doctors.<sup>32</sup> Racial disparities in access were also reduced (although not eliminated) for children who were uninsured and subsequently enrolled in SCHIP.<sup>33</sup>

The quality of care for children in SCHIP appears to be similar to that for children in Medicaid, but it is marked by the same problems as those affecting children with private coverage. A survey of states found that most contracted with managed care plans whose quality of care was reviewed by independent organizations (22 of 26 separate programs and 24 of 25 Medicaid expansions).<sup>34</sup> SCHIP’s emphasis has primarily been on quality measurement in preventive and primary care and less on inpatient care.<sup>35</sup> Surveys also have shown that parents generally support SCHIP and Medicaid. More than 85 percent of families of disenrolled children would have kept their children in the program if it were possible.<sup>36</sup> Yet, despite state efforts, a national study found that up to three-fourths of children do not receive recommended health care, including children enrolled in SCHIP.<sup>37</sup>

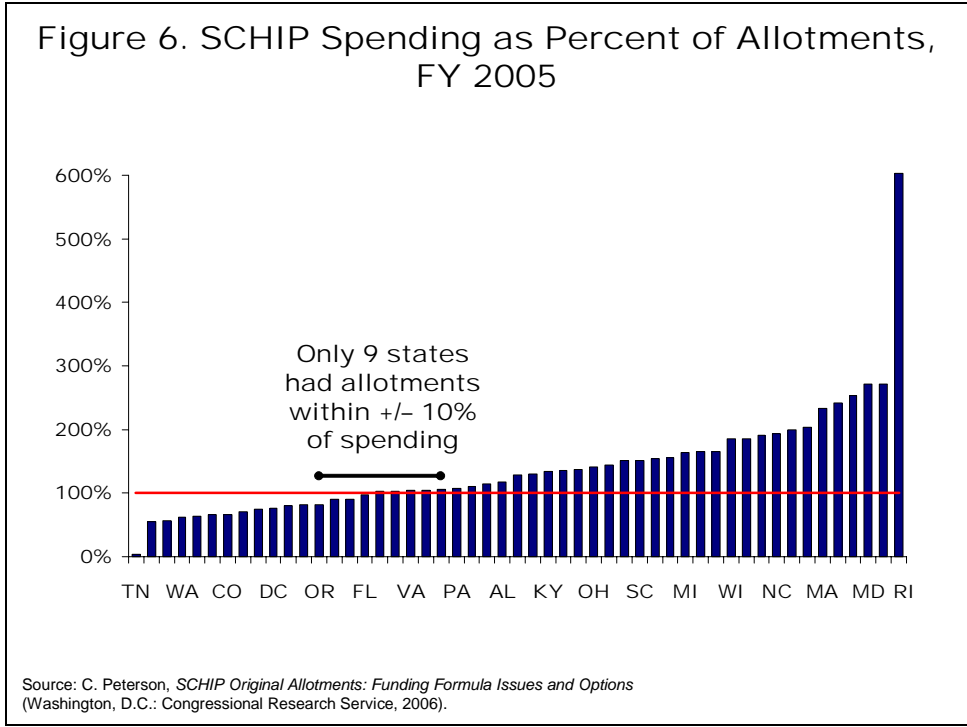
Few studies have examined health outcomes as they relate to SCHIP. One evaluation found that children who were uninsured and gained coverage through Medicaid or SCHIP had fewer asthma-related attacks after enrollment (3.8 vs. 9.5 attacks), with significant improvements in quality of care.<sup>38</sup> A broader measure of health is the quality of life. One study found that improvement in quality of life resulting from enrollment in SCHIP was equivalent to the benefits of treatment for a child newly diagnosed with cancer.<sup>39</sup>

## **Funding History**

The funding structure for SCHIP has for the most part been effective. It has succeeded in meeting the program's goal of encouraging state expansions while limiting federal liability, with a matching rate sufficient to encourage all states to expand coverage for children. Similarly, the policy to give unspent federal allotments to other states created pressure to implement SCHIP quickly and aggressively. Federal spending on SCHIP has been lower, in aggregate, than the amounts specified in legislation; prior to 2006, states generally had adequate federal funds to maintain their enrollment in SCHIP.

The program's success in enrolling children has, however, come up against its federal funding limits. Congress has acted six times in SCHIP's brief history to modify the program's state funding allocation rules. The first change related to the data source used for the original allocation of funds, the Current Population Survey (CPS). The CPS was, and continues to be, criticized for its insufficient sample size in small states, its unstable estimates from year to year, and its weak questions about insurance status.<sup>40</sup> In 1999, Congress acted to limit large annual changes in allotments and bolster the sample size in the survey to ameliorate these problems (P.L. 106-113).

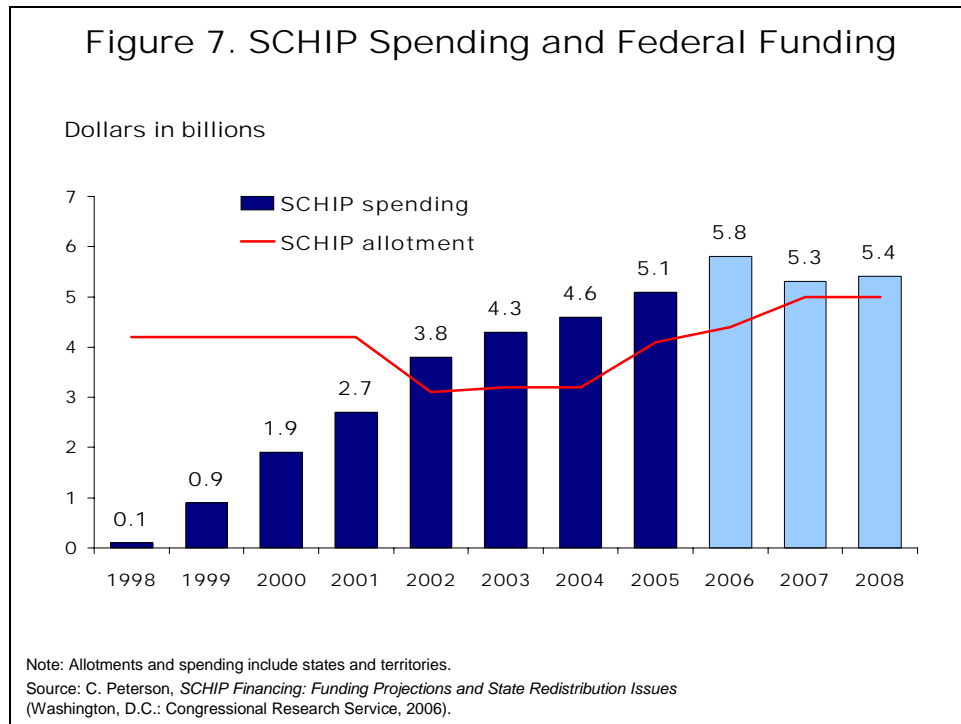
Subsequent legislation affected redistribution of funds. In 2000, Congress allowed states to retain some of their FY 1998 and 1999 allotments and have an extra year to spend them (P.L. 106-554). In 2003, two extra years were granted, and a similar policy was implemented for unspent funds from FY 2000 and 2001 (P.L. 108-74). Additionally, states that had expanded coverage prior to SCHIP (i.e., "qualifying states") were allowed to use up to 20 percent of their FY 1998–2001 allotments for Medicaid matching payments. Still, the gap between actual spending and the allotments is large, with only nine states in FY 2005 having spending and allotments within 10 percent of each other (Figure 6). The Deficit Reduction Act of 2005 provided new federal funds to fill in shortfalls in some states' 2006 allotments. Lastly, in the lame-duck session of 2006, Congress modified the redistribution formula to partially fill the state-specific shortfalls that loom for FY 2007 (P.L. 109-432).



A different sort of funding issue arose among states with allotments exceeding spending on children’s coverage. With encouragement from the Bush Administration, states used SCHIP options and waivers to draw down federal funding from their allotments for other populations, such as low-income parents and childless adults. In 2005, seven states used an option to cover pregnant women through SCHIP, and 11 states covered adults in SCHIP through a federal waiver.<sup>41</sup> States that used these waivers (or existing Medicaid options) to extend coverage to parents had the additional benefit of covering more children (see discussion of enrolling eligible children below). However, this also meant that states were using allotments more rapidly, leaving less to be redistributed to states that needed federal funding to insure children. Partly because of this concern, the authors of the Deficit Reduction Act of 2005 prohibited additional states from using SCHIP waivers for non-pregnant, childless adults. Similarly, the legislation that partially filled the FY 2007 shortfalls limited the use of new funding for enhanced match for coverage of adults through SCHIP.

Beyond these state distributional issues, the total amount of federal funding available through SCHIP has been an issue. The Balanced Budget Act of 1997, which created SCHIP, included other policies with savings and spending implications. Because the policies together were designed to meet specific deficit-reduction targets, federal funding for SCHIP was constrained over the entire budget window and for FY 2002 (the year in which the budget was projected to be balanced). This yielded an irrational funding

stream (Figure 7). Recognizing this, the legislation aimed to compensate for this through multiyear use of allotments and redistribution. Nevertheless, about \$1.1 billion in federal SCHIP funding has reverted to the federal treasury. Spending is now higher than the federal allotment in aggregate, as well as in 80 percent of states; this gap grows as the rate of growth in health care costs continues to rise.



### **FUTURE: MAJOR ISSUES IN SCHIP REAUTHORIZATION**

SCHIP policy is likely to be a major legislative focus in 2007. First, Congress is scheduled to reauthorize the program, since rules and funding set in 1997 expire at the end of FY 2007. Trends and circumstances may also precipitate change. The uptick in the rate of uninsured children has raised interest in changing federal and state policy. Broader concerns about the uninsured have also led some policymakers to consider expanding coverage for all children as the next major health reform.

In anticipation of SCHIP reauthorization, a number of groups have proposed general principles regarding what should—and should not—change in the program; others have set forth specific policy recommendations. (See box on next page.) Three major questions are likely to be contemplated by the Congress:

1. Who should be covered?
2. What coverage should children receive?
3. How should coverage be financed?



While many other issues will likely be raised in the context of reauthorization, few have the impact or potential controversy of these central questions.

<p>National Governors Association SCHIP Reauthorization Principles (excerpts)</p> <ul style="list-style-type: none"> <li>• Providing health coverage to children is a key goal for governors and must be balanced with the practical need for states to have predictability of funding in order to plan for program growth.</li> <li>• No SCHIP program should lack the federal matching funds required to cover its SCHIP population.</li> <li>• Investments in SCHIP must not come out of Medicaid or other state health and human services programs.</li> <li>• Any new outreach program must be designed so that it does not create fiscal problems for states or create expectations that cannot be met.</li> <li>• Innovative states should not be penalized for having expanded Medicaid coverage to children before the enactment of SCHIP.</li> <li>• The formula for redistributions should be predictable and fair for states.</li> </ul> <p>Source: NGA HHS-09, 7-20-05.</p>	<p>Selected Children’s Advocates’ Priorities for SCHIP Reauthorization*</p> <ul style="list-style-type: none"> <li>• Fund SCHIP: Prevent coverage loss, assure adequate funding for children’s coverage improvements.</li> <li>• Keep Medicaid strong: Medicaid cuts should not be used to offset new spending.</li> <li>• Cut red tape and provide states new tools to cover children: This includes federal support for successful outreach; reducing eligibility barriers; and better integrating SCHIP and employer coverage.</li> <li>• Quality and access: Establish standards and measures for all children.</li> </ul> <p>* Supported by American Academy of Pediatrics, March of Dimes, and National Association of Children’s Hospitals, as well as Georgetown Center for Children and Families.</p>
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**Who Should SCHIP Cover?**

With 9 million children still uninsured, Congress will likely ask: How can Medicaid and SCHIP better enroll eligible children? And should the programs be extended to cover the remaining, uninsured children? Following are several options regarding eligibility and enrollment.

*Enroll already eligible children.* Emphasizing outreach seems like an obvious solution to the millions of children who are eligible for, yet do not participate in, SCHIP. Medicaid and SCHIP already include options for outreach, and many states have adopted these. A small number of options would require a change in the law (e.g., linking eligibility to other programs for low-income children),<sup>42</sup> while others involve tradeoffs between policy goals and costs.

Experience and research have identified a number of practices for enrolling uninsured children. As described earlier, this includes simple applications and re-enrollment procedures, seamless eligibility rules, and aggressive marketing. While requiring states to use these best practices would most likely be the most effective and efficient approach, this would violate a core SCHIP principle—allowing state flexibility. Similarly, the recent law that requires documentation of citizenship for Medicaid eligibility will affect enrollment of children in SCHIP as well as in Medicaid, since SCHIP has to screen children applying for Medicaid eligibility.<sup>43</sup> Eliminating this provision, however, runs counter to a wave of policies aimed at limiting public assistance for people thought to be in the United States illegally.

Another proven way to raise participation of children in health insurance programs is to make their parents eligible as well. Uninsured children tend to have uninsured parents and vice versa: 61 percent of low-income children of uninsured parents were uninsured, compared with only 9 percent of low-income children of insured parents.<sup>44</sup> In one study, participation of children in SCHIP and Medicaid was 14 percentage points higher when parents themselves were eligible.<sup>45</sup> Children are also more likely to use preventive services and seek care when needed when their parents are insured.<sup>46</sup> Yet, increasing enrollment of children by enrolling their parents clearly adds to the cost of the program and dilutes its mission.

From a state's perspective, the most significant barrier to outreach is probably cost. Since nearly two-thirds of uninsured children are eligible for Medicaid and SCHIP, successful outreach is likely to be expensive. While federal policymakers want states to aggressively enroll children, their own fiscal liability is capped; states bear all of the incremental cost of success once the federal funding allotment limit is reached. As such, enrolling all eligible but uninsured children would likely require a change in the level or structure of federal financing for SCHIP.

***Include low-income children ineligible for SCHIP.*** Another option is to stop excluding children who are income-eligible but otherwise barred from participating in SCHIP. The law prohibits states from covering several sets of low-income children in SCHIP to prevent crowd-out. The most obvious is children who are already insured; SCHIP requires that children be uninsured prior to joining SCHIP. The policy aims to maximize the impact of limited federal funding for insuring children. Yet, eliminating some of the crowd-out rules could make SCHIP simpler and encourage enrollment of children. In addition, potential reductions in efficiency of reduced crowd-out policies could be offset by increases in equity: Why should a responsible parent who privately insures his or her

child be denied assistance when the program helps uninsured children of parents at the same income level?<sup>47</sup>

Another excluded group is immigrant children. The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) specifies that legal immigrants can only qualify for public programs after a five-year waiting period; undocumented children are totally barred from federal funding. Some states have used their own funds to cover such children, but others seek access to federal SCHIP funding for this group on the basis of public health and economics, since the uncompensated care costs associated with legal immigrants are significant.

A third income-eligible group excluded from SCHIP coverage is children of state employees. The law aimed to prevent states from off-loading existing health benefits costs for state workers onto SCHIP; yet many of these employees cannot afford state coverage. Moreover, the exclusion is perceived as arbitrary, since there is no similar exclusion for the children of federal employees.<sup>48</sup> For a similar reason, income-eligible children in institutions (e.g., those for mental disease) are excluded from SCHIP because there are, in theory, alternative sources of financing for their care.

Some states would like to enroll in SCHIP lower-income children who are eligible for Medicaid. But SCHIP law requires states to enroll Medicaid-eligible children—for example, those living below the poverty level—in Medicaid. States argue that some parents prefer to enroll their children in SCHIP and should be allowed that choice. In addition, some parents find it difficult to navigate the two programs—for example, when a single family has children eligible for the different programs.<sup>49</sup> Yet, relaxing the enrollment requirements along these lines would require a reexamination of the fundamental roles of Medicaid and SCHIP. Specifically, it would raise questions about the adequacy of SCHIP's benefits for poor or medically vulnerable populations as well as the ability to ensure informed and fair choices among the programs.

*Include children with higher income.* A final option would open SCHIP to all uninsured children, regardless of income. Some child health advocates, like the Children's Defense Fund, believe Congress should use SCHIP as a means of achieving universal coverage for children. This could be done in a number of ways. The law could allow a buy-in option, meaning that families with income above a set threshold could purchase SCHIP coverage but would receive no SCHIP subsidy to do so (e.g., Kids Come First Act of 2005, S. 114). It could provide middle-income families with tax credits to purchase SCHIP coverage as well as employer coverage (e.g., presidential candidate John Edwards's campaign proposal in 2004). States could be offered this eligibility expansion as an option

with financial incentives, as in the original SCHIP program, or be required to expand eligibility. Similarly, families could be offered incentives or be required to enroll their children, assuming accessible, affordable options are created.

The political and policy implications of these options—as well as the cost—would depend on the details, which would also determine whether other aspects of the program require changing. For example, federal financing for SCHIP could not remain capped if families were required to insure their children. Benefits would also likely be modified if extended to children in middle-income families. And, clearly, federal costs along with coverage would be highest under this option. Estimates based on similar policies suggest that covering all children in a manner that is affordable to families could increase federal spending by \$15 billion to \$30 billion per year.<sup>50</sup>

### **What Coverage Should Children Receive?**

For the most part, the states, which are allowed flexibility, and the federal government, which upholds benefit standards, have achieved a sustainable balance in designing SCHIP's benefit package. Even so, ideas for increasing or decreasing benefit standards are emerging as the reauthorization deadline approaches, along with opinions on the type and nature of coverage.

*Benefit standards.* State SCHIP directors have expressed a desire for greater flexibility to implement partial benefit packages. Currently, coverage must meet either the legislation's benchmarks or approval of the Secretary of Health and Human Services. Although Secretary Leavitt has approved reduced benefit packages under this authority, states would like additional flexibility to design packages that wrap around other coverage and fill in gaps.<sup>51</sup>

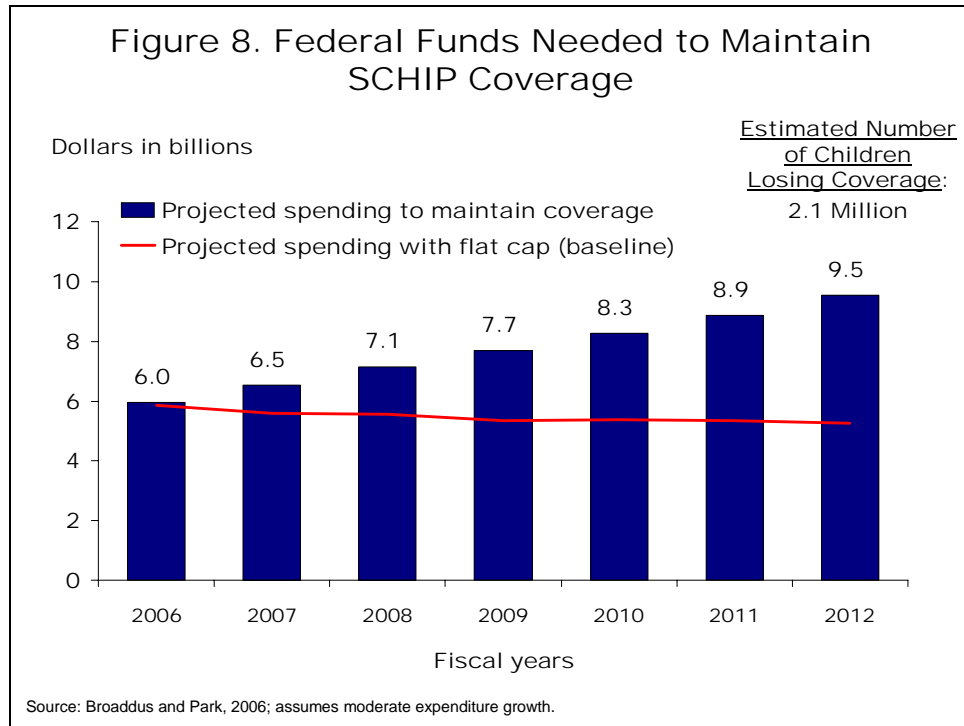
On the other hand, there are concerns over substandard benefits in SCHIP. Some states have adopted as their child coverage benchmarks high-deductible health plans offered to state employees. The higher out-of-pocket costs associated with these plans, some fear, could limit families' access to care. More broadly, research has shown that SCHIP is as likely to enroll children with special health care needs as it is to enroll healthy children, even though the program's benefit standards are geared toward healthier children.<sup>52</sup> Allowing Medicaid-eligible children to enroll in non-Medicaid SCHIP plans would likely increase concern that special-needs children would not have full access to needed services.<sup>53</sup> Lastly, SCHIP has not expressly focused on emerging health threats like childhood obesity and its benefits standards could be strengthened to address this.

*Premium assistance.* In addition to the kinds of benefits covered, how children are covered may generate attention. States have expressed interest in simplified premium assistance: the SCHIP option for states to subsidize employer-based family coverage for eligible children. Rules for use of this option set minimums for benefits and the employer contribution; they also established a cost-effectiveness test. Designed to limit crowd-out, they are considered onerous by states.<sup>54</sup> As of 2005, only nine states had implemented premium-assistance programs.<sup>55</sup> Some states seek more flexibility to work with employers to sustain children's coverage, although this comes at the risk of weaker benefit standards and consumer protections for SCHIP-eligible children.

*Quality of coverage.* The nature of the coverage is also a focal point. SCHIP and Medicaid have made inroads in improving quality and access of care for children, but more remains to be done. Some policymakers see low payment rates relative to those of private insurance as part of the problem. Others argue that the type of measurements that have been successfully used to improve quality for privately insured populations could be applied more aggressively in SCHIP.<sup>56</sup> Although improving quality standards may be viewed by some states and employers as constraining, there is wide support for doing so.

### **How Should SCHIP Be Financed?**

If Congress does not act in FY 2007, SCHIP will come to an end. The budget offices assume that some continuation of the program will occur, with federal funding continued at its current level of \$5 billion per year. To maintain the current level of services, the overall amount of federal funding written into the reauthorization bill would need to adjust for population growth and health care inflation (Figure 8). This could cost an estimated \$12 billion to \$14.5 billion over five years, according to one assessment.<sup>57</sup> If, instead, the federal funding cap were kept at \$5 billion per year, the Administration estimates that enrollment in SCHIP would drop from 4.4 million in FY 2006 to 2.5 million in FY 2016.<sup>58</sup>



Four components of SCHIP’s financing structure could be affirmed or changed in the reauthorization process: the federal matching rate for program costs, the aggregate amount of the federal allotment, the allocation of the federal allotment across states, and the redistribution of unused funds. These four components all interact. For example, as the aggregate amount of federal funds grows, the state allocation formula becomes less important and the redistribution formula becomes more important (and vice versa). SCHIP funding affects Medicaid spending as well; for example, increased funding aimed at boosting SCHIP enrollment is likely to increase enrollment and costs in Medicaid as well.

A number of options exist for extending, modifying, or overhauling SCHIP’s financing structure. Three options likely to be considered by Congress are described below.

***Better use of existing funding.*** One option for financing SCHIP is to keep the aggregate funding relatively low but better targeted. One way to accomplish this is to redistribute unspent allotments more aggressively. The Administration estimates that, in FY 2006, there was \$4.1 billion in unspent allotments but only \$173 million available for redistribution. The FY 2008 budget proposed redistribution after one, rather than three, years, allowing for a greater amount of federal funding to be redistributed to those states experiencing shortfalls. Similarly, the budget proposes to limit SCHIP enhanced matching payments for coverage other than for children, as was included in the policy that

temporarily filled SCHIP shortfalls in December 2006. More aggressive redistribution of existing funds would by definition create more shortfall states, because states that use unspent allotments to prevent them from becoming shortfall states would no longer have that option. In the absence of an increased national allotment, redistribution would also not be enough to sustain coverage much beyond FY 2007 since health cost and enrollment growth would dry up all unspent state allotments by then.<sup>59</sup> Even with retargeting and an extra \$5 billion over five years, the Administration's FY 2008 budget estimates that coverage of children will not keep pace with population growth.

A more aggressive policy would target or even restrict the use of SCHIP funding to low-income, uninsured children—the program's "core population."<sup>60</sup> One reason for shortfalls in SCHIP funding is that some states use allotments for higher-income children and other populations, such as low-income adults. If funds could not be used for such populations, then additional amounts of the existing federal funding would be available for states to use for core populations. To accomplish this, SCHIP would have to set an income ceiling and require states to use standard definitions for income for children's eligibility. Currently, some states subtract expenses like taxes and child care costs from gross income for eligibility. Inequities could also result because the poverty threshold does not take into account differences in health care and costs of living across states, resulting in effectively higher eligibility in low-cost states.<sup>61</sup> Excluding parents from coverage through SCHIP could lead to lower enrollment of targeted children, as participation is higher when whole families are eligible. And this would run counter to the promotion of SCHIP waivers, support for state flexibility, and expanding coverage to additional low-income adults.

*Improvements within the existing structure.* When it reauthorizes SCHIP, Congress could work within the program's current structure to mitigate the problems that have emerged. Raising the overall level of federal funding—by increasing the total allotment to keep pace with medical inflation, projected enrollment growth, and/or national health expenditure growth—is one way to do this. Adjustments could also be made to the base-year funding, recognizing that federal spending on SCHIP now exceeds the \$5 billion federal allotment on the books. Increasing the aggregate amount of federal funding would lessen the pressure to change the allocation and redistribution formulas, as these would be less important to ensuring sufficient state financing. At the same time, significantly increasing federal funding could encourage "mission creep"—use of SCHIP funds for activities other than insuring low-income, targeted children.

In addition, experts have proposed different ways of allocating the aggregate level of funding. Some involve technical changes, for example, switching to a more stable data

source. Others, however, have policy significance. For example, the current formula blends states' low-income uninsured children and already-insured children. If SCHIP went back to allocating funds based only on the number of uninsured children, states would get less funds as they insure more children—a potential disincentive for aggressive enrollment policies. Rhode Island, for example, has one of the lowest uninsured rates in the country but spends the most relative to its allotment. An allotment formula weighted toward states with large numbers of uninsured would lower Rhode Island's federal SCHIP funding and make it difficult for the state to sustain its level of children's coverage. Alternatively, given the budget deficit and fiscally tight environment, some experts argue that all available funding should be targeted toward those that need it most.<sup>62</sup>

A different approach to allocating federal funds would be to consider states' historical SCHIP spending along with their need.<sup>63</sup> For example, half of the total amount allocated in a year could be based on the distribution of spending in the previous year, while the other half could be based on the number of low-income, uninsured children. Such a formula would help sustain states that have strong programs as well as ensure that additional funds are available for states with continued, unmet need. There is a possible drawback, however: basing allocation on gross spending could be perceived as “rewarding” costly or inefficient states and as shifting funding from poor to wealthy states, which have the means to build large SCHIP programs.

Lastly, “risk corridors,” performance bonuses, or other policies to promote enrollment in the context of limited federal funding could be considered for SCHIP allotments. An inherent tension exists within a block grant aimed at expanding coverage, since it is difficult to project adequate funding for expansion at the federal and state levels. When the financial cap is lower than spending, states are as likely to limit enrollment of children as to limit their cost per child—an incentive that undermines the program's goal of expanding coverage. Options for addressing this include allowing allotments to be automatically adjusted based on actual enrollment, or increasing allotments if certain performance targets are met (e.g., expanded or sustained coverage at specified levels). These options would reduce states' incentives to use waiting lists and lower eligibility limits in the face of federal funding limits. However, in addition to the potential difficulty of implementing such changes is the concern about changing SCHIP's block-grant approach to federal financial liability—an important compromise in the original legislation.

***Removal of the allotment structure.*** Finally, policymakers might consider eliminating the cap on federal matching payments, aligning its financing structure with Medicaid's. Under this option, the aggregate and state-specific allotments would be removed, lifting



the limit on federal matching payments for child health assistance. The current higher matching rate for SCHIP children's coverage could continue, or it could be blended with the rate for Medicaid children. Creating one federal matching rate for both programs would limit the incentive to miscategorize children so they could be enrolled into SCHIP with its higher federal contribution. It would also encourage states to promote enrollment in Medicaid as well as SCHIP. Eliminating allotments would probably also mean eliminating higher matching rates for adults through SCHIP waivers, as there would no longer be extra allotments used for other populations.

Arguments can be made both in favor of and against eliminating allotments in SCHIP. There is little disagreement that the program's financing structure has been its biggest weakness. The allocation and redistribution rules are the only programmatic areas both revisited by Congress on multiple occasions and at the top of states' list of concerns in reauthorization. More broadly, the idea of block grants for coverage suffers from inherent challenges in predicting health spending growth.<sup>64</sup> Historically, predictions have been flawed, causing problems in their use in health programs. The caps in some states have hampered achieving the goal of insuring low-income, uninsured children. Politically, states have proven that they can responsibly manage costs without the one-sided fiscal limit imposed by the federal allotments.

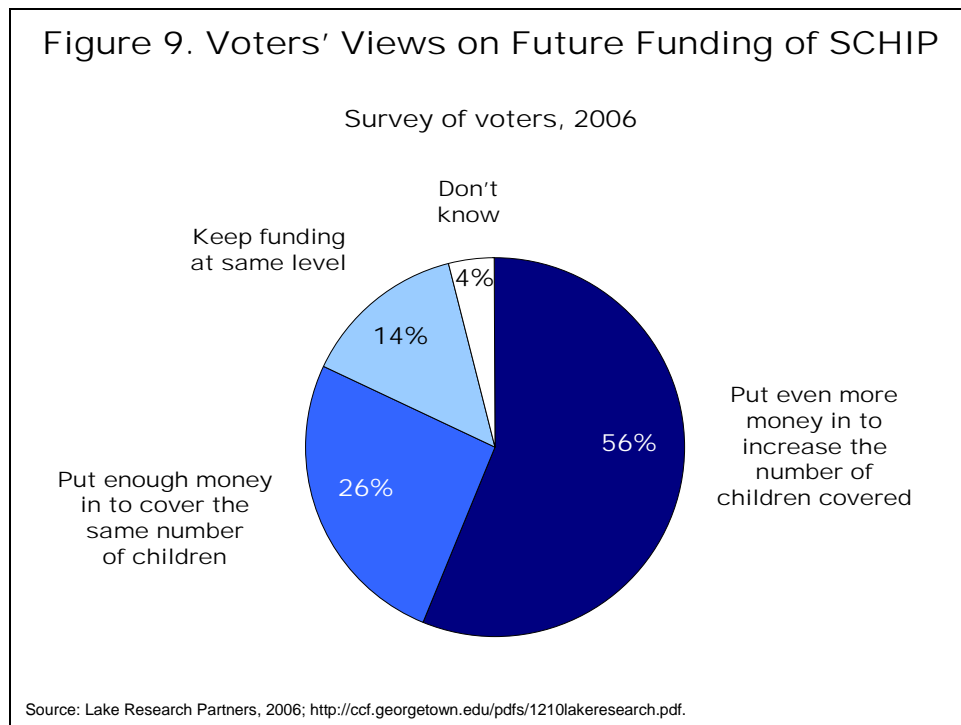
But removing the allotments, with the current federal matching rate, could cause other problems. States that spend more than their allotments might now expand their programs, covering more children but at a higher federal budgetary cost. States might see their share of program costs grow without the countervailing pressure of a federal limit to use in state budget negotiations. Politically, the balance of SCHIP could be thrown off. For example, the federal government might add rules to ensure program integrity—potentially undermining state support. And fiscal conservatives would raise concerns about entitlements, substituting the “formula fights” that have plagued SCHIP with ideological fights that have hindered progress in health reform.

## **CONCLUSION**

The 10th anniversary of SCHIP will likely be marked by celebrations. A wide range of policymakers, advocates, experts, and health providers will hail the program as a rare instance of successful, bipartisan, federal-state collaboration that improved the nation's health coverage. SCHIP was implemented quickly and relatively smoothly; it allowed for state variation within national standards; and it contributed to a reduction in the number and rate of uninsured children. The coverage the program provides is more

impressive when viewed in the larger context of an eroding and fracturing employer-based coverage system.

SCHIP's expiration in 2007 will force policymakers to revisit this program. Given the program's success, as well as budget pressures and competing policy priorities, Congress may simply choose to "stay the course." SCHIP could be sustained with minimal programmatic changes. Choosing this path would avoid a reopening of the issue of state funding allocation and a re-litigating of the federal-state and Medicaid-SCHIP balances. Still, sustaining the program will require an increase in federal funding; if such an increase is offset with spending cuts in Medicaid or Medicare, even this least controversial of options could prove difficult to enact. In general, however, the public supports increasing funding for coverage of children (Figure 9).



Alternatively, major changes in SCHIP may be made to increase its efficiency and performance in covering low-income children. While coverage of such children is a universally shared goal, support among states wanes if there are tighter eligibility rules to prevent crowd-out, if there is less tolerance for states that have underperformed, and if there is no commensurate increase in federal financial support. To lessen this state opposition, Congress could keep SCHIP funding fixed and relatively low, directing states to cover uninsured children, but removing federal rules to allow flexible means for covering eligible, uninsured children. This would create a different set of opponents—

some children's advocates, providers, and experts—who would fear that this is no more than an unaccountable, inefficient block grant.

The debate over SCHIP may also focus on simplifying it, and Medicaid. Sentiment against overly complex policy (e.g., the Medicare drug benefit) may spill over to SCHIP. Policymakers could seek to create simple national standards for eligibility and benefits, limit anti-crowd-out policy, and promote financial incentives to enroll children in both SCHIP and Medicaid. Doing so would limit state flexibility but increase federal funding—while losing the support of some fiscal conservatives. However, if simplification means making Medicaid more like SCHIP, some children's advocates may oppose it, fearing an erosion of benefits and protections for vulnerable children.

Finally, SCHIP may get swept up in the call for change that characterized the 2006 midterm elections. Populism has come back into style, bringing with it demands for bold ideas, including major health care reform.<sup>65</sup> In 2007, some legislators—maybe many—will call for insuring all children, possibly as part of a larger effort to cover all Americans. On the surface, this may be the most achievable coverage expansion: of all non-elderly groups in America, children already have the lowest uninsured rate. Moreover, the idea of covering children enjoys particular broad popular support.

Yet, this only lessens, rather than eliminates, the policy and political obstacles that have blocked universal coverage in the past. Questions may arise about the use of SCHIP for high-income children, the nature of financing, and the definition of benefits. In addition, if expanding coverage for children is financed by cutting public funding for health providers, support could diminish.

As such, SCHIP reauthorization will be a test of the 110th Congress. Expanding and improving children's health insurance is a fundamental, shared goal that policymakers will strive to advance. Accomplishing this goal faces challenges that are serious but surmountable, as demonstrated in the original passage of the program. Regardless of outcome, the debate over SCHIP reauthorization will offer an opportunity to reassess health coverage priorities and approaches. The balance of federal and state governance, the relative roles of public and private insurers, the definition of coverage, and the public's willingness to pay for results will be reviewed, argued, and potentially resolved in SCHIP reauthorization. This will not only affect the health insurance coverage for millions of low-income children, but will inform future debates over improving the coverage system for all Americans.

## NOTES

<sup>1</sup> J. Carter, “Health Care Legislation Message to the Congress,” *The American Presidency Project*, Apr. 25, 1977, available at <http://www.presidency.ucsb.edu/ws/index.php?pid=7401&st=children%5C%27s+health&st1> (accessed Nov. 18, 2006).

<sup>2</sup> In 2006, the federal poverty level for a family of three was \$16,600 and a family of four was \$20,000. Throughout the report, the term “percent of poverty” refers to the federal poverty level.

<sup>3</sup> A maintenance of effort provision was established to prevent federal SCHIP funding to be used for children who were eligible for Medicaid prior to the implementation of the program.

<sup>4</sup> Other children ineligible for SCHIP include children eligible for state employee insurance and children in institutions for mental disease.

<sup>5</sup> M. McClellan, *Testimony Before the Senate Finance Subcommittee on Healthcare, Hearing on the State Children’s Health Insurance Program* (Washington, D.C.: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, July 25, 2006). Note: “states” includes the District of Columbia.

<sup>6</sup> Ibid.

<sup>7</sup> E. P. Baumrucker, *Testimony Before the Senate Finance Subcommittee on Healthcare, Hearing on the State Children’s Health Insurance Program* (Washington, D.C.: Congressional Research Service, July 25, 2006). Note that some states with separate programs offer different packages to different children; as such, the numbers add up to more than the number of states with separate state programs.

<sup>8</sup> The territories’ allotments are based on a pool of funds set aside from the federal limit.

<sup>9</sup> About \$1.1 billion unspent, redistributed funds has reverted to the Treasury since the program began.

<sup>10</sup> For a review of the legislative history, see M. McClellan, *Testimony*, 2006.

<sup>11</sup> C. L. Peterson, “SCHIP Original Allotments: Funding Formula Issues and Options,” *CRS Report for Congress* (Washington, D.C.: Congressional Research Service, Apr. 18, 2006).

<sup>12</sup> M. Broaddus and E. Park. “SCHIP Financing Update: In 2007, 17 States Will Face Federal Funding Shortfalls of \$800 Million in Their SCHIP Programs” (Washington, D.C.: Center on Budget and Policy Priorities, Sept. 21, 2006), available at <http://www.cbpp.org/6-5-06health2.htm> (accessed Nov. 19, 2006).

<sup>13</sup> D. C. Ross and L. Cox, *In a Time of Growing Need: Health Coverage Access for Children and Families: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP for Children and Families* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Oct. 2005).

<sup>14</sup> J. Woolridge, G. Kenney, C. Trenholm et al., *Congressionally Mandated Evaluation of the State Children’s Health Insurance Program: Final Report to Congress* (Washington, D.C.: Mathematica Policy Research, Urban Institute, 2005).

<sup>15</sup> Office of Management and Budget, “Program Assessment: State Children’s Health Insurance Program,” *Expect More. Gov* (Washington, D.C.: U.S. Executive Office of the President, 2003), available at <http://www.whitehouse.gov/omb/expectmore/summary.10000306.2005.html> (accessed Nov. 27, 2006).

<sup>16</sup> D. Bergman, *Perspectives on Reauthorization: SCHIP Directors Weigh In* (Portland, Maine: National Academy for State Health Policy, June 2005).

<sup>17</sup> See, for example, O. Hatch, *Statement Before the Senate Finance Subcommittee on Healthcare, Hearing on the State Children's Health Insurance Program* (Washington, D.C.: U.S. Senate, July 25, 2006); J. D. Rockefeller IV, *Statement Before the Senate Finance Subcommittee on Healthcare, Hearing on the State Children's Health Insurance Program* (Washington, D.C.: U.S. Senate, July 25, 2006).

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Appendix. Key Data on States and the State Children's Health Insurance Program

	Uninsured ages 0-18 2004-05		Low-income uninsured ages 0-18 2003-05		Percent change in rate of uninsured ages 0-17 1997-98 to 2003-05	Type of SCHIP program July 2006	Upper income eligibility July 2006	Enrollment in SCHIP FY 2005 (thousands)	Federal allotment FY 2005 (\$ millions)	Federal spending FY 2005 (\$ millions)	Spending as percent of allotment FY 2005
	Number (thousands)	Pct	Number (thousands)	Pct							
Alabama	70	6%	48	10%	-47%	S	200%	82	\$ 68	\$ 80	118%
Alaska	18	9	10	15	-11	M	175	22	9	24	271
Arizona	271	16	187	25	-43	S	200	88	107	198	186
Arkansas	68	9	37	11	-60	C	200	1	49	63	129
California	1,381	14	835	20	-32	C	250	1,223	667	760	114
Colorado	176	14	110	28	25	S	200	60	58	39	67
Connecticut	72	8	37	17	-15	S	300	22	37	21	56
Delaware	25	12	13	19	-29	C	200	10	9	6	71
District of Columbia	9	8	7	11	-39	M	200	7	10	7	77
Florida	733	17	431	26	-13	C	200	385	249	244	98
Georgia	294	12	196	20	-25	S	235	307	131	202	154
Hawaii	17	6	8	9	-2	M	300	21	12	13	105
Idaho	45	11	28	17	-34	C	185	22	21	17	80
Illinois	386	11	230	19	-12	C	200	281	165	320	194
Indiana	161	10	95	15	-28	C	200	130	73	76	104
Iowa	44	6	33	14	-21	C	200	47	28	41	144
Kansas	50	7	34	13	-22	S	200	47	29	43	151
Kentucky	82	8	68	15	-29	C	200	64	54	71	131
Louisiana	101	9	88	15	-39	M	200	109	78	110	142
Maine	22	7	11	10	-50	C	200	31	13	21	165
Maryland	137	9	73	18	-32	C	300	120	48	122	253
Massachusetts	88	6	50	12	1	C	300	163	59	122	205
Michigan	160	6	88	9	-27	C	200	89	111	172	155
Minnesota	86	7	45	15	-18	C	280	5	39	72	185
Mississippi	106	13	71	17	-31	S	200	79	48	113	233
Missouri	124	8	71	13	-20	M	300	115	54	89	164
Montana	35	15	24	23	-5	S	150	16	12	13	104
Nebraska	28	6	19	13	-9	M	185	45	17	34	199



	Uninsured ages 0-18 2004-05		Low-income uninsured ages 0-18 2003-05		Percent change in rate of uninsured ages 0-17 1997-98 to 2003-05	Type of SCHIP program July 2006	Upper income eligibility July 2006	Enrollment in SCHIP FY 2005 (thousands)	Federal allotment FY 2005 (\$ millions)	Federal spending FY 2005 (\$ millions)	Spending as percent of allotment FY 2005
	Number (thousands)	Pct	Number (thousands)	Pct							
Nevada	104	16%	63	26%	-15%	S	200%	39	\$ 40	\$ 27	66%
New Hampshire	20	6	7	11	-28	C	300	12	9	8	82
New Jersey	251	11	125	23	-11	C	350	130	85	205	242
New Mexico	94	18	61	22	-18	M	235	24	42	23	55
New York	385	8	248	13	-36	S	250	619	270	363	134
North Carolina	266	12	179	19	-21	S	200	196	110	211	191
North Dakota	15	10	10	18	-44	C	140	6	6	8	130
Ohio	242	8	153	15	-10	M	200	216	126	172	137
Oklahoma	131	15	86	21	-5	M	185	108	57	64	111
Oregon	100	11	63	17	8	S	185	53	47	39	82
Pennsylvania	281	9	175	17	19	S	200	180	131	141	108
Rhode Island	20	8	10	11	-17	C	250	27	9	56	600
South Carolina	102	10	66	14	-46	M	150	81	54	57	106
South Dakota	18	9	9	12	-28	C	200	14	8	12	151
Tennessee	145	10	101	17	2	S	200	180	131	141	108
Texas	1,367	20	927	29	-14	S	200	526	450	288	64
Utah	96	12	52	18	-10	S	200	44	32	29	91
Vermont	8	6	3	7	-22	S	300	7	5	4	76
Virginia	170	9	88	16	-20	C	200	124	76	80	105
Washington	128	8	72	13	-3	S	250	16	65	40	62
West Virginia	36	9	20	11	-8	S	200	39	24	33	136
Wisconsin	92	7	60	12	8	M	185	57	52	86	166
Wyoming	14	11	6	15	-17	S	200	6	6	6	89
United States	9,035	12	5,532	18	-21			6,114	4,040	5,045	125

Notes: In the "Type of SCHIP program" column, M=Medicaid SCHIP program, S=Separate state SCHIP program, and C=Combination of Medicaid and separate state SCHIP program. "Enrollment in SCHIP" is ever-enrolled rather than a point in time (the concept in the number and rate of uninsured children). Tennessee has covered children through a pre-1997 1115 waiver.

Sources: Kaiser Family Foundation analysis of CPS data for 2004-05 (<http://www.statehealthfacts.org>); Census Bureau; RWJF State of Kids' Coverage 2006; CMS July 12, 2006; CRS 2006.

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