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CHILDREN'S HEALTH INSURANCE

States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization

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Highlights

Highlights of GAO-07-501T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

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Why GAO Did This Study

In August 1997, Congress created the State Children's Health Insurance Program (SCHIP) with the goal of significantly reducing the number of low-income uninsured children, especially those who lived in families with incomes exceeding Medicaid eligibility requirements. Unlike Medicaid, SCHIP is not an entitlement to services for beneficiaries but a capped allotment to states. Congress provided a fixed amount—approximately $40 billion from fiscal years 1998 through 2007—to states with approved SCHIP plans. Funds are allocated to states annually. Subject to certain exceptions, states have 3 years to use each year's allocation, after which unspent funds may be redistributed to states that have already spent all of that year's allocation.

GAO's testimony addresses trends in SCHIP enrollment and the current composition of SCHIP programs across the states, states' spending experiences under SCHIP, and considerations GAO has identified for SCHIP reauthorization.

GAO's testimony is based on its prior work, particularly testimony before the Senate Finance Committee on February 1, 2007 (see GAO-07-447T). GAO updated this work with the Centers for Medicare & Medicaid Services' (CMS) January 2007 approval of Tennessee's SCHIP program.

www.gao.gov/cgi-bin/getrpt?GAO-07-501T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

What GAO Found

SCHIP enrollment increased rapidly during the program's early years but has stabilized over the past several years. As of fiscal year 2005, the latest year for which data are available, SCHIP covered approximately 6 million enrollees, including about 639,000 adults, with about 4 million enrollees in June of that year. Many states adopted innovative outreach strategies and simplified and streamlined their enrollment processes in order to reach as many eligible children as possible. States' SCHIP programs reflect the flexibility federal law allows in structuring approaches to providing health care coverage. As of July 2006, states had opted for the following from among their choices of program structures allowed: a separate child health program (18 states), an expansion of a state's Medicaid program (11), or a combination of the two (21). In addition, 41 states opted to cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher, with 7 of these states covering children in families with incomes at 300 percent of FPL or higher. Thirty-nine states required families to contribute to the cost of their children's care in SCHIP programs through a cost-sharing requirement, such as a premium or copayment; 11 states charged no cost-sharing. As of January 2007, GAO identified 15 states that had waivers in place to cover adults in their programs; these included parents and caretaker relatives of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

SCHIP spending was initially low, but now threatens to exceed available funding. Since 1998, some states have consistently spent more than their allotments, while others spent consistently less. States that earlier overspent their annual allotments over the 3-year period of availability could rely on other states' unspent SCHIP funds, a portion of which were redistributed to cover other states' excess expenditures. By fiscal year 2002, however, states' aggregate annual spending began to exceed annual allotments. As spending has grown, the pool of funds available for redistribution has shrunk. As a result, 18 states were projected to have "shortfalls" of SCHIP funds—meaning they had exhausted all available funds—in at least one of the final 3 years of the program. To cover projected shortfalls faced by several states, Congress appropriated an additional $283 million for fiscal year 2006.

SCHIP reauthorization occurs in the context of debate on broader national health care reform and competing budgetary priorities, highlighting the tension between the desire to provide affordable health insurance coverage to uninsured individuals, including low-income children, and the recognition of the growing strain of health care coverage on federal and state budgets. As Congress addresses reauthorization, issues to consider include (1) maintaining flexibility within the program without compromising the primary goal to cover children, (2) considering the program's financing strategy, including the financial sustainability of public commitments, and (3) assessing issues associated with equity, including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you address the reauthorization of the State Children's Health Insurance Program (SCHIP). In August 1997, Congress created SCHIP with the goal of significantly reducing the number of low-income uninsured children.[1] Prior to SCHIP, approximately 19 million Medicaid beneficiaries were children, and combined federal and state expenditures on their behalf totaled $32 billion. However, there remained an estimated 9 million to 11.6 million children who were uninsured at some time during 1997. SCHIP was established to provide health coverage to uninsured children in families whose incomes exceeded the eligibility requirements for Medicaid. Without health insurance coverage, children are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses.

SCHIP offers states flexibility in how they provide health insurance coverage to children. States implementing SCHIP have three choices in designing their programs: (1) a Medicaid expansion, which affords SCHIP-eligible children the same benefits and services that a state's Medicaid program provides; (2) a separate child health program distinct from Medicaid that uses, for example, specified public or private insurance plans; or (3) a combination program, which has a Medicaid expansion and a separate child health program. At the time of enactment, Congress appropriated a fixed amount of funds—approximately $40 billion from fiscal years 1998 through 2007—to be distributed among states with approved SCHIP plans. Unlike Medicaid, SCHIP is not an entitlement to services for beneficiaries, but a capped grant—or allotment—to states. SCHIP funds are allocated annually to the 50 states, the District of Columbia, and the U.S. commonwealths and territories.[2] Each state's annual SCHIP allotment is available as a federal match based on state expenditures and is available for 3 years, after which time any unspent

[1]Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552-570 (Aug. 5, 1997) (adding Title XXI and new sections 2101-2110 to the Social Security Act, codified, as amended, at 42 U.S.C. §§ 1397aa-1397jj). For the remainder of this testimony, we will only refer to provisions of the U.S. Code when referencing SCHIP requirements.

[2]This testimony focuses on SCHIP programs in the 50 states and the District of Columbia. While Tennessee has not had a SCHIP program since October 2002, in January 2007, the Centers for Medicare & Medicaid Services (CMS) approved the state's plan for a separate child health program under SCHIP. According to state information, the program will be implemented in early 2007.

funds may be redistributed to states that have already spent their allotments.[3]

As Congress considers reauthorization of the SCHIP program, my remarks will address (1) recent data regarding trends in SCHIP enrollment and the estimated number of children who remain uninsured, (2) the current composition of SCHIP programs—including their overall design—across the states, (3) states' spending experiences under SCHIP, and (4) issues we have identified for consideration during SCHIP reauthorization. My testimony is based on prior GAO work, particularly testimony before the Senate Finance Committee on February 1, 2007.[4] We updated this work based on the Centers for Medicare & Medicaid Services' (CMS) January 2007 approval of Tennessee's new SCHIP program. We conducted our work in February 2007 in accordance with generally accepted government auditing standards.

In summary, SCHIP enrollment increased rapidly during the program's early years but has stabilized over the past several years. SCHIP programs reported total enrollment of approximately 6 million individuals—including about 639,000 adults—as of fiscal year 2005, the latest year for which data were available, with about 4 million individuals enrolled in June of that year. Many states adopted innovative outreach strategies, and simplified and streamlined their enrollment processes in order to reach as many eligible children as possible. Nevertheless, about 11.7 percent of children nationwide remain uninsured, many of whom are eligible for SCHIP or Medicaid. The rate of uninsured children varies widely across states, ranging from a low of 5.6 percent to a high of 20.4 percent.

States' SCHIP programs reflect the flexibility allowed in structuring approaches to providing health care coverage through a Medicaid expansion or a separate child health program. In fiscal year 2005, 41 states had opted to cover children in families with incomes at 200 percent of the federal poverty level (FPL) or higher, including 7 states that covered children in families with incomes at 300 percent of FPL or higher. In addition, 39 states required families to contribute to the cost of their children's care in SCHIP programs through some type of cost-sharing

[3]In some cases, states have been allowed to retain a portion of unspent allotments.

[4]See GAO, *Children's Health Insurance: State Experiences in Implementing SCHIP and Considerations for Reauthorization*, GAO-07-447T (Washington, D.C.: February 1, 2007). Related GAO Products are included at the end of this statement.

requirement, such as premiums or copayments; 11 states charged no cost-sharing. Few states (9) reported operating premium assistance programs, which allow states to use SCHIP funds to help pay premiums for available employer-based health plan coverage, in part because states often find these programs are difficult to administer. As of January 2007, we identified 15 states that had approved waivers to cover one or more of three categories of adults: parents and caretaker relatives of eligible Medicaid and SCHIP children, pregnant women, and childless adults.

SCHIP program spending was low initially but now threatens to exceed available funding. Since 1998, some states have consistently spent more than their allotments, while others have consistently spent less. In the first years of the program, states that overspent their annual allotments over the 3-year period of availability could rely on other states' unspent SCHIP funds, which were redistributed to cover excess expenditures. Over time, however, spending has grown, and the pool of funds available for redistribution has shrunk. As a result, in at least one of the final 3 years of the program, 18 states were projected to have "shortfalls" of SCHIP funding—that is, they were expected to exhaust available funds, including current and prior-year allotments. To cover projected shortfalls faced by states, Congress appropriated an additional $283 million for fiscal year 2006. As of January 2007, 14 states were projected to exhaust their allotments in fiscal year 2007.

SCHIP reauthorization is occurring within the context of consideration of broader national health care reform and competing budgetary priorities. There is an obvious tension between the desire to provide affordable health insurance coverage for uninsured individuals, including low-income children, and the recognition of the high cost that health care coverage exerts as a growing share of federal and state budgets. As Congress addresses SCHIP reauthorization, issues that may be considered include (1) maintaining flexibility within the program without compromising the primary goal to cover children, (2) considering the program's financing strategy, including the financial sustainability of public commitments, and (3) assessing issues including better targeting SCHIP funds to achieve certain policy goals more consistently nationwide.

Background

In general, SCHIP funds are targeted to uninsured children in families whose incomes are too high to qualify for Medicaid but are at or below 200 percent of FPL.[5] Recognizing the variability in state Medicaid programs, federal SCHIP law allows a state to cover children in families with incomes up to 200 percent of FPL or 50 percentage points above its existing Medicaid eligibility standard as of March 31, 1997.[6] Additional flexibility regarding eligibility levels is available, however, as Medicaid and SCHIP provide some flexibility in how a state defines income for purposes of eligibility determinations.[7] Congress appropriated approximately $40 billion over 10 years (from fiscal years 1998 through 2007) for distribution among states with approved SCHIP plans. Allocations to states are based on a formula that takes into account the number of low-income children in a state. In general, states that choose to expand Medicaid to enroll eligible children under SCHIP must follow Medicaid rules, while separate child health programs have additional flexibilities in benefits, cost-sharing, and other program elements. Under certain circumstances, states may also cover adults under SCHIP.

SCHIP Allotments to States

SCHIP allotments to states are based on an allocation formula that uses (1) the number of children, which is expressed as a combination of two estimates—the number of low-income children without health insurance and the number of all low-income children, and (2) a factor representing state variation in health care costs. Under federal SCHIP law and subject to certain exceptions, states have 3 years to use each fiscal year's allocation, after which any remaining funds are redistributed among the states that had used all of that fiscal year's allocation.[8] Federal law does

[5]FPL refers to the federal poverty guidelines, which are used to establish eligibility for certain federal assistance programs. The guidelines are updated annually to reflect changes in the cost of living and vary according to family size. For example, in 1998, 200 percent of FPL for a family of four was $32,900, compared with $41,300 in 2007.

[6]42 U.S.C. § 1397jj(b). For example, Alabama covered children aged 15 to 18 up to 15 percent of FPL, while Washington covered this same group up to 200 percent of FPL. Therefore, Alabama would be allowed to establish SCHIP eligibility for children in families with incomes up to 200 percent of FPL, while Washington would be allowed to go as high as 250 percent of FPL.

[7]Some states have expanded income eligibility levels for families through "income disregards," which ignore certain types of family income for purposes of determining eligibility. Such disregards have been imposed as high as 100 percent of FPL, which means that a family with an income equal to 300 percent of FPL is treated as if its income were 200 percent of FPL.

[8]42 U.S.C. § 1397dd(e),(f).

not specify a redistribution formula but leaves it to the Secretary of Health and Human Services (HHS) to determine an appropriate procedure for redistribution of unused allocations.[9] Absent congressional action, states are generally provided 1 year to spend any redistributed funds, after which time funds may revert to the U.S. Treasury. Each state's SCHIP allotment is available as a federal match based on state expenditures. SCHIP offers a strong incentive for states to participate by providing an enhanced federal matching rate that is based on the federal matching rate for a state's Medicaid program—for example, the federal government will reimburse at a 65 percent match under SCHIP for a state receiving a 50 percent match under Medicaid.

There are different formulas for allocating funds to states, depending on the fiscal year. For fiscal years 1998 and 1999, the formula used estimates of the number of low-income uninsured children to allocate funds to states. For fiscal year 2000, the formula changed to include estimates of the total number of low-income children as well.[10]

SCHIP Design Choices

SCHIP gives the states the choice of three design approaches: (1) a Medicaid expansion program, (2) a separate child health program with more flexible rules and increased financial control over expenditures, or (3) a combination program, which has both a Medicaid expansion program and a separate child health program. Initially, states had until September 30, 1998, to select a design approach, submit their SCHIP plans, and obtain HHS approval in order to qualify for their fiscal year 1998 allotment.[11] With an approved state child health plan, a state could begin to enroll children and draw down its SCHIP funds.

[9]42 U.S.C. § 1397dd(f).

[10]For fiscal year 2000, the allocation formula used 75 percent of the number of uninsured low-income children plus 25 percent of the number of all low-income children. For fiscal year 2001 and subsequent fiscal years, the allocation formula evenly weighted the number of uninsured low-income children (50 percent) and the total number of low-income children (50 percent). 42 U.S.C. § 1397dd(b). See also Congressional Research Service (CRS), *SCHIP Original Allotments: Funding Formula Issues and Options* (Washington, D.C.: Apr. 18, 2006).

[11]In May 1998, Congress extended this deadline, allowing states to receive fiscal year 1998 funding if they had submitted and received approval of a state child health plan by September 30, 1999. 1998 Supplemental Appropriations and Rescissions Act, Pub. L. No. 105-174, § 4001, 112 Stat. 1500 (May 1, 1998).

The design approach a state chooses has important financial and programmatic consequences, as shown below.

- **Expenditures.** In separate child health programs, federal matching funds cease after a state expends its allotment, and non-benefit-related expenses (for administration, direct services, and outreach) are limited to 10 percent of claims for services delivered to beneficiaries. In contrast, Medicaid expansion programs may continue to receive federal funds for benefits and for non-benefit-related expenses at the Medicaid matching rate after states exhaust their SCHIP allotments.

- **Enrollment.** Separate child health programs may establish separate eligibility rules and establish enrollment caps. In addition, a separate child health program may limit its own annual contribution, create waiting lists, or stop enrollment once the funds it budgeted for SCHIP are exhausted. A Medicaid expansion must follow Medicaid eligibility rules regarding income, residency, and disability status, and thus generally cannot limit enrollment.

- **Benefits.** Separate child health programs must use, for example, benchmark benefit standards that use specified private or public insurance plans as the basis for coverage. However, Medicaid—and therefore a Medicaid expansion—must provide coverage of all benefits available to the Medicaid population, including certain services for children. In particular, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requires states to cover treatments or stabilize conditions diagnosed during routine screenings—regardless of whether the benefit would otherwise be covered under the state's Medicaid program.[12] A separate child health program does not require EPSDT coverage.

- **Beneficiary cost-sharing.** Separate child health programs may impose limited cost-sharing—through premiums, copayments, or enrollment fees—for children in families with incomes above 150 percent of FPL up to 5 percent of family income annually. Since the Medicaid program did not

[12]While coverage of EPSDT is difficult to measure, federal studies have generally found state efforts to be inadequate. See GAO, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001).

previously allow cost-sharing for children, a Medicaid expansion program under SCHIP would have followed this rule.[13]

SCHIP Coverage of Adults

In general, states may cover adults under the SCHIP program under two key approaches.

- First, federal SCHIP law allows the purchase of coverage for adults in families with children eligible for SCHIP under a waiver if a state can show that it is cost-effective to do so and demonstrates that such coverage does not result in "crowd-out"—a phenomenon in which new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.[14] The cost-effectiveness test requires the states to demonstrate that covering both adults and children in a family under SCHIP is no more expensive than covering only the children. The states may also elect to cover children whose parents have access to employer-based or private health insurance coverage by using SCHIP funding to subsidize the cost.

- Second, under section 1115 of the Social Security Act, states may receive approval to waive certain Medicaid or SCHIP requirements or authorize Medicaid or SCHIP expenditures. The Secretary of Health and Human Services may approve waivers of statutory requirements or authorize expenditures in the case of experimental, pilot, or demonstration projects that are likely to promote program objectives.[15] In August 2001, HHS indicated that it would allow states greater latitude in using section 1115 demonstration projects (or waivers) to modify their Medicaid and SCHIP programs and that it would expedite consideration of state proposals. One initiative, the Health Insurance Flexibility and Accountability Initiative (HIFA), focuses on proposals for covering more uninsured people while at the same time not raising program costs. States have received approval of

[13]As of March 31, 2006, states may impose cost-sharing for children whom the state has chosen to cover under Medicaid. 42 U.S.C. § 1396o-1. If a state imposes cost-sharing for Medicaid, a Medicaid expansion program for SCHIP-eligible children would follow this rule.

[14]See 42 U.S.C. § 1397ee(c)(3).

[15]42 U.S.C. § 1315.

section 1115 waivers that provide coverage of adults using SCHIP funding.[16]

SCHIP Enrollment Has Grown Rapidly; States' Rates of Uninsured Children Vary Significantly

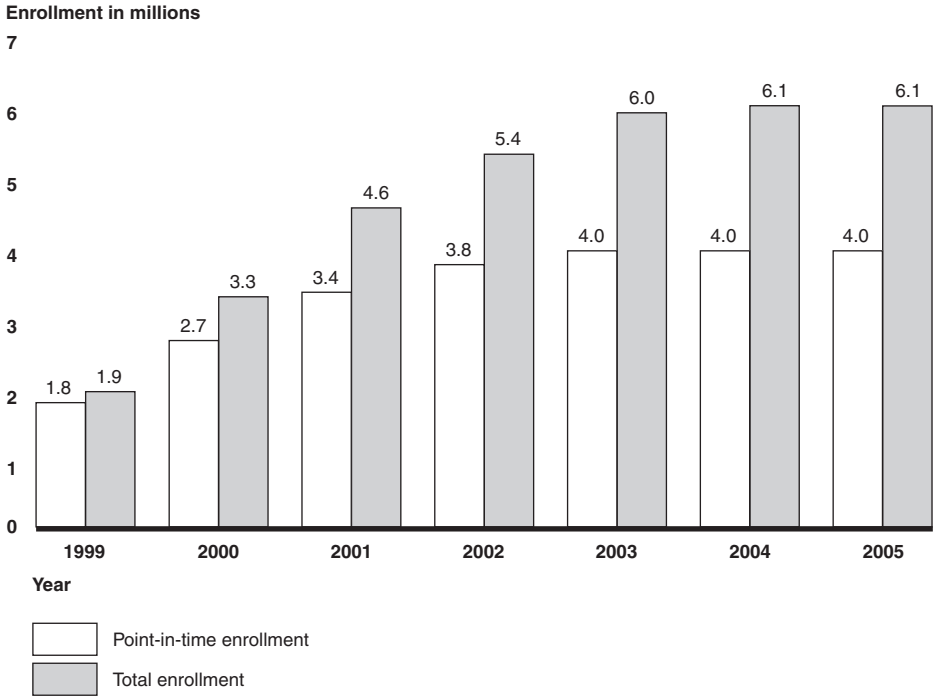
SCHIP enrollment increased rapidly over the first years of the program, and has stabilized for the past several years. In 2005, the most recent year for which data are available, 4.0 million individuals were enrolled during the month of June, while the total enrollment count—which represents a cumulative count of individuals enrolled at any time during fiscal year 2005—was 6.1 million. Of these 6.1 million enrollees, 639,000 were adults. Because SCHIP requires that applicants are first screened for Medicaid eligibility, some states have experienced increases in their Medicaid programs as well, further contributing to public health insurance coverage of low-income children during this same period. Based on a 3-year average of 2003 through 2005 Current Population Survey (CPS) data, the percentage of uninsured children varied considerably by state, with a national average of 11.7 percent.

SCHIP annual enrollment grew quickly from program inception through 2002 and then stabilized at about 4 million from 2003 through 2005, on the basis of a point-in-time enrollment count. Total enrollment, which counts individuals enrolled at any time during a particular fiscal year, showed a similar pattern of growth and was over 6 million as of June 2005 (see fig. 1).[17] Generally, point-in-time enrollment is a subset of total enrollment, as it represents the number of individuals enrolled during a particular month. In contrast, total enrollment includes an unduplicated count of any individual enrolled at any time during the fiscal year; thus the data are cumulative, with new enrollments occurring monthly.

[16]As of October 1, 2005, the Secretary of Health and Human Services was prohibited from approving new section 1115 waivers that use SCHIP funds to provide coverage of nonpregnant childless adults. See Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397gg).

[17]The 4 million enrollment count is based on "point-in-time enrollment," representing the number of enrollees in states' SCHIP programs for the month of December for 1999 through 2004; for 2005, data for the month of June were used. See Vernon K. Smith, David Rousseau, and Caryn Marks, *SCHIP Program Enrollment: June 2005 Update* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, December 2006). The total enrollment count reflects all enrollees in the SCHIP program for a fiscal year from 1999 through 2005. See, for example, the 2005 annual enrollment report, at http://www.cms.hhs.gov/NationalSCHIPPolicy/06_SCHIPAnnualReports.asp (downloaded Jan. 28, 2007).

Figure 1: SCHIP Enrollment, 1999-2005



Source: CMS and state enrollment data.

Note: Point-in-time enrollment represents the number of enrollees in states' SCHIP programs for the month of December for 1999 through 2004; for 2005, data for the month of June were used. Total enrollment represents the cumulative number of individuals who enrolled in the program at any time during the fiscal year. We obtained enrollment data from Vernon K. Smith, David Rousseau, and Caryn Marks, *SCHIP Program Enrollment: June 2005 Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, December 2006); Vernon K. Smith and David M. Rousseau, *SCHIP Enrollment in 50 States: December 2004 Data Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, September 2005); and Vernon K. Smith, David M. Rousseau, and Molly O'Malley, *SCHIP Program Enrollment: December 2003 Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, July 2004).

Our prior work has shown that certain obstacles can prevent low-income families from enrolling their children into public programs such as Medicaid or SCHIP.[18] Primary obstacles included families' lack of knowledge about program availability and that, even when children were

[18]GAO-03-191; GAO, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May 14, 1999); and *GAO*, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*, GAO/HEHS-98-93 (Washington, D.C.: Mar. 20, 1998).

eligible to participate, complex eligibility rules and documentation requirements complicated the application process.

During the early years of SCHIP program operation, we found that many states developed and deployed outreach strategies in an effort to overcome these enrollment barriers. Many states adopted innovative outreach strategies and simplified and streamlined their enrollment processes in order to reach as many eligible children as possible.[19] Examples follow.

- States launched ambitious public education campaigns that included multimedia campaigns, direct mailings, and the widespread distribution of applications.
- To overcome the barrier of a long, complicated SCHIP eligibility determination process, states reduced verification and documentation requirements that exceeded federal requirements, shortened the length of applications, and used joint SCHIP-Medicaid applications.
- States also located eligibility workers in places other than welfare offices—schools, child care centers, churches, local tribal organizations, and Social Security offices—to help families with the initial processing of applications.
- States eased the process by which applicants reapplied for SCHIP at the end of their coverage period. For example, one state mailed families a summary of the information on their last application, and asked families to update any changes to the information.

Because states must also screen for Medicaid eligibility before enrolling children into SCHIP, some states have noted increased enrollment in Medicaid as a result of SCHIP. For example, Alabama reported a net increase of approximately 121,000 children in Medicaid since its SCHIP program began in 1998. New York reported that, for fiscal year 2005, approximately 204,000 children were enrolled in Medicaid as a result of outreach activities, compared with 618,973 children enrolled in SCHIP. In contrast, not all states found that their Medicaid enrollment was

[19]See GAO, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, GAO-01-883 (Washington, D.C.: Sept. 10, 2001); *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits*, GAO/HEHS-00-86 (Washington, D.C.: Apr. 14, 2000); and GAO/HEHS-99-65.

significantly affected by SCHIP. For example, Idaho reported that a negligible number of children were found eligible for Medicaid as a result of outreach related to its SCHIP program. Maryland identified an increase of 0.2 percent between June 2004 and June 2005.

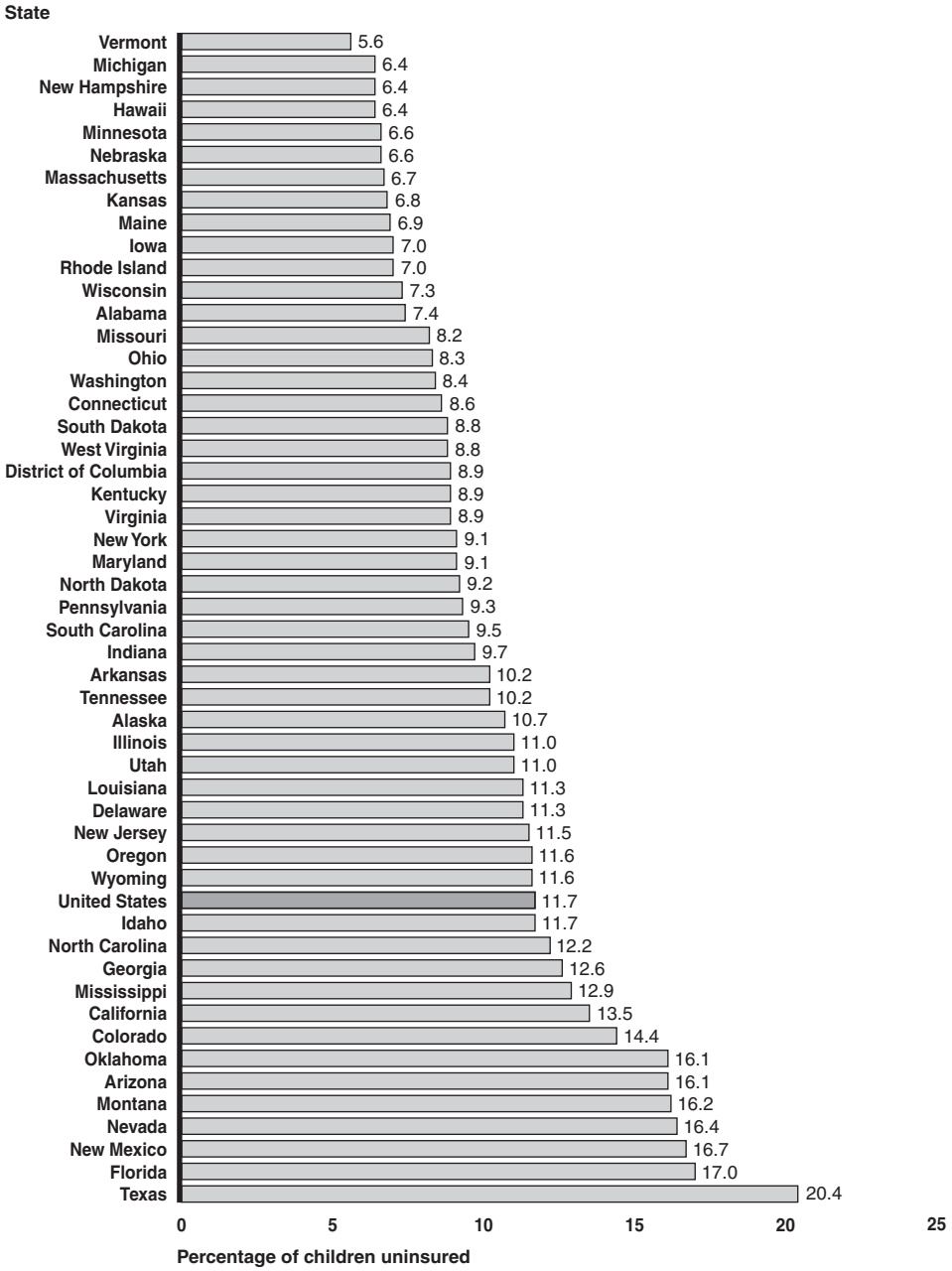
Based on a 3-year average of 2003 through 2005 CPS data, the percentage of uninsured children varied considerably by state and had a national average of 11.7 percent.[20] The percentage of uninsured children ranged from 5.6 percent in Vermont to 20.4 percent in Texas (see fig. 2).[21] According to the Congressional Research Service (CRS) analysis of 2005 CPS data, the percentage of uninsured children was higher in the southern (13.7 percent) and western (13.8 percent) regions of the United States compared with children living in northeastern (8.5 percent) and midwestern (8.2 percent) regions.[22] Nearly 40 percent of the nation's uninsured children lived in three of the most populous states—California, Florida, and Texas—each of which had percentages of uninsured children above the national average.

[20]Estimates of the number of uninsured children are derived from the annual health insurance supplement to the CPS. Health insurance information is collected through the Annual Social and Economic Supplement, formerly termed the March supplement.

[21]Because sample sizes can be relatively small in less populous states, state estimates are developed using a 3-year average, which is the same method used in the formula to allocate funds to states for SCHIP. Since the authorization of SCHIP in 1997, there have been changes to the CPS. In March 2001, the CPS sample was expanded, which was expected to result in more precise state estimates of individuals' health insurance status for all states.

[22]CRS, *Health Insurance Coverage of Children, 2005* (Washington, D.C.: Sept. 6, 2006).

Figure 2: Percentage of Uninsured Children, by State, 2003-2005



Source: GAO analysis of CPS data, 3-year average (2003 through 2005).

Variations across states in rates of uninsured children may be linked to a number of factors, including the availability of employer-sponsored coverage.[23] We have previously reported that certain types of workers were less likely to have had access to employer-sponsored insurance and thus were more likely to be uninsured.[24] In particular, those working part-time, for small firms, or in certain industries such as agriculture or construction, were among the most likely to be uninsured. Additionally, states with high uninsured rates and those with low rates often were distinct with regard to several characteristics. For example, states with higher than average uninsured rates tended to have higher unemployment and proportionally fewer employers offering coverage to their workers. Small employers—those with less than 10 employees—were much less likely to offer health insurance to their employees than larger employers.

States' SCHIP Programs Reflect a Variety of Approaches to Providing Health Care Coverage

States' SCHIP programs reflect the flexibility allowed in structuring approaches to providing health care coverage, including their choice among three program designs—Medicaid expansions, separate child health programs, and combination programs, which have both a Medicaid expansion and a separate child health program component. As of fiscal year 2005, 41 state SCHIP programs covered children in families whose incomes are up to 200 percent of FPL or higher, with 7 of the 41 states covering children in families whose incomes are at 300 percent of FPL or higher. States generally imposed some type of cost-sharing in their programs, with 39 states charging some combination of premiums, copayments, or enrollment fees, compared with 11 states that did not charge cost-sharing. Nine states reported operating premium assistance programs that use SCHIP funding to subsidize the cost of premiums for private health insurance coverage. As of January 2007, we identified 15 states with approved section 1115 waivers to cover adults, including parents and caretaker relatives, pregnant women, and, in some cases, childless adults.

[23]Genevieve Kenney and Allison Cook, "Coverage Patterns among SCHIP-Eligible Children and Their Parents," *Health Policy Online*, no. 15 (February 2007), downloaded on 2/12/2007 from http://www.urban.org/url.cfm?ID=311420; and Linda J. Blumberg, Amy J. Davidoff, *Exploring State Variation in Uninsurance Rates among Low-Income Workers* (Washington, D.C.: Urban Institute, Oct. 8, 2003).

[24]See GAO, *Health Insurance: States' Protections and Programs Benefit Some Unemployed Individuals*, GAO-03-191 (Washington, D.C.: Oct. 25, 2002).

States Employ All Three Design Approaches, with Coverage Generally Extending to 200 Percent of FPL

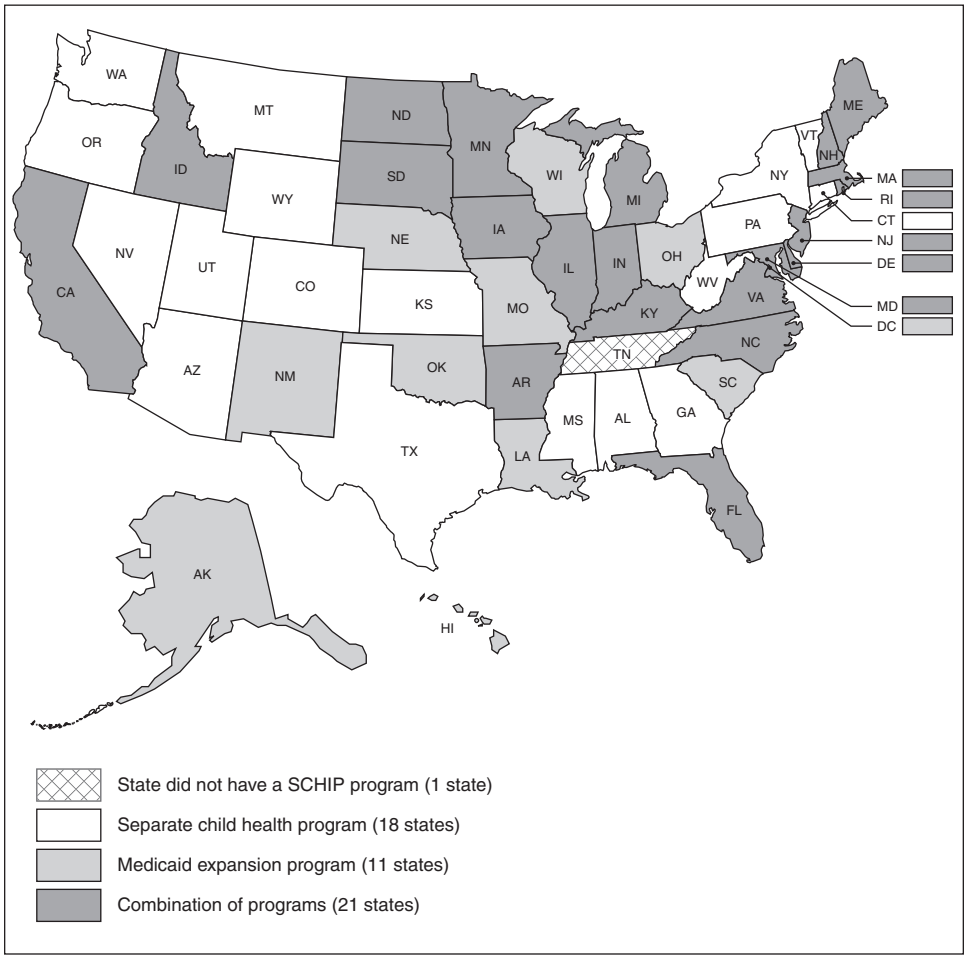
As of July 2006, of the 50 states currently operating SCHIP programs, 11 states had Medicaid expansion programs, 18 states had separate child health programs, and 21 states had a combination of both approaches (see fig. 3).[25] When the states initially designed their SCHIP programs, 27 states opted for expansions to their Medicaid programs.[26] Many of these initial Medicaid expansion programs served as "placeholders" for the state—that is, minimal expansions in Medicaid eligibility were used to guarantee the 1998 fiscal year SCHIP allocation while allowing time for the state to plan a separate child health program. Other initial Medicaid expansions—whether placeholders or part of a combination program—also accelerated the expansion of coverage for children aged 14 to 18 up to 100 percent of FPL, which states are already required to cover under federal Medicaid law.[27]

[25]The 50 states include the District of Columbia. In January 2007, CMS approved Tennessee's plan for a separate child health program under SCHIP. According to state information, the program will be implemented in early 2007.

[26]GAO/HEHS-99-65.

[27]42 U.S.C. § 1396a(a)(10)(A)(i)(vii) requires states to provide Medicaid coverage to children born after September 30, 1983, aged 6 to 18.

Figure 3: State SCHIP Design Choices as of July 2006



Source: Copyright © Corel Corp. All rights reserved (map); GAO analysis of CMS data.

Note: In January 2007, CMS approved Tennessee's plan for a separate child health program under SCHIP. According to state information, the program will be implemented in early 2007.

A state's starting point for SCHIP eligibility is dependent upon the eligibility levels previously established in its Medicaid program. Under federal Medicaid law, all state Medicaid programs must cover children aged 5 and under if their family incomes are at or below 133 percent of FPL and children aged 6 through 18 if their family incomes are at or below 100 percent of FPL.[28] Some states have chosen to cover children in families

[28]42 U.S.C. § 1396a(a)(10)(A)(i), (iv), (vi), (vii).

with higher income levels in their Medicaid programs.[29] Each state's starting point essentially creates a "corridor"—generally, SCHIP coverage begins where Medicaid ends and then continues upward, depending on each state's eligibility policy.[30]

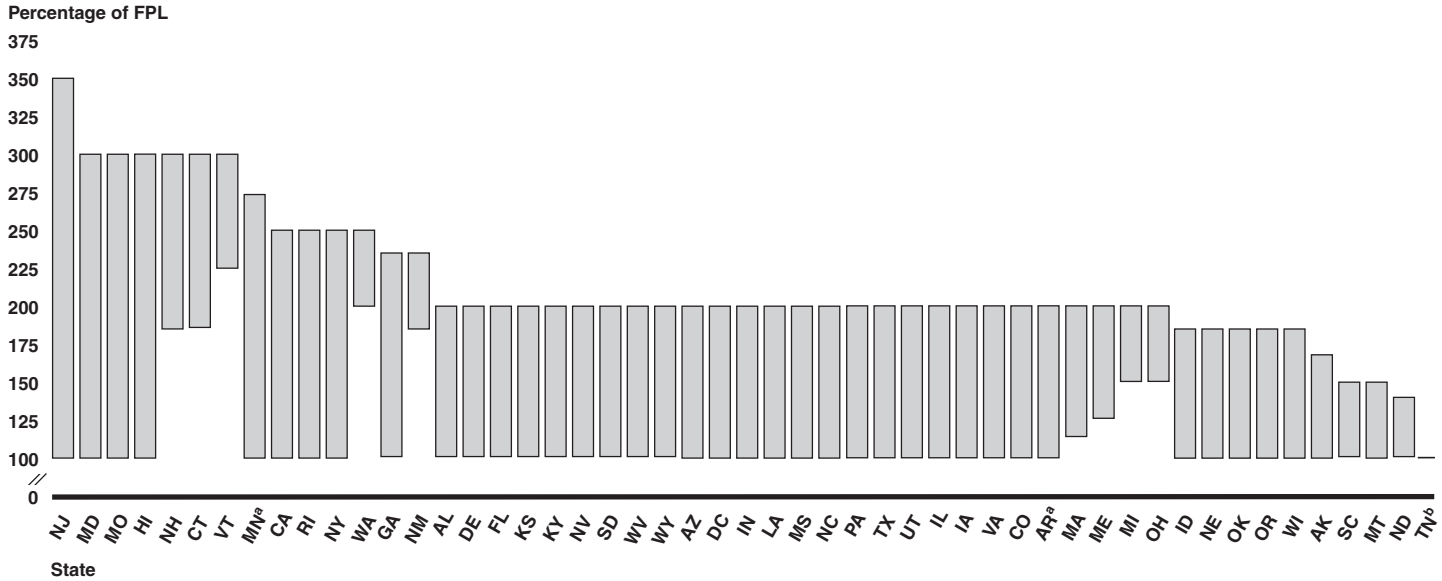
In fiscal year 2005, 41 states used SCHIP funding to cover children in families with incomes up to 200 percent of FPL or higher, including 7 states that covered children in families with incomes up to 300 percent of FPL or higher.[31] In total, 27 states provided SCHIP coverage for children in families with incomes up to 200 percent of FPL, which was $38,700 for a family of four in 2005. Another 14 states covered children in families with incomes above 200 percent of FPL, with New Jersey reaching as high as 350 percent of FPL in its separate child health program. Finally, 9 states set SCHIP eligibility levels for children in families with incomes below 200 percent of FPL. For example, North Dakota covered children in its separate child health program up to 140 percent of FPL. (See fig. 4.) (See app. I for the SCHIP upper income eligibility levels by state, as a percentage of FPL.)

[29]States also have the option under federal Medicaid law to extend coverage of children in families with incomes at or below 185 percent of FPL, or even at higher income levels under a section 1115 waiver. 42 U.S.C. §§ 1315, 1396a(a)(10)(A)(ii)(ix).

[30]The corridor represents the FPL levels in states' SCHIP programs above the levels offered by their Medicaid programs. A state's starting point for SCHIP eligibility is dependent on the eligibility levels previously established in its Medicaid program. However, states' SCHIP programs may provide coverage to individuals who have incomes at the Medicaid level if they cannot qualify for Medicaid. For example, states may offer SCHIP coverage to individuals whose incomes are at the Medicaid level, but who cannot qualify for Medicaid because they cannot meet citizenship or other Medicaid eligibility requirements.

[31]In January 2007, CMS approved Tennessee's SCHIP plan, which covers pregnant women and children in families with incomes up to 250 percent of FPL. According to state information, the program will be implemented in early 2007.

Figure 4: Corridor of SCHIP Eligibility for Children Aged 6 through 18 Years, Fiscal Year 2005



Source: GAO analysis of states' annual SCHIP reports for 2005 and the National Academy for State Health Policy.

Note: In some cases, we obtained data from Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

The corridor represents the FPL levels in states' SCHIP programs above the levels offered by their Medicaid programs. A state's starting point for SCHIP eligibility is dependent on the eligibility levels previously established in its Medicaid programs. However, states' SCHIP programs may provide coverage to individuals who have incomes at the Medicaid level if they cannot qualify for Medicaid. For example, states may offer SCHIP coverage to individuals whose incomes are at the Medicaid level, but who cannot qualify for Medicaid because they cannot meet citizenship or other Medicaid eligibility requirements.

[a]State did not have an FPL eligibility level for SCHIP that was above its Medicaid eligibility level for this age group because its Medicaid program also covered children up to this FPL level. The state provided SCHIP coverage to individuals whose incomes are at the Medicaid level but who cannot qualify for Medicaid because of citizenship or other requirements.

[b]In January 2007, CMS approved Tennessee's SCHIP plan, which covers pregnant women and children in families with incomes up to 250 percent of FPL. According to state information, the program will be implemented in early 2007.

Separate Child Health Program Benefit Packages Reflect the Full Range of SCHIP Options

Under federal SCHIP law, states with separate child health programs have the option of using different bases for establishing their benefit packages. Separate child health programs can choose to base their benefit packages on (1) one of several benchmarks specified in federal SCHIP law, such as the Federal Employees Health Benefits Program (FEHBP) or state employee coverage; (2) a benchmark-equivalent set of services, as defined under federal law; (3) coverage equivalent to state-funded child health

programs in Florida, New York, or Pennsylvania; or (4) a benefit package approved by the Secretary of Health and Human Services (see table 1).

Table 1: Basis for Required Scope of Health Insurance Coverage for States with Separate Child Health Programs

Basis of coverage	Description	State
Benchmark (14 states)	Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield standard option, or coverage generally available to state employees, or coverage under the states' health maintenance organization with the largest insured commercial non-Medicaid enrollment.	Alabama, California, Connecticut, Delaware, Iowa,[a] Kansas, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, North Carolina, Texas
Benchmark-equivalent (12 states)	Basic coverage for inpatient and outpatient hospital, physicians' surgical and medical, laboratory and x-ray, and well-baby and well-child care, including age-appropriate immunizations. Coverage must be equal to the value of benchmark coverage.	Colorado, Georgia, Illinois, Indiana, Iowa,[a] Kentucky, Montana, North Dakota, Rhode Island, Utah, Virginia, West Virginia
Existing comprehensive state coverage (3 states)	Coverage equivalent to state-funded child health programs in Florida, New York, or Pennsylvania.	Florida, New York, Pennsylvania
Secretary-approved (8 states)[b]	Coverage determined appropriate for targeted low-income children.	Arizona, Arkansas, Idaho, Maine, Nevada, Oregon, Vermont, Wyoming

Source: Assistant Secretary for Planning and Evaluation SCHIP Database, 2001; states' annual SCHIP reports for 2002 through 2005; and GAO, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May 14, 1999).

[a]State's SCHIP program reports using two bases of coverage—benchmark and benchmark-equivalent.

[b]In January 2007, CMS approved Tennessee's SCHIP plan, which has a Secretary-approved benefits package. According to state information, the program will be implemented in early 2007.

In some cases, separate child health programs have changed their benefit packages, adding and removing benefits over time, as follows.

- In 2003, Texas discontinued dental services, hospice services, skilled nursing facilities coverage, tobacco cessation programs, vision services, and chiropractic services. In 2005, the state added many of these services (chiropractic services, hospice services, skilled nursing facilities, tobacco cessation services, and vision care) back into the SCHIP benefit package and increased coverage of mental health and substance abuse services.

- In January 2002, Utah changed its benefit structure for dental services, reducing coverage for preventive (cleanings, examinations, and x-rays) and emergency dental services in order to cover as many children as possible with limited funding. In September 2002, the dental benefit package was further restructured to include dental coverage for accidents, as well as fluoride treatments and sealants.

Most SCHIP Programs Require Cost-Sharing, but Amounts Charged Vary Considerably

In 2005, most states' SCHIP programs required families to contribute to the cost of care with some kind of cost-sharing requirement. The two major types of cost-sharing—premiums and copayments—can have different behavioral effects on an individual's participation in a health plan.[32] Generally, premiums are seen as restricting entry into a program, whereas copayments affect the use of services within the program. There is research indicating that if cost-sharing is too high, or imposed on families whose income is too low, it can impede access to care and create financial burdens for families.[33]

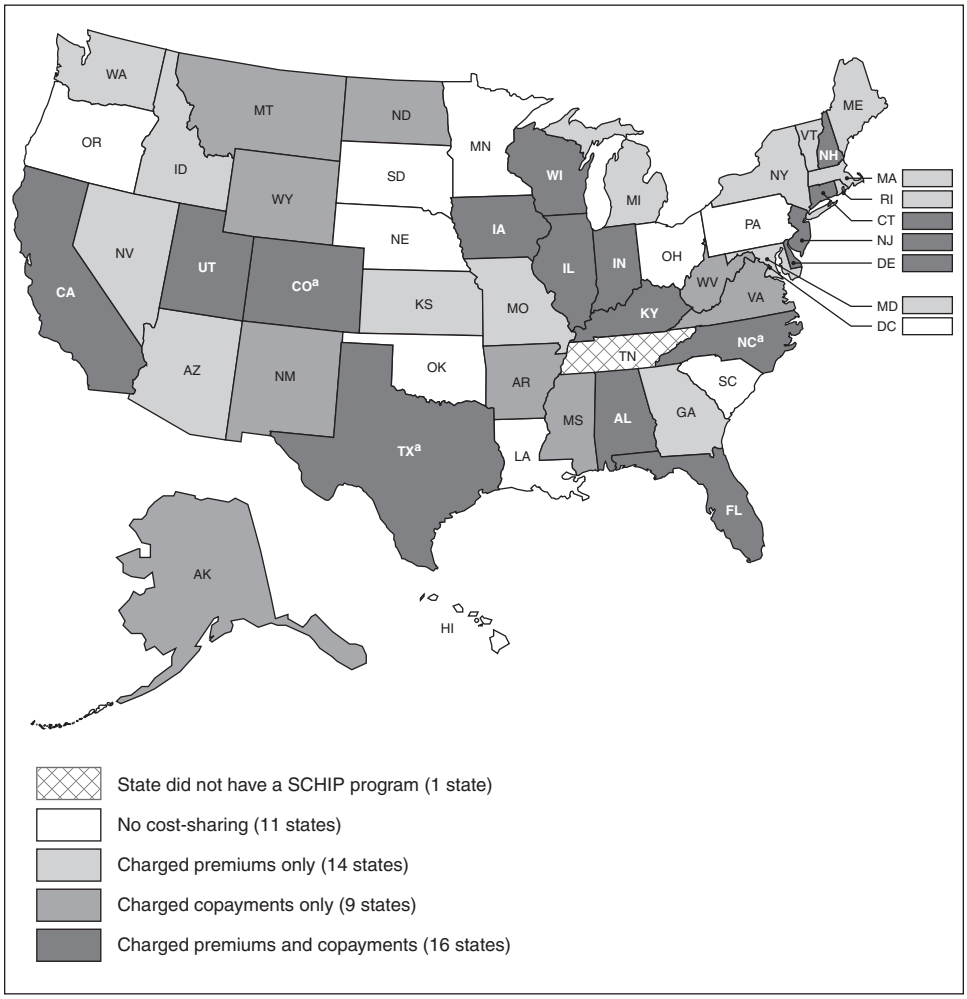
In 2005, states' annual SCHIP reports showed that 39 states had some type of cost-sharing—premiums, copayments, or enrollment fees—while 11 states reported no cost-sharing in their SCHIP programs.[34] Overall, 16 states charged premiums and copayments, 14 states charged premiums only, and 9 states charged copayments only (see fig. 5).

[32]Opinions differ over the extent to which different types of cost-sharing are appropriate and useful tools for managing health care utilization among low-income populations. Premiums are sometimes viewed as promoting personal responsibility by having the beneficiary participate in the cost of coverage. Proponents of cost-sharing believe that copayments can make individuals more price-conscious consumers of health care services, which may reduce the use of unnecessary services. Others believe that cost-sharing requirements may limit service use, such as physician visits, causing individuals to defer necessary treatment, resulting in more severe conditions and potentially higher expenses. See GAO, *Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries*, GAO-04-491 (Washington, D.C.: Mar. 31, 2004).

[33]See Tricia Johnson, Mary Rimsza, and William G. Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health* (April 2006); Leighton Ku and Teresa A. Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington, D.C.: The Urban Institute, Mar. 1, 1997); and Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, May 2005).

[34]In January 2007, CMS approved Tennessee's SCHIP plan, which allows the state to impose copayments on services. According to state information, the program will be implemented in early 2007.

Figure 5: Types of Cost-Sharing under SCHIP, Fiscal Year 2005



Source: Copyright © Corel Corp. All rights reserved (map); GAO analysis of states' annual SCHIP reports.

Note: In January 2007, CMS approved Tennessee's SCHIP plan, which allows the state to impose copayments on services. According to state information, the program will be implemented in early 2007.

[a]State charged an enrollment fee.

Cost-sharing occurred more frequently in the separate child health programs than in Medicaid expansion programs. For example, 8 states with Medicaid expansion programs had cost-sharing requirements, compared with 34 states operating separate child health program

components.[35] The amount of premiums charged varied considerably among the states that charged cost-sharing. For example, premiums ranged from $5.00 per family per month for children in families with incomes from 150 to 200 percent of FPL in Michigan to $117 per family per month for children in families with incomes from 300 to 350 percent of FPL in New Jersey. Federal SCHIP law prohibits states from imposing cost-sharing on SCHIP-eligible children that totals more than 5 percent of family income annually.[36] In addition, cost-sharing for children may be imposed on the basis of family income. For example, we earlier reported that in 2003, Virginia SCHIP copayments for children in families with incomes from 133 percent to below 150 percent of FPL were $2 per physician visit or per prescription and $5 for services for children in families with higher incomes.[37]

Few States Offer Premium Assistance Programs

In fiscal year 2005, nine states reported operating premium assistance programs (see table 2), but implementation remains a challenge. Enrollment in these programs varied across the states. For example, Louisiana reported having under 200 enrollees and Oregon reported having nearly 6,000 enrollees.[38] To be eligible for SCHIP, a child must not be covered under any other health coverage program or have private health insurance. However, some uninsured children may live in families with access to employer-sponsored health insurance coverage. Therefore, states may choose to establish premium assistance programs, where the state uses SCHIP funds to contribute to health insurance premium

[35]States that opt for Medicaid expansions must follow Medicaid rules—and cost-sharing for children is generally not allowed.

[36]42 U.S.C. § 1397cc(e). Federal SCHIP regulations include other limits on cost-sharing. For example, states with separate child health programs are not permitted to impose any cost-sharing on covered well-baby and well-child care services. Additionally, states may require cost-sharing for children in families with incomes at or below 150 percent of FPL, but premium amounts cannot exceed the maximum charges that are permitted under Medicaid. States are also prohibited from charging cost-sharing to American Indians or Alaska Natives. 42 C.F.R. §§ 457.520, et. seq.

[37]GAO-04-491.

[38]Data for premium assistance program enrollment for Louisiana were obtained from CMS's 2005 annual SCHIP report and for Oregon from Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

payments.[39] To the extent that such coverage is not equivalent to the states' Medicaid or SCHIP level of benefits, including limited cost-sharing, states are required to pay for supplemental benefits and cost-sharing to make up this difference. Under certain section 1115 waivers, however, states have not been required to provide this supplemental coverage to participants.

Table 2: Premium Assistance Programs in Nine States, Fiscal Year 2005

State	Design of SCHIP program	Authority for premium assistance program	Population covered under authority		Supplemental coverage for benefits or cost-sharing
			Children	Adults	
Idaho	Combination	Section 1906	✔		No
		Section 1115 HIFA	✔	✔	
Illinois	Combination	Section 1115 HIFA	✔	[a]	No
Louisiana	Medicaid expansion	Section 1906	✔	✔	Yes, for benefits and cost-sharing
Massachusetts	Combination	Premium assistance under SCHIP plan	✔		No
		Section 1115 non-HIFA	✔		
New Jersey	Combination	Section 1115 non-HIFA	✔	✔	Yes, for benefits and cost-sharing
Oregon	Separate program	Section 1115 HIFA	✔	✔	No
Rhode Island	Combination	Premium assistance under SCHIP plan	✔		Yes, for benefits and cost-sharing
		Family coverage under SCHIP plan	✔	✔	
		Section 1115 non-HIFA	✔	✔	
		Section 1906		✔	
Virginia[b]	Combination	Premium assistance under SCHIP plan	✔		Yes, for benefits[c]
		Section 1115 HIFA	✔		
		Section 1906	✔	✔	
Wisconsin	Medicaid expansion	Section 1115 non-HIFA	✔	✔	Yes, for benefits and cost-sharing

Source: CMS; states' Annual SCHIP Reports for 2005; and Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

[a]Coverage of adults under Illinois' program became effective January 1, 2006.

[39]States may establish premium assistance programs under separate child health programs or under Medicaid programs, including as part of a section 1115 waiver. See 42 U.S.C. §§ 1315, 1396e; 42 C.F.R. § 457.810.

[b]Virginia offered a SCHIP premium assistance program from October 2001 until July 31, 2005, entitled the Employer Sponsored Health Insurance (ESHI) program. On August 1, 2005, the ESHI program was replaced by a new SCHIP premium assistance program entitled Family Access to Medical Insurance Security (FAMIS) Select. CMS approved this program on July 1, 2005, as part of a section 1115 waiver.

[c]Virginia's supplemental payments were limited to immunizations not covered by the employer/private health plan.

Several states reported facing challenges implementing their premium assistance programs. Louisiana, Massachusetts, New Jersey, and Virginia cited administration of the program as labor intensive. For example, Massachusetts noted that it is a challenge to maintain current information on program participants' employment status, choice of health plan, and employer contributions, but such information is needed to ensure accurate premium payments. Two states—Rhode Island and Wisconsin—noted the challenges of operating premium assistance programs, given changes in employer-sponsored health plans and accompanying costs. For example, Rhode Island indicated that increases in premiums are being passed to employees, which makes it more difficult to meet cost-effectiveness tests applicable to the purchase of family coverage.[40]

Adult Coverage in SCHIP Is Primarily Accomplished through Waivers

States opting to cover adult populations using SCHIP funding may do so under an approved section 1115 waiver. As of January 2007, we identified 15 states with approved waivers to cover at least one of three categories of adults: parents of eligible Medicaid and SCHIP children, pregnant women, and childless adults. (See table 3.) The Deficit Reduction Act of 2005 (DRA), however, has prohibited the use of SCHIP funds to cover nonpregnant childless adults.[41] Effective October 1, 2005, the Secretary of Health and Human Services may not approve new section 1115 waivers that use SCHIP funds for covering nonpregnant childless adults. However, waivers for covering these adults that were approved prior to this date are allowed to continue until the end of the waiver. Additionally, the Secretary may continue to approve section 1115 waivers that extend SCHIP coverage to pregnant adults, as well as parents and other caretaker relatives of children eligible for Medicaid or SCHIP.

[40]The cost-effectiveness test requires the states to demonstrate that covering both adults and children in a family under SCHIP is not more expensive than covering only the children. 42 U.S.C. §1397ee(c).

[41]DRA, Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified as amended at 42 U.S.C. § 1397gg).

Table 3: States Covering Adults in SCHIP under Section 1115 Waivers, Categories of Covered Adults, and Upper Income Eligibility Thresholds as a Percentage of FPL

	Covered adults			
State	Parents	Pregnant women	Childless adults[a]	Percentage of FPL
Arkansas	✔		✔	200
Arizona	✔		✔	200 (parents); 100 (childless adults)
Colorado		✔		200
Idaho	✔	✔	✔	185
Illinois	✔		✔	200 (parents); 185 (childless adults)
Michigan			✔	35
Minnesota	✔			200
Nevada	✔	✔		200 (parents); 185 (pregnant women)
New Jersey	✔	✔		200
New Mexico	✔		✔	200
Oregon	✔	✔		185
Rhode Island	✔	✔		185 (parents); 250 (pregnant women)
Utah	✔		✔	150
Virginia		✔		200
Wisconsin	✔			200

Source: GAO analysis of waiver documents and correspondence, as of January 2007.

[a]The DRA prohibited the use of SCHIP funds to cover nonpregnant childless adults. Effective October 1, 2005, the Secretary of Health and Human Services may not approve new section 1115 waivers that use SCHIP funds for covering nonpregnant childless adults. However, waivers approved prior to that date are allowed to continue until the end of the waiver.

States' SCHIP Spending Was Initially Low but Now Threatens to Exceed Available Funding

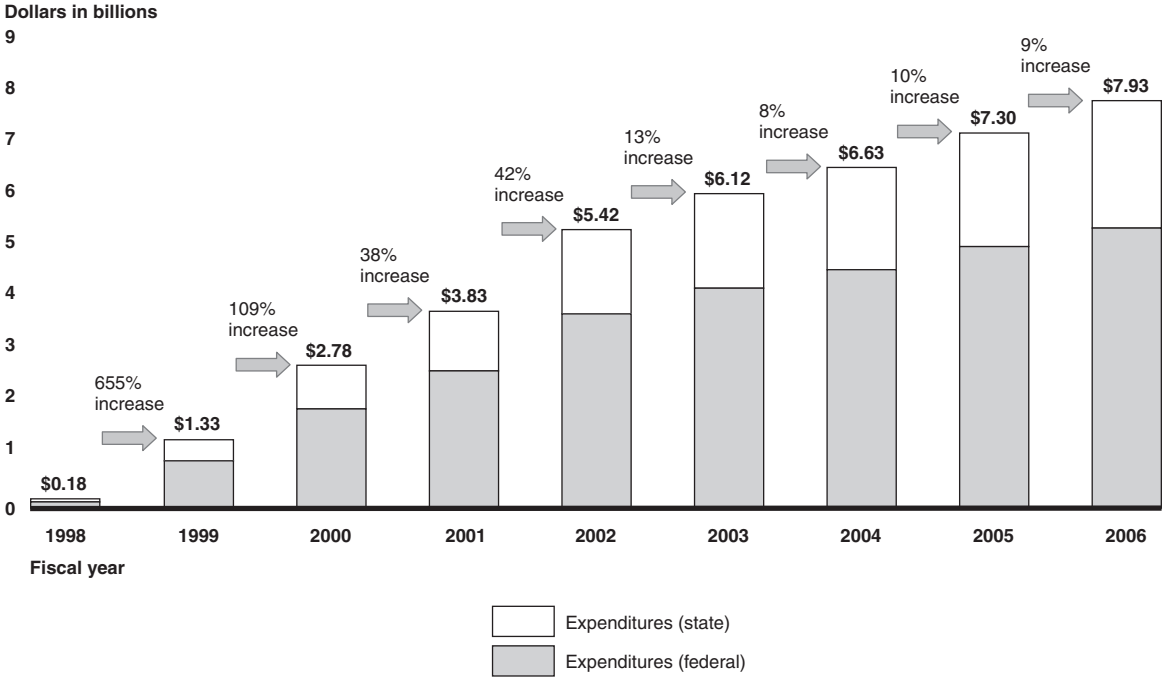
SCHIP program spending was low initially, as many states did not implement their programs or report expenditures until 1999 or later, but spending was much higher in the program's later years and now threatens to exceed available funding. Beginning in fiscal year 2002, states together spent more federal dollars than they were allotted for the year and thus relied on the 3-year availability of SCHIP allotments or on redistributed SCHIP funds to cover additional expenditures. But as spending has grown, the pool of funds available for redistribution has shrunk. Some states consistently spent more than their allotted funds, while other states consistently spent less. Overall, 18 states were projected to have

shortfalls—that is, they were expected to exhaust available funds, including current and prior-year allotments—in at least 1 year from 2005 through 2007. To cover projected shortfalls that several states faced, Congress appropriated an additional $283 million for fiscal year 2006. As of January 2007, 14 states are projected to exhaust their allotments in fiscal year 2007.

Program Spending, Low in SCHIP's Early Years, Exceeded Allotments by 2002

SCHIP program spending began low, but by fiscal year 2002, states' aggregate annual spending from their federal allotments exceeded their annual allotments. Spending was low in the program's first 2 years because many states did not implement their programs or report expenditures until fiscal year 1999 or later. Combined federal and state spending was $180 million in 1998 and $1.3 billion in 1999. However, by the end of the program's third fiscal year (2000), all 50 states and the District of Columbia had implemented their programs and were drawing down their federal allotments. Since fiscal year 2002, SCHIP spending has grown by an average of about 10 percent per year. (See fig. 6.)

Figure 6: Combined State and Federal SCHIP Expenditures, Fiscal Years 1998-2006

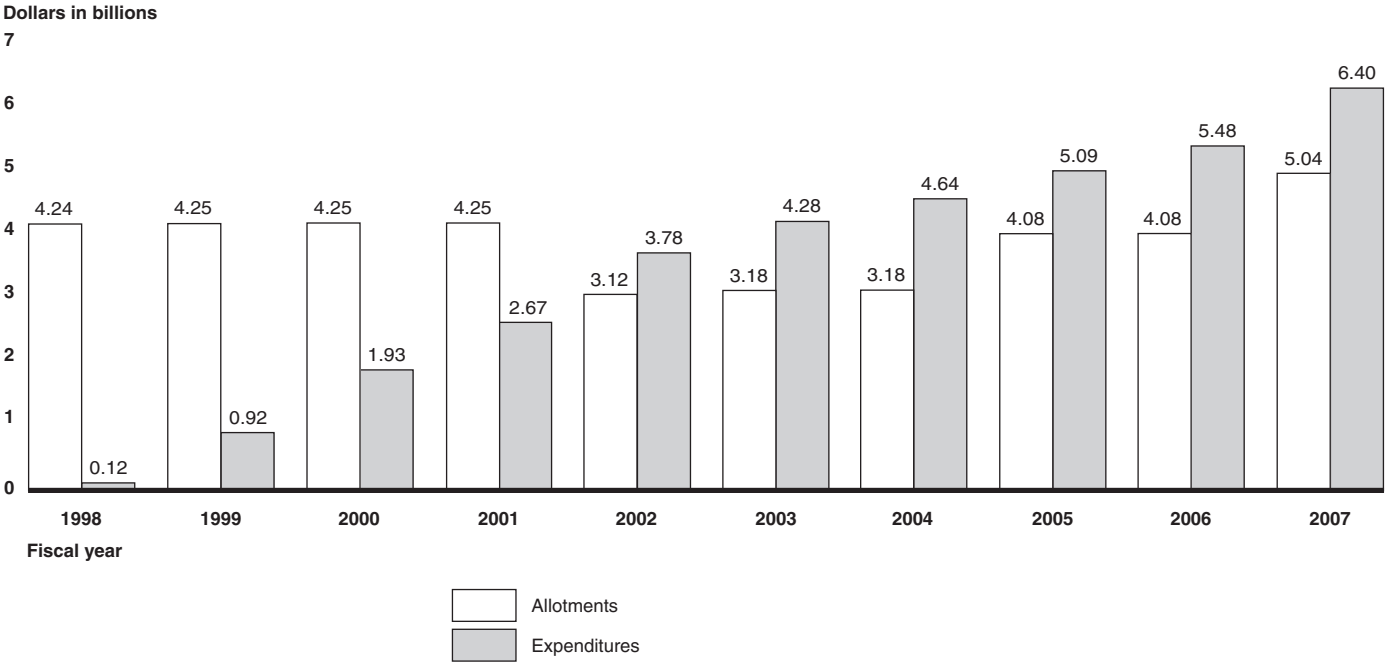


Source: GAO analysis of CMS data.

From fiscal year 1998 through 2001, annual federal SCHIP expenditures were well below annual allotments, ranging from 3 percent of allotments in fiscal year 1998 to 63 percent in fiscal year 2001. In fiscal year 2002, the states together spent more federal dollars than they were allotted for the year, in part because total allotments dropped from $4.25 billion in fiscal year 2001 to $3.12 billion in fiscal year 2002, marking the beginning of the so-called "SCHIP dip."[42] However, even after annual SCHIP appropriations increased in fiscal year 2005, expenditures continued to exceed allotments (see fig. 7). Generally, states were able to draw on unused funds from prior years' allotments to cover expenditures incurred in a given year that were in excess of their allotment for that year, because, as discussed earlier, the federal SCHIP law gave states 3 years to spend each annual allotment. In certain circumstances, states also retained a portion of unused allotments.

[42]The SCHIP dip refers to the decrease in SCHIP appropriations for fiscal years 2002 through 2004, which was necessary to address budgetary constraints applicable at the time the BBA was enacted.

Figure 7: SCHIP Allotments and Federal Expenditures, Fiscal Years 1998-2007

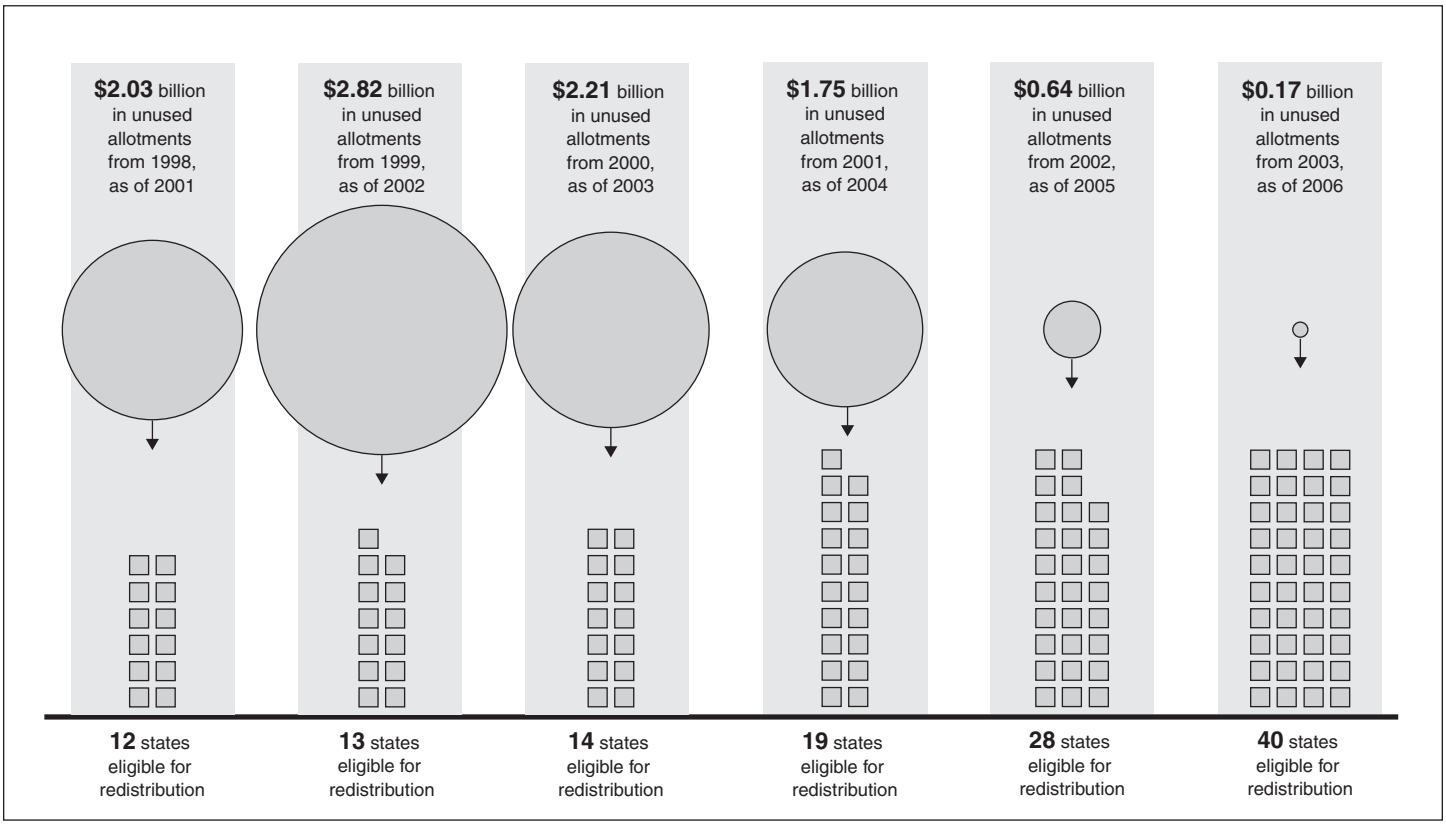


Source: GAO analysis of CMS data.

Notes: Fiscal year 2007 expenditures are estimates based on budgets submitted by the states to CMS in November 2006. Expenditures may exceed allotments in any single year because allotments are available for 3 years and may be expended in years later than allotted.

States that have outspent their annual allotments over the 3-year period of availability have also relied on redistributed SCHIP funds to cover excess expenditures. But as overall spending has grown, the pool of funds available for redistribution has shrunk from a high of $2.82 billion in unused funds from fiscal year 1999 to $0.17 billion in unused funds from fiscal year 2003. Meanwhile, the number of states eligible for redistributions has grown from 12 states in fiscal year 2001 to 40 states in fiscal year 2006. (See fig. 8.)

Figure 8: Unused SCHIP Allotments from Fiscal Year 1998 through 2003 and Number of States Eligible for Redistribution, Fiscal Years 2001-2006



Source: GAO analysis of CMS data.

Note: States are eligible to receive redistribution in a particular fiscal year if they have expended all of their allotment for that year.

Congress has acted on several occasions to change the way SCHIP funds are redistributed. In fiscal years 2000 and 2003, Congress amended statutory provisions for the redistribution and availability of unused

SCHIP allotments from fiscal years 1998 through 2001,[43] reducing the amounts available for redistribution and allowing states that had not exhausted their allotments by the end of the 3-year period of availability to retain some of these funds for additional years. Despite these steps, $1.4 billion in unused SCHIP funds reverted to the U.S. Treasury by the end of fiscal year 2005.

Congress has also appropriated additional funds to cover states' projected SCHIP program shortfalls. The DRA included a $283 million appropriation to cover projected shortfalls for fiscal year 2006.[44] CMS divided these funds among 12 states as well as the territories.

In the beginning of fiscal year 2007, Congress acted to redistribute unused SCHIP allotments from fiscal year 2004 to states projected to face shortfalls in fiscal year 2007.[45] The National Institutes of Health Reform Act of 2006 makes these funds available to states in the order in which they experience shortfalls. In January 2007, CRS projected that although 14 states will face shortfalls, the $147 million in unused fiscal year 2004 allotments will be redistributed to the five states that are expected to experience shortfalls first. The NIH Reform Act also created a redistribution pool of funds by redirecting fiscal year 2005 allotments from

[43]The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) allowed states that used their fiscal year 1998 and 1999 allotments to receive redistributed funds and allowed states that had not used these allotments to retain a portion of remaining funds. BIPA also extended the availability of all redistributed and retained funds through the end of fiscal year 2002. BIPA, Pub. L. No. 106-554, § 1(a)(6), 114 Stat. 2763, 2763A-578—580 (Dec. 21, 2000) (codified, as amended, at 42 U.S.C. § 1397dd(g)). The State Children's Health Insurance Program Allotments Extension Act (SCHIP Extension Act) further extended the availability of redistributed and retained allotments from fiscal years 1998 and 1999 another 2 years, to the end of fiscal year 2004. The law also established a new method for reallocating unspent allotments from fiscal years 2000 and 2001, allowing states that did not expend these funds to retain 50 percent of the funds and redistributing the remaining 50 percent to states that had spent their allotments. In addition, the law established authority for certain states—generally, states that covered at least one category of children other than infants in families with incomes up to at least 185 percent of FPL—to use up to 20 percent of original fiscal year allotments for 1998 through 2001 for Medicaid eligible children with family income over 150 percent of FPL. SCHIP Extensions Act, Pub. L. No. 108-74, §§ 1(a)(4), 1(b), 117 Stat. 895-896 (Aug. 15, 2003) (codified, as amended, at 42 U.S.C. § 1397dd(g), 1397ee(g)).

[44]DRA, Pub. L. No. 109-171, § 6101(a), 120 Stat. 130 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397dd(d)).

[45]National Institutes of Health Reform Act of 2006 (NIH Reform Act), Pub. L. No. 109-482, § 201, 120 Stat. 3675 (Jan. 15, 2007) (to be codified at 42 U.S.C. § 1397dd(h)).

states that at midyear (March 31, 2007) have more than twice the SCHIP funds they are projected to need for the year.[46]

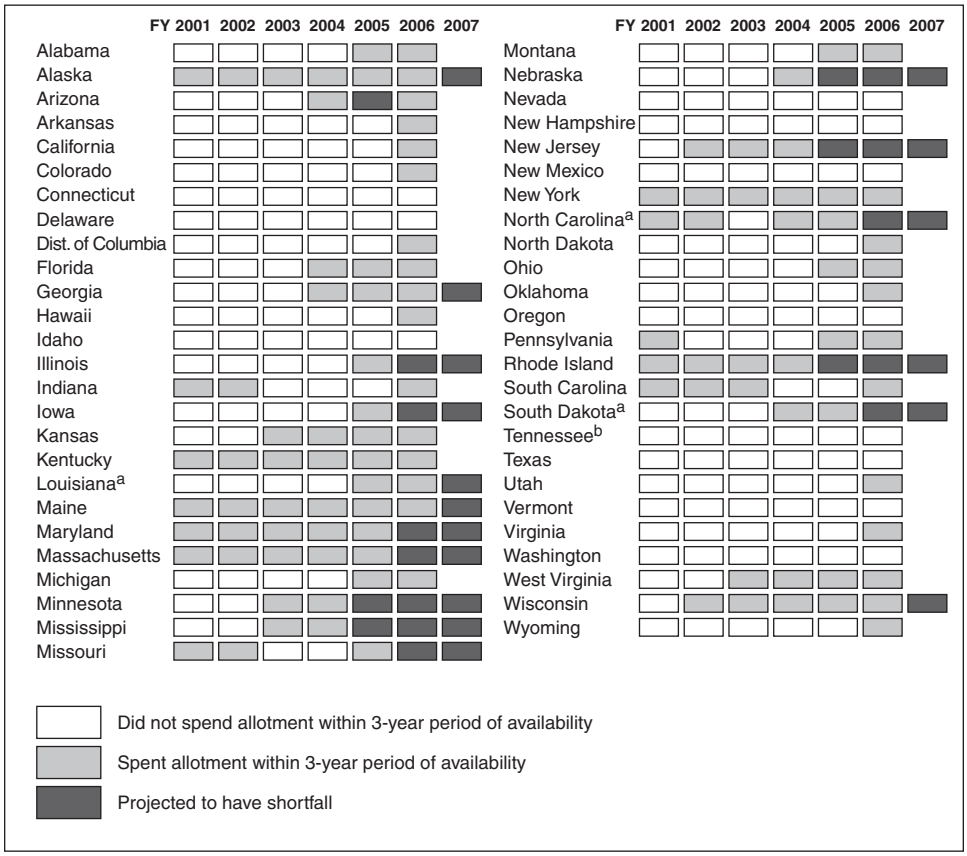
Some States Consistently Spent More than Their Allotted Funds

Some states consistently spent more than their allotted funds, while other states consistently spent less. From fiscal years 2001 through 2006, 40 states spent their entire allotments at least once, thereby qualifying for redistributions of other states' unused allotments; 11 states spent their entire allotments in at least 5 of the 6 years that funds were redistributed. Moreover, 18 states were projected to face shortfalls—that is, they were expected to exhaust available funds, including current and prior-year allotments—in at least 1 of the final 3 years of the program.[47] (See fig. 9.) As of January 2007, 14 states were projected to exhaust their allotments in fiscal year 2007.

[46]These states are required to contribute half of their remaining 2005 allotments, up to a maximum of $20 million, to the redistribution pool. NIH Reform Act, Pub. L. No. 109-482, § 201, 120 Stat. 3675 (Jan. 15, 2007) (to be codified at 42 U.S.C. § 1397dd(h)). CRS estimates the redistribution pool to have $125 million available. According to CMS projections, as of January 2007, these funds will be distributed to seven states, including the five projected to receive redistributed 2004 allotments.

[47]In fiscal years 2005 and 2006, CMS projected that 13 states would face shortfalls of SCHIP funds in one or both of those years, and in October 2006, CRS projected that 17 states would face shortfalls in fiscal year 2007. The 17 states CRS identified include 12 of the 13 states CMS identified, for a total of 18 states identified as facing shortfalls in fiscal years 2005, 2006, and/or 2007.

Figure 9: States that Did or Did Not Spend Allotments and/or Were Projected to Have Shortfalls



Source: GAO analysis of data obtained from CMS and Congressional Research Service (CRS).

Note: The years refer to the fiscal years in which unspent allotments from 3 years prior became available for redistribution. Under federal SCHIP law, subject to certain exceptions, states were given 3 years to spend each allotment, after which any unspent funds were to be redistributed among states that had spent their entire allotments. States projected to have shortfalls were projected to exhaust available funds, including current and prior-year allotments. Shortfalls for 2005 and 2006 were projected by CMS in those years. Shortfalls for 2007 were projected by CRS in October 2006 on the basis of states' budget data from August 2006. States that had spent their entire 2004 allotments had not been announced by the Secretary of Health and Human Services as of January 25, 2007.

[a]As of January 2007, CRS was no longer projecting a shortfall for this state for fiscal year 2007.

[b]Although Tennessee did not have a SCHIP program as of October 2002, it continued to be allotted SCHIP funds. On September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL. CMS approved this plan in January 2007; according to state information, the program will be implemented in early 2007.

When we compared the 18 states that were projected to have shortfalls with the 32 states that were not, we found that the shortfall states were more likely to have a Medicaid component to their SCHIP program, to

have a SCHIP eligibility corridor broader than the median,[48] and to cover adults in SCHIP under section 1115 waivers (see table 4). It is unclear, however, to what extent these characteristics contributed to states' overall spending experiences with the program, as many other factors have also affected states' program balances, including prior coverage of children under Medicaid, and SCHIP eligibility criteria, benefit packages, enrollment policies, outreach efforts, and payment rates to providers. In addition, we and others have noted that the formula for allocating funds to states has flaws that led to underestimates of the number of eligible children in some states and thus underfunding.[49] Fifteen of the 18 shortfall states (83 percent) had Medicaid expansion programs or combination programs that included Medicaid expansions, which generally follow Medicaid rules, such as providing the full Medicaid benefit package and continuing to provide coverage to all eligible individuals even after the states' SCHIP allotments are exhausted. The shortfall states tended to have a broader eligibility corridor in their SCHIP programs, indicating that, on average, the shortfall states covered children in SCHIP from lower income levels, from higher income levels, or both. For example, 33 percent of the shortfall states covered children in their SCHIP programs above 200 percent of FPL, compared with 25 percent of the nonshortfall states. Finally, 6 of the 18 shortfall states (33 percent) were covering adults in SCHIP under section 1115 waivers by the end of fiscal year 2006, compared with 6 of the 32 nonshortfall states (19 percent).

[48]The SCHIP eligibility corridor is defined as the difference between the highest and lowest income levels (expressed as a percentage of FPL) eligible for SCHIP within a specified age group. For example, if a state covers children aged 6 and older with family incomes from 100 percent to 200 percent of FPL, the eligibility corridor for this age group is 100 percentage points (200 minus 100). In 2006, the median SCHIP eligibility corridor for children aged 6 and older was 100 percentage points.

[49]See CRS, *SCHIP Original Allotments: Funding Formula Issues and Options*; GAO, *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-97 (Washington, D.C.: October 18, 2006); Genevieve Kenney and Debbie I. Chang, "The State Children's Health Insurance Program: Successes, Shortcomings, And Challenges," *Health Affairs*, vol 23, no. 5 (2004): 51-62.; and GAO/HEHS-99-65.

Table 4: Selected SCHIP Program Characteristics of Shortfall and Nonshortfall States

SCHIP program characteristic	Percentage of states	
	Shortfall states (n=18)	Nonshortfall states (n=32)
Medicaid expansion or combination programs	83	53
Eligibility corridor for children aged 6 and older that is broader than the median[a]	28	16
Adult coverage in SCHIP under section 1115 waivers before FY 2007[b]	33	19

Source: GAO analysis, as of January 29, 2007, of data obtained from CMS, CRS, and NASHP.

Note: Shortfall states are states that were identified by CMS or CRS as being unable to cover their projected SCHIP expenditures with available funds in fiscal years 2005, 2006, and/or 2007 in the absence of redistributions or additional appropriations. Nonshortfall states are states that were not projected to experience such shortfalls in any of the 3 years. Tennessee did not have a SCHIP program as of October 2002. However, on September 6, 2006, the state submitted a SCHIP plan that proposes to cover pregnant women and children in families with incomes up to 250 percent of FPL. CMS approved this plan in January 2007; according to state information, the program will be implemented in early 2007.

[a]The SCHIP eligibility corridor is defined as the difference between the highest and lowest income levels (expressed as a percentage of FPL) eligible for SCHIP within a specified age group. For example, if a state covers children aged 6 and older with family incomes from 100 percent to 200 percent of FPL, the eligibility corridor for this age group is 100 percentage points (200 minus 100). In 2006, the median SCHIP eligibility corridor for children aged 6 and older was 100 percentage points.

[b]In fiscal year 2007, two nonshortfall states implemented SCHIP-funded coverage for adults—Arkansas on October 1, 2006, and Nevada on December 1, 2006.

On average, the shortfall states that covered adults began covering them earlier than nonshortfall states and enrolled a higher proportion of adults. At the end of fiscal year 2006, 12 states covered adults under section 1115 waivers using SCHIP funds.[50] Five of these 12 states began covering adults before fiscal year 2003, and all 5 states faced shortfalls in at least 1 of the final 3 years of the program. In contrast, none of the 4 states that began covering adults with SCHIP funds in the period from fiscal year 2004

[50]As of January 2007, we had identified 15 states with approved section 1115 waivers to cover adults with their SCHIP allotments (see table 3). One state, Utah, had an approved waiver but had not yet implemented it. In fiscal year 2007, two additional states began covering adults under SCHIP—Arkansas on October 1, 2006, and Nevada on December 1, 2006.

through 2006 faced shortfalls.[51] On average, the shortfall states covered adults more than twice as long as nonshortfall states (5.1 years compared with 2.3 years by the end of fiscal year 2006).

Shortfall states also enrolled a higher proportion of adults. Nine states, including six shortfall states, covered adults using SCHIP funds throughout fiscal year 2005.[52] In these nine states, adults accounted for an average of 45 percent of total enrollment. However, in the shortfall states, the average proportion was more than twice as high as in nonshortfall states. Adults accounted for an average of 55 percent of enrollees in the shortfall states, compared with 24 percent in the nonshortfall states. (See table 5.)

[51]Three states began covering adults under section 1115 waivers in fiscal year 2003; one faced shortfalls and two did not.

[52]On July 1, 2005, three additional states began using SCHIP funds to cover adults under section 1115 waivers.

Table 5: SCHIP Total Enrollment in States Using SCHIP Funds to Cover Adults under Section 1115 Waivers throughout Fiscal Year 2005

	Total enrollment			
State[a]	Total	Children	Adults	Adults as a percentage of total[b]
Shortfall states[c]				
Arizona	201,626	88,005	113,621	56
Illinois	457,426	281,432	175,994	38
Minnesota	40,087	5,076	35,011	87
New Jersey	196,418	129,591	66,827	34
Rhode Island	51,313	27,144	24,169	47
Wisconsin	165,973	57,165	108,808	66
Nonshortfall states[d]				
Colorado	61,105	59,530	1,575	3
Michigan	190,540	89,257	101,283	53
Oregon	64,088	52,722	11,366	18
Summary				
Shortfall states (6)	1,112,843	588,413	524,430	55
Nonshortfall states (3)	315,733	201,509	114,224	24
All states (9)	1,428,576	789,922	638,654	45

Source: GAO analysis of CMS data.

[a]As of January 2007, we had identified 15 states with approved section 1115 waivers to cover adults with their SCHIP allotments. Six of these 15 states were omitted from the table. Idaho, New Mexico, and Virginia implemented section 1115 waivers for adults on July 1, 2005, and are omitted from the table because only partial-year data are available for them for fiscal year 2005. The remaining three states had not implemented their waivers as of 2005: Arkansas and Nevada implemented section 1115 coverage for adults in fiscal year 2007, while Utah had not implemented its approved waiver.

[b]Summary data shown in this column are averages of the state percentages.

[c]Shortfall states are states that were identified by CMS or the Congressional Research Service (CRS) as being unable to cover their projected SCHIP expenditures with available funds in fiscal years 2005, 2006, and/or 2007.

[d]Nonshortfall states are states that were not projected to experience such shortfalls in any of the 3 years.

While analyses of states as a group reveal some broad characteristics of states' programs, examining the experiences of individual states offers insights into other factors that have influenced states' program balances. States themselves have offered a variety of reasons for shortfalls and surpluses. These examples, while not exhaustive, highlight additional factors that have shaped states' financial circumstances under SCHIP.

- **Inaccuracies in the CPS-based estimates on which states' allotments were based**. North Carolina, a shortfall state, offers a case in point. In 2004, the state had more low-income children enrolled in the program than CPS estimates indicated were eligible. To curb spending, North Carolina shifted children through age 5 from the state's separate child health program to a Medicaid expansion, reduced provider payments, and limited enrollment growth.

- **Annual funding levels that did not reflect enrollment growth**. Iowa, another shortfall state, noted that annual allocations provided too many funds in the early years of the program and too few in the later years. Iowa did not use all its allocations in the first 4 years and thus the state's funds were redistributed to other states. Subsequently, however, the state has faced shortfalls as its program matured.

- **Impact of policies designed to curb or expand program growth**. Some states have attempted to manage program growth through ongoing adjustments to program parameters and outreach efforts. For example, when Florida's enrollment exceeded a predetermined target in 2003, the state implemented a waiting list and eliminated outreach funding. When enrollment began to decline, the state reinstituted open enrollment and outreach. Similarly, Texas—commensurate with its budget constraints and projected surpluses—has tightened and loosened eligibility requirements and limited and expanded benefits over time in order to manage enrollment and spending.

Considerations for SCHIP Reauthorization

Children without health insurance are at increased risk of foregoing routine medical and dental care, immunizations, treatment for injuries, and treatment for chronic illnesses. Yet, the states and the federal government face challenges in their efforts to continue to finance health care coverage for children. As health care consumes a growing share of state general fund or operating budgets, slowdowns in economic growth can affect states' abilities—and efforts—to address the demand for public financing of health services. Moreover, without substantive programmatic or revenue changes, the federal government faces near- and long-term fiscal challenges as the U.S. population ages because spending for retirement and health care programs will grow dramatically.[53] Given these

[53]GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, GAO-05-325SP (Washington, D.C.: February 2005); and GAO, *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, GAO-02-544T (Washington, D.C.: Mar. 21, 2002).

circumstances, we would like to suggest several issues for consideration as Congress addresses the reauthorization of SCHIP. These include the following:

- **Maintaining flexibility without compromising the goals of SCHIP**. The federal-state SCHIP partnership has provided an important opportunity for innovation on the part of states for the overall benefit of children's health. Providing three design choices for states—Medicaid expansions, separate child health programs, or a combination of both approaches—affords them the opportunity to focus on their own unique and specific priorities. For example, expansions of Medicaid offer Medicaid's comprehensive benefits and administrative structures and ensure children's coverage if states exhaust their SCHIP allotments. However, this entitlement status also increases financial risk to states. In contrast, SCHIP separate child health programs offer a "block grant" approach to covering children. As long as the states meet statutory requirements, they have the flexibility to structure coverage on an employer-based health plan model and can better control program spending than they can with a Medicaid expansion.

  However, flexibility within the SCHIP program, such as that available through section 1115 waivers, may also result in consequences that can run counter to SCHIP's goal—covering children. For example, we identified 15 states that have authority to cover adults with their federal SCHIP funds, with several states covering more adults than children. States' rationale is that covering low-income parents in public programs such as SCHIP and Medicaid increases the enrollment of eligible children as well, with the result that fewer children go uninsured.[54] Federal SCHIP law provides that families may be covered only if such coverage is cost-effective; that is, covering families costs no more than covering the SCHIP-eligible children. We earlier reported that HHS had approved state proposals for section 1115 waivers to use SCHIP funds to cover parents of SCHIP- and Medicaid-eligible children without regard to cost-effectiveness.[55] We also reported that HHS approved state proposals for section 1115 waivers to use SCHIP funds to cover childless adults, which in our view was inconsistent with federal SCHIP law and allowed SCHIP

[54]See Leighton Ku and Matthew Broaddus, *Coverage of Parents Helps Children, Too* (Washington, D.C.: Center on Budget and Policy Priorities, Oct. 20, 2006).

[55]GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817 (Washington, D.C.: July 12, 2002).

funds to be diverted from the needs of low-income children.[56] We suggested that Congress consider amending the SCHIP statute to specify that SCHIP funds were not available to provide health insurance coverage for childless adults. Under the DRA, Congress prohibited the Secretary of Health and Human Services from approving any new section 1115 waivers to cover nonpregnant childless adults after October 1, 2005, but allowed waivers approved prior to that date to continue.[57]

It is important to consider the implications of states' use of allowable flexibility for other aspects of their programs. For example, what assurances exist that SCHIP funds are being spent in the most cost-effective manner, as required under federal law? In view of current federal fiscal constraints, to what extent should SCHIP funds be available for adult coverage? How has states' use of available flexibility to establish expanded financial eligibility categories and covered populations affected their ability to operate their SCHIP programs within the original allotments provided to them?

- **Considering the federal financing strategy, including the financial sustainability of public commitments**. As SCHIP programs have matured, states' spending experience can help inform future federal financing decisions. CRS testified in July 2006 that 40 states were now spending more annually than they received in their annual original SCHIP allotments.[58] While many of them did not face shortfalls in 2006 because of available prior-year balances, redistributed funds, and the supplemental DRA appropriation, 14 states are currently projected to face shortfalls in 2007. With the pool of funds available for redistribution virtually exhausted, the continued potential for funding shortfalls for many states raises some fundamental questions about SCHIP financing. If SCHIP is indeed a capped grant program, to what extent does the federal government have a responsibility to address shortfalls in individual states, especially those that have chosen to expand their programs beyond certain parameters? In contrast, if the policy goal is to ensure that states do not exhaust their federal SCHIP allotments, by providing for the

[56]See GAO-02-817 and GAO, *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals*, GAO-04-166R (Washington, D.C.: Jan. 5, 2004).

[57]DRA, Pub. L. No. 109-171, § 6102, 120 Stat. 131-132 (Feb. 8, 2006) (codified, as amended, at 42 U.S.C. § 1397gg).

[58]*Federal SCHIP Financing*, Hearing Before the Subcomm. on Health Care of the Senate Finance Comm., 109th Cong., 2nd Sess. (Jul. 25, 2006) (statement of the Congressional Research Service).

continuing redistribution of funds or additional federal appropriations, does the program begin to take on the characteristics of an entitlement similar to Medicaid? What overall implications does this have for the federal budget?

- **Assessing issues associated with equity**. The 10 years of SCHIP experience that states now have could help inform any policy decisions with respect to equity as part of the SCHIP reauthorization process. Although SCHIP generally targets children in families with incomes at or below 200 percent of FPL, 9 states are relatively more restrictive with their eligibility levels, while 14 states are more expansive, ranging as high as 350 percent of FPL. Given the policy goal of reducing the rate of uninsured among the nation's children, to what extent should SCHIP funds be targeted to those states that have not yet achieved certain minimum coverage levels? Given current and future federal fiscal constraints, to what extent should the federal government provide federal financial participation above certain thresholds? What broader implications might this have for flexibility, choice, and equity across state programs?

  Another consideration is whether the formulas used in SCHIP—both the formula to determine the federal matching rate and the formula to allocate funds to states—could be refined to better target funding to certain states for the benefit of covering uninsured children. Because the SCHIP formula is based on the Medicaid formula for federal matching funds, it has some inherent shortcomings that are likely beyond the scope of consideration for SCHIP reauthorization.[59]

  For the allocation formula that determines the amount of funds a state will receive each year, several analysts, including CRS, have noted alternatives that could be considered. These include altering the methods for estimating the number of children at the state level, adjusting the extent to which the SCHIP formula for allocating funds to states includes the number of uninsured versus low-income children, and incorporating

[59]The Medicaid formula uses a state's per capita income (PCI) in relation to national PCI to determine the federal share of matching funds for a state's allowable Medicaid spending. We earlier reported, however, that the use of PCI as a measure of states' funding ability is problematic because it does not accurately represent states' funding ability or account for the size and cost of serving states' poverty populations. See GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620 (Washington, D.C.: July 10, 2003). We also recently reported on potential strategies to help make the Medicaid formula more responsive to economic downturns, which could have implications for the SCHIP formula. See GAO-07-97.

states' actual spending experiences to date into the formula. Considering the effects of any one or combination of these—or other—policy options would likely entail iterative analysis and thoughtful consideration of relevant trade-offs.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other members of the Subcommittee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please contact Kathryn G. Allen at (202) 512-7118 or at allenk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Carolyn L. Yocom, Assistant Director; Nancy Fasciano; Kaycee M. Glavich; Paul B. Gold; JoAnn Martinez-Shriver; and Elizabeth T. Morrison made key contributions to this statement.

Appendix I: SCHIP Upper Income Eligibility by State, Fiscal Year 2005

State	Upper income eligibility, expressed as a percentage of FPL
Alabama	200
Alaska	168
Arizona	200
Arkansas	200
California	250
Colorado	200
Connecticut	300
Delaware	200
District of Columbia	200
Florida	200
Georgia	235
Hawaii	300
Idaho	185
Illinois	200
Indiana	200
Iowa	200
Kansas	200
Kentucky	200
Louisiana	200
Maine	200
Maryland	300
Massachusetts	200
Michigan	200
Minnesota	280
Mississippi	200
Missouri	300
Montana	150
Nebraska	185
Nevada	200
New Hampshire	300
New Jersey	350
New Mexico	235
New York	250
North Carolina	200

State	Upper income eligibility, expressed as a percentage of FPL
North Dakota	140
Ohio	200
Oklahoma	185
Oregon	185
Pennsylvania	200
Rhode Island	250
South Carolina	150
South Dakota	200
Tennessee	[a]
Texas	200
Utah	200
Vermont	300
Virginia	200
Washington	250
West Virginia	200
Wisconsin	185
Wyoming	200

Source: GAO analysis of states' annual SCHIP reports for 2005 and the National Academy for State Health Policy.

Note: In some cases, we obtained data from Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, Me.: National Academy for State Health Policy, September 2006).

[a]While Tennessee has not had a SCHIP program since October 2002, in January 2007, CMS approved Tennessee's SCHIP plan, which covers pregnant women and children in families with incomes up to 250 percent of FPL. According to state information, the program will be implemented in early 2007.

Related GAO Products

Children's Health Insurance: State Experiences in Implementing SCHIP and Considerations for Reauthorization. GAO-07-447T. Washington, D.C.: February 1, 2007.

Children's Health Insurance: Recent HHS-OIG Reviews Inform the Congress on Improper Enrollment and Reductions in Low-Income, Uninsured Children. GAO-06-457R. Washington, D.C.: March 9, 2006.

21st Century Challenges: Reexamining the Base of the Federal Government. GAO-05-325SP. Washington, D.C.: February 2005.

Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries. GAO-04-491. Washington, D.C.: March 31, 2004.

SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals. GAO-04-166R. Washington, D.C.: January 5, 2004.

Medicaid Formula: Differences in Funding Ability among States Often Are Widened. GAO-03-620. Washington, D.C.: July 10, 2003.

Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care. GAO-03-222. Washington, D.C.: January 14, 2003.

Health Insurance: States' Protections and Programs Benefit Some Unemployed Individuals. GAO-03-191. Washington, D.C.: October 25, 2002.

Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns. GAO-02-817. Washington, D.C.: July 12, 2002.

Children's Health Insurance: Inspector General Reviews Should Be Expanded to Further Inform the Congress. GAO-02-512. Washington, D.C.: March 29, 2002.

Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets. GAO-02-544T. Washington, D.C.: March 21, 2002.

Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care. GAO-01-883. Washington, D.C.: September 10, 2001.

Children's Health Insurance: SCHIP Enrollment and Expenditure Information. GAO-01-993R. Washington, D.C.: July 25, 2001.

Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services. GAO-01-749. Washington, D.C.: July 13, 2001.

Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits. GAO/HEHS-00-86. Washington, D.C.: April 14, 2000.

Children's Health Insurance Program: State Implementation Approaches Are Evolving. GAO/HEHS-99-65. Washington, D.C.: May 14, 1999.

Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies. GAO/HEHS-98-93. Washington, D.C.: March 20, 1998.

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