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SCHIP
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Recent public policy changes have expanded states' options for covering low-income parents.

Early Experience with Covering Uninsured Parents Under SCHIP

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The State Children's Health Insurance Program (SCHIP) was enacted as Title XXI of the Social Security Act in 1997, with the goal of providing health insurance coverage to low-income uninsured children who are not eligible for Medicaid and do not have private coverage. The new program makes approximately \$4 billion available to states each year, beginning in fiscal year 1998. While covering parents was not an explicit goal of SCHIP, the original legislation did mention family coverage as an option. On July 31, 2000, the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration [HCFA]) issued guidance allowing states to apply for waivers to modify their SCHIP programs in various ways, including covering parents.

While recent attention has focused on the problem of uninsurance among low-income children, uninsurance among low-income adults is an even larger problem. In 1999, 37 percent of low-income adults were uninsured, compared with 22 percent of low-income children (Zuckerman, Haley, and Holahan 2000). In addition to improving access to care for the parents themselves, covering parents may increase coverage for their children (Dubay and Kenney 2001; Lambrew 2001; Ku and Broaddus 2000) and have a positive impact on the care that their children receive (Davidoff et al. 2002; Hanson 1998).

This brief examines the opportunity under SCHIP to provide coverage for low-income parents. It draws on information collected in semi-structured interviews

with state and federal officials,¹ published and unpublished reports, and state SCHIP enrollment data. Below we highlight the experience of four states: Minnesota, New Jersey, Rhode Island, and Wisconsin. These are the first four states to apply for and receive waivers to use SCHIP funding to cover parents. Their experience should help other states as they examine this option for expanding eligibility to cover uninsured parents of Medicaid and SCHIP children.

How Can States Cover Uninsured Parents?

Recent public policy changes have expanded states' options for covering low-income parents under Medicaid and SCHIP. Before the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), states could only cover parents up to the income level for state welfare benefits (with the exception of pregnant and postpartum women), levels that were set substantially below the federal poverty level (FPL) in most states. Enacted as part of Section 1931 of the Social Security Act, PRWORA allowed states to cover more low-income parents under Medicaid without waivers. By July 2000, five states had adopted this approach to covering parents up to at least 100 percent of FPL (Blaney et al. 2001).

States can also use Section 1115 Medicaid demonstration waivers to cover parents, and 10 states have done so (Krebs-Carter and Holahan 2000). Under these waivers, the Secretary of Health and

Human Services can waive provisions of the Social Security Act for research and demonstrations that further the intent of the law. Medicaid waivers must meet a budget neutrality standard, so that overall Medicaid expenditures do not exceed what they would have been without the waiver.

Using another vehicle to cover parents through both Medicaid and SCHIP, states are allowed to buy into employer-sponsored family insurance as long as the cost does not exceed the cost of covering those already entitled to Medicaid and/or SCHIP. Few states have used these buy-in options, because of administrative complexity, the difficulty of meeting the cost-effectiveness standard in typical families, and the fact that a very small number of low-income uninsured families actually have an offer of private health insurance coverage (Lutzky and Hill 2002).

Recognizing that covering parents could provide a way to reach more uninsured children eligible for SCHIP or Medicaid, in July 2000 CMS issued guidance that specifies considerations for states wanting to apply for Section 1115 SCHIP demonstration waivers to cover parents of either SCHIP or Medicaid children (Health Care Financing Administration 2000). There are several incentives for states to apply for SCHIP waivers, in contrast to other potential approaches to covering parents. First, a state can receive a higher SCHIP-based federal matching rate than could be obtained through a Medicaid expansion (Section 1931) approach or a 1115 Medicaid demonstration waiver. Also, there is no requirement for budget neutrality or cost-effectiveness, although SCHIP waivers must be “allotment neutral,” meaning a state cannot spend more than its total SCHIP allotment with the waiver.

Under SCHIP 1115 waivers, states are allowed to cover:

- Parents. States that expanded coverage for parents prior to March 31, 2000, can obtain an enhanced match for parents with incomes above 100 percent of FPL, while Medicaid matching funds must be used to cover parents below 100 percent of FPL. States that expanded coverage after this date can obtain

the enhanced match for parents at any income level.

- Pregnant women with incomes above 185 percent of FPL. In order to receive an enhanced SCHIP match for these women, a state must already cover pregnant women up to 185 percent of FPL under Medicaid.

To cover parents or pregnant women under an SCHIP 1115 waiver, the state must have had at least one year of experience running a SCHIP program and be up to date on all SCHIP evaluations required by federal law. A state also has to demonstrate that it is effectively covering the core population of low-income children targeted by SCHIP—that is, children below 200 percent of FPL. Finally, a state’s SCHIP budget projections under the waiver must be within its original SCHIP allotment. In budget projections, the state cannot include funds it may receive when other states’ unspent SCHIP allotments are redistributed.

The First Four SCHIP Waivers to Cover Parents

The first four states to obtain 1115 waivers to cover parents under SCHIP were Minnesota, New Jersey, Rhode Island, and Wisconsin.² Three obtained their waivers on January 18, 2001, and Minnesota received its waiver on June 13, 2001. Their programs—MinnesotaCare, NJ Family Care, BadgerCare, and RIteCare—offer comprehensive health insurance coverage for low-income families.

Although all four states had already expanded coverage for parents to some degree through Medicaid or state-only funds, CMS approved their waiver requests to also use SCHIP funds for such coverage. CMS staff report that the agency did not want to penalize states that had already implemented significant expansions to parents by denying them use of SCHIP funds that other states could obtain.

In telephone calls with officials in these four states, we learned why they chose this form of expansion to parents over other available options. All four states wanted to use federal and state funds to cover as

many uninsured low-income people as could be afforded.

Specifically:

- Minnesota had been covering parents through MinnesotaCare since 1992, originally with state-only funds and then an 1115 Medicaid waiver.
- New Jersey had been covering parents with incomes up to 200 percent of FPL since the fall of 2000, using Medicaid Section 1931 authority for parents up to 133 percent of FPL and state-only funds for those with higher incomes.³ The SCHIP waiver gave the state the opportunity to receive federal matching funds for parents with incomes above 133 percent of FPL and the higher federal match for all expansion parents, beginning in January 2001.
- Rhode Island had been using Section 1931 to cover parents under Medicaid up to 185 percent of FPL since November 1998. The SCHIP waiver allowed the state to cover the 100–185 percent of FPL parents and 186–250 percent of FPL pregnant women at a higher match rate.
- Wisconsin wanted to help families that were transitioning from welfare to private employment by offering them subsidized health insurance. It began covering parents under its Medicaid 1115 waiver (BadgerCare) in July 1999. The SCHIP waiver allows Wisconsin to receive enhanced SCHIP match funds for parents with incomes between 101 and 185 percent of FPL.

How Do These States Differ from States without SCHIP Waivers for Parents?

Table 1 shows characteristics of the four states with waivers for SCHIP coverage of parents. These characteristics suggest in part why the states requested SCHIP waivers to cover parents so soon after CMS guidance allowed them to do so. First, because these four states were already covering parents to some degree, they had experience enrolling this population and had “money on the table.” Thus, their deci-

sion to apply for an SCHIP waiver was easier than for a state that had not yet decided to allocate additional spending for covering parents.

Table 1 shows that three of these states have relatively low rates of uninsurance among parents below 200 percent of FPL, while New Jersey’s rate of 34.8 percent is quite close to the national rate of 34.3 percent. The lower uninsurance rates put these four states at less risk of opening up an extremely large new population to public coverage than is true for many states.

Additionally, in some states the differential between SCHIP and Medicaid match rates is greater than in others. States with the lowest federal Medicaid match rate have the greatest differential (50 percent for Medicaid and 65 percent for SCHIP) while states with the highest Medicaid match have the smallest differential (77 percent for Medicaid and 84 percent for SCHIP). All four states in the initial group with parent waivers have relatively low Medicaid match rates, ranging from 50 percent in New Jersey to 59.3 percent in Wisconsin. Consequently all have a greater incentive to obtain the SCHIP match than states with higher Medicaid match rates.

Finally, as shown in the table, none of these four states had spent a high proportion of its total SCHIP allotment at the time they applied for the waiver. All faced the likelihood of losing a substantial amount of federal SCHIP funding due to underspending. This is in contrast to some states, such as New York, that cannot use an SCHIP waiver to cover parents, having spent their SCHIP allotment covering children.

Reaching Out to Parents

According to state officials, one effective way to reach parents is to build on existing outreach programs for children. Because families tend to acquire health insurance for the whole family, state officials argued that reaching both groups through a common approach makes sense. For example, Rhode Island first began coverage of parents of Medicaid children in November 1998, using Section 1931 Medicaid authority. SCHIP coverage of children was also being implemented at this time, so the state developed an outreach approach that

TABLE 1. *Characteristics of Four States Covering Parents Under SCHIP*

	Minnesota	New Jersey	Rhode Island	Wisconsin
Date SCHIP waiver to cover parents approved	6/13/01	1/18/01	1/18/01	1/18/01
Type of SCHIP program	Medicaid expansion	Combination	Medicaid expansion	Medicaid expansion
Family income for parents under SCHIP waiver (% of FPL)	101–200	0–200	101–185	101–185 ^e
Family income for pregnant women covered by SCHIP waiver (% of FPL)	No coverage	186–200	186–250	No coverage
Number of parents covered under waiver (November 2001)	23,156	101,016 (1 pregnant woman)	12,913 (78 pregnant women)	31,598 (Oct. 2001)
Any previous coverage of parents (effective date) ^a	Yes, Medicaid 1115 waiver (Oct. 1992)	Yes, Medicaid Section 1931 (Sept. 2000)	Yes, Medicaid Section 1931 (Nov. 1998)	Yes, Medicaid 1115 waiver (July 1999)
Percentage of parents below 200% of FPL who are uninsured ^b	25.4	35.8	20.9	24.5
FY 2001 ^c Medicaid match rate/SCHIP match rate (%)	51.1/65.8	50.0/65.0	53.8/67.7	59.3/71.5
SCHIP expenditures as a percentage of total 1998–2000 allotment ^d	0	32	20	18

Sources:

- a. Holahan and Pohl 2001.
 b. U.S. Census Bureau, Current Population Survey, averaged across 2000 and 2001.
 c. U.S. Department of Health and Human Services 2000.
 d. Kenney, Ullman, and Weil 2000. All other information obtained directly from state officials.

Note:

- e. Once enrolled, parents remain eligible up to 200 percent of FPL.

targeted both groups. The state entered into contracts with community agencies and paid an incentive for enrollment. Special outreach was targeted to Latino families. The state also added a question to the school lunch form asking whether parents would like someone to contact them about health insurance.

New Jersey launched a special outreach initiative directed specifically toward parents, using an intensive two-month statewide media campaign. The state spent \$2 million on the campaign, which was headlined by then-Governor Whitman, shown eating ice cream and saying that both ice cream and health insurance are for all members of the family. The state sent parents of children already enrolled in

SCHIP a packet of information inquiring about their interest in Family Care, and enclosing an application form. In the future state officials plan another special mailing through the Department of Taxation. The mailing will target families with incomes up to 350 percent of FPL who have children under 18 years old.

In 1999 Wisconsin implemented a public information campaign to spread the message that welfare reform did not affect Medicaid eligibility, and that families could continue to get health insurance coverage (BadgerCare) as they moved into private employment. The campaign included television ads with then-Governor Thompson promoting “health insurance for working families.” Outstationed eligibility workers

with laptop computers were sent to schools, food pantries, and day care centers, and nonprofit groups were trained about the changes in BadgerCare. The state also targeted families enrolled in Medicaid, food stamps, child care, or other social service programs for whom there was information in the state's Department of Human Services computer system. For example, a mother with an older child who was previously only eligible for food stamps could be identified and targeted for BadgerCare enrollment, as could a family with a younger child enrolled in Medicaid whose older siblings and parents were previously ineligible. In the first year of the expansion, officials estimate that half of new enrollees were in families that were already "in the system."

Enrollment Success

States report that parents are enrolling readily in Medicaid and SCHIP. Table 1 shows the number of parents now covered under the SCHIP waivers in these four states, ranging from 10,593 in Rhode Island to 101,016 in New Jersey as of November 2001. The three states most recently implementing parent coverage all met or exceeded their enrollment targets. Rhode Island initially projected an enrollment gain of 10,000 parents of already enrolled children. As of January 2002, the state has added 20,000 parents and 20,000 children through both Medicaid and SCHIP provisions. State officials conclude that enrolling parents has led to substantial gains in child enrollment in both Medicaid and SCHIP, with child enrollment growing more rapidly than it did during the Medicaid child-only coverage expansions of the 1990s.

New Jersey reports a rapid response to expanding eligibility to parents. When it began parental coverage under the Section 1931 Medicaid provision, New Jersey projected enrolling 125,000 parents within three years. However, within the first few months the program had enrolled 60,000 parents, and it reached its full enrollment target less than a year after implementation.

State officials believe families also may be drawn into other public programs through the parent expansion. Wisconsin

reports that the state's regular and Healthy Start (pregnant women and children up to age 6) Medicaid enrollment levels are the highest they have ever been, and Food Stamp enrollment, after years of decline, began to increase after July 1999.

Administration of Parent Coverage

While adding parents inevitably adds some administrative complexity, these four states have not encountered major administrative difficulties in adding parents to SCHIP and Medicaid. All four states market a single program to families and administer parent and child coverage under a single agency. All states use a "seamless" application and enrollment process. The application form is the same for parents and children, as are other basic aspects of program administration such as managed care arrangements. Modifications to the program to incorporate parents were easiest in the three states where the SCHIP program expanded Medicaid. In those states, parents and children move back and forth between Medicaid and SCHIP coverage as family income changes. States must obviously track and report such changes, because of differences in federal matching rates. However, since this must be done for children, there is no additional administrative burden to adding parents.

Given these administrative challenges, and the lack of advance knowledge of how many parents will enroll and how quickly, states moving to add parental coverage may want to phase in coverage gradually. In retrospect, New Jersey officials would have preferred to roll out the program on a phased basis; for example, targeting outreach initially only to parents of children who were already enrolled.

Financing Concerns

Since coverage of parents under the SCHIP waiver depends both on state financing and federal SCHIP matching funds, it is important to consider what could happen to parent coverage when states begin to deplete their SCHIP allotments or face other financial constraints. In states with Medicaid expansion programs (three of the

four states studied), parents are entitled to full Medicaid entitlement protections, which means the state cannot implement a waiting list for parents. Moreover, these states receive a Medicaid match on the amount spent above the SCHIP allotment. Separate state programs such as New Jersey's do not receive additional federal funds after their SCHIP allocation is depleted.

As SCHIP allotments diminish, and as economic conditions make it more difficult to allocate state matching funds, states may need to make changes to parent coverage. In facing an SCHIP budget shortfall caused by either state budget problems or a shrinking SCHIP allotment, a state is required to eliminate parent coverage before restricting coverage for children. A Medicaid expansion state could either lower its Medicaid income eligibility threshold, eliminate parent coverage altogether, or impose other restrictions such as benefit limits. Separate or combination SCHIP programs, such as New Jersey's, could take the same steps or cap the enrollment of parents at a certain level with or without a waiting list. Any state that exceeds its SCHIP allotment can retain the existing program structure with state-only funds.

Will Use of SCHIP Waivers to Cover Parents Become More Widespread?

A large number of states meet the criteria set out by HCFA in its July 31, 2000, guidance on applying for SCHIP 1115 waivers to expand coverage of parents. However, increasing state budgetary stress may limit how many states will be able to cover parents. The experience of these initial four states shows that, once offered, the demand for such coverage is high and SCHIP waivers can be a relatively straightforward way to implement family coverage. However, while in the early years of SCHIP states were struggling to spend their allotment, recently the Office of Management and Budget projected that by 2005 SCHIP funding will fall short of that needed to cover all children, even without parental coverage (Kaiser Commission on Medicaid and the Uninsured 2001).

While it is too soon to forecast whether more states will choose to cover parents using SCHIP waivers, the increases in rates of uninsurance for parents that are likely to come with an economic downturn are going to heighten the need to find solutions for providing health insurance to low-income families. At the same time, economic uncertainty and state budget shortfalls may dampen states' enthusiasm for implementing parental expansions. Some may choose to expand coverage for parents in a more limited way than for children, using perhaps the additional waiver options outlined in the HIFA initiative. In any case, initial lessons from the first year of covering low-income parents with SCHIP waivers in four states will help the states that choose to use this approach to reducing the number of uninsured people in their state.

Notes

1. Interview protocols are available from the authors upon request.
2. Federal policies regarding the use of 1115 waivers to cover parents and other adults are evolving. On August 4, 2001, HHS Secretary Thompson announced a new Health Insurance Flexibility and Accountability (HIFA) initiative, whereby states could obtain waivers to offer varying benefit packages to different Medicaid and SCHIP populations (U.S. Department of Health and Human Services 2001). Since then Arizona and California have obtained waivers to cover parents, and Utah has obtained a waiver to cover only primary care for adults.
3. Because New Jersey had a separate SCHIP program, and the highest income level for which all children were served by the Medicaid program was 133 percent of FPL, New Jersey could not use Section 1931 authority to cover parents above this level. (See Dubay et al. 2000 for a full discussion of this issue.)

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