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Report to the Ranking Member, Committee on Finance, U.S. Senate

November 2007

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States That Cover Adults

GAO-08-50

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Highlights

Highlights of GAO-08-50, a report to the Ranking Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

In 2006 about 4.5 million individuals were enrolled in the State Children's Health Insurance Program (SCHIP). Congress created SCHIP with the goal of significantly reducing the number of low-income uninsured children. Under certain circumstances, states may also cover adults, and in June 2006 about 349,000 adults were enrolled. Each state receives an annual allotment of federal funds, available as a federal match based on the state's expenditures. Generally, states have 3 years to use each fiscal year's allotment, after which unspent federal funds may be redistributed. Congress initially authorized SCHIP for 10 years, from 1998 through 2007, and provided approximately $40 billion for that period.

GAO examined (1) how 10 states that cover adults—parents, childless adults, or both—in SCHIP structured their programs; (2) these states' enrollment and expenditure experiences for adults, which GAO considered in the context of those for all other SCHIP populations (children and pregnant women); and (3) the approaches these states adopted to attract all eligible individuals. To accomplish this, GAO reviewed 10 states that covered adults in SCHIP as of 2007. GAO interviewed officials in the 10 states; reviewed states' 2006 annual reports and information available on states' Web sites; and analyzed enrollment and expenditure data obtained primarily from the 10 states, as well as from the Centers for Medicare & Medicaid Services (CMS) and published sources.

To view the full product, including the scope and methodology, click on GAO-08-50. For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

SCHIP program structures for adults in the 10 states varied, particularly in terms of the categories of adults covered—whether they were parents or childless adults—and the types of coverage offered. For fiscal year 2007, 5 of the 10 states (Arizona, Minnesota, New Jersey, Rhode Island, and Wisconsin) covered parents only, 1 state (Michigan) covered childless adults only, and 4 states (Idaho, Illinois, New Mexico, and Oregon) covered both. Three states offered direct coverage only (where the state provides coverage through contracts or agreements with managed care organizations, providers, and suppliers), 3 states offered premium assistance only (where the state pays for a portion of the premium costs of employer-sponsored or privately purchased insurance), and 4 states offered both. All 10 states required adults to contribute to the cost of their coverage.

Enrollment and expenditure experiences with adult coverage varied widely across the states reviewed. In 2006, adult enrollment as a proportion of the total number of individuals covered through SCHIP was less than 25 percent in 3 states, 33 to 50 percent in 4 states, and more than 50 percent in 3 states. Overall, the 343,000 adults covered in the 10 states comprised about 40 percent of the total number of individuals covered through SCHIP in these states. Adults accounted for widely varying proportions of total SCHIP expenditures in the 9 states for which GAO had fiscal year 2006 expenditure data—1 percent in 1 state, 32 to 42 percent in 3 states, and more than 50 percent in 5 states. Overall, adults accounted for about 54 percent of total SCHIP expenditures in the 9 states.

The 10 states reviewed used three approaches in their outreach efforts: targeting hard-to-reach populations, targeting families instead of adults specifically, and relying on new and established partnerships to locate and enroll all eligible individuals. In some cases, states' current outreach approaches reflected smaller state budgets for such activities, and most states reviewed said they relied on new and existing partnerships with entities that, for example, regularly come into contact with families in their efforts to find and enroll eligible individuals. States' efforts to assess the effectiveness of different outreach approaches ranged from little or no evaluation to more formal methods of analyzing outcomes.

In commenting on a draft of this report, CMS stated that the report mischaracterized coverage of unborn children in SCHIP as coverage for adults, thereby inflating adult enrollment and expenditures for states that cover unborn children, and that the report did not use CMS data systems and therefore did not use consistent data. Regarding coverage of unborn children, CMS is incorrect: the report categorized coverage of unborn children as coverage for pregnant women, not as coverage for adults. Regarding the data systems, GAO relied on state data primarily because CMS data systems do not provide enrollment and expenditure data broken out by all of the population and coverage categories that were important to this analysis.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FPL	federal poverty level
HHS	Department of Health and Human Services
HIFA	Health Insurance Flexibility and Accountability Initiative
MBES/CBES	Medicaid Budget and Expenditure System/State Children's Health Program Budget and Expenditure System
SCHIP	State Children's Health Insurance Program
SEDS	Statistical Enrollment Data System

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United States Government Accountability Office
Washington, DC 20548

November 26, 2007

The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

Dear Senator Grassley:

In June 2006 about 4.5 million children and adults were enrolled in the State Children's Health Insurance Program (SCHIP). Congress created SCHIP, a joint federal-state program, in August 1997 with the goal of significantly reducing the number of low-income uninsured children, especially those who live in families with incomes too high to qualify for health care coverage under the Medicaid program.[1] Under certain circumstances, states may also cover adults in their SCHIP programs, and in June 2006 about 349,000 adults were enrolled.[2] States with approved SCHIP plans receive an annual allotment of federal funds, based on a funding formula that takes into account the number of low-income children in each state. Each state's SCHIP allotment is available as a federal match based on state expenditures. Subject to certain exceptions, states have 3 years to use each fiscal year's allotment, after which unspent federal funds may be redistributed among the states that have used all of that fiscal year's allotments. Congress initially authorized the program for a 10-year period from fiscal year 1998 through 2007 and provided approximately $40 billion for the 10 years.

States have a choice of three approaches in designing their SCHIP programs: (1) a Medicaid expansion program, which affords SCHIP-eligible children the same benefits and services that a state's Medicaid program provides; (2) a separate child health program with more flexible rules than Medicaid's and increased control over program structure and operations; or (3) a combination program, which has both a Medicaid expansion program and a separate child health program. Under the SCHIP statute, states operating separate child health programs have the option of

[1]Medicaid is a federal-state health financing program established in 1965 to provide health care coverage to certain categories of low-income adults and children.

[2]*See* The Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, et seq., 111 Stat. 251, 552.

using different bases for establishing their benefit packages, including using one of several benchmarks specified in the SCHIP statute, such as the Federal Employees Health Benefits Program or state employee coverage.[3]

States may cover adults in their SCHIP programs if certain conditions are met, including approval from the Department of Health and Human Services (HHS). First, the SCHIP statute allows the purchase of coverage for adults in families with children eligible for SCHIP if a state can show that it is cost-effective to do so.[4] As of September 2007, the Centers for Medicare & Medicaid Services (CMS), the agency within HHS that oversees states' Medicaid and SCHIP programs, identified 2 states that cover adults in their SCHIP state plan on the basis of meeting these cost-effectiveness requirements. Second, under section 1115 of the Social Security Act, states may receive approval from the Secretary of Health and Human Services to waive certain SCHIP requirements or authorize expenditures that would not otherwise be authorized under the program.[5] As of August 2007 we identified 14 states that cover adults—including parents, pregnant women, and childless adults—through the use of section 1115 waivers. However, the Deficit Reduction Act of 2005 (DRA), enacted February 8, 2006, prohibits the Secretary of Health and Human Services from approving new section 1115 waivers that permit the use of SCHIP funds for covering nonpregnant childless adults. Waivers for covering these adults that were approved before October 1, 2005, as well as any extensions, renewals, or amendments of those waivers, are not affected by this provision of the DRA.

Opinions differ on the appropriateness of using SCHIP funding for adult populations. Proponents argue that covering some adults brings more children into the program and leads to better access to services for families. Others counter that the intent of the SCHIP legislation is to cover children and that states should not be permitted to use limited SCHIP

[3]Other bases for establishing benefit packages are using (1) a benchmark-equivalent set of services, as defined under federal law; (2) coverage equivalent to state-funded child health programs in Florida, New York, or Pennsylvania; or (3) a benefit package approved by the Secretary of Health and Human Services.

[4]The cost-effectiveness test requires a state to demonstrate that covering both adults and children in a family under SCHIP is not more expensive than covering only the children. A state must also demonstrate that the coverage does not substitute for private coverage that is available.

[5]Throughout this report we refer to these arrangements as section 1115 waivers.

funds to cover adults when many children remain uninsured. As Congress considers reauthorization of SCHIP, you were interested in learning more about adult coverage in SCHIP.

This report examines (1) how states that cover adults under SCHIP structured this coverage, (2) states' enrollment and expenditure experiences covering adults in their SCHIP programs, and (3) approaches states that covered adults adopted to attract all individuals eligible for SCHIP and the extent to which these states have evaluated their outreach approaches.

To examine these issues, we limited our review to 10 of the 14 states that covered adults—specifically, parents, childless adults, or both—through the use of section 1115 waivers as of August 2007. These 10 states were Arizona, Idaho, Illinois, Michigan, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, and Wisconsin. We excluded 4 states—2 states (Arkansas and Nevada) that implemented adult coverage in fiscal year 2007 and thus had less than 2 years' experience with this coverage at the time we began our review, and 2 more states (Colorado and Virginia) that did not meet our criteria because they covered only pregnant women.[6] In our analysis of how the 10 states structured adult coverage, we focused on parents and childless adults. However, for our analysis of enrollment and expenditure trends, in addition to adults, we considered two other categories of individuals—children and pregnant women. We separated pregnant women from other coverage categories because pregnant women can be treated differently depending on how states have obtained approval to cover them.[7] For example, pregnant women can be covered under section 1115 waivers or covered through states' SCHIP plans under

[6]States' coverage of adults using SCHIP funds is likely to continue to change over time. For example, CMS noted that three of the states in our sample—Illinois, Oregon, and Wisconsin—have made or are planning changes in the extent to which they are using SCHIP funds to cover adults.

[7]Pregnant women accounted for about 1 percent of the total number of individuals covered through SCHIP in 2006 in the 10 states. In 4 of the 5 states that covered pregnant women (generally through coverage of their unborn children) in 2006 and that provided data to us, this population accounted for less than 3 percent of the total number of individuals covered through SCHIP. The exception was Minnesota, where pregnant women accounted for 12 percent of the total number of individuals covered through SCHIP. Of the 5 other states, 4 states either did not offer coverage through SCHIP to pregnant women or enroll any in 2006, and 1 state did not provide data on the number covered.

provisions for the unborn.[8] Our approach of placing pregnant women in a single category is different from that used by CMS, which treats pregnant women differently depending on whether they are covered through state plan provisions for the unborn, in which case they are considered children, or covered under a section 1115 waiver, in which case they are considered adults. In our analysis of states' outreach approaches, we considered efforts directed to all eligible individuals.

To gather information about how the 10 states structured their SCHIP-funded coverage for adults, we interviewed officials in the 10 states and reviewed materials such as waiver documents, information available on state Web sites, and states' 2006 annual reports. We examined several dimensions of SCHIP program structure in our review. Two dimensions we examined were the categories of adults covered and the type of coverage offered—whether it was direct coverage (where the state provides coverage through contracts or agreements with managed care organizations, providers, and suppliers), premium assistance (where the state pays for a portion of premium costs of employer-sponsored or privately purchased insurance), or both. Other dimensions we examined included the benefit packages offered and cost-sharing requirements. To examine states' enrollment and expenditure experiences covering adults under their SCHIP programs, we analyzed the share of enrollment and expenditures attributable to adults—parents and childless adults—and compared this with the share attributable to other SCHIP populations—pregnant women and children. We also compared the relative share of enrollment and expenditures across states, including monthly expenditures for different SCHIP populations. Finally, we examined the extent to which states' spending met or exceeded their SCHIP allotment amounts. In conducting these analyses, we relied primarily on data obtained from the states or from state annual reports. Our enrollment analysis covered all 10 states (using estimated enrollment figures for one state), while our expenditure analysis covered the 9 states that provided data.[9] We also drew on national data on SCHIP allotments and federal expenditures, obtained from CMS and published sources, to place

[8]*See* 67 Fed. Reg. 61956 (October 2, 2002). Under SCHIP, states may choose to extend eligibility to unborn children and provide prenatal care and delivery.

[9]Illinois did not provide enrollment or expenditure data. We estimated the number of adults enrolled in the state's SCHIP program at the end of fiscal year 2006 from the number ever enrolled as reported in the state's 2006 annual report, but we were not able to estimate the percentage of expenditures attributable to adults. We provided the state with an opportunity to comment on these estimates prior to publication.

information about the 10 states in a national context.[10] To assess the reliability of the data obtained from the states, we compared them with one another and with data available in published sources—such as states' 2006 annual reports and CMS enrollment and expenditure reports—and sought clarification from the states on any inconsistencies we identified. Although some of the data are preliminary and subject to change—for example, as states submit additional claims—we determined that they were sufficiently reliable for the purpose of characterizing states' enrollment and expenditure experiences. To gather information about the approaches the 10 states adopted to attract all individuals eligible for SCHIP and the extent to which these states have evaluated their outreach approaches, we drew on information obtained in interviews with state officials, from states' 2006 annual reports, and from states' Web sites. We conducted our work from April 2007 through November 2007 in accordance with generally accepted government auditing standards.

Results in Brief

SCHIP program structures for adults varied, particularly in terms of the categories of adults covered and the type of coverage offered in the 10 states we reviewed. For fiscal year 2007, 5 of the 10 states covered parents only, 1 state covered childless adults only, and 4 states covered both categories of adults. States were almost evenly divided in terms of whether they offered direct coverage only, where the state provides coverage through contracts or agreements with managed care organizations, providers, and suppliers (3 states); premium assistance only, where the state pays for a portion of the premium costs of employer-sponsored or privately purchased insurance (3 states); or both (4 states). In both direct coverage and premium assistance SCHIP programs, states were more likely to offer Medicaid and SCHIP benefit packages to parents than they were to childless adults. Moreover, all 10 states required adults to contribute to the cost of their coverage under SCHIP, and all established crowd-out prevention strategies intended to prevent the substitution of SCHIP for private health care coverage.

In 2006, enrollment and expenditure experiences for adult coverage varied widely across the states we reviewed. As a proportion of the total number of individuals covered through SCHIP in 2006 (adults, pregnant women, and children), adults—defined in this report as parents and childless

[10]Throughout this report, the term states refers to the 50 states and the District of Columbia.

adults—represented less than 25 percent in 3 states, 33 to 50 percent in 4 states, and more than 50 percent in 3 states. Overall, the 343,000 adults covered in the 10 states comprised about 40 percent of the total number of individuals covered through SCHIP for these states. As a proportion of total SCHIP expenditures (expenditures for adults, pregnant women, and children), adults constituted widely varying proportions in the 9 states for which we had fiscal year 2006 expenditure data—1 percent in 1 state, 32 to 42 percent in 3 states, and more than 50 percent in 5 states. Overall, adults accounted for about 54 percent of total SCHIP expenditures in the 9 states. Per capita expenditures for parents ranged from 41 to 135 percent higher than those for children in 5 of the 6 states that offered direct coverage to parents; the sixth state did not provide data. Projected shortfalls—meaning that states were expected to have SCHIP expenditures that would call for federal matching funds in excess of those available to them—occurred at least once for 6 of the 10 states during 2005 through 2007; in comparison, 10 of the 41 other states faced projected shortfalls at least once during the same time period. Because HHS requires that priority be given to children over adults if available federal funds are not sufficient, 2 of the 10 states stopped using SCHIP funds to cover certain adults for at least some period of time in fiscal year 2006 and used Medicaid funds for their coverage instead.

The 10 states we reviewed used three approaches in their outreach efforts: targeting hard-to-reach populations, targeting families, and relying on new and established partnerships to locate and enroll all eligible individuals. Six of 10 states reported targeting specific populations they considered hard to reach, such as immigrant, non-English-speaking, or ethnic populations. Most of the states also reported that they targeted outreach efforts toward families as a whole instead of adults specifically. In some cases, states' current outreach approaches reflected smaller state budgets for such activities. Most states we reviewed said they relied on new and existing partnerships with entities that, for example, regularly come into contact with families in their efforts to find and enroll eligible individuals. States' efforts to assess the effectiveness of different outreach approaches ranged from little or no evaluation to more formal methods of analyzing outcomes.

We received responses on a draft of this report from CMS and 5 of the 10 states that we reviewed. In its comments, CMS stated that the report mischaracterized SCHIP coverage of unborn children as coverage for adults, thereby inflating enrollment and expenditures for adults in states the cover unborn children, and that the report did not use CMS data systems and therefore did not use consistent data. Regarding coverage of

unborn children in SCHIP, CMS is incorrect: the report categorized coverage of unborn children as coverage for pregnant women, not as coverage for adults. Regarding the data systems, we relied on state data primarily because CMS data systems do not provide enrollment and expenditure data broken out by all of the population and coverage categories that were important to this analysis. CMS also commented on the scope of our work and provided technical comments for our consideration. Four of the five states also provided technical comments. We incorporated technical comments as appropriate.

Background

The SCHIP program targets children, but states may also receive approval from the Secretary of Health and Human Services to cover certain adults.

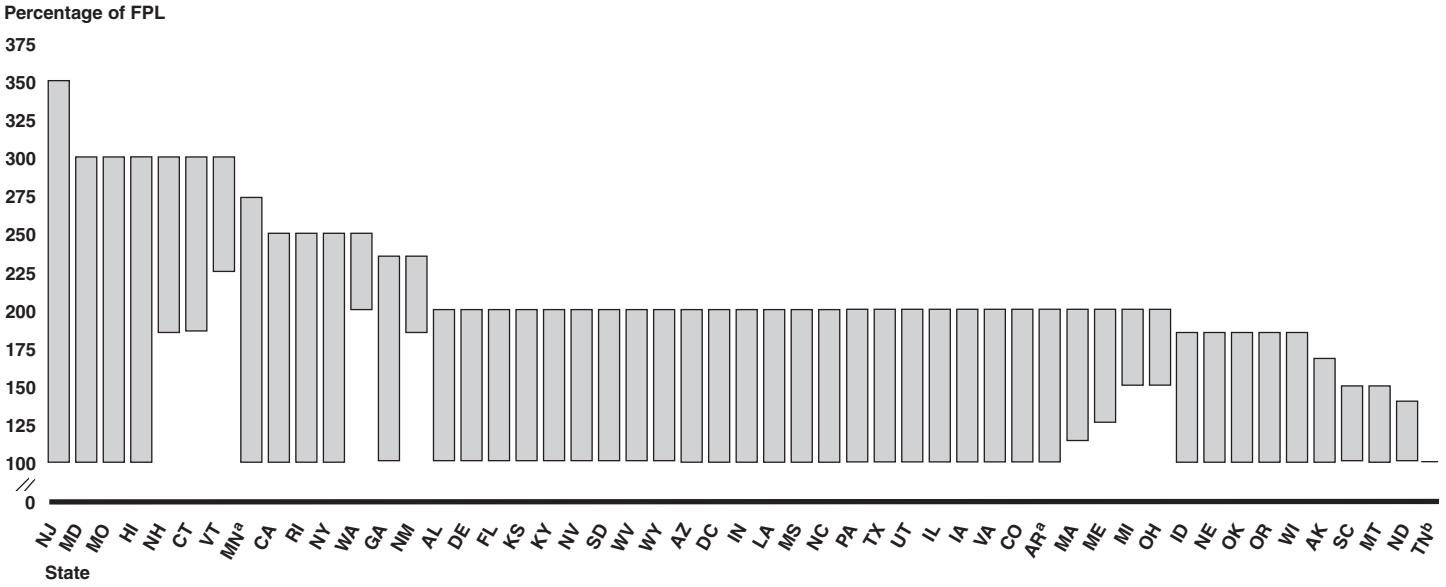
SCHIP Eligibility for Children

In general, the SCHIP statute allows states to cover children up to 200 percent of the federal poverty level (FPL) or 50 percentage points above their existing Medicaid eligibility standard in existence as of March 31, 1997.[11] Each state's starting point essentially creates a "corridor"—generally, SCHIP coverage begins where Medicaid ends and then continues upward to a level determined by each state's SCHIP eligibility policy.[12] In fiscal year 2005, 27 states covered children in families with incomes up to 200 percent of the FPL, which was $38,700 for a family of four in 2005; 14 states covered children in families with incomes above 200 percent of the FPL; and 9 states covered children in families with incomes below 200 percent of the FPL (see fig. 1).

[11]42 U.S.C. § 1397jj(b) (2000). For example, Alabama's Medicaid program covered children aged 15 to 18 up to 15 percent of the FPL, while Washington covered this same group up to 200 percent of the FPL. Therefore, Alabama was allowed to establish SCHIP eligibility for children in families with incomes up to 200 percent of the FPL, while Washington was allowed to go as high as 250 percent of the FPL.

[12]The corridor represents the FPL levels in states' SCHIP programs above the levels offered by their Medicaid programs. Additionally, a state's SCHIP program may provide coverage to individuals who have incomes at the Medicaid level if these individuals do not qualify for Medicaid.

Figure 1: 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.

Notes: 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 established in its Medicaid program. However, a state's SCHIP program may provide coverage to individuals who have incomes at the Medicaid level if they cannot otherwise qualify for Medicaid. In their determination of income eligibility for both programs, states may exclude certain family income, referred to as income disregards, in order to increase eligibility for both programs.

For some states, 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]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 were at the Medicaid level but who could not otherwise qualify for Medicaid.

[b]State did not have a SCHIP program in 2005. In January 2007, HHS approved Tennessee's SCHIP plan, which covers children and pregnant women covered through their unborn children in families with incomes up to 250 percent of the FPL.

HHS SCHIP policies have evolved. In August 2007, HHS sent a letter to states clarifying the agency's position on coverage of children in families whose income exceeds 250 percent of the FPL.[13] HHS expressed concern

[13]HHS, CMS, Dear State Health Official Letter (Baltimore, Md.: Aug. 17, 2007), http://www.cms.hhs.gov/SMDL/SHO/list.asp?intNumPerPage=all&cmdSubmit=Return+to+List&sortByDID=1&filterType=none&filterByDID=-99&sortOrder=ascending&submit.x=13&submit.y=8 (downloaded Aug. 27, 2007).

that setting upper eligibility thresholds above this income level would increase the likelihood of crowd-out. HHS noted that states have adopted what can be characterized as one or more of five specific strategies for preventing crowd-out. HHS stated that it will require states that cover children above 250 percent of the FPL to implement all five of these strategies.[14] In addition, HHS will require states to make assurances that they have enrolled at least 95 percent of SCHIP- or Medicaid-eligible children in families with incomes below 200 percent of the FPL if they wish to offer SCHIP coverage to individuals with incomes above 250 percent of the FPL. In communicating this new policy, the letter stated that HHS will apply this review strategy to SCHIP state plans and section 1115 demonstration waivers that include SCHIP populations and will work with states that currently provide services to children with effective family incomes above 250 percent of the FPL. HHS noted that it expected affected states to amend their SCHIP programs within 12 months to conform to the new requirements.

SCHIP Eligibility for Adults

The SCHIP statute allows states to provide coverage for adults with children eligible for SCHIP if the state can show that it is cost-effective to do so and that the purchase of coverage for the family does not substitute for private coverage that would otherwise be available, which is one form of crowd-out.[15]

States may also cover adult populations using SCHIP funding under an approved section 1115 waiver. Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive certain statutory requirements or approve expenditures that would not otherwise be allowable under the program in the case of experimental, pilot, or demonstration projects that the Secretary determines are likely to promote the objectives of the program whose requirements are being

[14]The crowd-out prevention strategies cited by HHS were (1) imposing waiting periods between dropping private coverage and enrollment, (2) imposing cost-sharing that is approximately equal to the cost of private insurance coverage, (3) monitoring health insurance status at the time of application, (4) verifying family insurance status, and (5) preventing employers from changing coverage policies in such a way as to favor a shift to public coverage.

[15]42 U.S.C. § 1397ee(c)(3) (2000).

waived.[16] The use of section 1115 waivers for purposes of covering adults in SCHIP has changed over time.

- Initially, HHS would not consider the use of section 1115 to waive SCHIP requirements until states had 1 year of operational experience with their SCHIP programs and had completed an evaluation.
- In July 2000, HHS formally notified states it would begin considering section 1115 demonstration proposals for covering populations other than SCHIP's targeted population of uninsured low-income children, such as uninsured parents of SCHIP- and Medicaid-enrolled children.
- 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. This initiative, termed the Health Insurance Flexibility and Accountability Initiative (HIFA), focused on proposals for covering more uninsured people.[17]

Officials in states that cover adults offer a variety of reasons for doing so, including their belief that covering adults will increase coverage rates for children; improve access, quality of care, or health status for families; and decrease inappropriate use of high-cost emergency room services. Other reasons officials cite for using SCHIP funds to cover adults include having already enrolled a high proportion of eligible children and having a surplus of SCHIP allotments.

SCHIP Coverage for Pregnant Women

Pregnant women who would not otherwise qualify for SCHIP can be covered through SCHIP either under a section 1115 waiver or through SCHIP state plan provisions for the unborn.[18] In July 2000, when HHS formally notified states it would begin considering section 1115

[16]42 U.S.C. § 1315(a)(2000).

[17]The Secretary of Health and Human Services is prohibited from approving new section 1115 waivers that permit SCHIP funds to provide coverage of nonpregnant childless adults; waivers approved before October 1, 2005, and extensions, amendments, or modifications of those waivers are not affected by this provision. *See* Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, § 6102, 120 Stat. 131-32 (Feb. 8, 2006) (codified at 42 U.S.C. § 1397gg(f)).

[18]Pregnant women who meet SCHIP age requirements for children's coverage could also be covered in SCHIP.

demonstration proposals for covering populations other than uninsured low-income children, the agency specifically noted that it would consider SCHIP demonstration requests to cover pregnant women. In October 2002, HHS published a regulation that provided states with a means to offer this coverage without having to request and obtain a waiver from HHS.[19] The regulation revised the definition of child for purposes of SCHIP to include the period from conception to birth, thereby permitting states to offer prenatal care and delivery to mothers and their unborn children. According to the preamble discussion to the regulation, the expectant mother's immigration status is not a relevant consideration for purposes of determining whether such benefits can be provided consistent with federal law that places restrictions on the receipt of public benefits by certain noncitizens.[20]

SCHIP Funding

SCHIP funds are allotted to each state annually based on an allocation formula that takes into account (1) the number of eligible children[21] and (2) state variation in health care costs.[22] Under the SCHIP statute, subject to certain exceptions, states generally have 3 fiscal years to use each fiscal year's allotment, after which any remaining funds may be redistributed among the states that have used all of a fiscal year's allotment.[23] States are generally given 1 year to spend any redistributed funds, but the statute also allows states additional time in which to spend redistributed funds

[19]*See* 67 Fed. Reg. 61956 (October 2, 2002); *see also* 42 C.F.R. §457.310 (2005).

[20]*See* 67 Fed. Reg. at 61965-67.

[21]The number of eligible children is calculated as a weighted average of the number of uninsured low-income children and the number of all low-income children. For fiscal year 2000, the allocation formula gave greater weight to the number of uninsured low-income children than to the number of low-income children (75 percent versus 25 percent). For fiscal year 2001 and subsequent fiscal years, the allocation formula gave equal weight to both numbers. 42 U.S.C. § 1397dd(b). See also Congressional Research Service, *SCHIP Original Allotments: Funding Formula Issues and Options* (Washington, D.C.: Apr. 18, 2006).

[22]The state health care cost factor is based on wages of employees in the health services industry and is intended to adjust for geographic variations in health care costs. The ratio of a state's average annual wages in the health industry is compared to the national average, and the allotments of states with above-average wages in the health services industry will increase, while states with averages less than the national average will have their allotments reduced.

[23]The SCHIP statute gives the Secretary of Health and Human Services discretion to determine an appropriate procedure for redistribution of unused allotments. *See* 42 U.S.C. § 1397dd(e),(f).

before they revert to the U.S. Treasury. SCHIP offers a financial incentive for states to participate by providing a federal matching rate that exceeds each state's Medicaid federal matching rate.[24] In addition, under certain circumstances, states can obtain Medicaid reimbursement for individuals enrolled in SCHIP or move Medicaid populations into the SCHIP program.[25]

In relation to total funding, SCHIP spending was low at the start of the program but has grown to exceed available funding. Since 1998, some states have consistently spent more over the period of availability than the available allotment, while others have consistently spent less. Early in the program, states that overspent their annual allotments over the 3-year period of availability could receive redistributions of a portion of the unspent SCHIP allotment funds from other states. By fiscal year 2002, however, states' aggregate annual spending began to exceed annual allotments. As spending grew, available funds for redistribution shrank. To cover projected shortfalls, Congress has, on occasion, appropriated additional funds to states facing shortfalls.

State SCHIP Program Structures Vary in the Adults Covered and Type of Coverage Offered

During fiscal year 2007, SCHIP program structures for adults varied, particularly in terms of the categories of adults covered and the type of coverage offered in the 10 states we reviewed. In both direct coverage and premium assistance SCHIP programs, states were more likely to offer a Medicaid benefit package to parents than they were to childless adults. All 10 states required adults to contribute to the cost of their coverage under SCHIP, and all established crowd-out prevention strategies intended to prevent the substitution of SCHIP for private health care coverage.

[24]For example, the federal government will reimburse at a 65 percent match under SCHIP for a state receiving a 50 percent match under Medicaid.

[25]For example, states that cover children in an SCHIP Medicaid expansion program can revert to Medicaid funding if they exhaust their SCHIP allotment. States that cover adults in a section 1115 waiver in SCHIP may also have the authority under the special terms and conditions of the demonstration to revert these populations to coverage with Medicaid funds.

Adult Populations Covered and Types of Coverage They Were Offered Varied across the 10 States

For the states we reviewed, the adult populations covered, and the type of coverage offered—direct, premium assistance, or both—varied. During fiscal year 2007, of the 10 states we reviewed that covered adults in SCHIP, 5 covered parents only, 1 covered childless adults only, and 4 covered both parents and childless adults.[26] The upper threshold of income eligibility for parents ranged from 133 to 200 percent of the FPL, while the upper threshold of income eligibility for childless adults ranged from 35 percent to 200 percent of the FPL. (See table 1.) In some cases, states that covered adult populations in SCHIP had previously covered them in Medicaid. In 2001, HHS approved requests by Minnesota and Wisconsin to roll over from Medicaid to SCHIP parents with household incomes ranging from 100 to 200 percent of the FPL, and by Rhode Island to do the same for parents with household incomes ranging from 100 to 185 percent of the FPL.

Table 1: Upper Threshold of Income Eligibility as a Percentage of the Federal Poverty Level in 10 States' SCHIP Programs, by Adult Coverage Category and Type of Coverage, Fiscal Year 2007

	Direct coverage[a]		Premium assistance coverage[b]	
State	Parents	Childless adults	Parents	Childless adults
Arizona[c]	200			
Idaho			185	185
Illinois	185[d]	185[d]	185	
Michigan		35		
Minnesota	200			
New Jersey[e]	133		133	
New Mexico[f]			200	200
Oregon			185	185
Rhode Island	185		185	
Wisconsin[g]	200		200	

Sources: GAO analysis of federal and state waiver data.

Notes: An empty cell indicates that the state did not offer this type of coverage to a specific adult population.

Adult coverage categories include parents and childless adults, but do not include pregnant women.

[26]States differed in how they defined parents eligible for SCHIP coverage. For example, some states included other caretaker adults, while other states did not.

No states covered adult populations in their SCHIP programs at income thresholds higher than any of their child populations. Four additional states provided coverage to adults: Arkansas and Nevada implemented adult coverage in fiscal year 2007, and Colorado and Virginia covered only pregnant women.

[a]Direct coverage means the state itself provides health benefit coverage through contracts or agreements with managed care organizations, providers, and suppliers.

[b]Premium assistance means the state pays for a portion of the premium costs of employer-sponsored or privately purchased insurance.

[c]State officials informed us that the state has authority to cover childless adults with SCHIP funds, but in fiscal year 2007 childless adults were enrolled in Medicaid, not in SCHIP.

[d]According to CMS officials, the state covered a small group of parents and childless adults in its programs for hemophiliacs and in the state high-risk pool for the uninsurable.

[e]State initially covered parents (which includes caretaker adults) up to 200 percent of the FPL, but closed enrollment in June 2002. The state reopened enrollment in September 2005 at 100 percent of the FPL, increased it to 115 percent of the FPL in September 2006, and then increased it to 133 percent of the FPL in September 2007. Parents covered up to 200 percent of the FPL prior to June 2002, who otherwise remained eligible after subsequent reduction in income eligibility thresholds, were permitted to continue participating in the program.

[f]State defined its target population as uninsured working adults, which includes both parents and childless adults. At present, unemployed adults are also permitted to buy into the state's premium assistance program by paying both employer and employee shares of the premium.

[g]State covered new applicants up to 185 percent of the FPL, but enrollees remain eligible until their income exceeds 200 percent of the FPL.

States were nearly evenly divided in the type of coverage offered to adults, with three states offering direct coverage only, three states offering premium assistance only, and four states offering both. Three of the four states that offered both types of coverage required adults to enroll in the premium assistance program if they had access to employer-sponsored coverage that met state requirements, such as a prescribed employer contribution toward premium costs. Premium assistance programs varied in their structures and operations (see app. I).

States Were More Likely to Offer a Medicaid Benefit Package to Parents than They Were to Childless Adults

In direct coverage programs, states were more likely to offer a Medicaid benefit package to parents than they were to childless adults. (See table 2.) The two states that offered direct benefits to childless adults offered these adults a less comprehensive benefit package than Medicaid. For example, Michigan, which covered childless adults but not parents, offered a primary care package with no inpatient coverage. According to CMS, the benefit packages of states with premium assistance SCHIP programs could vary depending on the benefit packages that individual employers offered. However, in three states (New Jersey, Rhode Island, and Wisconsin), individuals who needed benefits not provided through their employer-sponsored or individually purchased insurance could obtain them through states' direct coverage Medicaid or SCHIP programs.

Table 2: Benefit Packages Provided to Adults Covered in SCHIP in 10 States, Fiscal Year 2007

	Direct coverage[a]		Premium assistance coverage[b]	
State	**Parents**	**Childless adults**	**Parents**	**Childless adults**
Arizona	●			
Idaho			○	○
Illinois	●[c]	○[c]	○	
Michigan		○		[d]
Minnesota	●			
New Jersey	⊙		⊙[e]	
New Mexico			○	○
Oregon			○[f]	○[f]
Rhode Island	●		●[e]	
Wisconsin	●		●[e]	

Sources: GAO analysis of federal and state waiver data.

Legend

● Medicaid benefit package

⊙ SCHIP benchmark benefit package

○ Other benefit package

Notes: An empty cell indicates that the state did not offer this type of coverage to a specific adult population.

Adult coverage categories include parents and childless adults, but do not include pregnant women.

[a]Direct coverage means the state itself provides health benefit coverage through contracts or agreements with managed care organizations, providers, and suppliers.

[b]Premium assistance means the state pays for a portion of the premium costs of employer-sponsored or privately purchased insurance. According to CMS, benefit packages could vary according to specific state regulations governing benefit requirements of employer-sponsored insurance.

[c]According to CMS officials, the state covered a small group of parents and childless adults in its programs for hemophiliacs and in the state high-risk pool for the uninsurable.

[d]According to state officials, state has authority to operate a premium assistance program; however, as of May 2007, no one has qualified to participate.

[e]State provides directly any Medicaid or SCHIP benefits not covered in the employer-sponsored or individually purchased insurance (also known as wraparound coverage).

[f]According to an Oregon state official, to qualify to participate in Oregon's SCHIP premium assistance program, private insurance plans must offer benefit packages that are the actuarial equivalent to Medicaid mandated services.

All States Required Enrollee Contributions toward Cost of Coverage

All 10 of the states that we reviewed required adults to contribute to the cost of their coverage under SCHIP. Enrollee contributions included premiums—a payment required for insurance coverage for a given period of time—and cost-sharing—an out-of-pocket payment for part of the cost of services used by a beneficiary.

Premiums

Nine of the 10 states required at least some adults to pay premiums or some contribution toward premium costs in their direct coverage program, their premium assistance program, or both. (See table 3.) Six of the 7 states providing direct coverage required at least some covered adults to pay monthly premiums, with 4 states charging covered adults premiums if family income equaled or exceeded 150 percent of the FPL, and 2 states charging covered adults if family income equaled or exceeded 100 percent of the FPL. All 7 states providing premium assistance also required at least some covered adults to contribute to premium costs. Of the 7 states providing premium assistance, 4 charged covered adults premiums if family income equaled or exceeded 100 percent of the FPL. The other 3 states required premium contributions from all enrolled adults. Of these 3 states, 2 required covered adults to pay premium costs remaining after the states paid out their premium subsidies. One state charged all covered adults premiums on a sliding scale based on family income.

Table 3: Enrollee Premiums Required for Covered Adults in 10 States' SCHIP Programs, Fiscal Year 2007

	Direct coverage[a]		Premium assistance coverage[b]	
State	Income level at which premiums start (percent of FPL)	Amounts vary with income?	Income level at which premiums start (percent of FPL)	Amounts vary with income?
Arizona	100	Yes		
Idaho			0[c]	No
Illinois	150[d]	Yes[e]	33[c, f]	No
Michigan	N/A[g]	N/A[g]		
Minnesota	100[d]	Yes		
New Jersey	150	Yes	150	Yes
New Mexico			100	Yes
Oregon			0[c, h]	Yes
Rhode Island	150	Yes	150	Yes
Wisconsin	150	Yes	150	Yes

Sources: GAO analysis of federal and state waiver data.

Notes: An empty cell indicates that the state did not offer this type of coverage to adults.

Adult coverage categories include parents and childless adults, but do not include pregnant women.

[a]Direct coverage means the state itself provides health benefit coverage through contracts or agreements with managed care organizations, providers, and suppliers.

[b]Premium assistance means the state pays for a portion of the premium costs of employer-sponsored or privately purchased insurance.

[c]State required covered adults to pay any additional premium costs that exceeded its subsidy.

[d]State scaled premiums for covered adults according to number of family members.

[e]State charged premiums for some childless adults (high-risk pool).

[f]Percentage represents the FPL for a family size of one or two individuals. The FPL eligibility level changes depending on family size.

[g]State did not require covered adults to pay premiums.

[h]State charged all covered adults premiums on a sliding scale based on family income.

Cost-Sharing

Five of seven states providing direct coverage charged cost-sharing for covered adults (Arizona, Illinois, Michigan, Minnesota, and New Jersey). The other two states (Rhode Island and Wisconsin) did not charge covered adults cost-sharing.[27] In all 7 states that provided premium assistance,

[27]In Wisconsin, persons who choose to seek care outside the approved managed care plans are charged a copayment.

covered adults were responsible for cost-sharing. Some states—for example, Rhode Island—reimbursed covered adults for a portion of the cost-sharing.

All States Established Crowd-Out Prevention Strategies

All 10 states we reviewed discouraged crowd-out of SCHIP for private coverage, using one or more strategies. Most states required adults to be uninsured for periods ranging from 3 to 6 months before they could become eligible for enrollment in SCHIP. (See table 4.) Some states exempted people from waiting periods if they lost coverage involuntarily (e.g., through the loss of a job or because their employer no longer offered coverage).

Table 4: Crowd-Out Prevention Strategies for Adults in SCHIP, Fiscal Year 2007

State	Must be uninsured to enroll in SCHIP?	Length of waiting period (months)	Same crowd-out prevention strategies for children?
Arizona	Yes	3[a]	Yes
Idaho	Yes	6[a]	Yes
Illinois	Yes[b]	0	Yes
Michigan	Yes[b]	0	No[c]
Minnesota	Yes[b]	4[d]	No
New Jersey[e]	Yes[b]	3[a, g]	Yes
New Mexico	Yes	6	Yes
Oregon[e]	Yes	6[a]	Yes
Rhode Island[e]	Yes	0[c]	Yes
Wisconsin[e]	Yes[b]	3[a, f]	Yes

Sources: GAO analysis of federal and state data.

Notes: Crowd-out refers to the substitution of SCHIP (or other public coverage) for private insurance coverage.

Adult coverage categories include parents and childless adults, but do not include pregnant women.

Unless otherwise noted, length of the waiting period is the same for all covered adults enrolled in direct coverage and premium assistance programs.

[a]State made exceptions to the waiting period if the applicant had lost private insurance through no fault of his or her own (i.e., employer-driven) or due to hardship.

[b]State allowed some insured adults to be covered under Medicaid.

[c]State did not allow children in its separate SCHIP program to have had other insurance coverage during the past 6 months.

[d]State did not allow parents to enroll if their employers had dropped employer-sponsored coverage within the past 18 months.

[e]State required individuals to enroll in qualifying employer-sponsored insurance if available.

[f]State waiting period for covered adults in premium assistance was 6 months.

[g]According to CMS officials, state waiting period for covered adults in premium assistance was 6 months.

Enrollment and Expenditures for Adults Varied Widely across States Reviewed

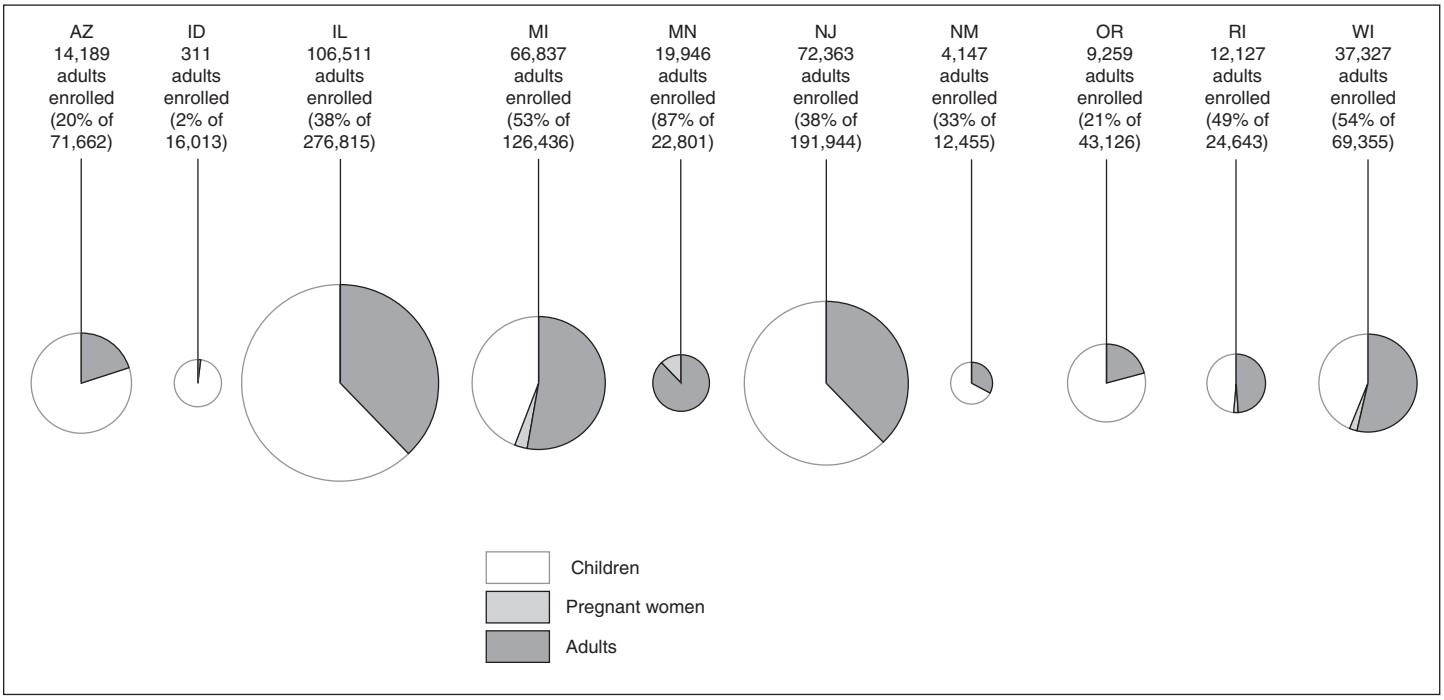
Enrollment and expenditure experiences with adult coverage varied widely across the states we reviewed. Adults constituted widely varying proportions of the total number of individuals covered through SCHIP in the 10 states in 2006, ranging from 2 percent to 87 percent. Similarly, expenditures for adults as a proportion of total expenditures ranged from 1 percent to 80 percent for 2006. Six of the 10 states, compared with 10 of the 41 other states, were projected to face shortfalls in SCHIP funds in at least one of the years from 2005 through 2007.

Adult Enrollment in SCHIP Varied Widely across the 10 States

Enrollment experiences with adult coverage varied widely across the states we reviewed. Adults constituted widely varying proportions of the total number of individuals covered through SCHIP in the 10 states in 2006—less than 25 percent in 3 states, 33 to 50 percent in 4 states, and more than 50 percent in 3 states. (See fig. 2.) About 343,000 adults were enrolled, comprising about 40 percent of the total number of individuals covered through SCHIP in these states.[28] The 3 states with the largest overall SCHIP enrollment (Illinois, Michigan, and New Jersey) accounted for over two-thirds of the total number of adults enrolled, with numbers ranging from approximately 67,000 to approximately 107,000 apiece. In contrast, 5 states had fewer than 15,000 adults enrolled, and 1 of the 5 states (Idaho) had only about 300 adults enrolled.

[28]Point-in-time enrollment for Illinois was estimated from the number of adults and children ever enrolled during the year. Data for New Jersey and Wisconsin were as of June 2006 and December 2006, respectively. Data for the other seven states were as of September 2006.

Figure 2: Adults as a Percentage of the Total Number of Individuals Covered through SCHIP in 10 States That Covered Adults, 2006



Source: GAO analysis of state data.

Notes: Adults include parents and childless adults. Pregnant women include individuals covered through state plan provisions for coverage of the unborn and under section 1115 waivers. In New Jersey, the number of pregnant women covered is too small (0.03 percent) to be visible in the chart.

The numbers represent point-in-time enrollment. Point-in-time enrollment for Illinois was estimated from the number of adults and children ever enrolled during the year; no data were available on pregnant women. Data for New Jersey and Wisconsin were as of June 2006 and December 2006, respectively. Data for the other seven states were as of September 2006.

The pie charts vary in size with the total number of individuals covered through SCHIP.

In the four states that covered both parents and childless adults under SCHIP in 2006, the percentage of total adult enrollment that each group represented varied widely, although parents were in the majority in three of the four states (see table 5).

Table 5: Parents and Childless Adults as a Percentage of Total Adult Enrollment in the Four States That Covered Both Groups in 2006

State	Parents	Childless adults
Idaho	76	24
Illinois	99	1
New Mexico	43	57
Oregon	55	45

Source: GAO analysis of state data.

Notes: These numbers represent point-in-time enrollment as of September 2006. For Illinois and New Mexico, point-in-time enrollment for these groups of adults was estimated from the number ever enrolled during the year. Data for Idaho and Oregon were as of September 2006.

Adult coverage categories include parents and childless adults, but do not include pregnant women.

Arizona covered childless adults in SCHIP from fiscal year 2002 through fiscal year 2005. To avoid a shortfall of SCHIP funds in 2006, the state covered these adults in Medicaid. In 2005, parents and childless adults represented 44 percent and 56 percent, respectively, of the state's adult enrollment in SCHIP.

In two states that offered both direct coverage and premium assistance, enrollment in the direct coverage program was at least 74 times greater than in the premium assistance program. In New Jersey, 72,086 adults were enrolled in direct coverage, compared with 277 in premium assistance. In Wisconsin, 36,829 adults were enrolled in direct coverage, compared with 498 in premium assistance.[29]

The percentage of SCHIP enrollment that adults comprised in each state likely reflected a combination of characteristics unique to the state, including the income eligibility levels the state set for children in Medicaid prior to SCHIP (which affected the levels of income it could cover in SCHIP), the type of coverage offered to adults and how that coverage was structured, and how long the state had enrolled adults. Examples from either end of the enrollment spectrum illustrate the variation among states with regard to these characteristics:

- Minnesota, the state in which adults comprised the highest percentage of the total number of individuals covered through SCHIP (87 percent), had only 22 children enrolled at the end of fiscal year 2006, compared with

[29]Illinois and Rhode Island, which also offered both types of coverage, did not provide data on enrollment in each program.

about 20,000 adults.[30] Prior to the enactment of SCHIP, Minnesota had the nation's highest income eligibility levels for children in Medicaid, covering children with family incomes up to 275 percent of the FPL. The state implemented only a small Medicaid expansion in SCHIP, covering children under age 2 with family incomes between 275 and 280 percent of the FPL. With so few children enrolled in SCHIP, the state spent only 0.02 percent of its allotments in the 3 years before it enrolled adults in 2001. In 2006, nearly all of the children whose parents were covered in SCHIP were themselves covered in Medicaid.[31]

- Idaho, the state in which adults comprised the lowest percentage of the total number of individuals covered through SCHIP (2 percent), provided only premium assistance and was also one of the last of the 10 states we reviewed to implement coverage for adults in SCHIP—in July 2005. Idaho restricts enrollment in the premium assistance program to employees of small businesses and initially required that employers pay at least 50 percent of premiums for employees' spouses as well as employees. An Idaho official reported that employer participation was low in the program's first year because of this requirement, leading the state to eliminate it in December 2006.[32]

In several states, adult enrollment has fluctuated over the years as the states implemented enrollment caps or shifted adults previously covered in SCHIP to Medicaid:

- Michigan closed enrollment for childless adults in July 2004, just 6 months after implementing coverage, when enrollment exceeded the state's target of 60,000. As a result, the number of adults ever enrolled during the year dropped by 24 percent from 2004 to 2005. The state has restricted open enrollment periods to between 1 and 3 months per year in order to keep expenditures within budget.

[30]Minnesota's SCHIP program also had 2,833 pregnant women covered through their unborn children.

[31]Although Minnesota is an extreme case, many of the children whose parents were covered in SCHIP in the other nine states we reviewed were covered in Medicaid. Because Medicaid income eligibility levels are generally higher for children than for adults in these states, and SCHIP eligibility generally begins where Medicaid ends, some parents with family incomes below the thresholds for children in Medicaid were covered in SCHIP.

[32]Enrollment was much higher in New Mexico, the other state that implemented premium assistance for adults in SCHIP in July 2005. New Mexico structured its program so that adults could obtain coverage regardless of whether their employers offered it or how that coverage was structured if they did.

- In New Jersey, the number of adults ever enrolled during the year dropped by 53 percent from 2002 to 2005, when the state closed enrollment due to higher than anticipated enrollment and costs, coupled with state revenue shortfalls, and rose by 33 percent from 2005 to 2006, after enrollment reopened.[33]

- Faced with an impending shortfall in SCHIP funds, Arizona rolled over childless adults from SCHIP to Medicaid during fiscal year 2006, thereby lowering the number of adults covered in SCHIP. Adults constituted 20 percent of the total number of individuals covered through SCHIP at the end of 2006, compared with 37 percent at the end of 2005.

Proportion of Expenditures for Adults Varied Widely across States Reviewed

As with enrollment, adults accounted for widely varying proportions of total SCHIP expenditures in the nine states for which we had expenditure data—1 percent in one state, 32 to 42 percent in three states, and more than 50 percent in five states (see fig. 3).[34] In five states, adults accounted for more than half of total SCHIP expenditures.[35] For the nine states, SCHIP-funded expenditures for adults totaled about $674 million in 2006 and comprised 54 percent of total SCHIP expenditures, compared with 41 percent of enrollment.

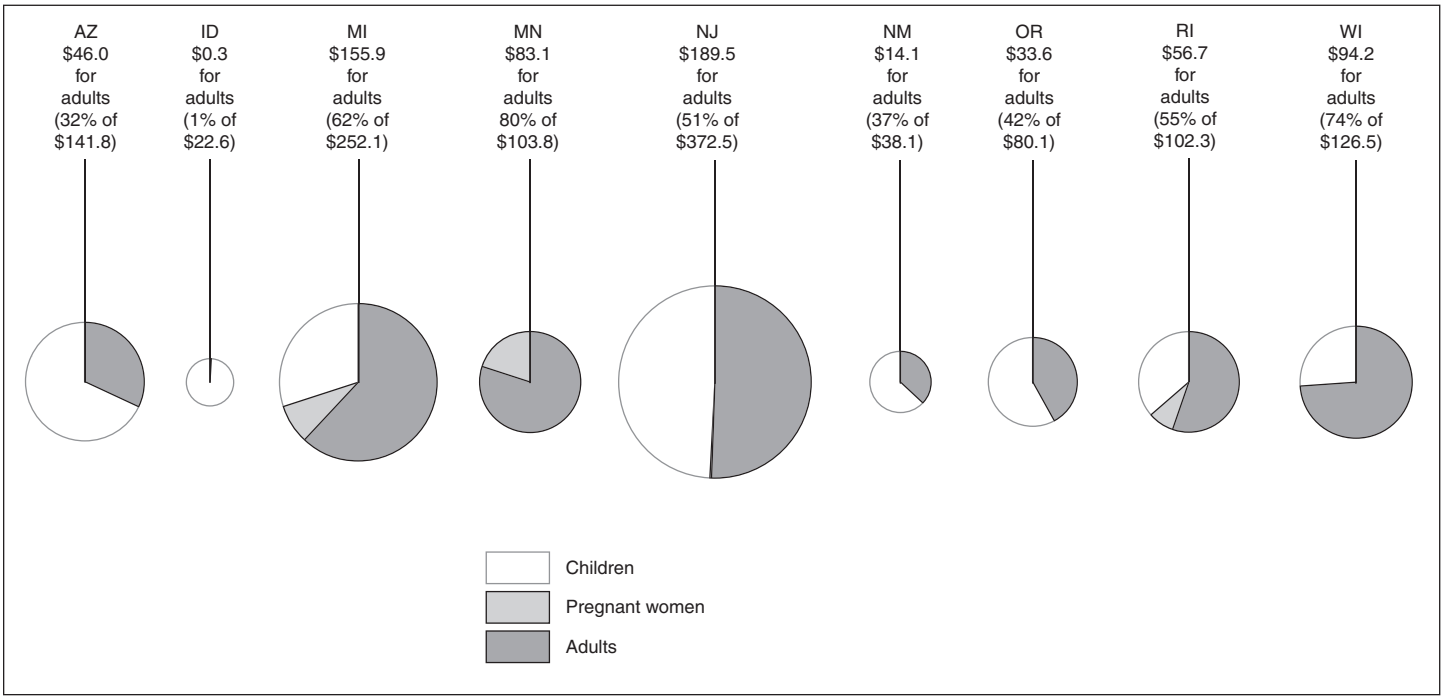
[33]The state reopened enrollment for parents with family incomes at or below 100 percent of the FPL in September 2005, and then raised this threshold to 115 percent a year later, and to 133 percent a year after that.

[34]Illinois did not provide expenditure data.

[35]We were unable to evaluate the extent to which adults contributed to the cost of their coverage in the 10 states, as only 3 states provided data on enrollee premium payments by population. In these 3 states, the share of combined expenditures—state expenditures plus enrollee premiums—that parents paid through their premiums varied. The percentages were similar in Arizona (7.2 percent) and Minnesota (7.1 percent) but considerably lower in New Jersey (0.2 percent), probably because the state was no longer enrolling parents with incomes above 150 percent of the FPL, the income level at which premiums were imposed.

Figure 3: Expenditures for Adults as a Percentage of Total SCHIP Expenditures in Nine States That Covered Adults, 2006

Dollars in millions



Source: GAO analysis of state data.

Notes: Adults include parents and childless adults. Pregnant women include individuals covered through state plan provisions for coverage of the unborn and those covered under section 1115 waivers. In New Jersey, expenditures for pregnant women covered are too low (0.4 percent) to be visible in the figure.

Illinois did not provide expenditure data. Data for Arizona, Michigan, Minnesota, Oregon, Rhode Island, and Wisconsin were obtained directly from the states. Data for Idaho, New Jersey, and New Mexico were obtained from state annual reports.

The pie charts vary in size with total SCHIP expenditures.

Individually, adults generally were more expensive to cover than children in the same type of coverage—either direct or premium assistance. In the five states that provided information on monthly expenditures per enrollee in their direct coverage programs, for example, expenditures for parents

ranged from 41 percent higher in Rhode Island to 135 percent higher in Wisconsin.[36] In dollar terms,

- monthly expenditures per child ranged from $95 to $201 and averaged about $144;
- monthly expenditures per parent ranged from $222 to $333 and averaged about $260; and
- monthly expenditures per childless adult in Michigan, the one state that provided direct coverage to these adults in SCHIP in fiscal year 2006 and provided data to us, were $213.[37]

Compared with direct coverage programs, monthly expenditures per parent for premium assistance were somewhat lower in one of the three programs about which we obtained information ($213 in Oregon) and considerably lower in the two others ($64 in New Jersey and $94 in Idaho).[38] In Oregon, most families enrolled in the premium assistance program did not have access to employer-sponsored insurance and were therefore enrolled in privately purchased insurance with no employer contribution. In addition, most enrollees qualified to receive a 95 percent subsidy from the state. In contrast, both New Jersey and Idaho limited their costs for premium assistance by subsidizing only employer-sponsored insurance and requiring that employers pay a percentage of premiums.[39] In addition, New Jersey charged participating adults with family incomes above 150 percent of the FPL a fixed premium

[36]Illinois, the other state that provides direct coverage to adults, did not provide expenditure data. For Arizona, Minnesota, and New Jersey, monthly expenditures per parent were 67 percent, 86 percent, and 79 percent higher, respectively, than monthly expenditures per child.

[37]Michigan provided only a limited outpatient service package to childless adults. In contrast, Arizona, which rolled childless adults over from SCHIP to Medicaid coverage in 2006, provided most Medicaid services and reported monthly expenditures per childless adult of $579.

[38]The other states that offered SCHIP-funded premium assistance to adults were Illinois, New Mexico, Rhode Island, and Wisconsin.

[39]New Jersey required that employers pay at least 50 percent of the enrollee's premium, and in fiscal year 2006 Idaho required that employers pay at least 50 percent of both the enrollee's and his or her spouse's premiums. Since December 1, 2006, Idaho has no longer required employers to contribute to spouses' premiums.

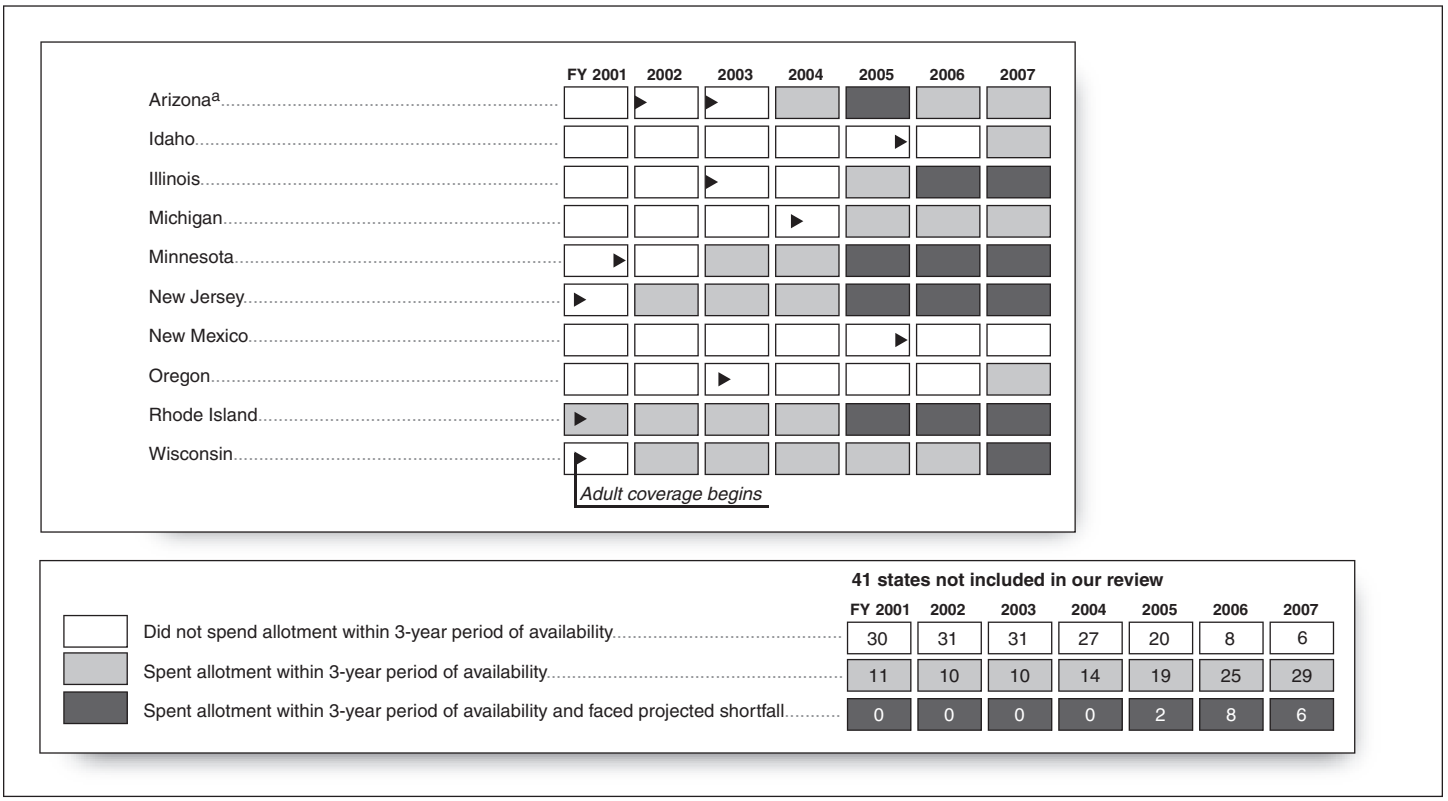
contribution, and Idaho capped its monthly subsidy at $100 per adult ($500 per family).

Six of 10 States That Covered Adults Faced Projected Funding Shortfalls

Six of the 10 states we reviewed, along with 10 of the 41 other states, faced projected shortfalls—that is, they were projected to have SCHIP expenditures that would call for federal matching funds in excess of those available to them—in at least one of the years from 2005 through 2007. Illinois and New Jersey, states with above-average enrollments of both children and adults, accounted for nearly half (47 percent) of the $932 million shortfall projected for 2007 for states nationwide. Seven of the 10 states—like 21 of the 41 other states—qualified for redistributions of other states' unused allotments in all 3 of these years.[40] (See fig. 4.)

[40]In general, a state that spent its allotment for a given year within the 3-year period of availability qualified for redistribution of other states' unused allotments. For example, a state that spent its fiscal year 2003 allotment by the end of fiscal year 2005 qualified for redistribution in fiscal year 2006.

Figure 4: Status of States' SCHIP Allotment Expenditures and Whether States Faced Projected Shortfalls, Fiscal Years 2001-2007



Sources: GAO analysis of data obtained from CMS and *Federal Register*.

Note: The years refer to the fiscal years in which unspent allotments from 3 years prior became available for redistribution. Under the SCHIP statute, subject to certain exceptions, states were given 3 years to spend each allotment, after which any unspent funds could be redistributed among states that had spent their entire allotments. States projected to face shortfalls were those projected by CMS to have SCHIP expenditures that would call for federal matching funds in excess of those currently available to them.

[a]Arizona began enrolling childless adults on October 1, 2001, and parents on October 1, 2002.

The states that implemented adult coverage earlier were more likely than states that implemented it later to consistently spend their entire allotments. Minnesota, New Jersey, Rhode Island, and Wisconsin, all of which began enrolling adults in SCHIP-funded direct coverage with Medicaid benefits in the first year HHS approved such coverage (2001), qualified for redistributions in at least 5 of the 7 years in which funds were

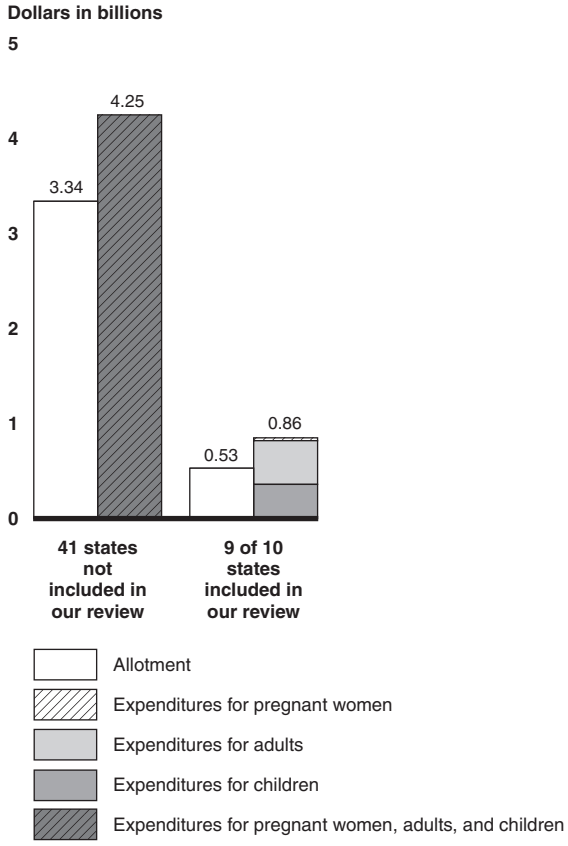
redistributed.[41] In contrast, Idaho and New Mexico, which began enrolling adults in SCHIP-funded premium assistance programs in 2005, were among the small number of states in the nation that either never spent their entire allotments within the 3-year period of availability or did so only in one year.

Collectively, the 9 states that we reviewed for which we had expenditure data by population—like the group of 41 states we did not review—spent more federal dollars in fiscal year 2006 than they were allotted for that year (see fig. 5).[42]

[41]Twelve of the 41 states not included in our review qualified for redistributions in at least 5 of the 7 years in which funds were redistributed.

[42]In general, states were able to draw on unused funds from prior fiscal years' allotments to cover expenditures incurred in a given year that were in excess of their allotment for that fiscal year, because under the SCHIP statute, states generally have 3 years to spend each annual allotment.

Figure 5: SCHIP Allotments and Federal Expenditures for Two Groups of States, Fiscal Year 2006



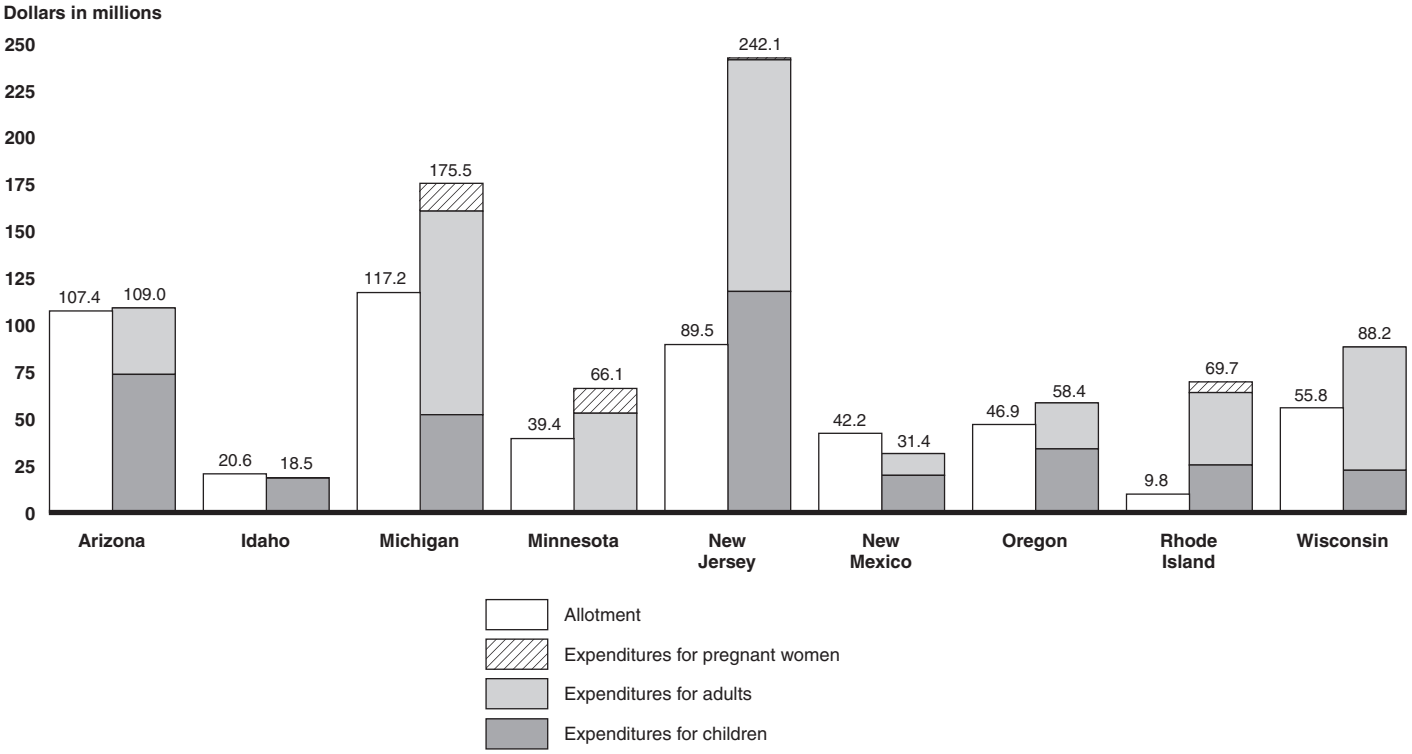
Sources: GAO analysis of CMS and state data.

Notes: Adults include parents and childless adults. Pregnant women include individuals covered through state plan provisions for coverage of the unborn and those covered under section 1115 waivers.

Illinois did not provide expenditure data. For expenditures by population group, data for Arizona, Michigan, Minnesota, Oregon, Rhode Island, and Wisconsin were obtained directly from the states, and data for Idaho, New Jersey, and New Mexico were obtained from state annual reports.

Of these nine states, seven had federal expenditures in excess of their allotments in fiscal year 2006. In two of the seven states (New Jersey and Rhode Island), federal expenditures for children alone exceeded the state's allotment, and in four of the seven states (Minnesota, New Jersey, Rhode Island, and Wisconsin), expenditures for adults alone exceeded the state's allotment. (See fig. 6.)

Figure 6: SCHIP Allotments and Federal Expenditures for Nine States That Covered Adults, Fiscal Year 2006



Sources: GAO analysis of CMS and state data.

Notes: Adults include parents and childless adults. Pregnant women include individuals covered through state plan provisions for coverage of the unborn and those covered under section 1115 waivers.

Illinois did not provide expenditure data. For expenditures by population group, data for Arizona, Michigan, Minnesota, Oregon, Rhode Island, and Wisconsin were obtained directly from the states, and data for Idaho, New Jersey, and New Mexico were obtained from state annual reports.

Officials in 2 of the 10 states we reviewed reported that they stopped covering some adults in SCHIP for some period of time in fiscal year 2006 to comply with the allotment neutrality requirements for section 1115 waivers and instead covered those adults in Medicaid. The allotment neutrality policy requires states covering adults under waiver authority to ensure that all necessary SCHIP funds are available for children. States are not permitted to reduce coverage for children—by capping enrollment, decreasing eligibility standards, increasing cost-sharing or decreasing benefits—while covering adults. In addition, states are required to monitor their expenditures to ensure priority is given to children over adults if available federal funds are not sufficient to cover both populations. Seven

of the 10 states in our review have joint Medicaid-SCHIP waivers and therefore may be permitted to roll over adults from SCHIP to Medicaid and claim the lower Medicaid federal matching rate for these populations. Two of the states have done so to comply with SCHIP allotment neutrality requirements.

- Arizona, as noted earlier, covered in Medicaid in 2006 childless adults who were previously covered in SCHIP. Under the terms of Arizona's waiver agreement, priority for funding coverage goes first to children, next to parents, and last to childless adults.

- Minnesota claimed Medicaid rather than SCHIP federal funding for parents for the last month of fiscal year 2006 because it anticipated having insufficient SCHIP allotment dollars to cover this population along with children and pregnant women for the entire year.

States' Outreach Approaches Target Specific Populations and Use Partnerships to Locate and Enroll All Eligible Individuals

The 10 states we reviewed used three approaches in their outreach efforts: (1) targeting populations they considered hard to reach, such as immigrant, non-English-speaking, or ethnic populations; (2) directing outreach to entire families; and (3) relying on established relationships and new partnerships to continue outreach because in some cases changes in state budgets constrained funding for these efforts. States' efforts to assess the effectiveness of different outreach approaches ranged from little or no evaluation to more formal methods of analyzing outcomes.

States' Outreach Approaches Targeted Hard-to-Reach Populations

Six of the 10 states that we reviewed reported targeting populations that they considered hard to reach—immigrant, non-English-speaking, or ethnic populations—generally because of language barriers and the individuals' concerns about immigration status. Two of the states we reviewed—Idaho and Illinois—noted that citizen children of undocumented workers in particular are difficult to identify and enroll in SCHIP because their parents are reluctant to approach a government program for fear of being identified. States provided some examples of their efforts to target program materials or outreach to immigrant or non-English-speaking populations in their 2006 SCHIP Annual Reports:

- Illinois distributed fact sheets about its SCHIP program in many different languages, and its program call line used a language translation service to enable staff to speak to callers in their native language;

- New Jersey used cable television, radio, and print media geared toward the minority community to inform them about the program;
- New Mexico placed a special emphasis on reaching out to Native American populations and told us that they held health fairs in local Native American chapter houses and worked with the Indian Health Service on media campaigns;
- Oregon, Rhode Island, and Wisconsin reached out to Hispanic communities through the use of foundations, community-based organizations, and outreach materials; and
- Wisconsin provided materials such as fact sheets for the SCHIP prenatal program in English, Spanish, Russian, and Hmong.

Most States' Outreach Approaches Targeted Entire Families

Most of the states we reviewed reported that they directed their outreach efforts toward families as a whole and not specifically toward adults. For example, an Arizona SCHIP official said that outreach now is directed toward the whole family, a contrast to initial outreach efforts that targeted children in the program's early years. SCHIP officials from Minnesota, Oregon, and Rhode Island told us that they also reached out to the entire family or uninsured persons in general in their campaigns, and SCHIP officials from New Jersey cited a change in application and enrollment materials to notify applicants that the entire family may be eligible for coverage under SCHIP.

While most states did not direct their outreach to adults in particular, three states—Idaho, Oregon and New Mexico—reported reaching out to employers to generate participation in the states' premium assistance programs. An Idaho SCHIP official explained that the state's SCHIP program trains insurance brokers all over the state to conduct outreach to small businesses to generate interest in the state's premium assistance program. Oregon similarly trains insurance agents, and New Mexico reaches out to small businesses to generate participation in its adult coverage program.

States Relied on Established Relationships and New Partnerships for Outreach

Of the 10 states we reviewed, 8 indicated that they relied on established relationships or new partnerships to continue outreach because in some cases changes in state budgets constrained funding for these efforts. Seven of the 10 states that we reviewed indicated that they either had little

funding budgeted for outreach or were spending less than they had spent at the beginning of the program, as the following examples illustrate.

- An Arizona SCHIP official noted that the state did not have much funding budgeted for outreach since the initial push to get children enrolled at the beginning of the program. Estimates indicate that funding for outreach declined from 1999, when the program spent $217,246, to 2006, when it spent $17,000. However, in commenting on a draft of this report, officials told us that, in the fiscal year 2008 budget, the Governor and the State Legislature appropriated $480,000 for additional outreach activities at various sites, including schools. Arizona SCHIP officials indicated that an advocacy group continues to conduct outreach activities such as health fairs and enrollment events with the state even though there is no longer funding for these efforts.

- In two states—Michigan and Wisconsin—declines in funding reflected the perceived level of outreach needed. SCHIP officials in Michigan said that while the state conducted a great deal of outreach in SCHIP's early years, that level of effort was no longer needed because the public now has broad knowledge of the program. Additionally, Michigan officials explained that the state's early outreach activities established relationships and partnerships that continue to conduct outreach despite the change in funding and focus for these efforts that has occurred in the state.

Some states' SCHIP programs indicated that they also partnered with other state agencies that regularly come in contact with families in an effort to find and enroll eligible children, as shown in the examples below.

- New Jersey SCHIP officials noted that the state focused on what it termed "in-reach," meaning partnering with other state government programs and agencies. New Jersey SCHIP has partnered with agencies such as the Women, Infants, and Children program, which is a nutritional program for women and children at risk for poor nutrition; the state's Department of Health, which provides free immunizations; the Department of Motor Vehicles; and the Office of Unemployment to provide information about the program to parents who may be in need.

- In New Mexico, the state hospital association assists the state in enrolling applicants or referring them to the SCHIP or Medicaid programs. The state also works with community-based centers, health centers, and other interested associations across the state. Additionally, the SCHIP program has developed partnerships with tribal organizations and has stationed

outreach workers at sites convenient to tribal members in an effort help enroll individuals.

States Varied in the Extent to Which They Analyzed Outreach Effectiveness

States' efforts to assess the effectiveness of different outreach approaches ranged from little or no evaluation to more formal methods of analyzing outcomes. Six states reported that they evaluate the effectiveness of their outreach approaches. (See table 6 for a description of the six states' evaluation efforts.) The remaining four states indicated that they did not evaluate outreach approaches; had evaluated outreach in the past, but were not doing so currently; or had plans in place to better assess how well outreach was working. A SCHIP official from Wisconsin said that the state had evaluated outreach 1 year after Wisconsin implemented its SCHIP program but had since scaled back its evaluation and outreach efforts. Oregon SCHIP officials indicated that the state was working with advocates that perform outreach to help the state collect better data, which will help the state become more sophisticated in evaluating its outreach approaches.

Table 6: Six States' Examples of Current Approaches to Evaluating the Effectiveness of Outreach Strategies

State	Effort to evaluate outreach approaches
Arizona	• Monitors volume of calls received by the program call line and incoming applications following an outreach campaign
Idaho	• Monitors program call line, including asking callers how they heard about the program
Michigan	• Monitors the program call line and Internet Web site • Tracks the number of applications received and enrollment approvals from various sources, such as local public health departments • Reviews reports submitted by an enrollment broker on the number of applications processed and outreach performed under the contract
New Jersey	• Determines where applications originated by application assistance site • Codes projects and sites to determine effectiveness of particular effort or location
New Mexico	• Tracks calls made to program call line, including asking callers how they heard about the program • Examines the volume of applications associated with particular outreach efforts
Rhode Island	• Evaluates the effectiveness of its outreach partners' programs by monitoring the number of applications submitted and the number of children and adults enrolled

Source: GAO evaluation of information provided by state officials.

Agency and State Comments and Our Evaluation

We provided copies of a draft of this report to CMS and the 10 states we reviewed: Arizona, Idaho, Illinois, Michigan, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, and Wisconsin. We received written comments from CMS. (See app. II.) We address CMS comments below and incorporated CMS technical comments as appropriate. We also received responses from Arizona, Idaho, Michigan, Oregon, and Rhode Island. Arizona, Idaho, Oregon, and Rhode Island provided technical comments, which we incorporated as appropriate. Michigan reviewed the draft and did not have any comments.

In commenting on a draft of this report, CMS stated that because SCHIP is a very important program for the Administration and Congress the information that is conveyed to Congress must accurately reflect the operation of the program. The agency commented on four general issues in our report: (1) the characterization of services to unborn children; (2) the data sources we used; (3) the lack of information, in the states' outreach activities section, about whether the provision of coverage to parents resulted in the increased coverage of children; and (4) the information we included or did not include about recent HHS actions pertaining to SCHIP. These comments are addressed below.

CMS commented that the report mischaracterized SCHIP coverage of unborn children as coverage for adults. While acknowledging that SCHIP coverage benefits both the unborn child and its mother, CMS underscored that it is the unborn child who is eligible for coverage. CMS stated that the report disregarded the SCHIP definition of a child as "an individual under the age of 19, including the period from conception to birth";[43] that we classified coverage of unborn children as coverage of adults; and that, as a result, we inflated enrollment and expenditures for adults in states that cover unborn children in SCHIP. CMS's description of our analysis is incorrect. We did not categorize coverage of unborn children as coverage of adults, but as coverage of another category of individuals—pregnant women. We reported enrollment and expenditures separately for adults (parents and childless adults), pregnant women, and children. Our characterization of SCHIP coverage for unborn children as coverage for pregnant women reflects the common understanding that the coverage offered—prenatal care and delivery—is care that a pregnant woman receives for both her benefit and that of her unborn child. Moreover, CMS acknowledged this in the preamble discussion to the regulation that

[43]See 42 C.F.R. §457.10 (2005).

revised the definition of child for the purposes of SCHIP to include the period from conception to birth.[44] In response to comments on the regulation, CMS stated that the regulation was "simply an option to make it faster and easier for States that want to use SCHIP funds to expand prenatal services for low-income women and to do so without having to go through the 1115 [waiver] process or wait for the passage of legislation."[45] CMS also objected to the report's statement that a state's SCHIP program may provide coverage to individuals who have incomes at the Medicaid level but do not meet U.S. citizenship requirements, a reference to the mothers of unborn children covered in SCHIP, and stated that unborn children do not have immigration status as "aliens" and therefore are not precluded by federal law from receiving federal means-tested benefits. We recognize that this statement may require more explanation than is warranted in this report and have therefore deleted it.

Regarding our use of data sources, CMS commented that we did not use information from the approved demonstration terms and conditions, Statistical Enrollment Data System (SEDS), or Medicaid Budget and Expenditure System/State Children's Health Program Budget and Expenditure System (MBES/CBES) and therefore did not use consistent data. We did use information from the approved demonstration terms and conditions for the states we reviewed. We did not use SEDS or MBES/CBES data primarily because neither data system provides enrollment and expenditure data broken out by all of the population and coverage categories that were important to our analysis. In addition, because both data systems contain information submitted by the states and we would have needed to address any questions about the data to them, we chose to obtain data directly from the states. We also had concerns about the quality of the SEDS data. For example, in its technical comments, CMS questioned the number of adults (37,327) that we reported were enrolled in Wisconsin's SCHIP program as of December 31, 2006, and stated that SEDS showed 68,091 adults enrolled. A state official confirmed that the number we reported for SCHIP was correct and explained that the SEDS figure included adults covered in Medicaid.

[44]*See* 67 Fed. Reg. 61956, 61957-58 (2002).

[45]*See id.* at 61958.

Regarding states' outreach activities, CMS commented that our investigation of outreach activities did not consider whether the provision of coverage to parents resulted in increased enrollment of children. While this is an important question, analyzing the many factors that affect program enrollment was beyond the scope of our work.

Regarding its fourth issue, CMS commented that the report included some information that was not relevant—and failed to include some information that was. Regarding information that was not relevant, CMS cited our discussion of its August 2007 letter that clarified its position on regulations related to coverage of children in families whose income exceeds 250 percent of the FPL. CMS did not believe that this letter was of concern regarding adult enrollment. We agree that the contents of this letter are more relevant to the coverage of children in the SCHIP program. However, we included this description because it provides context with regard to how SCHIP policies have changed over time. Regarding information that was relevant but not included, CMS commented that the draft report did not summarize the Administration's plan to transition adult coverage from SCHIP, including ongoing efforts to move adults from SCHIP into Medicaid coverage. In the draft report, we noted that Illinois, Oregon, and Wisconsin have made or are planning changes in the extent to which they are using SCHIP funds to cover adults, based on some examples that CMS shared with us in September 2007. In its comments, CMS provided additional details about these and other planned changes.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies to the Administrator of CMS and interested congressional committees. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of

Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix III.

Sincerely yours,

James C. Cosgrove
Acting Director, Health Care

Appendix I: Premium Assistance Programs

Seven of the 10 states we reviewed provided premium assistance for adults. (See table 7.) Three of the 7 states also subsidized the purchase of private individual health insurance for enrollees who, for example, were unemployed, worked for an employer that did not offer coverage, or could not afford employer-offered coverage.

Table 7: Premium Assistance Provided to SCHIP-Covered Adults in States' SCHIP Programs, Fiscal Year 2007

	Type of premium assistance		
State	Employer-sponsored	Private individual	State also provides direct coverage?
Idaho	✓		No
Illinois	✓	✓	Yes
New Jersey	✓		Yes[a]
New Mexico	✓	✓	No
Oregon	✓	✓	No[a]
Rhode Island	✓		Yes[a]
Wisconsin	✓		Yes[a]

Sources: GAO analysis of federal and state waiver data.

Notes: An empty cell indicates that the state did not offer this type of coverage to a specific adult population.

Adult coverage categories include parents and childless adults, but do not include pregnant women.

[a]State required adults to enroll in qualifying premium assistance programs if they are available.

States structured and operated their premium assistance programs in various ways, as noted in the following examples:

- Five of the seven states providing premium assistance required employers to contribute part of an enrollee's premium (Idaho, New Jersey, New Mexico, Oregon, and Wisconsin). One state defined employer contributions in dollar amounts, while others defined contributions as percentages of the total premium. For example, New Mexico required employers to pay $75 per enrollee per month, while Idaho required employers to pay 50 percent of the premium per enrollee per month.

- Five of the seven states set enrollee premiums on a sliding scale. Three of these five states required enrollees to pay graduated premiums only if their family income exceeded 150 percent of the federal poverty level (FPL) (New Jersey, Rhode Island, and Wisconsin); one required enrollees to pay graduated premiums only if their family income exceeded 100 percent of

the FPL (New Mexico); and one scaled premiums throughout the income eligibility range, beginning at 0 percent of the FPL (Oregon).

- To reduce financial risk, three of the seven states capped their subsidies to beneficiaries (Illinois), or health plans (Idaho and New Mexico).

Three states reported facing challenges implementing their premium assistance programs, as noted in the following examples:

- Rhode Island, New Jersey, and Wisconsin cited program administration as labor intensive, especially in maintaining current information and changes in employer-sponsored health plans.

- These three states also stressed that rapidly increasing premiums and cost-sharing requirements made insurance less affordable.

Some states modified their premium assistance programs to attract and retain employers into the insurance market, as noted in the following examples:

- New Mexico implemented a unique insurance product to make coverage more affordable to small employers and their employees. The product is called a "three-share" model in which the state combines funds contributed by federal, state, and private employer/employee sources to finance coverage. Employers contribute $75 per employee per month, and employees pay their share of the premium based on a sliding scale according to family income.

- Rhode Island modified its premium assistance program to encourage employers to retain their health plans. For instance, the state began paying participating employees' premium share amounts directly to the employees without employers having to sign up and participate in the premium assistance program.

Appendix II: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: OCT 12 2007

TO: James Cosgrove
Director, Health Care
Government Accountability Office

FROM: Kerry Weems
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: "State Children's Health Insurance Program: Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States That Cover Adults" (GAO-08-50)

Background

The GAO examined: (1) how 10 States (Arizona, Idaho, Illinois, Michigan, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, and Wisconsin) that cover adults (parents, childless adults, or both) in the State Children's Health Insurance Program (SCHIP) structured their programs; (2) these States' enrollment and experiences for adults, which GAO considered in the context of those for all other SCHIP populations (children and pregnant women); and (3) the approaches these States adopted to attract eligible individuals. To accomplish this, GAO reviewed 10 States that covered adults in SCHIP as of 2007. GAO interviewed officials in the 10 States; reviewed States' 2006 annual reports and information available on States' Web sites; and analyzed enrollment and expenditure data obtained from 9 of the 10 States, and published sources.

Report Findings

- The SCHIP program structures vary for adults in the 10 study States in terms of the categories of adults covered and the type of coverage. For example, for fiscal year 2007, 5 of the 10 States only covered parents, 1 State only covered childless adults, and 4 States covered both.

- Enrollment and expenditure experiences with adult coverage varied widely across the States reviewed. According to the report, in 2006, adult enrollment as a proportion of total SCHIP enrollment was less than 25 percent in 3 States, 33 to 50 percent in 4 States, and more than 50 percent in 3 States.

- The 10 States reviewed used 3 approaches in their outreach efforts: targeting hard-to-reach populations, targeting families, and relying on new and established partnerships to locate and enroll all eligible individuals.

General Comments

Thank you for the opportunity to comment on this report. Although there are no recommendations in this report, SCHIP is a very important program for the Administration and for Congress, and therefore the information that is conveyed to Congress must accurately reflect the actual operation and administration of the program. To that end, we have several substantive issues that must be corrected before the report is transmitted to Congress. We also have a lengthy set of technical comments which we believe will greatly improve the accuracy of the report.

Issue 1. Inaccurate Characterization of Services to Unborn Children as Adult Coverage.

In this report, GAO disregards the SCHIP definition of a "child," articulated in Federal Regulations since 2002, (a child as an individual under the age of 19, including the period from conception to birth" (42 CFR 457.10) and inappropriately characterizes this coverage as coverage for adults. This reclassification of children (from conception to birth) as pregnant women and adults, colors and mischaracterizes numerous explanations and conclusions throughout the report, specifically regarding enrollment numbers, expenditure information, and statements about eligibility.

Specifically, mischaracterizing coverage for unborn children as coverage for adults inflates the enrollment and expenditures for States included in this report that provide coverage of unborn children. Additionally, this report also makes the erroneous statement numerous times that "a State's SCHIP program may provide coverage to individuals who have incomes at the Medicaid level but do not meet U.S. citizenship requirements," a reference to the mothers of the unborn children covered in SCHIP. Unborn children do not have immigration status as "aliens" and thus are not precluded from receiving Federal means-tested benefits under the provisions of Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PWORA). SCHIP coverage will obviously benefit both the unborn child and mother through the delivery of services; however, it is the unborn child who is eligible for coverage as clarified in our regulations.

We strongly believe that all the enrollment numbers, expenditure information, and statements relating to eligibility be reviewed to clearly address the legal status of these children, and that their eligibility category should not be arbitrarily included as adult services as determined by GAO.

Issue 2. Use of Data Sources.

The GAO did not use information from the approved demonstration special terms and conditions, Statistical Enrollment Data System (SEDS), or the Medicaid and State

Children's Health Insurance Budget Program and Expenditure System (MBES/CBES), which would have enabled them to use consistent data. For example, this report contains enrollment information with different dates for point in time enrollment numbers for States, and one State without any expenditure information. Not using the consistent data sources negates the ability for State-to-State comparisons and compromises GAO's analysis.

Issue 3. Investigation of Outreach Activities.

The section on outreach did not consider the question of whether the provision of coverage to parents resulted in the increased coverage of children. Since this was the Secretary's rationale for approving these demonstrations, it seems that this would be an important issue to answer, rather than providing a description that concludes that States did not specifically target adults in their outreach strategies.

Issue 4. Inclusion of Information not Relevant to the Purpose of the Report & Failure to Report Information Highly Relevant to the Purpose of the Report.

The GAO erroneously states that "recent actions by HHS have the potential to affect coverage of both adults and children under SCHIP," and cites the August 2007 letter concerning the coverage of children above 250 percent of the Federal poverty level (FPL). In fact, the August 2007 letter does not concern adult coverage, since coverage for adults under title XXI has never been approved to go above 200 percent of the FPL. Additonally, this report does not address information on the Administration's plan to transition adult coverage from SCHIP which CMS discussed extensively with GAO and believes is a critical point missed by this report that needs to be included.

We would first like to point out that under the Special Terms and Conditions (STCs) of section 1115 SCHIP demonstrations, all States are required to demonstrate allotment neutrality and have agreed to use State-only funds and/or explore other options for providing coverage to demonstration populations, should their allotment be exhausted. Specifically, CMS is currently working with States with section 1115 demonstrations to move their adult populations from SCHIP into Medicaid upon renewal of the demonstration.

In fiscal year (FY) 2006, approximately 700,000 adults were served in SCHIP waivers, of which 500,000 were parents of Medicaid or SCHIP children and 200,000 were childless adults. In some States, this move has already begun. For example, in January 2006, Arizona moved approximately 85,000 childless adults to Medicaid. Coverage of parents in Arizona will be moved from SCHIP to Medicaid once the demonstration is up for renewal. Illinois' demonstration, which covered both childless adults and parents under SCHIP expired on September 30, 2007, and the State is no longer receiving SCHIP funding for the 211,500 adults covered under its demonstration. The State has indicated that it would submit a State Plan Amendment to cover those 210,000 parents under the Medicaid State Plan and would use State-only funds for childless adults. Wisconsin already moved a significant portion of their parents from SCHIP to Medicaid in July

2007 and has indicated that the State will no longer be covering any of its adults with SCHIP funds as of December 31, 2008. Wisconsin and Illinois represent 320,000 of the 500,000 parents mentioned above and 1,500 of the childless adults. As of October 1, 2007, 296,000 parents and 86,500 childless adults or 54 percent of all adults ever enrolled in SCHIP in 2006 have been moved out of SCHIP.

Additionally, CMS will be working with Oregon to move its 13,750 parents to Medicaid by October 31, 2007, when the current waiver expires. And CMS plans to work with the remaining demonstration States to transition the adults to Medicaid when their waivers expire. Rhode Island's and Minnesota's waivers, covering a combined 55,000 parents in FY 2006, will expire in 2008. And New Jersey's waiver, covering 88,000 parents in FY 2006, will expire in 2009. Michigan's waiver, covering 102,000 childless adults (half of all childless adults covered in title XXI demonstrations) also expires in 2009. Idaho and New Mexico waivers also expire in 2009. By the end of 2009, there will be no childless adults funded with title XXI and only about 10 percent of the number of parents who were enrolled in FY 2006 would remain under SCHIP waivers until 2011, when all of the title XXI adult demonstrations will expire.

All of these States providing coverage to adults are being advised that they should consider the flexibilities provided under the "Deficit Reduction Act of 2005" (DRA), which provides States with greater benefit and cost sharing flexibilities for some Medicaid populations. We outlined some of those possibilities in our March 31, 2006 letter to State Governors. Pre-print pages related to the flexibility provided under the DRA are available on the CMS Web site.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove, (202) 512-7114, cosgrovej@gao.gov

Staff Acknowledgments

Kathryn Allen, Director, led the engagement through its initial phases. In addition, Carolyn L. Yocom, Assistant Director; Nancy Fasciano; Paul B. Gold; JoAnn Martinez-Shriver; Peter Mangano; Kevin Milne; and Elizabeth T. Morrison made key contributions to this report.

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