CENTER ON BUDGET AND POLICY PRIORITIES
820 First Street, NE, Suite 510, Washington, DC 20002
Tel: 202-408-1080 Fax: 202-408-1056 center@cbpp.org http://www.cbpp.org

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OMB ESTIMATES INDICATE 400,000 CHILDREN WILL LOSE HEALTH INSURANCE DUE TO REDUCTIONS IN SCHIP FUNDING

Use by States of Unspent SCHIP Funds to Provide Health Insurance to Unemployed Workers Could Worsen Effects of Funding Reduction on Children

by Edwin Park and Matthew Broaddus

Executive Summary

Starting in fiscal year 2002, federal funding for the State Children's Health Insurance Program (SCHIP) drops by 26 percent, or more than $1 billion a year. As a result of this funding reduction — which was written into the Balanced Budget Act that established SCHIP in 1997 to ensure the budget was balanced in 2002 under the budget assumptions in use at that time — the number of children insured through SCHIP eventually will fall. The Office of Management and Budget projected in April that while the effects of this funding reduction will be deferred for several years as states use up the unspent SCHIP funds from prior years, national SCHIP enrollment will decline by 400,000 children between 2004 and 2006.

These OMB estimates were made in April using economic projections that assumed no recession. Because the current economic downturn is likely to increase the number of children eligible for and enrolled in SCHIP, however, as families lose their jobs and their health insurance, SCHIP expenditures may rise at a faster pace in the next year or two than had previously been projected. That would leave fewer unspent funds available for states, which could result in an even larger number of children dropped from SCHIP.

On October 4, as part of its economic stimulus package, the Administration stated that states could apply for SCHIP waivers to provide health insurance to unemployed workers. The Administration cited the more than $11 billion in unspent SCHIP funds from previous years as a source of state financing for such coverage of the unemployed. These SCHIP funds, however, are not excess funds. To the contrary, these funds are needed in the next few years to prevent the drop in the number of children that SCHIP covers from growing larger and starting sooner. Given the need for these funds in SCHIP and the likelihood of greater-than-anticipated SCHIP expenditures during the economic downturn — as well as the budget deficits that most states are now facing, which make it difficult for them to contribute the added state matching funds required for states to expand SCHIP to cover the unemployed — it is unlikely that many states will take up the Administration's offer to use SCHIP funds for unemployed workers. Furthermore, if some states do cover laid-off workers with SCHIP funds, that could make the eventual decline in the number of low-income children that SCHIP insures even larger.

The Problem SCHIP Faces

When Congress created SCHIP in 1997, it provided states with $40 billion over ten years to expand health care coverage for low-income uninsured children but wrote into the law a substantial reduction in the SCHIP funding level for fiscal year 2002 and the two following fiscal years. Congress intended to balance the budget by 2002. To help achieve that goal, the Balanced Budget Act of 1997 — which created SCHIP — provided for a reduction in funding for several programs in 2002, including SCHIP. Without these reductions, the legislation would have fallen short of balancing the budget in 2002, under the economic and budget assumptions in use at that time. SCHIP funding is scheduled to drop by more than $1 billion, or 26 percent, in fiscal year 2002 and to remain at this reduced level through the end of fiscal year 2004.

This funding dip is taking effect at a time that states have an increased need for SCHIP funds. Although many states confronted a series of implementation challenges when they first established their SCHIP programs in the late 1990s and the program got off to a slow start in many areas, enrollment in SCHIP programs has been increasing sharply in the past few years. Federal SCHIP expenditures have increased correspondingly, jumping from $200 million in fiscal year 1998, the program's first year, to $600 million in fiscal year 1999 and $1.8 billion in fiscal year 2000. In its April 2001 estimates, OMB estimated that SCHIP expenditures would reach $3.4 billion in fiscal year 2002. Moreover, the April OMB estimates did not assume a recession. In a recession, more children will become eligible for SCHIP as their parents lose their jobs and health insurance. The most recent expenditure data indicate that SCHIP expenditures in 2002 are already likely to exceed OMB's April estimate.

Data and projections from the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services indicate how the reduction in SCHIP funding will affect states in the years ahead. These projections show that starting in fiscal year 2004, the level of federal SCHIP expenditures some states will need to sustain their projected SCHIP enrollment will exceed the *total* federal SCHIP funds available to these states, including unspent funds from prior years and funds reallocated from other states. As a result, these states will have to reduce the number of children they insure through SCHIP or provide additional state funds. The HHS projections also show that the number of states that will face this problem will grow substantially in years after 2004. Our analysis of the HHS data indicates that by fiscal year 2006, projected SCHIP expenditures in nine states will be more than *twice* the SCHIP funds available in those states.[1] If the affected states are unable (or unwilling) to increase state funding to compensate, they will have no choice but to cut their SCHIP programs.

As a result, a large number of children are expected to lose out on coverage. According to the April OMB estimates, the increase in the number of children enrolled in SCHIP programs nationally will slow markedly in 2002 as the effects of the funding reduction begin to be felt,

[1] As used here, the term "SCHIP expenditures" means the federal share of expenditures for health insurance programs funded through SCHIP, while the term "SCHIP funds" refers to federal SCHIP funding.

with SCHIP enrollment then nearly leveling off in 2004 and beginning to decline in 2005. OMB projected that SCHIP enrollment will reach 3.3 million in 2004 but fall to three million in fiscal year 2005 and 2.9 million in fiscal year 2006, a decline of 400,000 children in two years. Moreover, the April OMB estimates are likely to understate the decline in SCHIP enrollment. More recent SCHIP expenditure data from HHS indicate that SCHIP expenditures in fiscal year 2002 will be higher than OMB projected in April. In addition, the April estimates assumed no recession; SCHIP enrollment — and hence SCHIP expenditures — are likely to be higher during the downturn than would otherwise be the case. Since expenditures will be higher in the short term than OMB had expected, less in unspent funds will remain, with the result that the eventual drop in enrollment is likely to be larger than 400,000.[2]

Although this decline in *national* SCHIP enrollment will not appear until fiscal year 2005, children in some states are likely to begin losing out on coverage before then. As noted above, in some states, the SCHIP expenditures necessary to sustain projected enrollment are expected to exceed the available funds starting in 2004, making it likely these states will have to start scaling back their SCHIP programs by that year. The year 2005 is simply the year that an enrollment decline begins to show up in the national estimates. In addition, with a number of states concerned that their future SCHIP costs will outstrip their available funding, some states may take steps much earlier than 2005 — and possibly as early as this year — to halt or slow increases in SCHIP enrollment (and thereby cause fewer children to be insured than would otherwise be the case). Some states are likely to start taking such steps soon to avoid having to reduce the number of children insured through SCHIP in subsequent years.

North Carolina is a case in point. Despite having unspent funds from prior years, North Carolina placed a ceiling in January 2001 on the number of children it would enroll in its SCHIP program, established a waiting list, and stopped enrolling children. The state took these steps because its SCHIP expenditures were projected to exceed its annual SCHIP allotment starting in 2001 and state policymakers became concerned about the prospect of having insufficient federal SCHIP funds in the future. Although unspent SCHIP funds from prior years could ensure that North Carolina had sufficient funds for several years to come, state policymakers were concerned that when the unspent funds were exhausted, the state would have to reduce the number of children served. Since the legislators did not want the state to be in the position of having to cut off currently enrolled children in future years, they decided to limit enrollment now as a way to avoid future enrollment cutbacks. By April 2001, North Carolina had 12,413 uninsured low-

[2] Based on more recent expenditure data, we estimate that national SCHIP enrollment may decline by more than 480,000 between fiscal years 2004 and 2006. This estimate is an increase over the original April OMB estimate of 400,000 because of higher projected expenditures for fiscal years 2002 and 2003 than OMB assumed, which results in fewer unspent funds being available to offset the effects of the SCHIP funding reduction. This analysis is based on state-reported SCHIP expenditures from the Centers on Medicare and Medicaid Services, estimated per capita expenditures, and CBO projections for increases in medical costs for children over time. Even the 480,000 estimate could prove to be too low, depending on how much SCHIP enrollment and expenditures rise because of the economic downturn.

income children on its SCHIP waiting list.[3] (This fall, the state increased the enrollment cap in order to enroll the children then on the waiting list.) There is a risk that a number of other states whose SCHIP expenditures exceed their annual allotments will act as North Carolina did and scale back efforts to enroll more uninsured children despite having access to unspent funds from prior years.

The Administration's Proposal

Against this background, it can be seen that the Administration's suggestion that states can use unspent SCHIP funds to cover unemployed workers is not likely to result in many such workers gaining coverage. Since states already face a reduction in federal SCHIP funding and many states eventually will have to cut their SCHIP caseloads, states are unlikely to exacerbate these problems by diverting SCHIP funds now for other purposes.

To be sure, some states could conclude they have SCHIP funds that they cannot use and that could be devoted to covering unemployed workers. But such states are likely to be facing budget deficits because of the current economic downturn and to be unable to provide the additional state matching funds that would be needed to draw down more unspent federal SCHIP funds and finance an SCHIP expansion to the unemployed.

Moreover, if some states did extend SCHIP to the unemployed, one result could be an eventual increase in the number of uninsured children nationwide. While a temporary one- or two-year expansion of SCHIP to the unemployed in a few states might not enlarge the magnitude of the eventual decline in the number of children enrolled in SCHIP, longer-term expansions to the unemployed would likely result in many more children ultimately being dropped. Under SCHIP, any funds a state receives that remain unused after three years are reallocated to other states. A number of states rely upon these reallocated monies to fund their programs. If some of the states from which funds are recovered and reallocated were to use their SCHIP funds for unemployed workers, the states receiving the reallocated funds would get less of them. As a result, those states could have to cut back their programs to a greater degree, and the national decline in the number of children served could be larger. New York could be one of the states most adversely affected by such a development because it relies so heavily on the availability of reallocated funds to sustain its SCHIP program.

In short, Congress and the Administration will need to act to shore up SCHIP funding to prevent 400,000 or more children from losing SCHIP coverage starting in fiscal year 2005 (if not sooner because of the economic downturn). They should not be taking steps to aggravate this problem.

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[3] See, for example, North Carolina Child Advocacy Institute and North Carolina Budget and Tax Center "There's no cure for the cold, but there IS a cure for the freeze," Issue Brief issued March/April 2001.

States Also Unlikely to Use Medicaid Waivers to Cover Unemployed Workers

The Administration has suggested that states use a Medicaid and SCHIP waiver policy that the Administration announced in August as a way to provide health insurance coverage to workers laid-off during the economic downturn. Under this waiver policy, if states cannot (or do not wish to) use unspent SCHIP funds, they can expand coverage to unemployed workers by using savings derived by reducing benefits or imposing increased cost-sharing on current Medicaid beneficiaries. The Medicaid aspect of this policy is not likely to be an effective means of extending coverage to the unemployed. Few states are likely to use it for this purpose (although some states may use the waiver policy to reduce their Medicaid expenditures).

The waiver policy provides no additional federal resources to help cover the costs of extending insurance to more beneficiaries. The Bureau of National Affairs recently reported that according to state representatives, "states have been slow to use the new [waiver] initiative because no additional federal money is being offered to help finance coverage expansions."* States currently are undergoing severe fiscal stress. Many states may have difficulty just in providing the level of state resources needed to maintain coverage under their current Medicaid eligibility criteria as growing numbers of children and families meet those criteria and become eligible for the program due to the economic downturn. Expanding Medicaid eligibility criteria to cover more of the unemployed without any additional federal funding is not an appealing course to most states.

States likely would have to make painful and politically difficult cuts in Medicaid benefits to secure sufficient savings to finance a meaningful expansion to the unemployed. The Administration's waiver policy permits states to reduce or eliminate certain health care services that Medicaid covers in order to offset the costs of expanding coverage to groups such as the unemployed. However, 90 percent of the costs that, under the waiver policy, could be reduced by cutting back on covered services are costs for long-term care for frail elderly people and people with disabilities. States seeking to institute such cuts would face major political and possibly legal challenges. It is unlikely that states could produce a sufficient amount of savings in this manner to finance an expansion to the unemployed.

States using the Administration's waiver policy would face rigid budget neutrality rules that could cause them to lose federal funds. States implementing a waiver would be subject to rigid budget-neutrality ceilings. If federal Medicaid costs exceed the ceiling, the state would have to pay the federal government back for the difference. The budget neutrality ceilings are supposed to reflect the level of federal Medicaid costs that would be incurred in a state in the absence of a waiver. But such costs are inherently difficult to predict, since they depend on trends in health care inflation and utilization. The methods that HHS has announced it will use to set budget neutrality ceilings under these waivers are seriously flawed and would place states securing such waivers at considerable risk of losing substantial federal funding. This is another reason that few states are likely to use these waivers to extend Medicaid to the unemployed.

For example, in states granted such a waiver, federal Medicaid costs per beneficiary may be limited to the state's current costs per beneficiary, adjusted only by changes in the national Consumer Price Index for medical care. Yet the CPI for medical care has risen only about *half as fast* in recent years as actual increases in Medicaid costs per beneficiary (or for that matter, as increases in *private* health care costs per beneficiary). This is because the CPI for medical care does not capture increases in cost due to changes in the utilization of health care services, technological advances in health care, or changes in the types of services that patients receive. Alternatively, instead of being adjusted by the CPI for medical care, the budget neutrality ceiling for a state seeking a waiver can be adjusted in accordance with federal projections of what the national average increase in Medicaid costs per beneficiary will be in the years the waiver covers. Since these projections reflect the anticipated *average* rate of increase in cost across states, however, they are likely to understate the rate of increase in Medicaid costs per beneficiary in about half of the states. Finally, states that seek to offset the costs of extending coverage to the unemployed by requiring beneficiaries to pay premiums also would be at risk, since research indicates that increases in premiums lead to declines in enrollment; with the budget-neutrality ceilings set on a per beneficiary basis, states in which enrollment falls as a result of increases in cost sharing would lose federal funds. In short, states that agree to these terms may lock themselves into limits on federal Medicaid funding that prove unrealistically low and cause these states to lose millions of dollars in federal matching funds needed for health care coverage.

* Jennifer Combs, "Arizona First to Apply for HIFA Waiver; Other States Say No Money for Expansions," BNA Health Care Policy, Oct. 22, 2001.

One way for Congress to prevent children from being dropped from SCHIP would be to extend the life of certain SCHIP funds that, under the workings of current law, are projected to be returned to the Treasury. Under the law, states that receive unspent SCHIP funds reallocated from other states must return those funds to the U.S. Treasury if they do not use them within a certain period of time, usually one year. Because of a mismatch between the time when unspent funds will be reallocated to states and the time when a number of the states receiving these funds will need them, some states will be unable to use all of the reallocated funds within the required timeframe. As a result, HHS projects that about $3 billion of the $11 billion in unspent SCHIP funds from prior years will be returned to the Treasury by the end of fiscal year 2003. Most of this $3 billion, however, will come from states that subsequently will run out of SCHIP funds and have to begin cutting their programs only a couple of years later.[4] Action by Congress and the Administration to extend the life of these expiring funds and give states affected by the SCHIP funding reduction access to them — so that the funds do not have to be returned to the Treasury and are available when needed in subsequent years — could avert most of the cutbacks that otherwise will occur in the number of children that SCHIP insures.

[4] Some $2.3 billion of the $3 billion that is scheduled to expire and be returned to the Treasury by fiscal year 2003 will come from seven states that are projected to have to cut their SCHIP programs in subsequent years.