SCHIP in North Carolina: Evolution and Reauthorization Challenges and Opportunities

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EXECUTIVE SUMMARY

Since the State Children's Health Insurance Program (SCHIP) was established by Congress in 1997, the state of North Carolina has taken advantage of federal matching funding and program flexibility to expand public health insurance coverage to thousands of previously uninsured children. The North Carolina Health Choice for Children program has grown steadily, with approximately 110,000 children enrolled as of 2006.

This report explores the history of the Health Choice for Children program over the last decade, focusing on some of the major issues and challenges that have characterized the program to date. The report also summarizes the perspectives of several key stakeholders and experts about the major issues that will be discussed at the federal and state levels during the SCHIP reauthorization process, which is set to be completed before the end of Fiscal Year (FY) 2007 on September 30, 2007.

The Health Choice program has gained strong popularity among beneficiaries and their families, providers, and policymakers. Key factors that contribute to the popularity of the program include:

- The political consensus to make coverage available to uninsured children
- The program's non-entitlement structure (making it a program for which policymakers can exercise budget control)
- The relatively generous federal matching rate (making it an unattractive target for state budget cuts)
- The program's success in expanding health care coverage for thousands of low-income children in North Carolina

Despite being regarded as a successful program, particularly in terms of enrollment and outreach, Health Choice has faced funding shortfalls (at both the federal and state levels) that have contributed to instability in the program. For example, in 2001 North Carolina was the first state in the country to "freeze" enrollment in SCHIP.

The SCHIP reauthorization process that will take place in Washington, D.C. in 2007 will provide an important opportunity for federal policymakers to re-examine the federal role to assist states providing health care coverage for low-income uninsured children. At the same time, North Carolina leaders can use the reauthorization debates taking place at the federal level to examine the experience of Health Choice and evaluate their own commitments to the program's objectives.

The issues identified in this report that are likely to frame the reauthorization discussions at the federal level include the following:

- The amount of federal funding that will be made available to states
- The methods used to derive federal funding allocations
- The allocation formula itself
- The distribution and use of reallocated federal funds
- Broader discussions about the government's role in health care

Opportunities to expand or greatly modify Health Choice will be highly contingent on the level and form of funding made available at the federal level. However, this report also outlines several issues that state leaders in North Carolina can consider that may affect the stability and experience of the program in the future. These include the following:

- State funding sources
- Enrollment and outreach
- Evaluating Health Choice's new primary care management system
- Administrative structure
- Expanding Health Choice to include additional sub-populations of uninsured children

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I. BACKGROUND: THE LEGISLATIVE ORIGINS OF SCHIP

The large number of low-income children without health insurance coverage was a widely discussed policy issue in the 1990s. Nationally, the rate of uninsured children increased from 13.0% in 1990 to 15.0% by 1998.[1] The rate of uninsured children is even higher among families with low-incomes.[2] Growing public concern about the uninsured, along with the failure in 1994 of the comprehensive health care reform legislation promoted by the Clinton Administration, set the stage for the passage of a significant federal health insurance coverage expansion for uninsured children.

The Balanced Budget Act of 1997 (BBA) authorized the largest expansion of publicly-sponsored health insurance coverage since the creation of Medicare and Medicaid in 1965. The BBA amended the Social Security Act by adding Title XXI, also known as the State Children's Health Insurance Program (SCHIP). Under SCHIP, states and territories receive federal matching funds to provide comprehensive health care benefits for the uninsured children of low-income families. In response to the passage of the BBA, all fifty states, the District of Columbia, and five territories established child health insurance programs or expansions.

The BBA gave states discretion to design their own programs according to their specific needs, contexts, and capacities. For example, the BBA allowed states to expand their Medicaid programs, design new and separate child health care programs, or use a combination of the two approaches. As of 2006, 11 states and the District of Columbia had Medicaid SCHIP programs, 18 states had separate programs, and 21 states had a combination of the two approaches.[3] Within federal guidelines, states administer the program and determine eligibility standards, benefit packages, payments levels, and enrollment and other procedures.

The BBA authorized nearly $40 billion in federal funds to states over a ten-year period (FY 1998-2007). States can combine state funds and federal matching funds to extend coverage to low-income uninsured children whose families earn too much to qualify for Medicaid.[4] Thus, like Medicaid, SCHIP financing is a joint state/federal responsibility. However, Medicaid is an entitlement program, whereby those eligible for the program receive its benefits as long as they meet program eligibility guidelines. There is no cap on matching federal contributions. By contrast, federal policymakers that designed the SCHIP program favored a non-entitlement approach that would set an initial ten-year ceiling on federal financing responsibilities for the program. Accordingly, federal matching funds are available to states based on a formula-driven allotment system.

The statutory formula defining the federal government's SCHIP matching rate for each state is based on the number of low-income and uninsured children in each state, as determined by the Current Population Survey (CPS), as well as a cost factor representing the average wages in the state compared to the national average. Each state can receive federal matching funds up to its allotment amount and can retain

federal allocations for a period of three years.[5] If a state spends more than its budgeted allotment in a given year, it can draw upon any of its unspent federal allotment funds from previous years. At the end of the three-year period, however, all remaining funds from federal allotments are returned to the federal government to be reallocated among those states that spent beyond their earlier allocations.

On a matching rate basis, the federal government contributes relatively more to states for SCHIP than for Medicaid. To encourage state participation, federal policymakers set states' federal matching rates at 30 percentage points above 70 percent of their existing Medicaid matching rates, with an upper limit of 85 percent.[6] Thus, while the Medicaid federal medical assistance percentage (FMAP) ranged from 50% to 76% in FY 2006, the enhanced SCHIP FMAP ranged from 65% to 83% across states. In FY 2006, for every $1 spent on state child health insurance programs, the federal government share was $0.72 of spending, on average. This compares to an average federal share of $0.63 for every $1 spent on Medicaid. In North Carolina, the federal matching rate for Medicaid is 63.49% while the federal matching rate for SCHIP is 74.44% (FY 2006).[7]

Under SCHIP, states may design member cost-sharing arrangements to resemble the out-of-pocket payments made by enrollees in private health insurance plans. States that chose to implement SCHIP benefits through a Medicaid expansion must follow the cost-sharing rules of the Medicaid program. States that implement SCHIP through a separate state program must comply with maximum cost-sharing amounts based on a sliding scale that, in turn, is based on family income. The total annual aggregate cost sharing (including payments for premiums, deductibles, and co-payments) for SCHIP families may not exceed five percent of total family income in any given year.

SCHIP's initial period of authorization is scheduled to expire in September 2007. Thus, the program's future is an important item on the current federal policy agenda. The SCHIP reauthorization process will provide an important opportunity for federal policymakers to re-examine the federal role to assist states in providing health care coverage to low-income uninsured children. At the same time, states can use the reauthorization debates taking place in Washington, DC to examine the experience of their own programs and evaluate their own commitments to the same goal.

This report briefly outlines the legislative origins and some of the key features of the SCHIP experience in North Carolina (called "Health Choice for Children"). Based on a review of secondary literature and informal interviews with several stakeholders, advocates, and experts in North Carolina, the report also describes some of the key successes and challenges of the Health Choice program to date. The report concludes with several key funding-related issues that will be considered at the federal level during the federal reauthorization process. It also highlights several policy areas for consideration at the state level that may help the program to further achieve its objective to expand health care coverage opportunities for uninsured children in North Carolina.

II. BRIEF HISTORY OF HEALTH CHOICE FOR CHILDREN

Legislative Origins of Health Choice for Children

Even before federal policymakers settled on final provisions of the Balanced Budget Act that would establish SCHIP, policy officials and health care leaders in North Carolina were actively considering policy solutions to expand coverage to low-income uninsured children in the state. Aware that Congress would likely soon pass a significant appropriation for states for this purpose, the state Department of Health and Human Services (DHHS) in July 1997 asked the North Carolina Institute of Medicine (NCIOM) to co-sponsor a task force to explore numerous policy options. The list of policy alternatives produced by this task force included expanding Medicaid, establishing a separate state children's health insurance program, implementing a combination of both, and initiating a voucher system for families to purchase insurance for their children.

A bipartisan legislative task force chaired by Lieutenant Governor Dennis Wicker convened to consider the task force's recommendations and later to consider the details of Governor James Hunt's legislative proposal. In December 1997, Governor Hunt presented his proposal to develop a children's health insurance program that would take advantage of SCHIP funding made available at the federal level. The Governor's initial proposal was to expand eligibility in the state's Medicaid program from 100% of the federal poverty level (FPL) for uninsured children up to 200% of the FPL.[8] Families would not pay premiums for SCHIP coverage but would be responsible for modest co-payments for physician office visits, hospital visits, and prescription drugs.[9]

In February 1998, Governor Hunt called a special session of the General Assembly to enact the new program. During the special session, which began in March 1998, the Senate, controlled by Democrats, quickly embraced the Governor's plan. The Republican-led House, concerned that a new Medicaid expansion would limit future cost containment options, promoted a different plan for the program. The House proposal used the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (also referred to as the "State Health Plan", SHP) as the platform for the new program. The House version also called for the upper income threshold for eligibility determinations to be 185% of the FPL (rather than 200% as in the Governor's plan). It included slightly higher co-payments than the Senate's plan, an enrollment waiting period to discourage parents from dropping existing coverage and shifting responsibility for their children's coverage to the state, and modest sliding scale premiums to be paid by the families of enrolled children between 133% and 185% of the FPL.[10]

Both chambers passed competing bills in the opening days of the special session. Over the next six weeks, House and Senate negotiators struggled to reach consensus on the features of the new program. The resulting compromise, announced on April 28, 1998, arranged for the program to be jointly administered by the state's DHHS and the SHP. DHHS would maintain overall responsibility for ensuring that the program operates within state and federal budget guidelines.

Within DHHS, the Division of Medical Assistance (DMA) was appointed the lead agency for policy and for eligibility determination and the Department of Public Health (DPH) was made responsible for outreach and for the development of the special needs criteria to mirror the State's Title V program. Outreach was to be delivered at the local level through a partnership between county departments of health and social services and public health. The SHP would administer benefits and process claims through a traditional indemnity plan administered by Blue Cross Blue Shield of North Carolina (BCBSNC), which pays "any willing provider" on a fee-for service basis.

The compromise legislation extended eligibility to uninsured children in families with incomes of up to 200% of the FPL (or $32,900 for a family of four in 1998). Benefits for the program were to be tied to the SHP's package of benefits, with added benefits for vision, hearing, and dental care. Children with special health care needs would have access to benefits that essentially matched those under Medicaid. In addition, well-baby, well-child, and immunizations were also to be covered by the plan, and as required, there were no co-pays for preventive services.

The compromise bill did not require that families pay monthly premiums, but did require modest co-payments for families with incomes between 150% and 200% of the FPL. The SHP became responsible for paying providers at rates established for the SHP, which at the time exceeded prevailing Medicaid rates. The SHP was responsible for administering co-payments for covered families with incomes between 150% and 200% of the FPL. The compromise bill also assessed an annual enrollment fee of $50 per child up to $100 per family (for families with incomes between 150% and 200% of the FPL). The proceeds from annual enrollment fees are distributed to the county departments of social services to help offset the costs for their role in conducting outreach and making eligibility determinations.

House negotiators ensured that the final bill included "waiting period" provisions designed to deter families from dropping private insurance to sign up for the new public program. The initial waiting period was six months, although this dropped to only two months after program implementation began. Children would have to be uninsured for at least the duration of the waiting period prior to enrolling in Health Choice.[11]

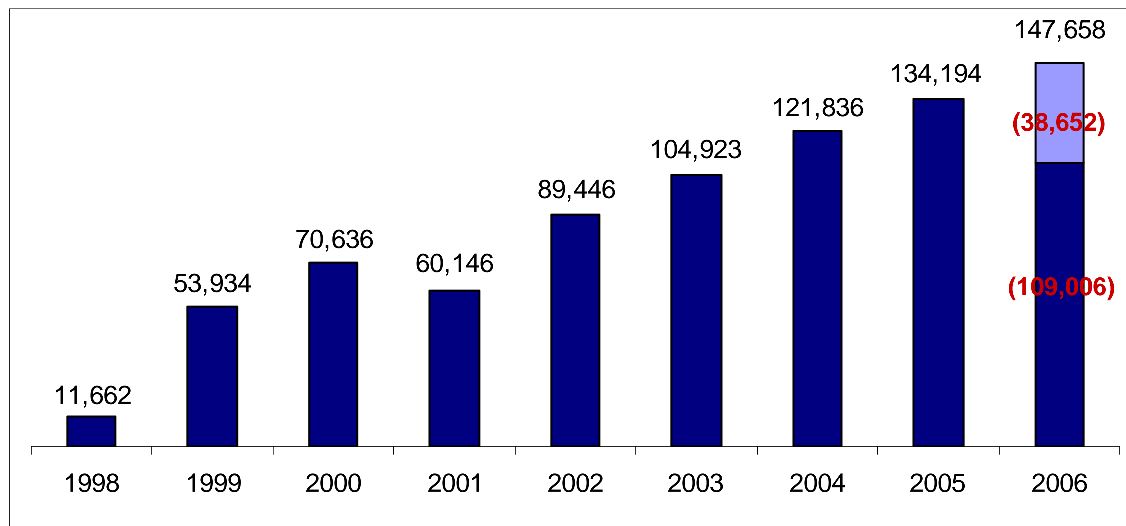
On April 30, 1998, the compromise bill passed the Senate 45-1 and the House 99-12. The new Health Choice program was formally approved by the federal government on July 14, 1998 and began enrolling children on October 1 of the same year.

The Early Years of Health Choice

The early years of Health Choice were focused primarily on outreach and enrollment. Unlike most states, North Carolina officials elected not to sponsor major television or radio advertisements encouraging families to enroll in the new program.[12] Instead, the state favored a novel approach that promoted county-based grassroots outreach. As noted, the legislation establishing Health Choice authorized enrollment to be conducted through county departments of social services and public health. Existing relationships between Medicaid program managers, local social services departments, and close networks of local non-profit and volunteer organizations across the state contributed to the state's local grassroots outreach program.

The DHHS, using the original enrollment projections provided by the federal government, had initially projected that about 71,000 uninsured children statewide would qualify for and enroll in the program. However, almost immediately upon the program's implementation, enrollment grew more rapidly than expected. In its first month of operation, Health Choice enrolled nearly 6,000 children, surpassing the state's projections. After three months of enrolling children, nearly 18,000 children were enrolled in the program. By July 1999, after the program had been in operation for less than a year, enrollment climbed to 45,245, already 64% of the projected target of 71,000 children. By the end of 2000, more than 72,000 children were enrolled. By 2006, the program provides benefits to nearly 148,000 children. See Exhibit 1.

Exhibit 1: Total Enrollment in Health Choice for Children (1998 – 2006)



Note: Figures displayed are based on point-in-time enrollment statistics (December of each year). For 2006, the total column (147,658) represents children receiving benefits through the program. However, the light blue portion (38,652) reflects those children (ages 0-5) that were transitioned to Medicaid effective January 1, 2006, making Health Choice a "combination" program. This transition is discussed in more detail below.
Source: North Carolina Department of Health and Human Services, Division of Medical Assistance, Health Choice for Children Enrollment, URL: http://www.ncdhhs.gov/dma/elig/elig.html

Early success was attributable to several factors. First, the state's grassroots outreach coalition strategy has been highly effective in taking advantage of existing organizations and networks at the local level.[13] Funding to select local coalitions through grants from The Robert Wood Johnson Foundation and The Duke Endowment assisted the outreach efforts by testing specific efforts to minority groups, businesses, church groups, and local government groups, giving counties the ability to use locally developed and tested success stories to design their own campaigns. Local coalitions have been supported by state organizations, such as the North Carolina Healthy Start Foundation, that produce and distribute promotional materials across the state. The Foundation has also sponsored a "Family Health Resource Line" that fields approximately 3,000 calls per month, with the vast majority of calls concerning public children's health insurance issues.[14]

Second, early Health Choice enrollment benefited from the decision of Blue Cross Blue Shield of North Carolina (BCBSNC) to terminate its own non-profit program (Caring Program for Children) when Health Choice was established. The program had enrolled approximately 8,000 uninsured children; BCBSNC suggested that affected families seek coverage in the state's new Health Choice program.

Third, the state made a simple enrollment form widely available in numerous settings. This form is used to determine eligibility for both Health Choice and Medicaid. If applicants are determined to be eligible for Medicaid, they are enrolled in that program. Applicants determined to be ineligible for Medicaid but eligible for Health Choice are enrolled in Health Choice.

Fourth, institutional providers have also grown increasingly proactive in helping to ensure that children eligible for Medicaid or SCHIP are enrolled in these programs at the point of service. This helps reduce uncompensated care incurred by hospitals and other provider groups while also ensuring that eligible children receive and maintain access to program coverage.

Fifth, from the program's inception, Health Choice has been popular among health care providers. Popularity among providers was due in part to relatively generous provider reimbursement, which has resulted in broad provider participation in the Health Choice program across the state. The program's structure ensured that providers would be reimbursed through the SEHP's BCBSNC rates instead of lower Medicaid rates. However, as will be discussed in greater detail below, the General Assembly effectively lowered Health Choice rates to Medicaid rates in 2005.

Finally, state officials contend that enrollment growth rapidly eclipsing the state's original enrollment projections resulted from underestimating the number of children that would qualify and thereby enroll in the program. As noted previously, original estimates projected that 71,000 children would qualify for and enroll in Health Choice. Both the federal allotments for North Carolina and the state's own appropriations for Health Choice were based on this original number. However, as is discussed below, this figure proved to be an underestimate and has contributed to instability in the program.

Enrollment Freeze

By late 2000, while the state was in the midst of a budget shortfall, DHHS determined that by the end of the state fiscal year (June 30, 2001), DHHS would effectively run out of state funds that the General Assembly had appropriated to finance the Health Choice program. Accordingly, the state submitted a state plan amendment to the federal government to close SCHIP to new enrollment effective January 1, 2001. The federal government approved this plan amendment on February 16, 2001.[15] North Carolina thereby became the first state in the country to "freeze" new enrollment in their SCHIP program.[16]

Under the freeze, existing enrollees continued to receive coverage. However, several categories of children who were determined to be eligible for Health Choice were placed on a waiting list. This included children who were no longer eligible for

Medicaid due to increases in family income or because they "aged" out of Medicaid coverage (that is, became eligible for Health Choice when their age exceeded the eligibility threshold of Medicaid). The wait list also included children whose parents did not seek to re-enroll in the program within a specified period. The waiting list peaked at over 34,000 children.[17] As a result of the enrollment freeze, enrollment in Health Choice dropped from a high of 72,024 in January of 2001 to 59,294 children by June of that same year, a 29 percentage decline.[18]

The program was partially re-opened starting in July 2001 as the Governor authorized the DHHS to begin lifting the enrollment cap. Since the number of enrolled children had dropped enough so that the state had enough funds to cover some of the children on the waiting list, the DHHS first began to enroll wait-listed children without yet fully opening the program to new applicants. However, total enrollment continued to decline until it reached a low of 51,294 by October of 2001. The enrollment freeze was lifted for *new* applicants on October 8, 2001 as the General Assembly appropriated new funding for the program. Enrollment grew rapidly once the program was fully re-opened; by July 2002, enrollment in the program climbed to over 84,000.

The 2001 enrollment freeze occurred because as program spending was projected to increase, the DHHS faced a shortage of appropriated state funds that could be used to generate federal matching funds. The DHHS did not have the authority to reduce provider reimbursement since payment rates were tied to an existing contract between the SHP and BCBSNC. Since the program's benefit package was legislatively mandated by the General Assembly, the DHHS also did not have the discretion to cut services in order to contain costs that might avoid or delay the enrollment freeze. Moreover, the DHHS did not (then) have the authority to draw upon additional state funds beyond what had been originally budgeted by the General Assembly. Thus, a freeze on enrollment was the only viable option that DHHS could consider in the short-term, absent action by the General Assembly (which was not in session at the time).

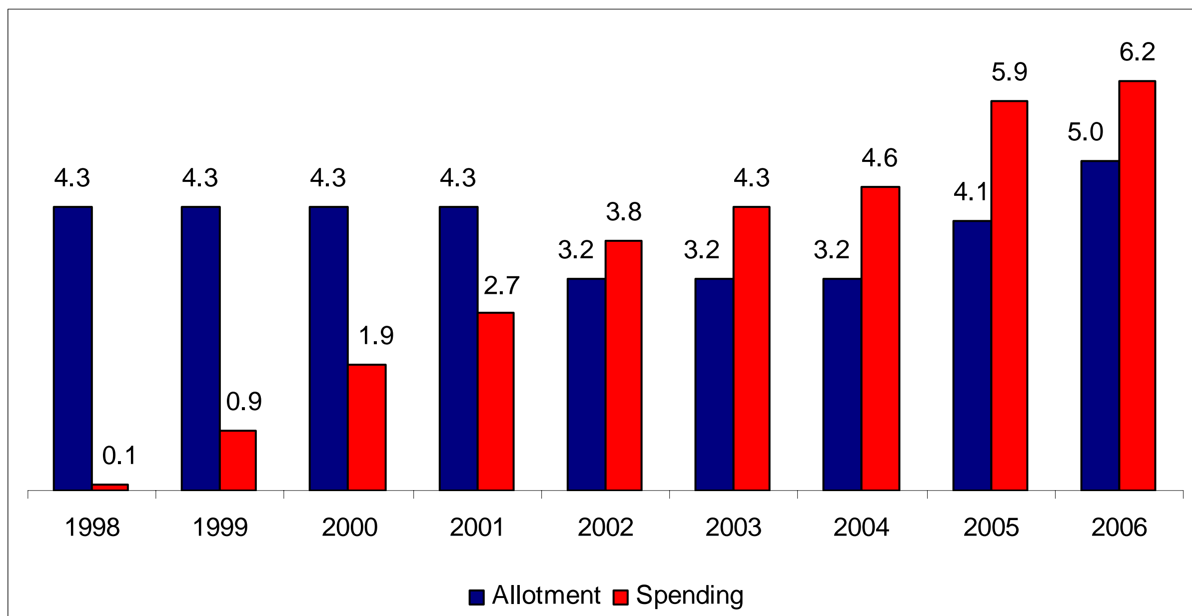
Since the enrollment freeze of 2001, DHHS has faced similar challenges of program costs exceeding appropriated state funds. In fact, the DHHS has considered freezing SCHIP enrollment on several different occasions since 2001. However, as is discussed in more detail below, the General Assembly has periodically requested and received guidance from the NCIOM about measures to avoid new enrollment freezes. The General Assembly has also added sufficient funding to temporarily avoid new enrollment freezes. Moreover, in 2003, the General Assembly granted the DHHS the authority to transfer necessary funds within DHHS into the Health Choice program to help prevent future freezes absent direct General Assembly action.

Health Choice and Reallocated Federal Funds

While the enrollment freeze of 2001 was associated with a lack of appropriated state funds, the Health Choice program is also increasingly challenged by the reduced availability of federal matching funds to finance the program.

Historically, North Carolina has used all of its original federal allotments to fund the program.[19] On an aggregate national level, total SCHIP spending was less than total allotment levels in the early years of the program. This created opportunities for states like North Carolina to receive reallocated federal funds that had been originally allocated (but were unspent by) other states. However, as other states enrolled more children and expanded eligibility and/or benefits, excess allotments declined, making fewer reallocated funds available to states like North Carolina that have regularly spent more than their annual allotments. Total SCHIP annual spending across the fifty states (in absolute dollars and as a proportion of the allotted funds that were made available in the BBA) has increased sharply during the program's tenure, more than tripling since 2001. See Exhibit 2.

Exhibit 2: SCHIP Federal Allotments and Aggregate State Spending (All States), in billions



Source: Centers for Medicare and Medicaid Services.

In addition to providing additional state funds to support the growing Health Choice program, the state has taken other measures to avert additional enrollment freezes. The General Assembly took many of these measures in response to the recommendations of

the NCIOM, which issued several policy recommendations in 2003 as directed by the General Assembly.[20] In state budget discussions in August 2005, for example, the General Assembly shifted Health Choice children ages five and younger to the Medicaid program by extending Medicaid eligibility to this sub-population. This strategy created a coverage "entitlement" for affected children newly enrolled in Medicaid. The strategy also temporarily averted the possibility of another SCHIP enrollment freeze by taking advantage of "savings" available from lower provider reimbursement rates paid to Medicaid providers relative to the rates paid to providers on behalf of Health Choice and SHP beneficiaries.

Summary of Health Choice Evolution

Several key issues have characterized the experience of the Health Choice program in North Carolina. The plight of low-income uninsured children reached the political and policy agenda in North Carolina before passage of the BBA that would establish SCHIP. However, the federal government's role in making funding available has been critical in helping North Carolina policymakers and advocates to achieve their goal of expanding public coverage. The administration of the Health Choice program, including its innovative grassroots outreach program, has also succeeded in enrolling low-income children in the state. As the reauthorization debate draws near, ensuring the availability of additional state and federal funds will remain critical for the state's ability to put its successful outreach program to work to not only enroll more eligible but unenrolled children, but also to consider any policy proposals that might expand eligibility to additional sub-populations of low-income uninsured children.

III. PREPARING FOR REAUTHORIZATION

SCHIP's initial period of federal authorization will expire on September 30, 2007. Congress and the President will determine the conditions under which the program will be reauthorized. The debate over reauthorization will take place at a time when the uninsured rate for children is once again on the rise and budget pressures are contributing to constraints on publicly financed health care coverage.[21]

The reauthorization debate will be dominated by the level and form of federal funding that will be committed to states. States' recent experiences with the program underscore the importance of federal financing considerations in the reauthorization process. For example, in FY 2006, 38 states' SCHIP spending exceeded their federal allotments.[22] Funds available to redistribute from FY 2003 unspent funding was insufficient to fill this gap. This led Congress to include $283 million in the Deficit Reduction Act of 2005 (P.L. 109-171) to temporarily fill these gaps.[23] In FY 2007, an estimated 17 states (including North Carolina) face financial shortfalls totaling over $1 billion.[24] After Congress modified the redistribution formula in December 2006 (P.L.

109-432), the total estimated shortfall is $920 million, including $17.6 million for North Carolina.[25]

Federal policymakers are likely to approach the reauthorization debates with several key priorities in mind. First, policymakers will seek to ensure that children currently enrolled in SCHIP keep their coverage. Second, policymakers may also seek to provide sufficient funding that would allow states to conduct further outreach to currently eligible but uninsured children. Finally, policymakers may promote opportunities to expand eligibility to additional low-income children without a current source of health care coverage. Underlying each of these likely policy priorities will be the federal government's role in providing funding to states.

In North Carolina, policy discussions concerning the reauthorization debate are already taking place among key program stakeholders, advocates, and policymakers. Based on a high-level review of the history of the Health Choice program in North Carolina and interviews with several program stakeholders, this section outlines some of the key components of the federal reauthorization debate that will directly affect the states' Health Choice program. Also included is a discussion of several issues that state leaders may consider to help improve the program's ability to meet its objectives.

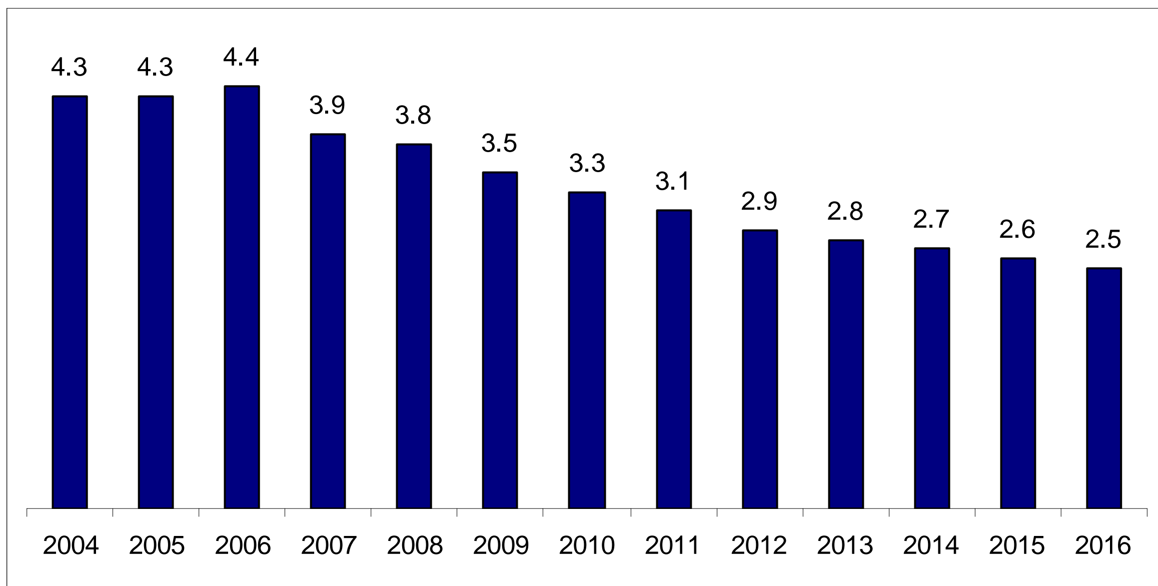
Issues for Consideration at the Federal Level

Several aspects of SCHIP's financing arrangements will be considered in the reauthorization process. The most important aspect of the reauthorization debate for North Carolina, as for all states, is the actual amount of federal funding that will be made available to support the program in future years.

The Congressional Budget Office (CBO) assumes that Congress will reauthorize SCHIP at FY 2007 funding levels.[26] Thus, CBO budget forecasting begins with a baseline assumption that the program will be effectively "frozen" for the next several years at $5 billion per year. This is consistent with the President's FY 2008 Budget, which set aside approximately $5 billion over five years for additional SCHIP allotment funds.[27]

However, some analysts predict that reauthorizing SCHIP at 2007 funding levels would result in program shortfalls in North Carolina of $54.9 million by 2008 and $199.3 million by 2012 (assuming moderate expenditure growth and no change to rules for allocating and redistributing federal funds).[28] Such funding shortfalls would likely result in declining enrollment if the state is unable or unwilling to keep up with annual increases in enrollment and overall health care costs. According to the Kaiser Commission on Medicaid and the Uninsured, holding federal SCHIP allotments fixed at $5 billion after FY 2007 would result in steady declines in SCHIP enrollment nationwide.[29] See Exhibit 3.

Exhibit 3: Projected SCHIP Enrollment Based on Current Funding Levels (in millions, 2004 – 2016)



Source: The Kaiser Commission on Medicaid and the Uninsured. (Assuming federal SCHIP allotments remain at $5 billion after FY 2007).

In addition to the actual amount of funds that the federal government will make available to states, stakeholders and experts interviewed identified several additional issues related to program financing that are likely to be considered in federal discussions about SCHIP reauthorization. These include the data used to derive federal funding allocations, the allocation formula itself, and the distribution and use of reallocated federal funds. These issues are discussed below.

Data Used to Derive Federal Funding Distribution

As noted previously, the amount of matching funds that the federal government has allocated to North Carolina is determined by an allocation formula. This formula, in turn, is based on information obtained from the Current Population Survey (CPS), a monthly survey of 60,000 households conducted by the U.S. Bureau of Labor Statistics (BLS). The CPS compiles information on insurance coverage for children and the number of children from low-income families (defined by BLS as those earning less than 200% of the FPL). State officials in North Carolina contend that the CPS underestimated the number of uninsured children in the state. This does not appear to be a North Carolina-specific issue. Indeed, the CPS has been criticized for its insufficient sample size in small states, its unstable estimates from year to year, and its inadequate questions about individuals' insurance status.[30] In 1999, Congress acted to limit large annual changes in allotments and bolster the sample size in the survey to ameliorate these problems (P.L. 106-113). However, state leaders we interviewed suggest that the reauthorization debate should include a discussion about alternative

ways to improve the reliability and accuracy of the estimates used as the basis for SCHIP's funding formula.

Allocation Formula

SCHIP's formula for determining federal allocations to states does not allow flexibility to accommodate changes that affect demand for the program, such as changes in the number of uninsured children in the state. The state's share of the total federal allotment is based in part on its share of low-income children and low-income uninsured children. However, the allocation formula is designed such that the only way the state can receive a larger allocation is if the rate of increase in uninsured children in North Carolina exceeds that of the nation as a whole.

Thus, an increase in the actual number of uninsured children in the state does not necessarily translate into larger federal allocations to support the program. Our interviewees noted that states are effectively "punished" by withdrawn federal funds for succeeding in insuring children, which presents an illogical cycle since if available federal funds are depleted, these same children may become uninsured again. Moreover, the formula is based on a three-year average, which reduces flexibility for states to respond to any major economic cycles and other changes that may affect demand for the program.

Stakeholders interviewed cited the program's allocation formula as a challenge for North Carolina in recent years. Even in times of increasing need (e.g., economic recessions, increases in plant closings or business downsizings), the state has been unable to receive additional federal allocations.

The Distribution and Use of Reallocated Federal Funds

As noted above, states can retain their federal allotments for a period of three years before reverting unused funds back to the federal government. Funds left over from states that did not fully expend their allocation have been collected and re-distributed to those states that overspent their allocations. North Carolina has historically been on the receiving end of this arrangement.

However, states receiving reallocated federal funds only have one year in which to spend these redistributed funds before the funds revert again back to the federal government. The unpredictability of the amount and timing of reallocations gives states inadequate time to obtain necessary matching state funds to trigger the flow of reallocated federal funds.

Our interviewees suggested that extending the time during which redistributed funds can be used would provide the necessary flexibility for state officials to use reallocated funds appropriately and efficiently while still providing the federal government with budgetary predictability and a ceiling on total costs.

Each of the above issues is likely to play an important role in the reauthorization debate at the federal level. However, the underlying pressure that drives each of these issues is the allotment structure of the program itself. In a capped block grant program, a fixed amount of dollars being distributed over a fixed number of states and territories is likely to generate persistent conflicts over resources and funding formulas. Within this structure, the issue with the greatest impact on the future of the program is the actual amount of funding that will be made available to states.

Moreover, in advance of the 2008 presidential and congressional elections, candidates, advocates, and policymakers are developing health coverage reform proposals that may affect health care coverage for children and adults. To the extent that these health policy discussions and debates continue to accelerate in 2007, SCHIP reauthorization discussions may also be framed within the broader discussion about the government's role in health care financing and delivery.

Issues for Consideration at the State Level

State leaders may use the reauthorization discussion taking place at the federal level as an opportunity to engage in state-level policy discussions to consider opportunities to further advance the program's objective of reducing the number of uninsured children in low-income families. This section provides examples of issues for consideration at the state level.

Exhibit 4: State Funding of Health Choice for Children

SFY 98-99	SFY 99-00	SFY 00-01	SFY 01-02	SFY 02-03
$7,491,362	$21,812,862	$26,207,471	$27,927,830	$43,753,153
SFY 03-04	**SFY 04-05**	**SFY 05-06**	**SFY 06-07**	
$53,867,815	$69,965,357	$67,553,586	$25,140,369	

Source: Office of the Governor.
Notes: NCHC became effective on October 1, 1998.
SFY 2006-07 expenditures only include 6 months of data.

State Funding Sources

State leaders could pursue creative strategies or opportunities to ensure the availability of sufficient state funding to generate federal matching contributions. The enrollment freeze of 2001 occurred because the state could not quickly make state funds available to generate federal matching contributions. While the DHHS now has greater discretion to draw upon its available funds to avoid enrollment freezes, North Carolina policymakers may also explore other innovative approaches that could further ensure that sufficient funding is available if warranted. This could include establishing or re-directing "rainy day" or other dedicated funding streams that may be made available to ensure the continued success and stability of the Health Choice program. Dedicated

funding streams may also provide enhanced opportunities to expand the program to other uninsured populations.

Outreach

Since the inception of Health Choice, North Carolina has been seen as a national leader in outreach and enrollment efforts.[31] Despite this success, our interviewees believe there are still thousands of children that are eligible but are unenrolled in Health Choice and Medicaid. In fact, Action for Children North Carolina (ACNC), a non-profit child advocacy organization, cites census estimates that approximately 177,000 children are income-eligible for Medicaid or Health Choice, but are not enrolled and remain uninsured.[32,33]

Thus, notwithstanding the financing challenges discussed in this report, there is still room for more outreach to help these children enroll. Assuming sufficient state and federal funds are available to support greater enrollment, several options have been suggested to reach out to children that are eligible for the program, but not currently enrolled. For example, practicing physicians could be better encouraged and equipped to help children enroll in Medicaid or SCHIP at the point of service. Physicians could also help to ensure that children actively reenroll in Health Choice, which is required every twelve months for ongoing enrollment. Continuous enrollment, assuming eligibility remains constant, provides children with more stability and continuity of care over time and provides physicians with financial reimbursement for providing care.

Evaluating Health Choice Program's New Primary Care Management System

Providing a usual source of care has been an important policy goal for children's health care for many decades.[34] Having a usual source of care has been linked to many positive outcomes, such as increased use of preventive care, decreased use of emergency room care, and better continuity of care.[35]

In 1998, the state's Medicaid program established pilot community-based medical care management programs called Community Care of North Carolina (CCNC).[36] The CCNC program is a system of local networks of primary care providers coordinating prevention, treatment, referral, and institutional services for Medicaid beneficiaries. In addition, participating providers serve as gatekeepers to other needed health care services. In 2002, the General Assembly legislated a statewide expansion of the CCNC program.[37]

Starting in 2005, Health Choice children ages five and under who were transferred to the Medicaid program now have the added benefit of being enrolled in Medicaid's CCNC program. Beginning in March 2007, children (ages 6-18) enrolled in Health Choice will also be eligible to select primary care physicians from the CCNC program. For the first time in the Health Choice program, this will provide dedicated case

management for covered children. However, there will be some differences with the community care network in the Medicaid program. For example, in Health Choice the assigned primary care provider will not have the authority to act as a gatekeeper in referring enrollees to specialists as they do in CCNC. State officials should closely monitor the experience of new Health Choice children enrolled in the community care network and identify any opportunities to improve the program.

Administrative Structure

When SCHIP was authorized in 1997, the North Carolina General Assembly decided to make the Health Choice program a stand-alone program tied to the SHP.[38] With several years of experience with the program, policymakers can now evaluate the costs and benefits of the program's current administrative structure and consider whether other structures may be more appropriate.

One option available to states is to establish a Medicaid expansion program. The primary advantage of a Medicaid expansion program is that there would be a continuous source of income from the federal government, even after Health Choice federal matching funds run out. Since Medicaid "entitles" eligible children to coverage, children in states that use Medicaid for SCHIP remain eligible for coverage even if SCHIP funding runs out. Medicaid funding remains available at its lower matching rate once all SCHIP funds have been used. This may prevent the disruption of enrollment and outreach that North Carolina has experienced with the Health Choice enrollment freeze of 2001.

One possible reason that has been considered for structuring Health Choice as a Medicaid expansion is that, historically, Medicaid pays providers less than Health Choice. Thus, some savings opportunities may be associated with structuring Health Choice as a Medicaid expansion program. However, in the state budget that passed in 2005, the General Assembly cut Health Choice provider reimbursement rates down to prevailing Medicaid rates. Thus, a Medicaid expansion program would not be able to generate additional state savings through lower provider reimbursements.

It is also worth noting that lowering provider fees may have the indirect costs and risks associated with potentially making health care providers more reluctant to serve Health Choice. Several stakeholders who were interviewed acknowledged that, in an environment where Health Choice reimbursement had been cut, it is important to conduct continual monitoring of health care access issues in light of receive reimbursement changes.

Another issue associated with structuring the program as a Medicaid expansion is the potential public stigma associated with Medicaid as a "welfare" program, which could affect enrollment and outreach. The families of children enrolled in Health Choice carry a standard BCBSNC insurance card (since BCBSNC provides administrative services for

the SHP). By contrast, Medicaid recipients have a distinct Medicaid card that may deter enrollment of some families. According to a study conducted by the Cecil G. Sheps Center in 2003, parents of Health Choice children reported in focus groups that Health Choice is more "dignified" than Medicaid for these reasons.[39]

A third issue associated with structuring the program as a Medicaid expansion is that counties in the state are responsible for paying a portion of Medicaid costs. Shifting all Health Choice children to the Medicaid program would likely exacerbate the already challenging financial burden that is placed on the counties to fund a portion of the state's Medicaid costs.

Finally, while a Medicaid expansion program may offer benefits from the standpoint of avoiding enrollment freezes and ensuring continuous care for eligible beneficiaries, under a Medicaid expansion program, the state would lose some of its cost containment flexibility that is associated with Health Choice operating as a standalone program.

Expanding the Health Choice Program

Despite the success of Health Choice in enrolling low-income and previously uninsured children, state policymakers continue to monitor coverage rates for low-income children that currently do not qualify for public coverage. According to ACNC, approximately 38,000 children in families falling just outside the eligibility threshold for Health Choice (between 200-300% of the FPL) are uninsured.[40] Further, approximately 49,000 children in families making above 300% of the FPL are also uninsured.[41]

As of July 2006, 24 states have chosen to make SCHIP eligibility available for uninsured children in families earning less than 200% of the FPL. However, 17 states have chosen to expand eligibility to families greater than 200% of the FPL.[42] The upper income eligibility limit under SCHIP has reached as high as 350% of the FPL in one state.

Notwithstanding the financial challenges that are discussed in this report, state policymakers may open the Health Choice program to additional uninsured children. Several policy proposals to achieve these goals are likely to be considered in the coming year in North Carolina. For example, ACNC has developed a proposal ("Carolina Cares for Children") that would further extend public coverage to low-income uninsured children up to 300% of the FPL. Under the proposal, the state would provide a sliding scale premium subsidy for eligible working families with incomes between 200-300% of the FPL. Families with incomes above 300% of the FPL would be eligible to buy into the program at full premium cost. ACNC estimates annual public subsidy expenses for the program of $21 million.[43]

Another proposal under consideration in North Carolina would impact children's health care coverage, but also coverage for low-income adults. Specifically, the Medicaid "Light" proposal, which has recently emerged from a NCIOM Task Force on

Covering the Uninsured, would add to existing Medicaid coverage for parents and children earning up to 300% of the FPL but not currently qualifying for other public coverage.

The focus of the Task Force's proposal is to expand access to primary care and preventative services rather than more comprehensive coverage (for budget reasons). If approved by the General Assembly, the resulting Medicaid "Light" proposal would take the form of a Medicaid waiver that would then be considered by CMS. Under the waiver, a limited non-entitlement Medicaid expansion would draw down additional federal funds to add to state funds.

While this and other policy proposals will continue to be considered at the state level, the feasibility and implementation of such proposals are likely to be highly contingent on the level and form of federal funding made available for SCHIP though the reauthorization process.

IV. CONCLUSION

Since its creation in 1997, SCHIP has become an important source of health care coverage for children in the United States. SCHIP enrollment has increased steadily to 6.1 million children by FY 2005.[44] SCHIP has also had important positive impacts on Medicaid enrollment as well. For example, the same law that established SCHIP also allowed states to simplify and extend eligibility for children in Medicaid. Between 1997 and 2004, 6.8 million additional children enrolled in Medicaid. The creation of SCHIP as well as enrollment gains in Medicaid have both contributed to declines in the rate of uninsured children, from 13.9% in 1997 to 8.9% by 2005.[45] Among children in families earning less than 200% of the FPL, the percentage of children without health insurance dropped from 23% to 14%.[46]

A federally funded evaluation conducted by Mathematica Policy Research found SCHIP to be successful in nearly all of the areas examined.[47] Studies of SCHIP have found that, just like having health insurance coverage generally, enrollment improves access to health care. Relative to uninsured children, children enrolled in Medicaid or SCHIP reported much lower unmet health care needs (2% vs. 11%).[48]

Since the federal SCHIP program was established, the state of North Carolina has taken advantage of federal matching funds and program flexibility to expand public health insurance coverage to thousands of previously uninsured children in the state. The program has gained strong popularity among beneficiaries and their families, providers, and policymakers. Key factors that contribute to the popularity of the program include the political consensus to make coverage available to uninsured children, the program's non-entitlement structure (making it a program for which

policymakers can exercise some measure of budget control, relative to Medicaid), the relatively generous federal matching rate (making it an unattractive target for budget cuts), and the program's success in expanding health care coverage for thousands of low income children in North Carolina.

SCHIP's initial period of authorization is scheduled to expire on September 30, 2007. As reauthorization nears, policymakers at both the state and federal levels have begun to focus on areas of concern within the program and to identify recommendations for program changes. To be sure, the level of the federal government's funding of SCHIP will dominate the reauthorization process.

Beyond the sheer dollars that will be allocated to states, federal policy discussions regarding the allotment structure and funding formula and how they might be changed are key to the future of the Health Choice program (and any possible expansions to the program) in North Carolina. While much depends on the outcome of the reauthorization process that will take place in Washington, D.C., this report outlines several issues that state leaders in North Carolina can consider that may affect the stability and experience of the program in the future.

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