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United States General Accounting Office
Washington, DC 20548

July 25, 2001

The Honorable Christopher S. Bond
Ranking Minority Member
Committee on Small Business
United States Senate

Subject: Children's Health Insurance: SCHIP Enrollment and Expenditure Information

Dear Senator Bond:

The Congress created the State Children's Health Insurance Program (SCHIP) in 1997 to reduce the number of low-income uninsured children in families with incomes that are too high to qualify for Medicaid, the federal-state program that provides health care coverage to certain categories of low-income adults and children.[1] The Congress appropriated $40 billion over 10 years (fiscal years 1998 through 2007) for SCHIP and, on the basis of a formula accounting for the number of a state's low-income children, allocates funds annually to the 50 states, the District of Columbia, and the U.S. commonwealths and territories. Each state's SCHIP allotment is available as a federal match based on state expenditures.[2] Although the SCHIP statute generally targets children in families with incomes up to 200 percent of the federal poverty level, 13 states' programs cover children in families above 200 percent of the federal poverty level.[3]

Expanding the SCHIP-eligible population beyond children to include adults is an issue of ongoing interest. Some analysts have suggested that providing health

[1]Established as title XXI of the Social Security Act by Public Law 105-33, SCHIP is set out at 42 U.S.C. § 1397aa et seq.

[2]SCHIP and Medicaid both are financed jointly by the states and the federal government under a formula in which a state's share of program expenditures is based on its per capita income in relation to the national average. The federal share of expenditures for Medicaid can range from 50 to 83 percent, with the national average federal matching rate at about 57 percent. SCHIP offers an "enhanced" federal matching rate derived from the states' Medicaid rate, with a national average federal share of about 70 percent. Each state's SCHIP match is equal to 70 percent of its Medicaid matching rate plus 30 percentage points, not to exceed a federal share of 85 percent.

[3]Two hundred percent of the federal poverty level translated to $35,300 for a family of four in 2001. The statute allows a state to expand eligibility to 200 percent of the poverty level or up to 50 percentage points above its Medicaid eligibility standard as of March 31, 1997. See 42 U.S.C. § 1397jj(b)(1)(B)(ii)(I).

insurance to parents may lead to increased insurance coverage among children.[4] Medicaid set a precedent for a public program to provide health care coverage for pregnant women. Since the late 1980s, Medicaid has covered eligible pregnant women with the goal of reducing infant deaths and poor birth outcomes (currently, Medicaid requires states to cover pregnant women with incomes up to 133 percent of the federal poverty level). Although the SCHIP statute allows a state to enroll the parents of eligible children if the state can demonstrate it is cost-effective to do so, the cost-effectiveness test is difficult to pass.[5] Recent legislative proposals would broaden states' ability to spend federal SCHIP funds to insure the parents of children in public health programs and pregnant women who meet SCHIP income-eligibility criteria.

In response to your concern about ensuring that SCHIP funding is adequate to cover eligible children before considering expansion to others, we are providing information on (1) enrollment and federal expenditures for SCHIP and estimates of the number of and costs to enroll eligible unenrolled children and income-eligible pregnant women and (2) factors that may influence states' future expenditures for SCHIP and the availability of funding for any program expansion. To do our work, we analyzed the March supplements of the 1998 through 2000 Current Population Surveys for data on insurance coverage; interviewed officials from the Centers for Medicare and Medicaid Services (CMS),[6] which has oversight responsibility for both SCHIP and Medicaid, and the Health Resources and Services Administration (HRSA), which shares oversight responsibilities for SCHIP with CMS; reviewed the most current, available SCHIP enrollment and expenditure data through 2000;[7] interviewed private researchers with knowledge of state programs and SCHIP projections; and reviewed the SCHIP statute. We relied on prior and ongoing work and relevant published literature to identify

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[4]Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings About State Health Reforms* (Washington, D.C.: Center on Budget and Policy Priorities, Sept. 5, 2000), p. 14.

[5]Cost-effectiveness is achieved when the cost of covering both the adults and children in a family does not exceed the cost of covering only the eligible children. See *Children's Health Insurance Program: State Implementation Approaches Are Evolving* (GAO/HEHS-99-65, May 14, 1999), pp. 61-67.

[6]On June 14, 2001, the Secretary of Health and Human Services announced that the name of the Health Care Financing Administration (HCFA) had been changed to the Centers for Medicare and Medicaid Services. In this report, we will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

[7]The most current "point-in-time" data for SCHIP enrollment we identified are from a survey of all 50 states and the District of Columbia that allows for comparison of state enrollment from June 1999 through June 2000, conducted by Vernon K. Smith, Ph.D., *CHIP Program Enrollment: June 2000* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, Jan. 2001), p. 2. In its SCHIP enrollment reports, HCFA provided the number of children ever enrolled during a calendar quarter or federal fiscal year. Because of ongoing enrollment attrition, the number of children who are ever enrolled in a quarter or a year will be larger than the number enrolled at any point in time during that period.

factors that influence states' SCHIP enrollment and expenditures. (For detail on our methodology for determining enrollment and expenditures, see enc. I.) We did our work from April through July 2001 in accordance with generally accepted government auditing standards.

The following summarizes information on actual and estimated SCHIP enrollment and expenditures:

- About 2.3 million children were enrolled in SCHIP as of June 2000, the most current date for which a specific monthly enrollment figure was available. We estimated that another 2.8 million children may have been eligible but not enrolled at that time.
- Of the cumulative $12.6 billion in available federal allotments to states for fiscal years 1998 through 2000, the states spent about $2.9 billion (23 percent) by the end of fiscal year 2000, leaving approximately $9.7 billion (77 percent) unspent and available for future years (see enc. II).[8]
- Fiscal year 2000 expenditures were about $1.9 billion. We estimated that fiscal year 2000 SCHIP expenditures would have been between $3.3 billion and $3.9 billion, depending on the success with which states might have enrolled additional eligible children who were not enrolled as of June 2000 (see enc. III).[9] While these amounts are significantly greater than the actual $1.9 billion the states spent during that year, they are within the total SCHIP appropriation of $4.2 billion for 2000.
- Providing coverage to an estimated 41,000 pregnant women whose incomes met states' eligibility levels for SCHIP in fiscal year 2000 would have cost an estimated $247 million to $288 million if all those eligible were enrolled.

States' future SCHIP expenditures for both children and income-eligible pregnant women will be influenced by a variety of economic and demographic factors and state policy choices, such as the following:

- Any increase in the cost of health care services will affect the amount of SCHIP expenditures if SCHIP beneficiaries continue to use these services to the same or a greater degree. The CMS Office of the Actuary projects that

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[8]The SCHIP statute made a state's yearly allotment available for 3 years. Thus, the fiscal year 1998 allocation was made available from October 1, 1997, through September 30, 2000. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), enacted December 21, 2000, amended statutory provisions for redistributing funds from states with unspent allotments to states that had spent all of their annual SCHIP allotments for those years. The change allows states that did not spend all of their annual allotments to keep any unused funds not needed to cover the expenditures of the states that spent in excess of their allotments for 1998 and 1999. The 1998 and 1999 redistributions are available to states through 2002.

[9]Not all children who are eligible for a public program will enroll. Researchers have found that public program "take-up rates" range from 40 percent to 70 percent. Therefore, we developed scenarios based on this range of expected enrollment of children who were eligible but uninsured. See Sherry A. Glied, *Challenges and Options for Increasing the Number of Americans With Health Insurance* (New York, N.Y.: The Commonwealth Fund, Dec. 2000), pp. 7-9.

health care inflation will increase and be between 3.6 percent and 4.2 percent from 2001 through 2007, or an average of 4.1 percent per year.

- Any changes in the number of SCHIP-eligible children also would influence expenditures if these children were enrolled. The Bureau of the Census estimates that the number of children through age 19 will increase an average of 0.37 percent per year from 2001 through 2007, or a total of about 2.2 percent through the remaining years of the program's authorization. Changes in the economy may also affect the number of families with incomes that fall within SCHIP eligibility limits.
- Trends in the private insurance market are less certain and may increase or decrease the availability of employer-sponsored or privately purchased health insurance for persons at lower incomes.
- Slowdowns in economic growth may affect states' efforts to address the demand for public financing of health services. Some states may respond by increasing health care spending to reduce the numbers of uninsured children, while others may curtail their health care spending as a result of increased pressure on state budgets.
- States may choose to expand eligibility for children in the SCHIP program. For example, as of July 1, 2001, Maryland expanded its SCHIP coverage of children in families with incomes from 200 percent to 300 percent of the federal poverty level. (See enc. IV for states' current eligibility levels.)
- Additional states may seek authority to enroll adults in SCHIP. HCFA has approved section 1115 demonstration waivers for four states (Minnesota, New Jersey, Rhode Island, and Wisconsin) to enroll parents of children eligible for public health insurance programs, within state-defined income levels, without a cost-effectiveness test. As of July 20, 2001, California had a waiver request pending.[10] Massachusetts' and Wisconsin's original SCHIP plans authorized the states to provide family coverage when it proves cost effective.
- Because unused SCHIP funds can be redistributed among states, one state's choice to incur additional expenditures for eligible children or adults would affect the amount of available unused funds that another state could use for children.

We did not seek agency comments on this correspondence because it does not focus on agency activities. However, we briefed responsible officials within CMS and HRSA on our findings and incorporated their technical suggestions where appropriate.

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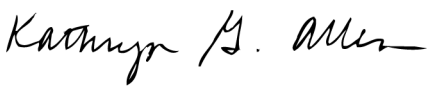
[10]Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive many statutory SCHIP requirements, thus enabling states to conduct demonstration projects that may provide additional opportunities to develop innovative methods for expanding children's coverage, promoting participation in SCHIP and Medicaid, and improving the scope and quality of the services available to children.

As arranged with your office, unless you release its contents earlier, we plan no further distribution of this correspondence until 30 days after its issuance date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrators of CMS and HRSA, and other interested parties. This correspondence also will be available on GAO's home page at http://www.gao.gov. If you or your staff have any questions regarding this correspondence, please contact me at (202) 512-7118 or Carolyn Yocom at (202) 512-4931. Staff acknowledgments are listed in enclosure V.

Sincerely yours,



Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Enclosures - 5

METHODOLOGY FOR DEVELOPING SCHIP ENROLLMENT AND EXPENDITURE INFORMATION

This enclosure describes our methods to develop information on (1) SCHIP enrollment and expenditures, (2) an estimate of the number of children eligible for but not enrolled in SCHIP, and (3) estimated federal expenditures if states enrolled both a greater number of eligible children and income-eligible pregnant women.

SCHIP ENROLLMENT AND EXPENDITURES

To identify SCHIP enrollment in 2000,]we reviewed the most current data available representing specific "point-in-time" enrollment for all 50 states and the District of Columbia published by the Kaiser Commission on Medicaid and the Uninsured.[11] Monthly point-in-time data are different from another commonly reported measure of enrollment—the number of children "ever enrolled" during a calendar quarter or federal fiscal year—which is often reflected in enrollment reports from CMS. We used point-in-time enrollment because it is comparable to our estimate of unenrolled eligible children that is calculated from the Current Population Survey (CPS).[12] To determine expenditures of SCHIP federal allotments from federal fiscal years 1998 through 2000, we used state-reported information from HCFA's on-line expenditure data system, the Medicaid and State Children's Health Insurance Program Budget and Expenditure System.

ESTIMATED CHILDREN ELIGIBLE BUT NOT ENROLLED, AND THOSE LIKELY TO ENROLL

In order to estimate the number of children eligible for but not enrolled in SCHIP, and the number likely to enroll, we used the Bureau of the Census' March supplements of the CPS for information on children's insurance status, income, and demographic characteristics such as age.[13] Because CPS counts are based on samples, we combined 3

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[11]See Vernon K. Smith, Ph.D., *CHIP Program Enrollment: June 2000* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, Jan. 2001). The unit of eligibility for SCHIP in most cases is a calendar month, and some children gain and lose eligibility from month to month. Therefore, the number of children who are ever enrolled in a quarter or year will be larger than the number enrolled in a specific month during that period.

[12]The CPS questions on health insurance refer to the previous year. However, some analysts consider that the CPS reflects the health insurance status of individuals in the survey during a point in time, for example, a typical month, rather than at any time during the previous year. See, for example, Paul Fronstin, *Counting the Uninsured: A Comparison of National Surveys* (Washington, D.C.: Employee Benefit Research Institute, Sept. 2000), pp. 4-5.

[13]The CPS is based on a sample designed to represent a cross-section of the nation's civilian noninstitutional population. For each of the March surveys, about 60,000 households were sampled, and about 47,000 of them, containing approximately 94,000 persons 15 years of age or older, were interviewed. The CPS can be used to calculate state-specific estimates of the uninsured; however, estimates for some states may be less accurate, particularly those for smaller states, which have small sample sizes.

years of CPS data, from 1998 through 2000, to improve the reliability of the estimates. These surveys represented children's insurance status from 1997 through 1999. If a child was reported to have had insurance at any time during the year, we considered that child to be insured.

Additionally, we made adjustments to the CPS data to reflect state-specific Medicaid and SCHIP income exclusions, the likelihood of some substitution of public for private insurance, and the expected enrollment of fewer than all eligible children. The SCHIP statute requires states first to determine a child is ineligible for Medicaid in order to consider the child for SCHIP. 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.[14] Income disregards typically include some portion of family income such as Supplemental Security Income (SSI), a portion of earnings, or child care expenses. In order to identify uninsured children with family incomes meeting SCHIP standards, for each state we adjusted income using Medicaid and SCHIP income disregards.[15] Because the CPS does not identify child care expenses, we assumed disregards at the level of state-specific maximums for all children in a family through age 12. If a state did not set a maximum child care disregard, we used a national average annual child care payment of $3,432 for each child through age 12 in a family.[16] Since we assumed child care disregards for all children through age 12, this may have the effect of overstating the number of families that actually pay for child care and increasing the number of children qualifying for either Medicaid or SCHIP.

Additionally, our estimate addressed the likelihood that some families may drop their existing private coverage in order to enroll children in SCHIP—a phenomenon known as "crowd out." To adjust for crowd out, we added to the estimate of uninsured SCHIP-eligible children a number equal to 20 percent of the number of children whose family incomes met the SCHIP eligibility requirements but were reported as being insured.[17]

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[14]The SCHIP statute contains a provision that, in order for a child to be eligible for SCHIP-funded coverage, the child's family income must exceed the Medicaid income level that was in effect on March 31, 1997.

[15]We used Medicaid and SCHIP income disregards as of October 1998, as reported by Leighton Ku, Frank Ullman, and Ruth Almeida, *What Counts? Determining Medicaid and CHIP Eligibility for Children* (Washington, D.C.: The Urban Institute, 1999). All but four states used Medicaid disregards. States with SCHIP income disregards included Alabama, California, Colorado, Massachusetts, Michigan, North Carolina, Vermont, and Virginia.

[16]See Linda Giannarelli and James Barsimantov, *Child Care Expenses of America's Families* (Washington, D.C.: The Urban Institute, Dec. 2000), pp. 3-4.

[17]The Congressional Budget Office (CBO) estimates that 20 percent of those who would have otherwise had insurance will participate in SCHIP.

Finally, because not all eligible uninsured children are eventually enrolled in public programs, we developed three scenarios for states' enrollment of a greater number of eligible children by using "take-up rates" of 40 percent (low-level additional enrollment), 55 percent (medium-level), and 70 percent (high-level) of our estimate.[18] Therefore, we estimated states' additional enrollment of eligible children in 2000 by adding to the actual June 2000 enrollment figures a number that is (1) the estimated number of children whose families would drop private insurance coverage in order to enroll in SCHIP and (2) 40 percent, 55 percent, and 70 percent, respectively, of the estimated number of eligible uninsured children; this number is reduced by the number of children representing the actual change in SCHIP enrollment from June 1999 through June 2000.[19]

ESTIMATED FEDERAL EXPENDITURES FOR ENROLLMENT OF ADDITIONAL CHILDREN AND PREGNANT WOMEN

To estimate expenditures in fiscal year 2000 for states to enroll both a greater number of eligible children and income-eligible pregnant women, we developed a state-specific fiscal year 2000 cost estimate for SCHIP children and a national estimate of the number of income-eligible pregnant women and the costs to insure them. We estimated federal expenditures for enrollment of additional children by multiplying our per-child cost estimates by each of the three enrollment scenarios.

For each state, we developed a cost per child by dividing the state's fiscal year 2000 federal expenditures by its full-year-equivalent enrollment. We approximated full-year-equivalent enrollment by using states' reports of the total number of months of children's enrollment (called "member months") and dividing that number by 12.[20] For example, one child may be enrolled in the program for 6 months, while another remains enrolled for 9 months. Together, the number of children's member months is 15. Calculating the full-year-equivalent enrollment provides a more specific estimate of the average annual cost per child.

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[18]Research findings indicate that public program take-up rates range from 40 percent to 70 percent. Additionally, in December 1997 CBO estimated that about 55 percent of children who were uninsured and eligible for SCHIP would enroll (corresponding to our medium-level scenario).

[19]Nine states (Alaska, Kentucky, Minnesota, Montana, Nevada, North Dakota, West Virginia, Wisconsin, and Wyoming) and the District of Columbia enrolled more children from 1999 through 2000 than the CPS estimated were available to be enrolled in some or all of our scenarios (using 40, 55, or 70 percent of the estimated number of eligible uninsured children). Therefore, we used the actual June 2000 enrollment figure for the scenarios in which there were no calculated additional children to enroll in a state.

[20]For the states that did not report member months for 1 of the 4 quarters in fiscal year 2000, we imputed the missing quarter by assuming the missing quarter member months would be in the same ratio to expenditures as that of the prior quarter's member months to that quarter's expenditures. Because reports from Alabama and Alaska did not provide enough data to make full-year-equivalent calculations, we used the number of children ever enrolled in fiscal year 2000 from HCFA's on-line Statistical Enrollment Data System (SEDS) for these states.

We estimated the number of pregnant women whose family incomes were within the SCHIP income eligibility range by using the number of eligible infants as a proxy. To the number of infants enrolled in SCHIP in fiscal year 2000 we added the CPS estimate of uninsured infants who were eligible but not enrolled, reduced by the change in enrollment of infants from 1999 through 2000.[21] This calculation yielded an estimate of 41,107 pregnant women who met SCHIP income eligibility criteria in 2000. We used a cost estimate for maternity coverage of between $6,000 and $7,000 per pregnant woman provided by the National Perinatal Information Center. Our estimate of the number of eligible pregnant women and the cost to insure them may be overstated because (1) teenage pregnant women may already be eligible for SCHIP as children and (2) we assume 100 percent enrollment rather than a low-, medium-, high-enrollment scenario.

[21]A monthly point-in-time enrollment figure for infants was not available for 1999 or 2000. Therefore, we used state-reported fourth quarter enrollment for 1999 and 2000 from the SEDS system.

Enclosure II

SCHIP APPROPRIATIONS AND EXPENDITURES

Fiscal year	Annual appropriation	Cumulative annual appropriation	Annual federal expenditures	Cumulative annual federal expenditures
1998	$4,224,262,500	$4,224,262,500	$121,232,954	$121,232,954
1999	4,204,312,500	8,428,575,000	901,848,306	1,023,081,260
2000	4,204,312,500	12,632,887,500	1,867,165,308	2,890,246,568
2001	4,204,312,500	16,837,200,000		
2002	3,082,125,000	19,919,325,000		
2003	3,142,125,000	23,061,450,000		
2004	3,142,125,000	26,203,575,000		
2005	4,039,875,000	30,243,450,000		
2006	4,039,875,000	34,283,325,000		
2007	4,987,500,000	39,270,825,000		

Note: The cumulative annual appropriation through 2007 to the states and the District of Columbia totals less than the total statutory appropriation of $40 billion because of two allocations. First, each year 0.25 percent of the total SCHIP appropriation is allocated to the U.S. territories and commonwealths. Second, two diabetes research programs receive $60 million a year through 2002 ($300 million in total) from the appropriation.

Source: GAO analysis of HCFA data.

SCHIP EXPENDITURES FOR FISCAL YEAR 2000: ACTUAL EXPENDITURES AND ESTIMATED EXPENDITURES FOR ADDITIONAL ELIGIBLE UNENROLLED CHILDREN

Dollars in thousands

				Estimated fiscal year 2000 expenditures including costs for a		
State	**Fiscal year 2000 allotment**	**Actual fiscal year 2000 expenditures**	**Total unspent allotments at end of fiscal year 2000[b]**	**Low level of additional enrollment[c]**	**Medium level of additional enrollment**	**High level of additional enrollment**
Alabama	$77,012	$31,948	$191,246	$59,081	$64,685	$70,289
Alaska[d]	7,730	18,089	-419	18,086	18,086	18,740
Arizona	130,213	29,406	325,015	67,006	79,925	92,845
Arkansas	53,754	1,523	147,141	13,114	14,770	16,426
California	765,548	187,279	2,213,789	387,612	443,106	498,599
Colorado	46,890	13,918	106,331	21,639	23,804	25,969
Connecticut	39,225	12,761	83,916	52,843	56,543	60,244
Delaware	9,036	1,542	22,815	2,946	3,360	3,773
District of Columbia[e]	10,817	5,764	28,650	9,774	10,505	11,382
Florida	242,045	125,684	598,152	180,497	198,658	216,819
Georgia	132,381	48,749	324,935	77,581	87,133	96,685
Hawaii	10,037	420	27,465	2,113	2,409	2,704
Idaho	17,818	7,496	36,726	7,634	8,267	8,900
Illinois	137,481	32,660	328,488	66,466	75,379	84,291
Indiana	63,161	53,705	88,432	108,218	117,578	126,938
Iowa	32,383	15,493	70,818	34,955	37,233	39,512
Kansas	30,321	12,771	69,927	19,336	21,206	23,077
Kentucky[f]	56,026	60,027	77,803	71,002	71,002	71,002
Louisiana	91,131	25,293	258,469	47,876	54,773	61,670
Maine	13,978	11,402	21,874	14,282	15,471	16,660
Maryland	56,870	92,159	73,549	122,251	129,200	136,148
Massachusetts[e]	48,064	44,165	53,983	46,043	46,069	48,988
Michigan	102,762	36,150	233,774	113,035	125,564	138,092
Minnesota[f]	31,861	8	88,504	9	9	9
Mississippi	58,036	21,086	140,627	58,518	68,175	77,832
Missouri	57,979	41,201	100,172	92,605	97,120	101,635
Montana[f]	13,173	4,288	31,711	5,609	5,609	5,609
Nebraska	16,576	6,744	35,714	8,381	8,841	9,302
Nevada[e]	30,526	8,954	78,133	10,501	11,338	12,190
New Hampshire	10,264	1,637	30,587	8,614	9,118	9,622
New Jersey	96,859	46,851	203,269	134,176	146,846	159,517
New Mexico	56,408	3,442	177,846	5,345	6,059	6,773
New York	286,822	401,010	106,350	461,065	486,001	510,938
North Carolina	89,211	65,490	147,442	104,182	113,067	121,951
North Dakota[f]	5,656	1,783	13,854	2,330	2,330	2,330
Ohio	129,858	53,069	263,200	92,991	99,322	105,654
Oklahoma[g]	76,765	51,257	196,501	42,344	45,887	49,429

State	Fiscal year 2000 allotment	Actual fiscal year 2000 expenditures	Total unspent allotments at end of fiscal year 2000[b]	Estimated fiscal year 2000 expenditures including costs for a Low level of additional enrollment[c]	Medium level of additional enrollment	High level of additional enrollment
Oregon	43,896	12,509	101,807	25,208	27,766	30,324
Pennsylvania	128,956	70,684	240,268	145,944	152,606	159,269
Rhode Island	9,571	10,350	18,218	14,207	14,558	14,910
South Carolina	71,314	46,591	82,058	49,056	50,463	51,870
South Dakota	7,951	3,109	20,338	6,822	7,397	7,972
Tennessee[g]	74,226	41,705	164,515	26,614	26,887	27,160
Texas	502,812	41,433	1,541,563	264,912	319,671	374,430
Utah	27,199	12,842	54,731	25,212	27,216	29,221
Vermont	3,967	1,430	9,066	3,966	4,048	4,130
Virginia	73,580	18,558	186,338	46,624	53,245	59,866
Washington	52,355	604	144,853	8,941	10,252	11,564
West Virginia[f]	21,146	9,692	57,477	10,758	10,758	10,758
Wisconsin[f]	45,592	21,394	103,204	66,174	66,174	66,174
Wyoming[f]	7,069	1,041	21,415	1,484	1,484	1,484
Total	**$4,204,313**	**$1,867,165**	**$9,742,641**	**$3,265,982**	**$3,576,974**	**$3,891,676**

[a]In general, a SCHIP fiscal year allotment is available for 3 fiscal years. Therefore, states may be expending funds from prior fiscal years as well as fiscal year 2000.

[b]Unspent allotments at the end of fiscal year 2000 include any funds remaining from allotments from fiscal years 1998, 1999, and 2000.

[c]We estimated fiscal year 2000 state expenditures to include states' additional numbers of eligible unenrolled children by adding to the actual June 2000 enrollment figures a number that is (1) the estimated number of children whose families would drop private insurance coverage in order to enroll in SCHIP and (2) 40 percent (a low-level estimate), 55 percent (medium-level), and 70 percent (high-level), respectively, of the estimated number of eligible uninsured children; this number is reduced by the number of children representing the actual change in enrollment from June 1999 through June 2000. The number of eligible uninsured children was based on the number of uninsured children meeting SCHIP income eligibility criteria from combined 1998, 1999, and 2000 March supplements to the CPS.

[d]Change in enrollment from 1999 through 2000 was greater than the CPS estimate of eligible unenrolled children at the low and medium levels of additional enrollment. Therefore, calculations of expenditure estimates use actual June 2000 enrollment. Additionally, Alaska's reported expenditures in fiscal year 2000 exceeded available allotments by $418,766. The excess expenditure was charged to the state's fiscal year 2001 allotments.

[e]Change in enrollment from 1999 through 2000 was greater than the CPS estimate of eligible unenrolled children when applying the low level of additional enrollment. Therefore, calculations for the expenditure estimate at the low level of additional enrollment use the actual June 2000 enrollment.

[f]Change in enrollment from 1999 through 2000 was greater than the CPS estimate of eligible unenrolled children at the low, medium, and high levels, respectively, of additional enrollment. Therefore, calculations of expenditure estimates use the actual June 2000 enrollment.

[g]The state began reporting enrollment in SCHIP in fiscal year 1998; however, the state did not begin to claim expenditures for 1998 and 1999 enrollment until fiscal year 2000. Therefore, fiscal year 2000 expenditures overstate actual expenditures incurred in the year. Expenditure estimates were calculated taking this overstatement into account by substituting expenditures from the same fiscal quarter in 2001 for the quarter with high expenditures in 2000. For example, we substituted Oklahoma's first quarter 2001 expenditures for first quarter 2000 expenditures.

STATE INCOME ELIGIBILITY LEVELS FOR SCHIP AND MEDICAID

SCHIP generally covers uninsured children in families with incomes too high to qualify for Medicaid but at or below 200 percent of the federal poverty level ($35,300 for a family of four in 2001). However, both the SCHIP and Medicaid statutes give states considerable flexibility in setting income eligibility standards (see table 1).[22] States' SCHIP upper income eligibility limits range from 100 percent to 350 percent of the federal poverty level. Thirteen states have set their upper income eligibility limits for SCHIP above 200 percent of the poverty level.[23]

The population of pregnant women who could be eligible for SCHIP is limited, in part, because of the broad eligibility this group already has in Medicaid. Seventeen states' and the District of Columbia's Medicaid income eligibility levels for pregnant women as of October 2000 were at or above the maximum income eligibility levels in their SCHIP programs.[24] Other states had a narrow income eligibility range in SCHIP above the Medicaid level. For example, North Dakota's SCHIP eligibility for pregnant women could range from 133 percent to 140 percent of the poverty level.

Table 1: SCHIP Upper Income Eligibility Limits and Medicaid Upper Income Eligibility Limits for Pregnant Women, by State, as of October 2000

Percentage of the federal poverty level

State	SCHIP upper income eligibility limit	Medicaid upper income eligibility limit for pregnant women[a]
Alabama	200	133
Alaska	200	200
Arizona	200	140
Arkansas[b]	100	133
California	250	200
Colorado	185	133
Connecticut	300	185
Delaware	200	200
District of Columbia	200	200
Florida	200	185
Georgia	235	235
Hawaii	200	185

[22]Recognizing the variability in state Medicaid programs, the statute allows a state to expand eligibility up to 50 percentage points above its Medicaid eligibility standard as of 1997. Additionally, because the statute does not define how a state counts income, a state may exclude certain types of family income by using income disregards in order to increase eligibility for the program.

[23]The 13 states are California, Connecticut, Georgia, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Washington.

[24]The 17 states are Alaska, Arkansas, Delaware, Georgia, Illinois, Iowa, Maine, Maryland, Massachusetts, Nebraska, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, West Virginia, and Wyoming.

State	SCHIP upper income eligibility limit	Medicaid upper income eligibility limit for pregnant women[a]
Idaho	150	133
Illinois[c]	185	200
Indiana	200	150
Iowa	200	200
Kansas	200	150
Kentucky	200	185
Louisiana[d]	150	133
Maine	200	200
Maryland[e]	200	200
Massachusetts	200	200
Michigan	200	185
Minnesota	280	275
Mississippi	200	185
Missouri	300	185
Montana	150	133
Nebraska	185	185
Nevada	200	133
New Hampshire	300	185
New Jersey	350	185
New Mexico	235	185
New York[f]	250	185
North Carolina	200	185
North Dakota	140	133
Ohio	200	150
Oklahoma	185	185
Oregon	170	170
Pennsylvania	235	185
Rhode Island	250	250
South Carolina	150	185
South Dakota	200	133
Tennessee	100	185
Texas	200	185
Utah	200	133
Vermont	300	200
Virginia	185	133
Washington	250	185
West Virginia[g]	150	150
Wisconsin	200	185
Wyoming[h]	133	133

[a]Federal Medicaid law mandates that states cover pregnant women up to 133 percent of the federal poverty level.

[b]Only children born after September 30, 1982, and before October 1, 1983, are eligible for Arkansas' SCHIP program. The state has received approval from HCFA for a separate child health program for children in families with incomes from 150 percent to 200 percent of the federal poverty level, but implementation depends on approval of an amendment to the state's Medicaid section 1115 demonstration.

[c]Infants in Illinois' SCHIP program born to Medicaid-enrolled mothers are covered to 200 percent of the poverty level; infants whose parents are not enrolled are covered up to 185 percent of the poverty level.

[d]Louisiana received approval to raise SCHIP income eligibility to 200 percent of the poverty level as of June 2001.

[e]Maryland implemented a separate child health program extending coverage to children in families with incomes above 200 percent but at or below 300 percent of the poverty level effective July 1, 2001.

[f]New York began covering pregnant women in Medicaid up to 200 percent of the federal poverty level as of November 1, 2000.

[g]Effective November 1, 2000, West Virginia increased its upper income eligibility limit to 200 percent of the poverty level.

[h]Effective September 1, 2001, Wyoming will increase its upper income eligibility limit to 150 percent of the poverty level.

Source: GAO analysis of CMS and state data, and *Maternal and Child Health (MCH) Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children* (Washington, D.C.: National Governors Association, Feb. 22, 2001).

Enclosure V

STAFF ACKNOWLEDGMENTS

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RELATED GAO PRODUCTS

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

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