

# Medicaid and SCHIP: Strong Foundations for Health Reform

Medicaid and the State Children's Health Insurance Program (SCHIP) provide publicly-funded health insurance coverage for low-income children, pregnant women, and parents, as well as some elderly and disabled Americans. Together with Medicare (the federally-managed program that covers virtually all American seniors and some people with disabilities) these public programs provide essential health care to nearly 50 million women.<sup>1</sup> Since Medicaid and SCHIP are managed by the states, they have some flexibility in designing the programs to fit the needs of their residents.

States pursuing health reform often look to bolster public coverage programs as a first step, or they include a public coverage expansion as just one component of a larger and more comprehensive health reform plan. Either way, state health reform proposals might extend Medicaid or SCHIP eligibility to uninsured women who have not traditionally qualified for the programs, strengthen existing program policies to encourage enrollment among those who are already eligible, or improve access to care for women already enrolled in Medicaid and SCHIP.

## Extending Eligibility Limits for Public Health Insurance Programs

In 2006, more than a third of all low-income women—those with annual incomes at or below 200 percent of the Federal Poverty Level (or FPL, \$33,200 for a family of three in that year)—lacked health coverage.<sup>2,3</sup> State governments have the ability to extend Medicaid and SCHIP eligibility so that more of these uninsured low-income women qualify. There are several reasons that states might look to these important programs as a first step to providing health care to more women and their families:

***Over two-thirds of all uninsured Americans live in low-income families—the very population that Medicaid and SCHIP were designed to serve.*** It makes sense to use Medicaid and SCHIP—programs created to provide health insurance to the nation's most vulnerable families—to expand coverage to the low-income uninsured. Nearly every state has expanded Medicaid and SCHIP eligibility to cover children in families with incomes at 200 percent

### Three Types of Public Health Insurance

**Medicaid** is the joint federal and state-funded health insurance program for certain low-income parents, children, seniors, and people with disabilities. Medicaid is currently the largest source of health care funding for low-income people in the United States, and nearly 70 percent of the program's adult beneficiaries are women.

The **State Children's Health Insurance Program (called SCHIP or CHIP)** is also a joint federal—and state-funded program that provides health insurance to uninsured children in families with modest incomes that are too high to qualify for Medicaid. Some states also receive special permission from the federal government to cover adults with their SCHIP funds, including pregnant women, parents, and childless adults.

**Medicare** is a federal health insurance program that covers virtually all U.S. citizens age 65 or older, regardless of income. The program also covers younger people with certain disabilities or diseases.

of the FPL or higher, but for adults the states have generally adopted Medicaid eligibility levels far below even 100 percent of the FPL. For 2008, the median state Medicaid eligibility level in the U.S. is 63 percent of the FPL for working parents. There is a great deal of room for improvement here; by increasing the income limits for their public coverage programs states can realize significant reductions in the number of uninsured.<sup>4</sup>

***States that expand their Medicaid and SCHIP programs to cover more uninsured residents can share the costs with the federal government.*** The federal government reimburses states for part of the costs of their Medicaid and SCHIP programs, based on a formula (called the Federal Medical Assistance Percentage, or FMAP) which depends on each state's per capita income, and therefore differs from state to state.

Generally, the federal reimbursement for Medicaid ranges from at least 50 percent for wealthier states to over 70 percent for the poorest states.<sup>5</sup> The federal government matches SCHIP spending at an enhanced rate—the FMAP for SCHIP might be as much as 10 to 15 percent more than the Medicaid FMAP.<sup>6</sup> Thus, when states increase their Medicaid and SCHIP eligibility levels, they take advantage of federal resources to help cover their uninsured population.

***Medicaid and SCHIP provide comprehensive and affordable coverage for families.*** The Medicaid program was designed to meet the needs of low-income, vulnerable populations and provides comprehensive benefits. Medicaid covers a broad set of services that are important for women and their families, including inpatient and outpatient care, prescription drugs, long-term care, prenatal care, family planning, and preventive health services.<sup>7</sup> Though states have more flexibility in setting their SCHIP benefit package, they are subject to minimum benefit levels set by federal regulations and most states have also adopted comprehensive benefit plans.

States are allowed to require some low-income families enrolled in Medicaid and SCHIP to share the costs of their medical care (typically through premiums or co-payments). Yet allowable family contributions are regulated by the federal government, and health coverage obtained through these programs is still more affordable than private coverage. In the Medicaid program, certain health services such as pregnancy-related care and family planning are exempt from cost-sharing.<sup>8</sup> In the SCHIP program, a family's cumulative cost-sharing cannot exceed 5 percent of annual family income.

#### Federal Actions Could Limit State Efforts to Expand Medicaid and SCHIP

Lack of support by federal authorities can be a major hurdle to state health care reform efforts. If reform plans rely on expanding Medicaid and other public programs to cover uninsured families who do not currently qualify for coverage, federal support is crucial for their efforts. This is because the Centers for Medicare and Medicaid (or CMS, the federal agency that oversees these programs) must approve state proposals to expand public coverage programs that are funded jointly by federal and state governments.

Yet, policymakers have differing philosophies on how and to what extent public health insurance programs should play a role in expanding coverage to the uninsured. For example, the Bush Administration has advanced policies that would limit public coverage to only the "poorest of the poor." A directive issued by CMS in August 2007 effectively barred states from using SCHIP funds to cover children in families with incomes above 250 percent of the FPL.

***Health care costs are lower for the government and consumers alike when coverage is provided by Medicaid or SCHIP rather than by private insurance.*** A recent study compared medical expenditures for low-income nonelderly individuals who were either uninsured, enrolled in Medicaid or SCHIP, or insured by private health insurance. After adjusting for health status and other demographic characteristics, researchers found that Medicaid/SCHIP coverage was associated with significantly lower per person medical spending and concluded that “efforts to expand health insurance coverage for low-income populations, whether conducted at the national or state level, would be less costly to society and much less costly to financially strapped beneficiaries if the expansions were based on public insurance like Medicaid and SCHIP.”<sup>9</sup>

### Medicaid and SCHIP Premium Assistance and Buy-In Programs

States can also use their Medicaid or SCHIP programs to offer premium assistance to families that cannot afford existing offers of employer-sponsored insurance (ESI). Employment-sponsored coverage continues to decline in the United States, especially among low-income workers. One study estimates that nearly half of the decline in ESI among low-income workers is attributable to a decline in take-up (that is, workers are offered health benefits by their employer but decline).<sup>10</sup> This is undoubtedly related to skyrocketing health insurance premiums; between 2001 and 2007, family premiums grew by 78 percent, on average, compared with 19 percent for worker earnings.<sup>11</sup>

Premium assistance programs subsidize some or all of an ESI premium for workers who are themselves eligible for Medicaid or SCHIP, or who have children who are eligible for one of these programs. The few states with premium assistance programs report relatively low enrollment in the programs, primarily because low-income working families have limited access to ESI—just an estimated 14-15 percent of low-income working families have an ESI offer that they are not taking up.<sup>12</sup>

Also, the private coverage subsidized through these programs may have benefit limits and burdensome cost-sharing requirements that could restrict low-income families’ ability to access needed services. The families participating in premium assistance programs may not receive the same benefit and cost sharing protections available through Medicaid or SCHIP coverage.<sup>13</sup>

States can also implement policies that allow individuals or employers to *buy-in* to Medicaid or SCHIP. Under this arrangement, people with incomes too high to qualify for public health coverage are allowed to purchase health insurance through the state’s Medicaid program or SCHIP, typically paying for all or most of the cost of that coverage. By December 2005, the seven states that had implemented SCHIP buy-in programs reported covering over 44,000 children; the majority did not impose an income eligibility limit for their programs, and most required families to pay the full cost of coverage for their children.<sup>14</sup>

While this represents a small fraction of SCHIP enrollment overall, these buy-in programs cost little for states to implement and fill an important coverage gap for families. Similarly, in 2006 thirty-three states covered over 80,000 working adults with disabilities through a special Medicaid buy-in program; these adults earn too much to qualify for public coverage but face challenges in securing adequate and affordable health coverage because of their disability.<sup>15</sup>



## Lessons from the States:

### Expanding and Strengthening Public Programs as the First Step to Reform

A number of states have recently expanded eligibility for Medicaid and SCHIP coverage as a first step in reforming their state health system. Some examples are:

- As part of the Massachusetts health reform effort, MassHealth (the state's Medicaid program) eligibility levels increased to cover children in families with incomes up to 300 percent of the FPL;
- Connecticut's Health First Connecticut and Healthy Kids Initiative legislation, passed in June 2007, increased Medicaid eligibility for parents up to 185 percent of FPL; and,
- In early 2008, Minnesota increased the eligibility limits for Minnesota Care (the state's Medicaid program) for childless adults to 200 percent of the FPL. By July 2009, eligibility will increase to 215 percent of the FPL.

States are also proposing Medicaid or SCHIP premium assistance and buy-in programs:

- Pennsylvania's "Cover All Kids" legislation, passed in 2006, allows families with incomes over 300 % of the FPL to buy coverage for their children (at full cost) through the state's SCHIP program.
- In January 2009, Kansas will begin implementation of a premium assistance program for low-income parents. When fully phased-in, the program will cover adults with incomes up to 100 percent of the FPL.

### Making Enrollment Easier for Women and Families Currently Eligible for Medicaid and SCHIP

Studies indicate that at least 62 percent of all uninsured children, as well as two-thirds of uninsured parents living below the poverty level, qualify for programs like Medicaid and SCHIP but are not enrolled.<sup>16</sup> Over the past decade, states have taken great strides to simplify enrollment procedures for children's public coverage programs. Indeed, many simplification strategies, such as eliminating face-to-face interview requirements and continuing eligibility for a full year, have been adopted by the vast majority of states for their children's programs.<sup>17</sup> These efforts have greatly increased the proportion of eligible children enrolled in public coverage.<sup>18</sup>

States have taken far fewer steps to simplify adult enrollment processes, and there are still significant barriers in place when eligible adults (compared to children) apply for public coverage. By simplifying the enrollment process for qualified, low-income families, states can reduce the ranks of their uninsured.

### Improving Access to Care through Adequate Provider Reimbursement

Some Medicaid enrollees face challenges in finding a provider that will accept their coverage. States have flexibility in setting Medicaid physician payment rates and, in most states, Medicaid reimbursement rates are lower than the rates that both Medicare and private insurers pay. Inadequate reimbursement rates may be a significant disincentive for providers to participate in public coverage programs; this, in turn, can affect program enrollees' access to health care services.

As part of their health reform efforts, states can address this barrier by adjusting the rate at which they reimburse participating Medicaid providers. Increasing Medicaid reimbursement rates has been shown to boost provider participation, which is sorely needed in many states.<sup>19</sup>



### **What Can Women's Advocates Do to Build and Strengthen Public Programs as a Foundation for Reform?**

#### ***Advocates can support eligibility expansions of state Medicaid programs and SCHIP.***

By increasing eligibility limits for these programs—especially for adults—states take advantage of an existing program structure and share the cost with the federal government. Since the majority of uninsured Americans are low-income, public coverage expansions have the potential to significantly reduce the ranks of the uninsured.

#### ***Advocates can promote changes that simplify Medicaid and SCHIP enrollment.***

Too many women and their families are eligible for some type of public coverage program yet are not enrolled, and complicated and burdensome enrollment procedures may provide a disincentive for enrollment. By making it easier to apply for and keep public coverage, states can improve their insurance coverage rates.

#### ***Advocates can promote changes that encourage increased provider participation in public coverage programs.***

Even when enrolled, Medicaid and SCHIP beneficiaries may have trouble getting the health care they need if they live in an area with few participating Medicaid providers. Inadequate reimbursement rates are often at the root of this problem—by raising these rates states can improve access for public coverage enrollees.

#### ***Advocates can challenge efforts by the federal government to restrict states' ability to expand and strengthen Medicaid and SCHIP programs in ways that will better meet their residents' health care needs.***

Policymakers have differing philosophies on how and to what extent Medicaid and other public programs should play a role in health reform, yet federal support is crucial for states that plan to use these programs to cover uninsured families who do not currently qualify for coverage.



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## Women and Medicaid

Medicaid, the national health insurance program for low-income people, plays a critical role in providing health coverage for poor women. Over 20 million women are covered through Medicaid, comprising the majority (69 percent) of the program's adult beneficiaries.<sup>1</sup> Women are more likely than men to qualify for Medicaid because they tend to be poorer and are more likely to meet the program's stringent eligibility criteria. Women are also more likely to hold low-wage or part-time jobs that do not offer employer-sponsored health benefits, so Medicaid may be their only possible source of coverage.<sup>2,3</sup>

### **One in ten women in the United States receives health care coverage through Medicaid.<sup>4</sup>**

- Medicaid is the most important source of coverage for low-income women. In 2006, over one-fifth of all poor women were enrolled in the program.<sup>5</sup>
- Low-income mothers depend on the Medicaid program. Nearly two-thirds of the nonelderly women enrolled in Medicaid in 2004 had dependent children.<sup>6</sup>

### **Medicaid ensures that women have access to a comprehensive set of important health care services.**

- Medicaid programs are required to provide certain health services to some covered populations—including family planning services, inpatient and outpatient hospital care, and pregnancy-related care—and the program has traditionally provided beneficiaries with a comprehensive set of health services. The Deficit Reduction Act of 2005, however, allows states to provide more limited benefit packages (without coverage for mental health or prescription drug services, for example) to certain enrollees.<sup>7</sup>
- Medicaid covers diagnosis and treatment of chronic illnesses including breast and cervical cancer and HIV/AIDS.<sup>8</sup>

### **Reproductive health services are a vital component of women's Medicaid coverage.**

- In 2006, Medicaid provided basic health services to 7.3 million American women of reproductive age (15-44 years old).<sup>9</sup>
- Medicaid is the largest source of public funding for family planning services in the United States. In 2006, the program contributed \$1.3 billion toward family planning, accounting for 71 percent of total public spending on these essential services.<sup>10</sup>
- Medicaid covers 41 percent all births in the United States. The program finances prenatal visits and vitamins, ultrasound and amniocentesis screenings, childbirth by vaginal or caesarean delivery, and 60 days of postpartum care.<sup>11</sup> Pregnancy-related services accounted for the largest share of Medicaid's hospital charges in 2004.<sup>12</sup>

### **Medicaid is important for low-income women of all ages.**

- For elderly women who meet income eligibility requirements, the program covers high-cost services provided in a skilled nursing facility, as well as home and community-based health care for women who are entitled to nursing facility services.<sup>13</sup>
- More than a third of all female Medicaid beneficiaries were age 45 or older in 2006.

These women typically rely on the program for: health care related to a physical or mental disability or chronic condition; treatment for breast or cervical cancer; long-term care services; or, cost-sharing required under Medicare.<sup>14</sup>



### Women and Medicaid: What Can Women's Advocates Do?

***Women's advocates can support reforms that protect and improve the Medicaid program without sacrificing women's access to health care services.***

Policymakers will continue to debate the role that Medicaid and other public coverage programs should play in the U.S. health care system. Advocates should understand Medicaid's significance for women and support health reforms that will strengthen this critical health insurance program and improve women's access to care.



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## Women and Medicare

Established in 1965, Medicare is a federal health insurance program that covers virtually all U.S. citizens age 65 or older, regardless of income. The program also covers younger people with permanent disabilities or certain diseases, who make up about 15 percent of all Medicare beneficiaries.<sup>1</sup> Medicare is primarily funded through a combination of payroll taxes and federal revenues, but most Medicare participants also pay premiums, deductibles, and additional out-of-pocket expenses for their medical care. From a beneficiary's point of view, Medicare may not seem any different than traditional private coverage, since private health insurers administer Medicare program benefits. But unlike traditional private coverage—and with the exception of Medicare Advantage plans (described below)—medical claims for Medicare beneficiaries are ultimately paid for by the federal government.

The Medicare program is divided into four parts:

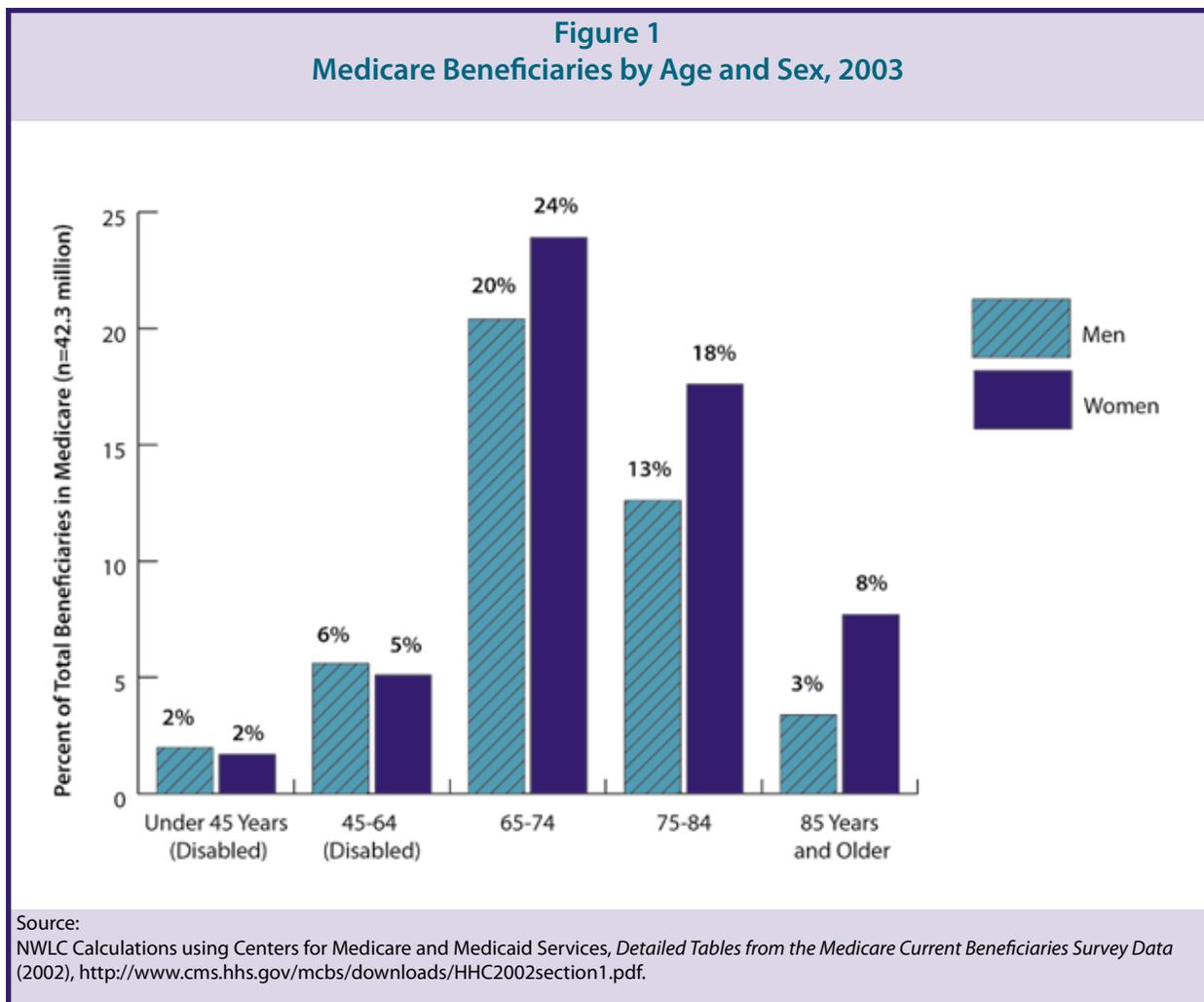
- Part A (“Hospital Insurance”) covers inpatient hospital, skilled nursing facility, and hospice services (funded through payroll taxes);
- Part B (“Supplementary Medical Insurance”) covers physician, outpatient, preventive, and other medically-necessary services. All but the poorest Medicare enrollees contribute to their Part B coverage via monthly premiums—in 2007, premiums were roughly \$94 per month<sup>2</sup>;
- Part C (“Medicare Advantage”) allows enrollees to receive their Medicare Part A and Part B benefits through private insurance carriers<sup>3</sup>; and,
- Part D covers outpatient prescription drugs.

Basic Medicare does not cover certain services, such as long term care, dental care, or hearing aids. Many Medicare beneficiaries purchase additional health insurance to cover these services—typically through their employer or directly from the private insurance market. If Medicare beneficiaries have a low enough income, they may have “dual-eligibility,” meaning that they also qualify for services available through the Medicaid program.

### The Medicare Program Plays a Vital Role for Women

Medicare is a critical source of health insurance for women over age 65 and for certain eligible women with disabilities. In 2003, the program covered over 23 million women, including roughly 21 million women ages 65 and older and nearly 3 million younger women with disabilities.<sup>4</sup> Because women generally have longer life expectancies than men, they are disproportionately represented among those enrolled in Medicare. Consider these facts:

- Women accounted for 56 percent of all Medicare beneficiaries in 2003.<sup>5</sup>
- They comprised nearly 70 percent of all Medicare enrollees aged 85 years and older (Figure 1).
- Over two-thirds of all Medicare beneficiaries living in long-term care facilities are women.<sup>6</sup>



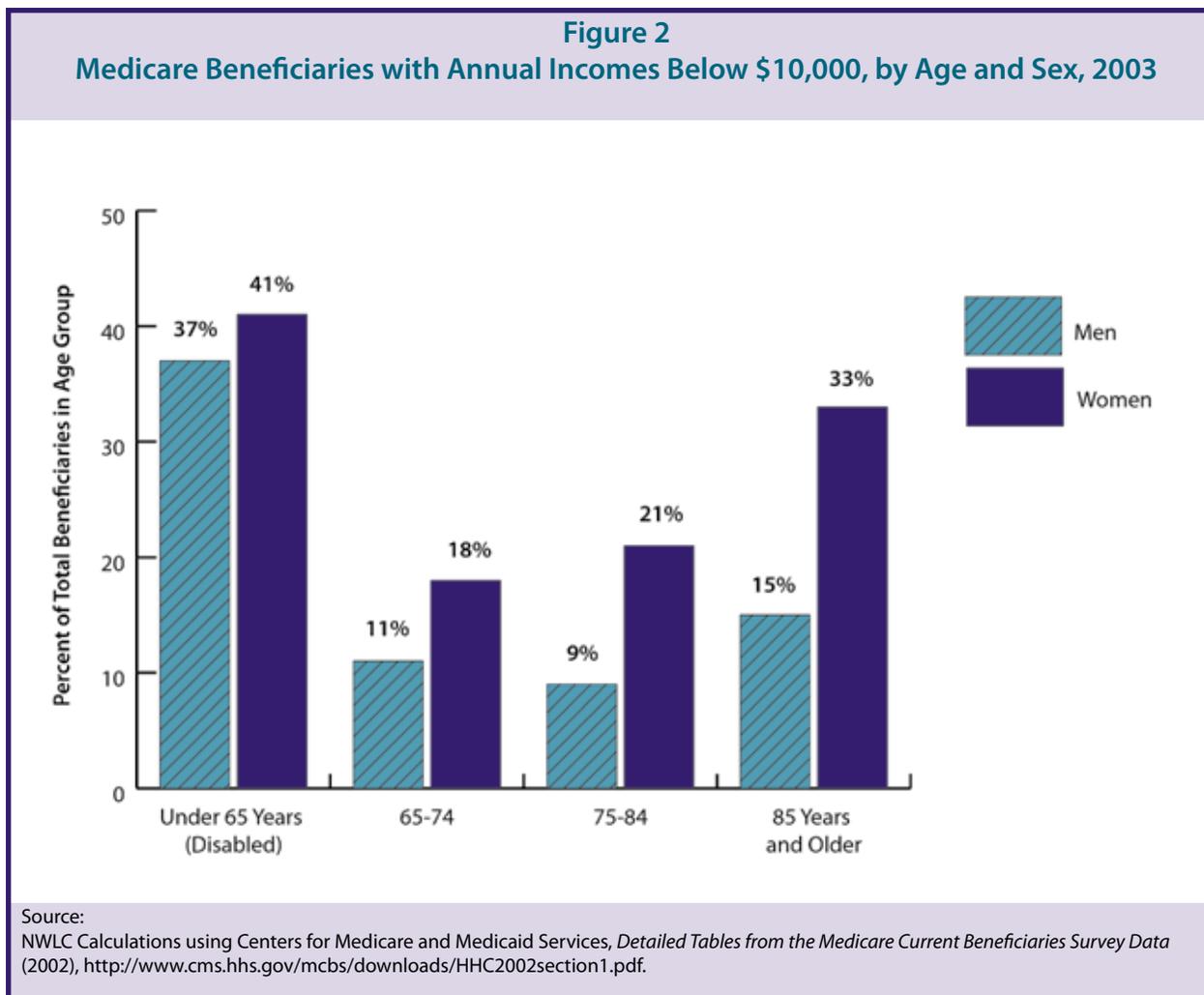
- Women in Medicare who are age 75 or older are more than twice as likely as men to have incomes of \$10,000 or less, which is below the federal poverty level (Figure 2).
- Because of their lower income, women are over-represented among those who are “dual-eligible” for Medicare and Medicaid: more than 60 percent of all dual-eligible beneficiaries are women.<sup>7</sup>

**Cost-sharing in Medicare: A Barrier to Health Care for Many Women**

Women in Medicare, when compared to men, pay a larger share of their income in out-of-pocket medical costs.<sup>8</sup> Cost-sharing in Medicare presents a potential barrier to health service access, especially for beneficiaries with few cash resources who might avoid or delay cost-effective preventive care if they cannot afford the out-of-pocket cost of that care. A recent study of rates of biennial breast-cancer screenings in Medicare plans with different levels of cost-sharing for mammography demonstrated that even nominal copayments were associated with significantly lower screening rates compared to plans with full coverage. These negative effects of cost-sharing were magnified among women living in low-income areas.<sup>9</sup>

**Medicare Advantage and the Debate on the Future of Medicare**

Over 44 million Americans currently participate in Medicare, and program participation is expected to experience rapid growth over the next two decades.<sup>10</sup> The total number of people enrolled in Medicare will nearly double between the years 2000 and 2030, eventually



reaching about 79 million beneficiaries.<sup>11</sup> This projected increase in program enrollment, in combination with the rapid growth of health care costs and the declining ratio of workers (i.e. those who fund Medicare through payroll taxes) to beneficiaries, has prompted some policymakers to debate whether and how Medicare can be sustained in the future.

A philosophical question that is central to this debate relates to Medicare Advantage (also known as Medicare’s Part C): should private and for-profit insurance companies be allowed to sell Medicare plans, or should the program continue to function as it has for over 40 years, as a traditional federal insurance program? Proponents of Medicare Advantage (MA) have claimed that by using private health plans, the program can contain costs and provide better health care for Medicare beneficiaries. But there is little evidence that MA plans have made good on their promise to provide better quality care or enhanced benefits, and there is ample evidence that the plans are significantly overpaid.<sup>12</sup> In 2008, private MA plans are being paid 13 percent more, on average, than it would cost traditional Medicare to cover the same beneficiaries.<sup>13</sup> MA overpayments have contributed to a rapid growth in private plan contracts; participation in these plans has grown from 5.3 million beneficiaries in 2003 to 8.7 million (or, about 20 percent of all beneficiaries) in 2007, with growth concentrated in the areas of highest overpayment.<sup>14, 15</sup>

These overpayments raise a number of concerns. They have accelerated rapidly-growing Medicare program costs, and private insurers offering MA plans have recently been under

scrutiny for preying on Medicare beneficiaries through aggressive and abusive marketing practices, arguably due to the overpayments.<sup>16</sup> Paying Medicare Advantage plans at rates equal to traditional Medicare could save an estimated \$54 billion over five years.<sup>17</sup>

### Medicare and Health Reform

One type of health reform proposal would expand Medicare so that most, if not all, Americans would be eligible to participate in the program. These “Medicare for All” plans would open Medicare to any American who wanted to buy-in to the program, while still allowing those who did not want to participate in Medicare to purchase private insurance.

Another type of proposal, which is typically just one component of a larger reform package, would lower the age of eligibility for Medicare (to age 55, for example). This type of reform could be of particular benefit to women. Since they are more likely to be married to an older spouse, women are at greater risk of losing dependent coverage and becoming uninsured when that spouse becomes eligible for Medicare (and therefore transitions out of job-based health insurance).<sup>18</sup> Indeed, among adults aged 50-64, women are more likely than men to be uninsured; for all other adult age groups this pattern is reversed.<sup>19</sup>



### Women and Medicare: What Can Women’s Advocates Do?

***Women’s advocates can support reforms that protect and improve the Medicare program without sacrificing women’s access to health care services.***

Debate around the future of Medicare is certain to continue, especially in the context of health reform. Advocates should understand the important role that Medicare plays in providing health coverage for women as well as the access barriers that low-income women with Medicare face, and they must support health reforms that address these challenges.



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- 13 MedPac (Medicare Payment Advisory Commission), *Report to the Congress: Medicare Payment Policy* (March 2008), [http://www.medpac.gov/documents/Mar08\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar08_EntireReport.pdf).
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# Women and the State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP) is a public health insurance program created by Congress in 1997 to expand health care coverage for low-income children whose families cannot afford private insurance but whose income is too high to qualify them for Medicaid.<sup>1</sup> In addition to providing children's coverage, some states use SCHIP to cover low-income adults who do not otherwise qualify for Medicaid. In 2007, the program—which is jointly funded by the federal and state governments—covered an estimated 7 million children and over half a million low-income parents, pregnant women and other adults who would otherwise go without health insurance.<sup>2</sup> Together, Medicaid and SCHIP successfully provide health insurance to nearly 70 million of the nation's most vulnerable people.

## Women's Health Insurance Coverage under SCHIP

When SCHIP was first implemented, some states had already expanded children's coverage through Medicaid and had limited ability to use SCHIP for children; consequently, these states were authorized to use their SCHIP allotments to expand coverage to poor adults. Other states have used SCHIP money to expand insurance coverage to adults as a strategy to reduce the growing number of uninsured Americans. Approximately 587,000 adults were enrolled in SCHIP in 2007, comprising about 8 percent of total program enrollment.<sup>3,4</sup> There are three categories of adults who can get coverage under SCHIP with special federal approval called a "waiver." Waivers allow states to use SCHIP money in ways that are not otherwise permitted by program rules. (Table 1 provides further detail on the states that have implemented each type of coverage):

- **Parents:** States can cover parents of Medicaid- and SCHIP-eligible children under SCHIP through a waiver. In 2007, 11 states used SCHIP to provide coverage for around 487,000 parenting adults who would otherwise be uninsured.<sup>5</sup>
- **Childless Adults:** Although states were also initially allowed to use their SCHIP funds to cover non-pregnant childless adults through a waiver, 2005 legislation prohibits any new waivers to cover this population. In 2007, four states used SCHIP to cover roughly 93,000 adults without children but for now, additional states cannot use SCHIP to expand coverage to more adults in this category.<sup>6</sup>
- **Pregnant Women:** States can cover pregnant women under SCHIP through a waiver. In 2007, five states had obtained waivers to cover a total of over 6,400 pregnant women under SCHIP.<sup>7</sup>

Additionally, states can cover pregnant women without a federal waiver by amending their state SCHIP plans to include an option authorized by the SCHIP "unborn child" regulation. This regulation allows states to use federal funds to provide health care to fetuses carried by women who meet income guidelines but who are otherwise ineligible for public insurance programs. In practice, the rule extends eligibility primarily to pregnant women who do not meet the immigration status requirements of Medicaid. While a woman covered under the "unborn child" regulation may not have the necessary citizenship status to qualify for a public insurance program<sup>8</sup>, the fetus will become a U.S. citizen upon birth and thus qualifies for SCHIP coverage during the gestational

period.<sup>9,10</sup> In June 2007, 12 states used the “unborn child” option to provide coverage to nearly 143,000 individuals.<sup>11</sup> Since then, one more state has received approval to implement this option.

**SCHIP at a Crossroads**

Since its creation over a decade ago, SCHIP has provided states with a unique opportunity to expand coverage for low-income children and adults at a time when rising health care costs and lack of health insurance are creating tremendous economic burdens for families. But in 2007, the reauthorization of this important program got caught in a broader debate about the role that SCHIP and other public coverage programs should play in the U.S. health care system and the best strategies for covering the uninsured. As part of this debate, President Bush vetoed bipartisan legislation reauthorizing SCHIP twice before agreeing to an 18-month program extension. Thus, while this successful public coverage program is currently viable, Congress will need to address SCHIP reauthorization again in early 2009.



**Women and SCHIP: What Can Women’s Advocates Do?**

***Women’s advocates can support legislation that reauthorizes and expands SCHIP, as well as reforms that would make it easier for states to use SCHIP to extend coverage to a greater number of uninsured residents, including adults.***

Given the broader debate about the role of SCHIP in addressing our health care crisis, advocates should understand that SCHIP—while a small program in comparison to Medicaid—provides essential health coverage for hundreds of thousands of women who would otherwise be uninsured. They should support health reforms that will strengthen this critical public coverage program and improve women’s access to health care.

**Table 1: Adult Coverage Under the State Children’s Health Insurance Program (SCHIP), 2007**

State	Covered Population		
	Pregnant Women	Parents	Childless Adults
Arizona		■	
Arkansas	■*	■	
California	■*		
Colorado	■		
Idaho		■	■
Illinois	■*	■	
Louisiana	■*		
Massachusetts	■*		
Michigan	■*		■
Minnesota	■*	■	
Nevada	■	■	
New Jersey	■	■	
New Mexico		■	■
Oklahoma	■*		
Oregon		■	■
Rhode Island	■**	■	
Tennessee	■*		
Texas	■*		
Virginia	■		
Washington	■*		
Wisconsin	■*	■	
<b>TOTAL</b>	<b>17</b>	<b>11</b>	<b>4</b>

**Notes:**

\* Denotes states that have used the “unborn child” regulation to cover pregnant women under SCHIP.

\*\* Denotes states that have used both an 1115 waiver and the “unborn child” regulation to cover pregnant women under SCHIP.

**Sources:**

Congressional Research Service, *Revised Memorandum on Estimates of SCHIP Child and Adult Enrollees*, (May 30, 2008); Samantha Artiga and Cindy Mann, Kaiser Commission on Medicaid and the Uninsured, *Family Coverage Under SCHIP Waivers* (May 2007); Personal communication between SCHIP administrators and NWLC staff, (May 2008).



### For further reading, see:

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U.S. Government Accountability Office, *State Children's Health Insurance Program: Program Structure, Enrollment and Expenditure Experiences, and Outreach Approaches for States That Cover Adults*, (Nov. 2007), <http://www.gao.gov/new.items/d0850.pdf>.

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- 3 *Id.*
- 4 This total does not include pregnant women who are covered under SCHIP's "unborn child" regulation.
- 5 Estimates of SCHIP, *supra* note 2.
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- 7 *Id.*
- 8 Under current law federal funds are theoretically unavailable to provide prenatal care to undocumented immigrants or legal immigrants who arrived after 1997 and have not been in residence for five years.
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- 11 Vernon Smith et al., Kaiser Commission on Medicaid and the Uninsured, *SCHIP Enrollment in June 2007: An Update on Current Enrollment and SCHIP Policy Direction* (Jan. 2008), [http://www.kff.org/medicaid/upload/7642\\_02.pdf](http://www.kff.org/medicaid/upload/7642_02.pdf).

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# The Federal Poverty Level: What Is It and Why Does It Matter?

The Federal Poverty Level (FPL) defines the income level under which an individual or family is considered to be “living in poverty.” The FPL is the primary factor used to determine eligibility for many government programs, including Medicaid, SCHIP, and premium subsidy programs aimed at helping moderate- and lower-income families purchase private insurance plans.

Use of the FPL is often criticized for its failure to reflect a typical family in the modern world, as it’s definition has not changed since its inception more than four decades ago.<sup>1,2</sup> For example, the FPL calculation does not take into account certain major costs like child care, because when the formula was established policymakers assumed that a family included at least one homemaker and that child care was not a typical item in the family budget. Moreover, the FPL does not reflect geographic differences in the cost of living.<sup>3,4</sup>

Adjusted annually to reflect inflation, the FPL for 2008 is \$17,600 of income per year for a family of three. Income includes—among other things—general earnings, unemployment compensation, worker’s compensation, income from Social Security payments, alimony or child support, and financial assistance from outside sources. In 2006, 17 percent of women—almost one in six—lived in families with incomes at or below 100 percent of the FPL.<sup>5</sup>

<b>2008 Federal Poverty Level (FPL) Guidelines</b> (Valid In the 48 contiguous states and D.C.)				
Number of Persons in Family or Household	100% FPL		200 % FPL	300 % FPL
	Income per <i>Year</i>	Income per <i>Month</i>	Income per <i>Year</i>	Income per <i>Year</i>
1	\$10,400	\$867	\$20,800	\$31,200
2	\$14,000	\$1,167	\$28,000	\$42,000
3	\$17,600	\$1,467	\$35,200	\$52,800
4	\$21,200	\$1,767	\$42,400	\$63,600
5	\$24,800	\$2,067	\$49,600	\$74,400
For each additional person	Add \$3,600	Add \$300	Add \$7,200	Add \$10,800

Source: U.S. Department of Health and Human Services, *2008 Federal Poverty Guidelines*, Federal Register Vol. 73 no. 15.

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## Upper Public Program Eligibility Levels for Children and Adults (DRAFT)

	Children (age 0-18) <sup>1</sup>	Parents/ Caretakers <sup>2,3</sup>	Childless Adults <sup>3</sup>
Alabama	200%	11%; 26%	
Alaska	175%	76%; 81%	
Arizona	200%	200%	100%
Arkansas	200%	14%; 18%	
California	250% <sup>4</sup>	100%; 106%	
Colorado	225%	60%; 66%	
Connecticut	300%	185%; 191%	
Delaware	200%	100%; 106%	100%
District of Columbia	300%	200%; 207%	
Florida	200%	21%; 56%	
Georgia	235%	30%; 53%	
Hawaii	300%	100%; 118%	
Idaho	185%	22%; 42%	
Illinois	200% <sup>5</sup>	185%; 191%	
Indiana	250%	20%; 26%	
Iowa	200%	30%; 89%	
Kansas	200%	28%; 34%	
Kentucky	200%	37%; 64%	
Louisiana	250%	13%; 20%	
Maine	200%	200%; 206%	100%
Maryland	300%	116%; 122%	
Massachusetts	300%	300%	300%
Michigan	200%	38%; 61%	35%
Minnesota	275% <sup>6</sup>	275%	
Mississippi	200%	26%; 32%	
Missouri	300%	20%; 39%	
Montana	175%	34%; 60%	
Nebraska	185%	48%; 59%	
Nevada	200%	27%; 94%	
New Hampshire	300%	44%; 55%	
New Jersey	350%	133%; 136%	
New Mexico	235%	27%; 63%	
New York	250% <sup>7</sup>	150%; 152%	100%; 150% <sup>8</sup>
North Carolina	200%	38%; 52%	
North Dakota	140%	37%; 63%	
Ohio	200%	90%; 94%	
Oklahoma	185%	33%; 50%	

Oregon	185%	46% <sup>9</sup>	
Pennsylvania	300%	29%; 59%	
Rhode Island	250%	175%; 181%	
South Carolina	200%	50%; 93%	
South Dakota	200%	56%	
Tennessee	250%	69%; 80%	
Texas	200%	13%; 28%	
Utah	200%	41%; 47%	
Vermont	300%	185; 191%	150%
Virginia	200%	24%; 31%	
Washington	250%	38%; 76%	
West Virginia	220%	18%; 35%	
Wisconsin	300%	200%	
Wyoming	200%	41%; 55%	

<sup>1</sup> The eligibility levels for children reflect the upper eligibility level for Medicaid and/or CHIP.

<sup>2</sup> The two eligibility levels reflect the income eligibility levels for non-working and working parents, respectively.

<sup>3</sup> Parent and childless adult eligibility levels reflect Medicaid programs that provide comprehensive benefits and cost-sharing protections, offer an adequate provider network, and allow individuals to enroll regardless of an employer decision to participate.

<sup>4</sup> Infants in California (age two and under) are eligible for CHIP up to 300 percent of poverty if they are born to women on the Access for Infants and Mothers (AIM) program, unless the child is enrolled in employer-sponsored insurance or no-cost full scope Medi-Cal.

<sup>5</sup> Illinois covers children regardless of income, but subsidies for children with family incomes over 200 percent of poverty are paid for with state-only funds.

<sup>6</sup> Infants in Minnesota (age two and under) are eligible for coverage up to 280 percent of poverty.

<sup>7</sup> New York covers children in families with incomes up to 400 percent of poverty with state-only funds.

<sup>8</sup> NY Family Health Plus provides coverage for single childless adults up to 100 percent of poverty and childless couples up to 150 percent of poverty.

<sup>9</sup> The Oregon Health Plan provides coverage to parents and childless adults up to 100 percent of poverty, but is currently closed to new enrollees. "Categorically eligible" parents (those who qualify as a "mandatory eligibles") can still enroll. The income limit listed is subject to change as we gather more information.