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State Implementation Approaches Are Evolving

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The Honorable Edward M. Kennedy
Ranking Minority Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Thomas J. Bliley
Chairman, Committee on Commerce
House of Representatives

An estimated 9 million to 11.6 million children were uninsured at some time during 1997, increasing their risk of forgoing routine medical and dental care, immunizations, treatment for injuries and chronic illnesses, and the continuity of care implicit in having a primary care physician. In August 1997, the Congress created the State Children's Health Insurance Program (SCHIP) with the goal of significantly reducing the number of low-income, uninsured children.[1] Under SCHIP, a state has the choice of (1) expanding Medicaid and thus building upon an existing program, (2) establishing a separate, stand-alone program that can include cost sharing and allows the states to adopt a benefit package that meets one of several employer-based benchmarks, or (3) combining these two approaches.[2] SCHIP appropriates about $40 billion over 10 years—enough money to potentially cut the number of uninsured children by half. Prior to SCHIP, approximately 19 million Medicaid beneficiaries—more than half—were children, and combined federal and state expenditures on their behalf totaled $32 billion.

You asked us to report on the first year of SCHIP's implementation and, in particular, to examine the states' (1) initial SCHIP design choices, including the use of the statutory flexibility to design their programs; (2) pursuit of statutory options, particularly extending coverage to adults in families with children; (3) development of innovative outreach strategies to enroll eligible children; and (4) tailoring of strategies to avoid the "crowd out" of both private insurance and Medicaid coverage by SCHIP. To conduct this review, we analyzed available data from research and advocacy groups, state agencies charged with implementing SCHIP, and the Department of Health and Human Services (HHS), the federal agency responsible for

[1]Established as title XXI of the Social Security Act by Public Law 105-33; SCHIP is codified as 42 USCS § 1397aa et seq. (1998).

[2]The terminology used in the forthcoming federal regulation governing the SCHIP program refers to stand-alone plans as "S-CHIP"—that is, separate child health programs.

approving SCHIP plans.[3] We focused on a sample of 15 states that used the three available options: California, Colorado, Connecticut, Florida, Massachusetts, Michigan, Missouri, New York, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, and Wisconsin. Overall, the sample reflects geographic diversity as well as a cross section of SCHIP approaches—stand-alone programs, Medicaid expansions, and efforts that combine these two alternatives. Four of our sample states—California, Florida, New York, and Texas—accounted for almost half of all funds allocated for SCHIP in fiscal year 1998. Five states in our sample—Massachusetts, New York, Oregon, Rhode Island, and Vermont—had operated their Medicaid programs under a section 1115 waiver for a number of years. We conducted our study between May 1998 and April 1999 in accordance with generally accepted government auditing standards.

Results in Brief

Despite the short implementation period and the related challenges of establishing a stand-alone program distinct from Medicaid, the states and the federal government have made considerable progress in getting SCHIP up and running—including the enrollment of about 982,000 children. However, the current distribution of design approaches will continue to evolve as states finalize their SCHIP plans.

- SCHIP design choices are currently almost evenly divided between expansions of state Medicaid programs and programs with a stand-alone component. As of April 1, 1999, 51 SCHIP plans had been approved, 2 were under review, and 3 had not been submitted.[4] SCHIP design is ongoing, and more states will ultimately embrace a stand-alone component that, unlike Medicaid, provides them with greater budgetary control over program costs, permits them to vary benefits, and allows cost sharing. For most children, the SCHIP stand-alone benefit packages in our sample offer coverage comparable to Medicaid; however, some states have imposed limits on service use similar to those applied to adults in Medicaid. With regard to cost sharing, our analysis suggests that the states' use of cost sharing under SCHIP is generally closer to 1 to 2 percent of income than to the 5-percent maximum allowed by the statute.
- A growing number of states are exploring statutory options under SCHIP, including family coverage and subsidizing insurance coverage through

[3]The Health Care Financing Administration (HCFA) within HHS has the primary responsibility for plan review and oversight.

[4]The 50 states, the District of Columbia, and 5 territories are all eligible to develop and implement SCHIP programs.

employers. However, meeting the statutory requirements associated with these options has proven challenging, and some question whether their use at such an early point in program implementation would be consistent with the statute's focus on children's insurance coverage. As of April 1, 1999, only Massachusetts and Wisconsin had received approval to use SCHIP funds to cover adults in families with children. Massachusetts' approval relied on an employer buy-in that has additional prerequisites to meet the family coverage cost-effectiveness test. That of Wisconsin relied primarily on a Medicaid section 1115 waiver to cover parents at the regular Medicaid matching rate; for coverage of certain families, Wisconsin will be able to claim an enhanced SCHIP match by using an employer buy-in that meets title XXI's cost-effectiveness test.

- Many states, including the 15 states in our sample, are developing innovative outreach strategies to widely publicize SCHIP and to provide families with applications and program information. In general, outreach strategies have worked to minimize the burden on both the beneficiary and the state by (1) developing new ways for families to submit applications such as by mail, facsimile, or the Internet; (2) increasing the number and operating hours of enrollment sites; and (3) reducing application processing times. While it is too early to judge the success of outreach efforts, some states are reporting that the publicity is attracting not only children eligible for SCHIP but also significant numbers of children who are eligible for Medicaid but not enrolled.
- The states' strategies to avoid crowd-out—the substitution of SCHIP for either private insurance or Medicaid—reflect the lack of consensus among states and researchers regarding the significance of crowd-out and uncertainty about the effectiveness of tools to deter the phenomenon. To prevent SCHIP from substituting for Medicaid, states with a stand-alone component must first screen for Medicaid and enroll any eligible children in that program. In addition, most of these states are facilitating screening by using joint applications, thereby helping to ensure that children are enrolled in the appropriate program. State tools to deter the crowding out of private insurance include instituting waiting periods of 1 to 12 months for children with previous private coverage, requiring families to participate in the cost of coverage by paying premiums and copayments, and studying and attempting to measure the extent of crowd-out.

Background

Medicaid is the starting point for the states' design and implementation of SCHIP. Created in 1965 as title XIX of the Social Security Act, Medicaid provides health coverage for poor Americans, primarily women and children, but also for individuals who are aged, blind, or disabled. In fiscal

year 1998, combined federal and state Medicaid expenditures totaled $177.1 billion. Subject to title XIX requirements as well as HHS guidance and review, each participating state designs and administers its own program by (1) setting certain income and asset eligibility requirements, (2) selecting which optional groups and services to cover, and (3) determining the scope of mandatory and optional services. Financing for Medicaid is provided jointly by states and the federal government under a formula in which poorer states contribute less and wealthier states contribute more to the cost of the program.

Title XXI of the Social Security Act, which established SCHIP, gives the states the choice of operating a children's health insurance program as an extension of Medicaid, as a stand-alone program with more flexible rules that also increase financial control over expenditures, or as a combination of the two.[5] SCHIP makes available annual allocations that range from a low of $3.2 billion to a high of $5 billion (see appendix I, figure I.1). Initially, the states had until October 1998 to select a design approach, draft their SCHIP plans, and obtain HHS approval.[6] With an approved plan, a state could begin to enroll children and draw down its fiscal year 1998 SCHIP allocation, which is based on an estimate of the number of low-income, uninsured children in the state. Allocations are available for a 3-year period, after which any unexpended funds will be redistributed among states that have used their full allocations. SCHIP offers a strong incentive for states to participate by providing an enhanced federal matching rate—for example, the federal government will reimburse at a 65-percent match under SCHIP for a state receiving a 50-percent match under Medicaid. The statute appropriated funding at this enhanced rate for 10 years.

The design approach a state chooses has important programmatic and financial consequences. A SCHIP Medicaid expansion must follow Medicaid rules, including eligibility determination, benefits, and cost sharing. Normally, Medicaid allows no cost sharing for children. A Medicaid expansion also creates an entitlement by requiring the states to continue providing services to eligible children even when their SCHIP allotment is exhausted. At that point, such states will revert to their regular Medicaid match. States choosing to expand Medicaid can take advantage of existing

[5]Unlike a Medicaid expansion, title XXI does not create an entitlement for beneficiaries when a state elects a stand-alone approach. See 42 USCS § 1397(b)(4). In addition, the states have greater control over expenditures under a stand-alone approach since they may set explicit enrollment caps, establish residency requirements, or institute time limits for program participation. See 42 USCS § 1397(1)(A).

[6]In May 1998, the deadline for securing fiscal year 1998 funding was extended to September 1999. Thus, a state that receives approval for its SCHIP program on September 30, 1999, will have until September 30, 2002, to exhaust its fiscal year 1998 allocation.

program administrative staff and procedures. In contrast, a state that chooses a stand-alone approach may introduce limited cost sharing and base its benefit package on one of several benchmarks specified in the statute, such as the Federal Employees Health Benefit Program (FEHBP) or state employee coverage. In addition, a state may limit its own annual contribution, create waiting lists, or stop enrollment once the funds it budgeted for SCHIP are exhausted.

In general, title XXI targets SCHIP funds at uninsured children in families whose income is too high to qualify for Medicaid but is at or below 200 percent of the federal poverty level ($32,900 for a family of four). The law prohibits coverage of children who already have health insurance, even if it is inadequate (for limited benefits such as primary care only) or expensive. Because of the concern that SCHIP not displace existing public or private health insurance, the states must implement strategies to address such crowd-out. Regarding the substitution of SCHIP for Medicaid, the states must establish a system that identifies children who qualify for Medicaid and enrolls them in that program. Since children in higher-income families with access to private employer-sponsored coverage may also be eligible for SCHIP, the states are required to develop a strategy to discourage the displacement of existing private coverage.

Finally, the statute allows the coverage of adults in families with children eligible for SCHIP if a state can show that it is cost effective to do so and demonstrates that such coverage does not crowd out other insurance. The cost-effectiveness test requires the states to demonstrate that covering both adults and children in a family under SCHIP is no more expensive than covering only the children. The states may also elect to cover children whose parents have access to employer-sponsored coverage by subsidizing the family's share of the cost of covering the child—an option referred to as an "employer buy-in." SCHIP, like Medicaid, allows the states to pursue the flexibility offered by section 1115 waivers; using this waiver authority, HCFA can exempt states from many title XIX or title XXI requirements, thus allowing demonstration projects likely to assist in promoting program objectives. Since the early 1990s, 17 states have used section 1115 Medicaid waivers to move their Medicaid programs closer to an employer-based insurance model by implementing managed care for targeted populations, deviating from the Medicaid benefit package, imposing cost sharing on beneficiaries, and covering individuals not traditionally eligible for Medicaid such as low-income single adults.[7]

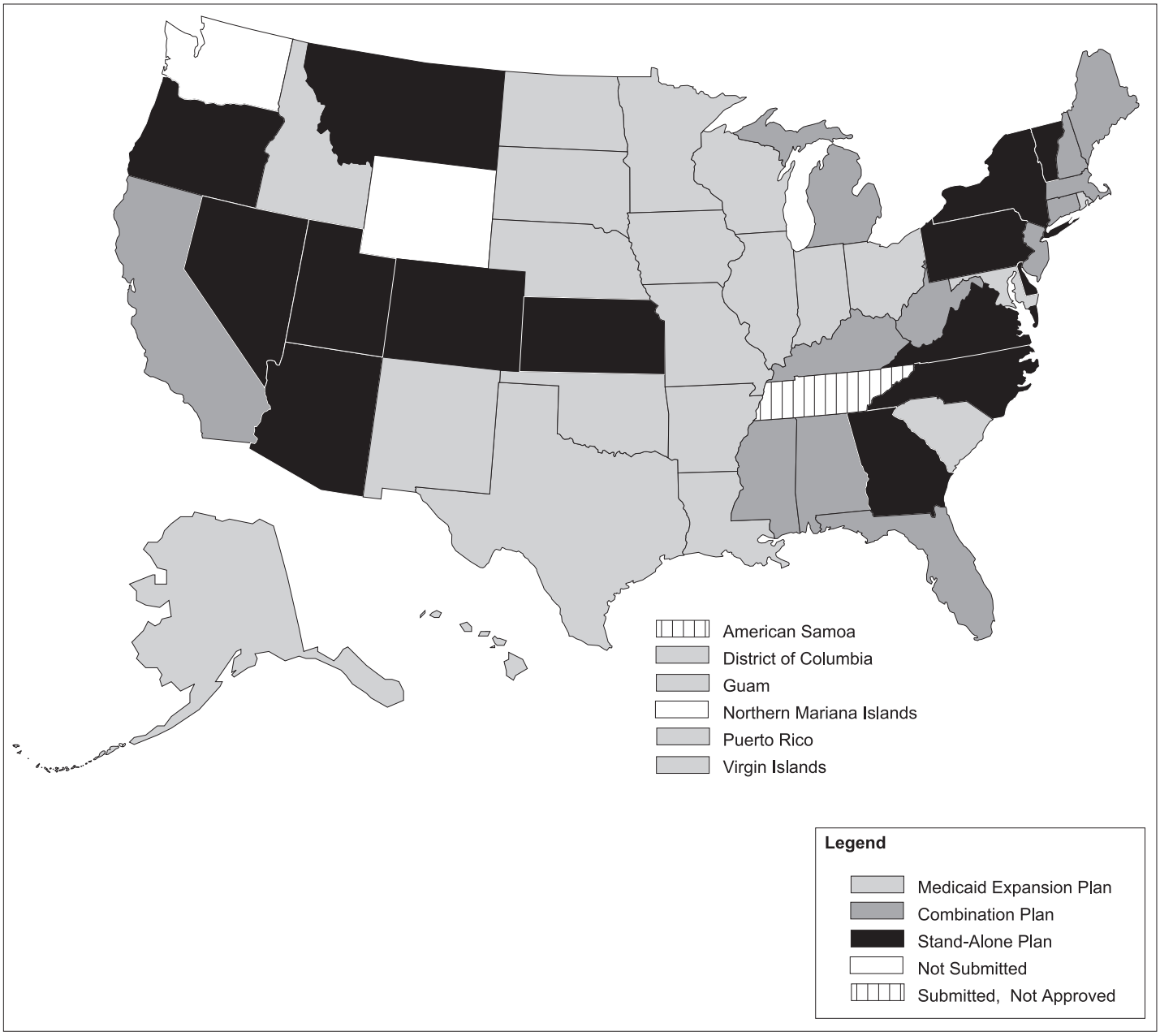
[7]Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs (GAO/HEHS-96-44, Nov. 8, 1995).

The SCHIP Design Phase Is Still Evolving

Initial SCHIP design choices are likely to evolve as the states continue their efforts to incorporate the flexibility offered by the SCHIP statute. Figure 1 shows the status of the 53 SCHIP plans submitted by the states and territories: As of April 1, 1999, 51 had been approved, 2 were under review, and 3 had not yet been submitted.[8] The submissions were almost evenly divided between expansions of state Medicaid programs on the one hand and stand-alone or combination programs on the other. However, this current landscape should not be used to draw conclusions about whether the program will eventually mirror Medicaid or look more like some employer-based coverage. As many as 14 initial Medicaid expansions were simply "placeholder plans" designed to secure access to a state's initial SCHIP allocation, and most of these states plan amendments to expand their initial designs. Two factors have contributed to a longer SCHIP design phase in which many state plans are still incomplete: (1) the short implementation lead times and (2) the challenges of taking advantage of the statute's flexibility to establish a stand-alone program.

[8]HHS was still reviewing the plans of American Samoa and Tennessee; Washington, Wyoming, and the Northern Mariana Islands had not yet submitted proposals.

Figure 1: State SCHIP Design Choices as of April 1, 1999



Source: HCFA.

The statutory time periods associated with SCHIP created design and implementation pressures for both HHS and the states. Less than 2 months separated the enactment of title XXI (August 5, 1997) and the beginning of fiscal year 1998, when the initial $4.3 billion appropriation became available. Moreover, until a May 1998 technical amendment, the states were required to have an approved SCHIP plan before October 1 of that year in order to secure their initial SCHIP allocations.[9] Given the 90-day review period allowed by the statute, the states had only until July 1998 to draft and submit their SCHIP plans to HHS. As a result, the states' focus in the 12 months following the enactment of SCHIP was primarily on understanding the statutory requirements and securing their fiscal year 1998 allocations.

The diversity of approaches makes it difficult to generalize about a state's SCHIP program from the descriptive labels attached—stand-alone, Medicaid expansion, or a combination of the two. A stand-alone program and a Medicaid expansion can be quite similar if the expansion is by a state already operating its Medicaid program under a section 1115 waiver that allows the state to impose cost sharing and to offer a different benefit package. Of the 27 states implementing a SCHIP Medicaid expansion, 8 are doing so in conjunction with a Medicaid section 1115 waiver.[10] Additionally, states such as Nevada and Vermont that elected a stand-alone program are actually offering Medicaid benefits, a feature usually associated with a Medicaid expansion. The number of states with combination programs does not necessarily suggest a commitment to a Medicaid SCHIP approach. The Medicaid expansion portion of a combination program often has a very limited goal in comparison with its stand-alone component. For example, some states have accelerated coverage for children aged 14 to 18 whose families' incomes are up to 100 percent of the poverty level—a group that is already being phased into Medicaid under current federal law.

Finally, even the income eligibility criterion selected by a state does not necessarily indicate the program's scope. A state that extends SCHIP coverage to children in families at income levels approaching 200 percent of the federal poverty level may cover relatively few uninsured children, while a state with an increase in eligibility to 100 percent may have the potential to enroll hundreds of thousands of uninsured children. For example, Vermont's stand-alone program covering from 225 percent to 300 percent of the poverty level is estimated to reach just over 1,000

[9]The amendment gave the states an additional year, until October 1, 1999, to secure their fiscal year 1998 allocations.

[10]Such states must still meet title XXI statutory requirements.

children; in contrast, Texas' more modest expansion of children aged 15 to 18 whose families' incomes range from 17 percent to 100 percent of the poverty level could provide coverage to more than 160,000 children.

The states' initial SCHIP designs grew out of the variety of eligibility levels and benefit choices that previously existed in their Medicaid programs. Reflecting earlier Medicaid expansions, more than half of the states in our sample made children eligible for SCHIP in families with incomes as high as 200 to 300 percent of the poverty level.[11] States with stand-alone components—either separately or in combination with a Medicaid expansion—used their title XXI flexibility to distinguish their programs from Medicaid by introducing benefit packages and cost sharing that more closely resembled employer-sponsored coverage available in the state. In general, the eight states in our sample with SCHIP stand-alone components covered services for five optional benefit categories—prescription drugs, mental health, vision, hearing, and dental. However, with the exception of prescription drugs, most of the eight states placed limits on the duration of treatment allowed or on the amount of services covered. For the majority of children, such benefit limitations are not likely to result in inadequate diagnosis and treatment. Children with special needs, however, may not receive the full range of services that their conditions might warrant. A few states have developed screening mechanisms to identify children with special needs, offering supplemental benefits to ensure that they receive the full range of necessary treatment.

Cost sharing was an important component of the states' stand-alone programs. Most states in our sample used premiums, copayments, or both as a means of incorporating utilization control, invoking personal responsibility, and responding to the potential for crowding out private insurance. In general, most states with a stand-alone approach in our sample imposed cost sharing that was closer to 1 to 2 percent than to the maximum 5 percent of family income allowed under SCHIP. Many of these states told us that they found the administrative burden of monitoring cost sharing out of proportion to the small amounts of cost sharing actually imposed. In particular, ensuring that families did not exceed the statutory 5-percent cap caused considerable concern during the review process as the states attempted to limit the administrative burden—on themselves, beneficiaries, and health plans—imposed by tracking a family's health expenditures. Finally, three states—Florida, New York, and Pennsylvania—had benefit packages from previously state-funded

[11]Poverty levels of 200 percent and 300 percent equate to $32,900 and $49,350, respectively, for a family of four. States' use of income disregards and provisions of title XIX to expand poverty level eligibility criteria are discussed more fully in appendix II.

children's insurance programs "grandfathered" into SCHIP. However, since the statute did not treat cost sharing as part of the benefit package, ultimately all three states altered their cost-sharing practices to comply with the law. For states operating less traditional Medicaid programs under a section 1115 waiver, HCFA has already allowed cost sharing, and thus these states had the option of imposing cost sharing under a Medicaid expansion. However, the levels must be consistent with those set forth in title XXI. Only one state in our sample with a Medicaid section 1115 waiver elected not to impose cost sharing. For additional information on initial state SCHIP design choices, see appendix II.

Family Coverage and Employer Subsidy Options Prove to Be Difficult Issues

A growing number of states are continuing to explore options that address broader goals, are consistent with title XXI, and fully use their available SCHIP funding. In particular, two options permitted by the statute have generated interest among the 15 states in our sample: (1) family coverage that includes the adults in families as well as the children if it proves "cost effective" to do so and addresses crowd-out and (2) an employer buy-in that helps families gain access to insurance available through their job by using SCHIP funds to pay a family's share of the cost of the child. An employer buy-in stretches SCHIP funds because many employers subsidize a large share of the cost of providing coverage to workers. As of April 1, 1999, efforts to apply these options have been largely unsuccessful. Only Massachusetts and, to a lesser degree, Wisconsin have been able to use SCHIP funds to achieve family coverage. Along with other states, Wisconsin primarily achieved family coverage by combining regular Medicaid for adults and SCHIP funds for children.

The cost-effectiveness standard outlined in title XXI has proven challenging to implement, because it specifies that the expense of covering both the adults and children in a family must not exceed the cost of covering only the children. Under these circumstances, cost effectiveness appears possible only when the cost to SCHIP of covering a family is subsidized—either by an employer or through some other means. Massachusetts and Wisconsin received approval of their title XXI family coverage proposals by relying on an employer buy-in—a distinct and challenging SCHIP option. Under an employer buy-in, benefits must be equivalent to one of the SCHIP benchmark packages, cost sharing for the child cannot exceed the statute's limit of 5 percent of family income, and copayments may not be imposed for preventive services. Massachusetts officials believe that HCFA's 1995 approval of a Medicaid section 1115 waiver permitting an employer buy-in for their traditional Medicaid

program greatly facilitated its use as their family coverage cost-effectiveness test.[12] By building upon the employer subsidy inherent in most coverage provided through the workplace, these states minimized the state subsidy of the cost of parental coverage.

For a few states, the goal of covering low-income working families has been facilitated by combining Medicaid and SCHIP funding. For example, Missouri is using SCHIP funds under a Medicaid expansion to cover children and regular Medicaid dollars for their parents. Connecticut is also in the process of developing a family coverage approach. Combining SCHIP and Medicaid funding streams, however, has proven problematic for other states such as Wisconsin and Vermont. Under an earlier proposal, Wisconsin tried to cover parents under regular Medicaid and children under a SCHIP stand-alone program, an effort that afforded parents an entitlement and their children a capped benefit. HCFA would not approve this arrangement because of rules associated with section 1115 waivers relating to budget neutrality and eligibility, so the state switched its program design to a Medicaid expansion similar to that of Missouri. In Vermont, previous expansions for children in its Medicaid program led to difficulties in adding parents to achieve family coverage. The state is now pursuing family coverage options through the use of title XIX funds.

Although title XXI provides the opportunity for section 1115 waivers of title XXI requirements, HCFA will not consider such waivers unless a state's SCHIP program has (1) been operational for at least 1 year and (2) completed an evaluation. HCFA's position reflects its belief that it is reasonable for the states to have experience in operating their new title XXI programs before designing and submitting demonstration proposals. Some states and state advocacy groups would like HCFA to begin allowing the states to tailor their SCHIP programs through the use of section 1115 waivers. Ultimately, the use and approval of section 1115 waivers under SCHIP will require a judgment regarding the consistency between state goals to broaden insurance coverage for families and children and the intent of title XXI. For additional information on state pursuit of the SCHIP family coverage and employer buy-in options, see appendix III.

[12]Massachusetts had the advantage of having spent much of 1994 and 1995 gaining approval for a section 1115 Medicaid waiver that allowed the state to subsidize family coverage provided by an employer. Thus, according to Massachusetts officials, in reviewing the Massachusetts SCHIP plan HCFA was not approving a new concept.

Facilitating Enrollment Is a Key Component of State Outreach Efforts

The states have developed a variety of innovative outreach approaches to overcome enrollment barriers and increase SCHIP participation. The Congress recognized the importance of encouraging outreach activities designed to educate families about the availability of coverage for their children and assist in program enrollment. At the same time, the Congress also placed limits on the amount of federal funding available for administration, including outreach spending, to preserve most of the funds for actual insurance. State outreach efforts encompass marketing approaches that range from sophisticated media campaigns and toll free hotlines to more informal, community-based enrollment efforts. While it is too early to judge the success of outreach efforts, some states are reporting that the publicity is attracting not only children eligible for SCHIP but also far greater numbers of children who were eligible for Medicaid but not enrolled.

The states have a significant opportunity under title XXI to provide health coverage to millions of uninsured children. Nevertheless, state experience with Medicaid demonstrates that eligibility does not necessarily guarantee enrollment. In 1996, about 23 percent, or 3.4 million, of the 15 million children eligible for Medicaid were not participating in the program. Factors that may prevent families from enrolling in Medicaid include (1) confusion over eligibility, especially in the wake of welfare reform; (2) lack of knowledge about the program; (3) complex eligibility rules and burdensome documentation requirements that complicate the enrollment process; (4) a belief that participation in the program is unnecessary when the children are relatively healthy; (5) a perceived stigma from the program's past link with welfare; and (6) language and cultural barriers or concerns about jeopardizing immigration status. Without attention, many of these barriers could also affect SCHIP, undermining the states' ability to find and enroll targeted children.

To receive the enhanced SCHIP federal match, expenditures for outreach, along with administration, other child health assistance, and other health initiatives may be no more than 10 percent of total SCHIP-related expenditures.[13] Tying outreach to program expenditures has been problematic for some states as they develop and implement SCHIP stand-alone plans. Because the 10-percent cap is based on a state's actual expenditures—and not a state's allotment—outreach spending can be completely matched with federal funds only if the state has also claimed a

[13]Other child health assistance includes health care delivered by community health centers.

significant amount of funds for actual service delivery.[14] For example, California believes that the limit is particularly difficult during the start-up phase of its SCHIP stand-alone program when enrollment is low and relatively few services are being provided. California officials believe, however, that the limit based on expenditures is a short-term problem and that the 10-percent limit may be reasonable once its program matures and expenditures increase. In the meantime, the state has established a $21 million outreach budget consisting of Medicaid, SCHIP, and a significant amount of state-only funds. In contrast, states like Massachusetts and New York that "rolled over" enrollment from existing programs already have significant health services expenditures that provide a larger base against which to claim costs associated with outreach efforts. For these states, the link between program expenditures and outreach limits is not a concern. The President's fiscal year 2000 budget includes a provision to establish an additional 3-percent allowance for outreach, which would continue to be tied to expenditures.

The states are making efforts to publicize SCHIP through multimedia campaigns, direct mailings and widespread distribution of applications, community involvement, and corporate participation. Strategies to market SCHIP as a "product" have inspired sophisticated media campaigns in some states. Some states have opted to mail SCHIP information directly, using various methods to identify and target families likely to have eligible children. Blanketing school-aged children and their families with program information through local school districts is another outreach technique that some states are finding particularly effective. Other outreach efforts intended to overcome barriers and minimize the burden on beneficiaries include the simplification of eligibility determination and enrollment procedures. All but one state in our sample are streamlining their eligibility processes to some extent by easing eligibility requirements, providing up to 12 months of continuous eligibility rather than conducting monthly or semi-annual redeterminations, or creating shorter or joint Medicaid and SCHIP application forms. Strategies to simplify enrollment include allowing families to submit applications by mail, telephone, facsimile, or Internet. Other efforts to facilitate enrollment involve increasing the number, location, and operating hours of enrollment sites, reducing application processing time, and implementing other measures such as follow-up systems to ensure that families do not get "lost" in the process. Further efforts are also being made by some states to focus

[14]HCFA officials acknowledged that this places some states in the position of either deferring outreach expenditures or committing a significant amount of state-only dollars during program start-up. HCFA has indicated that it is willing to work with the Congress and states on a legislative proposal to ensure that administrative funds are available "up front" to put stand-alone programs into place.

outreach on the needs of immigrant populations through the use of multilingual application materials and eligibility workers.

Assessing the effect of state outreach efforts and measuring the progress that they make in reducing the number of uninsured children poses challenges. HCFA has worked with the states and other interested groups to develop reporting requirements for key program indicators such as expenditures and enrollment. Despite efforts to standardize the way in which the states collect and report data, comparisons across states will be difficult because of differences in eligibility standards, the definition and categorization of income, and the lack of statistical reliability in estimates of the number of uninsured children, particularly for smaller states. Although states are working hard to get their reporting systems up-and-running, some were unable to meet the first reporting deadline set for January 30, 1999. In addition to year 2000 computer problems, the time that the states committed to program start-up contributed to reporting delays.

In April 1999, HCFA reported estimated SCHIP enrollment of 982,000 children. The data generally reflect enrollment as of December 31, 1998, for 42 states and territories with operational SCHIP programs.[15] For a number of reasons, initial enrollment data must be used cautiously in measuring the states' progress in reducing the number of uninsured children. First, enrollment data may appear to be low because some states had not yet begun enrollment or had only recently begun to enroll children. Second, some states had not yet made their SCHIP designs final and were implementing placeholder plans. Finally, states that had previously funded their own children's health insurance programs had a ready source of program applicants, resulting in significant early SCHIP enrollment. However, this SCHIP enrollment will not decrease the number of uninsured children because previous estimates are likely to have considered these children insured. Overall, efforts to determine the effectiveness of SCHIP in reducing the number of uninsured children are likely to be limited for the early years of the program's operation. For additional information on state outreach initiatives, see appendix IV.

[15]The Virgin Islands had an operational program but did not submit enrollment data. Estimates from Georgia, Kentucky, and North Carolina include enrollment from January and February 1999.

States Use Divergent Approaches to Address Crowd-Out Under SCHIP

In an effort to reduce or control "crowd out"—that is, the substitution of SCHIP for other public or private health insurance—title XXI mandates close coordination among SCHIP, private health insurance, and Medicaid.[16] Estimating the extent and effect of crowd-out under SCHIP is difficult and has led to diverging viewpoints on whether and how the states should develop prevention measures. The states held various views on the importance of crowd-out—differences reflected during the review of SCHIP plans. While some states originally included crowd-out prevention measures in their SCHIP plans, others added measures only after extensive discussion with HHS.

A review of studies examining previous public health insurance expansions found that they focused on populations quite different from those eligible for SCHIP and were conducted while states were not subject to required preventive safeguards. Studies that were national in scope generally found more crowd-out than state-focused studies. Nationally, estimates of new public insurance participants who gave up their private insurance ranged from 15 percent to 17 percent, compared with 5-to-7-percent displacement for state-focused studies. Several study results also indicated that substitution rates were higher for children, and especially women, at higher income levels. Researchers have found that, complicating these estimates, it is difficult to identify how much crowd-out is attributable to a public health insurance expansion and how much is caused by other insurance trends occurring simultaneously. For example, during the period from 1987 to 1996, access to employer-based health coverage for lower income families decreased, as did their ability to pay the cost of premiums.[17]

Not surprisingly, estimates of expected crowd-out under SCHIP also vary. One survey of small, medium, and large businesses that was regionally stratified found that most companies reporting were unlikely to reduce the health coverage offered to employees or dependents as a result of SCHIP.[18] However, other estimates of crowd-out ranged from a low of 22 percent up

[16]If a state could elect to provide services to an individual eligible for Medicaid under SCHIP, it would receive an enhanced federal matching rate. Thus, the federal government would pay more money to cover an individual under SCHIP than under Medicaid. Consequently, title XXI prohibits SCHIP from crowding out Medicaid coverage.

[17]See Ellen O'Brien and Judith Feder, How Well Does the Employment-Based Health Insurance System Work for Low-Income Families? (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, Sept. 1998).

[18]See Harriette B. Fox and Margaret A. McManus, The Potential for Crowd Out Due to CHIP: Results from a Survey of 450 Employers, The Child Health Insurance Project, Fact Sheet 3 (Washington, D.C.: Maternal and Child Health Policy Research Center, Mar. 1998).

to 40-percent displacement. The latter estimate by the Congressional Budget Office (CBO) is a long-term qualitative assessment that assumes an eventual adjustment in labor markets to the availability of federal subsidies. CBO projected that over time low-income workers would receive more compensation in the form of wages and less in the form of health insurance. In fact, CBO analysts suggest that some amount of displacement of private insurance signals a trade-off between the SCHIP goals of stable insurance coverage for children and crowd-out prevention. If children who move in and out of private insurance because of their families' changing jobs and incomes were to qualify for consistent coverage under SCHIP, their previous private insurance is crowded out. However, these children would theoretically have more reliable access to health coverage and a greater likelihood of receiving both preventive and primary health care, leading to improved health status.

The states covering children at higher income levels tended to have more aggressive crowd-out strategies. These strategies included waiting periods without insurance and requiring cost sharing similar to private insurance. The SCHIP plans of 13 of the 15 states in our sample included strategies that were intended, either directly or indirectly, to help prevent crowd-out. The most popular strategy was to impose a waiting period of between 1 and 12 months before allowing children to enroll in SCHIP. Three states with previous health insurance expansions that resisted incorporating prevention measures agreed to study crowd-out and institute waiting periods if they find problems. Some states disagreed with HHS' concern that subsidizing employer-based health insurance has significant potential for crowd-out. Massachusetts, which successfully included subsidies for employer-based insurance in its SCHIP plan, considered the subsidies as incentives for employees to retain coverage but conceded that employers may choose to reduce premium contributions.

To prevent the substitution of SCHIP for Medicaid, HHS' review of state plans led many states to upgrade their Medicaid screening and enrollment strategies and to create closer links between stand-alone programs and Medicaid. Medicaid expansion states are using the same administrative and application systems for both SCHIP and Medicaid. Most states with stand-alone components met the screening and enrollment mandate by determining eligibility first for Medicaid and enrolling applicants in that program if they were eligible. Most are also using a joint application form for both programs. Other Medicaid crowd-out prevention tactics that the states adopted include using a single agency or entity to screen and enroll for both programs, developing a coordination plan if two offices were

involved, or comparing SCHIP participant lists against Medicaid enrollment files to ensure that children were not already covered. As a result of these screens, several states found a significant number of children who were eligible for Medicaid as initial applicants for their SCHIP programs. For example, Massachusetts' SCHIP application process found two children eligible for Medicaid for every successful SCHIP application. Michigan state officials cited an early enrollment rate as high as 10 to 1. Now that the program is more mature, the state is enrolling two children eligible for Medicaid for every SCHIP enrollee. As SCHIP programs evolve, coordination plans may be complicated by periodic reviews of SCHIP eligibility under which the states would be required to shift any children found to be eligible for Medicaid into Medicaid. Some states have tried to address this situation by allowing continuous eligibility for up to 12 months for participants of both Medicaid and SCHIP. Eight of our 15 sample states used 12 months of continuous eligibility for SCHIP, while 3 chose 6 months. For additional information on crowd-out, see appendix V.

Conclusions

In retrospect, it seems clear that the SCHIP implementation schedule was ambitious, particularly for states interested in establishing SCHIP programs that are separate from Medicaid. The approximately 12 months initially authorized to claim the first-year allotment proved to be challenging for many states, given the need (1) to develop a benefit package and administrative structure essential for the operation of a SCHIP stand-alone program and (2) to secure the requisite state legislative approval. In view of the tight time periods, many states opted for placeholder Medicaid expansion plans that secured their initial SCHIP allocations; the large number of states initially choosing Medicaid expansions reflects the complexity of pursuing a stand-alone option. Although nearly all states have received approval for their SCHIP designs, many will need more time to develop a stand-alone component to their initial plans. Since SCHIP is not yet fully operational, any evaluation of its success based on early enrollment data alone is clearly premature.

Moreover, in fleshing out their SCHIP designs, the states are exploring family coverage and employer buy-in options. By including these options in title XXI, the Congress created the possibility that SCHIP could be used to achieve broader state goals. However, it has been difficult for some states to meet the statutory requirements. During the initial plan approval phase, HCFA worked with the states to help them achieve their goals within the limits of the statute. However, title XXI not only gives the states flexibility in designing their SCHIP programs but also grants HCFA considerable

discretion over state plan approval by permitting section 1115 waivers of title XXI provisions. Although HCFA has thus far declined to use this waiver authority, the agency's position was not a problem for most states because their initial focus was on submitting a SCHIP design to secure their first-year allocations. In general, most states were interested in but unprepared to submit plans that encompassed family coverage or an employer subsidy.

As the states continue to develop plans to fully use their SCHIP allocations, the issue of section 1115 waivers is likely to resurface. As a result, HCFA will have to determine the appropriate balance between state flexibility and the fundamental goal of title XXI—to reduce the number of uninsured children across the nation. This situation raises a number of issues:

- To what extent should SCHIP be used as a vehicle to achieve broader health policy goals such as (1) offering seamless coverage to families as a way to reach children, (2) subsidizing employer coverage that varies from generous benefits and minimal cost sharing to its antithesis, and (3) improving the affordability and coverage for low-income families who are underinsured?
- For states that have covered virtually all their uninsured children or that want to provide family coverage as a way to reach children, to what extent should they be allowed to use their SCHIP allocations for these broader coverage goals rather than reallocating funds to states that still have uninsured children?

HCFA's ability to respond to these issues, as well as monitoring the reduction in the number of uninsured through both Medicaid and SCHIP enrollment, will be key to ensuring the successful implementation of title XXI.

Agency and State Comments

We provided HHS and officials from the 15 states in our sample an opportunity to review a draft of this report. HHS and the states generally agreed with our findings and conclusions. HHS also identified several areas where the report could be updated and clarified. As a result, we (1) updated statistics on the number, type, and status of state SCHIP plan submissions and amendments and (2) clarified language to underscore the fact that family coverage and the employer buy-in are separate program options. Both HHS and the states provided other technical suggestions that we incorporated as appropriate. HHS' comments are included as appendix VII.

As agreed to with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. We will then send copies to the Secretary of Health and Human Services, the Administrator of HCFA, appropriate congressional committees, and others upon request.

If you or your staff have any questions, please call me at (202) 512-7118 or Walter Ochinko, Assistant Director of Health Financing and Public Health Issues, at (202) 512-7157. Other major contributors to this report were Carolyn Yocom, Karen Doran, JoAnn Martinez, and Behn Miller.

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Abbreviations

BBA	Balanced Budget Act of 1997
BLS	Bureau of Labor Statistics
CBO	Congressional Budget Office
CPS	Current Population Survey
DSS	Department of Social Services
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FEHBP	Federal Employees Health Benefit Program
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IHS	Indian Health Services
INS	Immigration and Naturalization Service
SCHIP	State Children's Health Insurance Program
WIC	Special Nutritional Program for Women, Infants, and Children

SCHIP Requirements

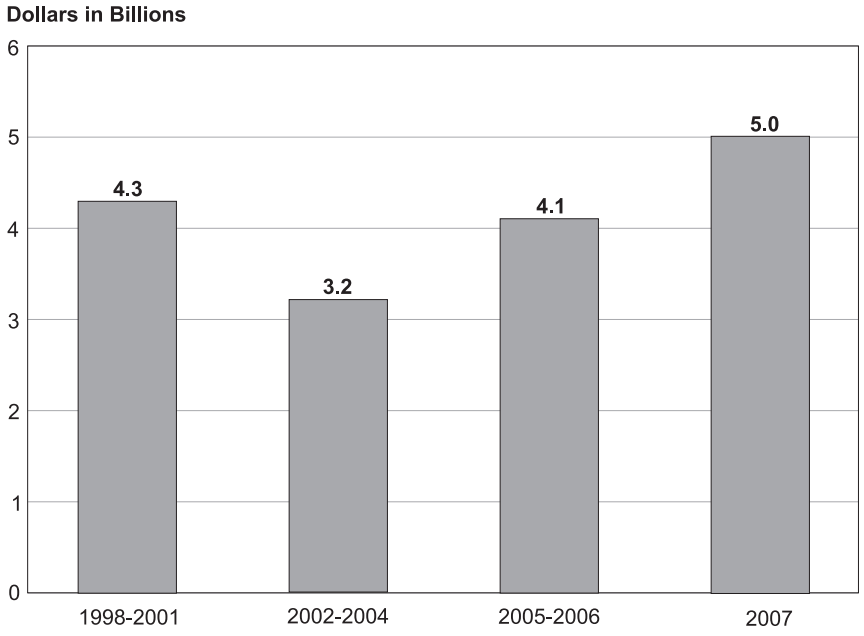
The August 1997 enactment of the State Children's Health Insurance Program (SCHIP) launched a major new initiative that allows the states to implement innovative approaches to providing health insurance to eligible, low-income, uninsured children.[19] In addition to giving states flexibility to design their own programs, SCHIP appropriates $40 billion over 10 years (see figure I.1).[20] Funds became available to the states on October 1, 1997, less than 2 months after the passage of SCHIP. The goal of SCHIP is to significantly reduce the number of uninsured children, an estimated 9 million to 11.6 million of whom lacked health insurance at some time during 1997.[21] Figure I.2 provides a snapshot of the key demographic characteristics of low-income, uninsured families with children, a group less likely to have access to affordable coverage. Children without health insurance are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses.

[19]SCHIP was authorized by the Balanced Budget Act of 1997 (BBA), which amended the Social Security Act, as Public Law 105-33.

[20]In addition to the federal SCHIP appropriation, BBA contained funds for several other provisions that affect children's coverage: (1) presumptive Medicaid eligibility that allows temporary benefits before an official eligibility determination, (2) restoration of Medicaid benefits for children who lost their disability status as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and (3) initiatives to enroll more children eligible for Medicaid. The $3.6 billion in funding for these provisions is often included in budgetary discussions in the $20.3 billion total for the initial 5 years of the SCHIP program (1998-2002).

[21]The estimate of 9 million children was derived from the 1997 National Survey of America's Families, conducted by the Urban Institute, while the 11.6 million total is derived from the Current Population Survey (CPS) by the Congressional Research Service. The Urban Institute suggests that a significant difference between the National Survey and the CPS is that the CPS does not directly ask respondents whether they are uninsured. Instead, the CPS asks respondents whether they or their family members have various types of insurance (such as private insurance, Medicaid, and CHAMPUS). Those who do not respond in the affirmative to any type of insurance coverage are counted as uninsured. The National Survey also asks the questions regarding type of insurance, but it goes on to ask directly whether respondents (or their children) are uninsured. The Urban Institute found that a significant number of respondents do report that they have insurance when they have been asked directly if they are uninsured.

Figure I.1: Annual SCHIP Appropriations, Fiscal Years 1998-2007



Source: 42 USCS § 1397aa et seq. (1998).

Figure I.2: Key Characteristics of Low-Income Families With Uninsured Children

- Most uninsured children live in families with at least one employed adult.
- There is a strong correlation between income and the likelihood that a family has access to and actually participates in employer-sponsored health insurance, the major alternative to public programs such as Medicaid. Lower-income jobs offer less access to health insurance, and their workers have more difficulty affording coverage.
- Children without health insurance tend to be from families where at least one adult is employed but one or both parents are self-employed, are part-time employees, or work for firms that either do not provide dependent coverage or offer this coverage at a price the parents consider unaffordable. Examples of employment that are less likely to offer health insurance include nonunion skilled labor, construction, agriculture, child care, and food service.
- Employment volatility places low-income individuals at greater risk of losing employer-sponsored coverage. Compared with higher-income workers, those in low-wage jobs change jobs more frequently or more often find that their jobs have been converted to less than full-time employment.
- Compared with all other age groups, 12-to-17-year-olds are the least likely to have health care coverage. Additionally, in 1996, 28.9 percent of Hispanic children had no health insurance, while 18.8 percent of African American children were without coverage. Among white children, 13.9 percent had no health insurance.
- The incidence of uninsurance is higher for families living in the southwestern and south central United States and lower for those in the midwestern and northeastern United States. States with low rates of private health insurance coverage also tend to have more uninsured residents.

States Have Flexibility in How to Expand Children's Health Insurance Coverage

SCHIP is an overlay on the already complex federal-state Medicaid program. In the effort to provide health insurance coverage to children, SCHIP attempts to balance state flexibility against minimum federal protections for low-income children. Recognizing these conflicting goals, SCHIP provides the states with the choice of establishing a new program distinct from Medicaid, expanding Medicaid, or combining these two approaches. Offering three general approaches affords the states the opportunity to focus on their specific priorities. For example, expansions of Medicaid offer title XIX's comprehensive benefits and administrative structures—but the entitlement status of Medicaid increases the financial uncertainty for states. In contrast, a SCHIP stand-alone component offers a "block grant" approach to covering children; as long as the states meet title XXI requirements, they have greater flexibility to structure coverage on an employer-based model and can better control their program costs.

Each state's SCHIP plan must operate within the parameters of title XXI, the new section of the Social Security Act that authorizes the program and spells out the rules for receiving federal matching funds. The following description of title XXI requirements focuses on features of the program

that are independent of the design approach selected by a state. A subsequent section then highlights the financial and programmatic consequences that flow from a state's decision to pursue either a Medicaid expansion or a stand-alone program.

Some SCHIP Requirements Apply to All State Programs

In general, SCHIP offers a strong inducement for states to participate by increasing the federal financial contribution beyond that available for Medicaid. At the same time, the publicity associated with SCHIP could increase states' Medicaid expenditures by attracting low-income families who were not aware that their children are eligible for Medicaid. SCHIP seeks to avoid undermining the employer-based system through which most Americans receive their health insurance by focusing on low-income, uninsured children—those who are the least likely to have access to coverage through a family member's job.

State Allotments

Total federal payments to the states for SCHIP are specified by statute and are allocated to them according to a statutory formula. Initially, the SCHIP allocation formula is based on (1) an estimate of the number of low-income, uninsured children in each state and (2) a factor representing state variation in health care costs.[22] Beginning in fiscal year 2001, the formula will change, gradually shifting funds from states with large numbers of uninsured low-income children toward states with high numbers of low-income children regardless of insurance status. The states have 3 years to use each year's allocation, after which any remaining funds will be redistributed among the states that have used all of that year's allocation, based on a procedure to be developed by HCFA. Table I.1 summarizes fiscal year 1998-99 SCHIP allocations for our 15-state sample.

[22]Estimates of the number of low-income uninsured children are derived from the annual health insurance supplement to CPS, the only nationwide source of information on uninsured children by state. The CPS data have a number of well-recognized shortcomings. The Congressional Budget Office (CBO) notes that state-level estimates are generally unreliable and exhibit volatility from year to year because of an inadequate sample size, particularly in small states. For example, given 1994-96 data, the number of uninsured children in Delaware ranges from 12,000 up to 32,000. The CPS also tends to overestimate the number of those lacking insurance because it underreports the number of people covered by Medicaid. To address the yearly volatility in CPS estimates, state allocations are based on a 3-year average; however, continued concern led the Congress to mandate essentially the same allotments (less additional funds for diabetes) for both fiscal year 1998 and fiscal year 1999.

Table I.1: State SCHIP Allocations and Federal Matching Rates for 15 States, Fiscal Years 1998-99

State	CPS estimate of low-income uninsured children (thousands)	Allocation ($ millions)[a]		Matching rate (percent)	
		1988	1999	1999 enhanced	1999 Medicaid
Medicaid expansions					
Missouri	97	$51.7	$51.4	72.17%	60.24%
Rhode Island	19	10.7	10.6	67.83	54.05
South Carolina	110	63.6	63.3	78.89	69.85
Texas	1,031	561.3	558.7	73.72	62.45
Wisconsin	75	40.6	40.4	71.20	58.85
Stand-alone programs					
Colorado	72	41.8	41.6	65.42	50.59
New York	399	255.6	254.4	65.00	50.00
Oregon	67	39.1	38.9	72.38	60.55
Pennsylvania	200	117.5	116.9	67.64	53.77
Vermont [b]	7	3.5	3.5	73.38	61.97
Combination programs					
California	1,281	854.6	850.6	66.9	51.55
Connecticut	53	34.9	34.8	65.00	50.00
Florida	444	270.2	268.9	69.07	55.82
Massachusetts	69	42.8	42.6	65.00	50.00
Michigan	156	91.6	91.2	66.91	52.72

[a]State fiscal year 1998 SCHIP allotments were initially published by the Health Care Financing Administration (HCFA) in the Federal Register on September 12, 1997. These original allotments did not include an additional $20 million appropriation available nationally for fiscal year 1998. In allocation calculations, as published in the September 12, 1997, Federal Register, Native American children with access to Indian Health Services (IHS) programs were counted as insured. As a result of a change in how the insured status of children with access to IHS programs is treated under the CPS, such children are now considered uninsured, and the allocations were recalculated. As a result, states with Native American populations saw an increase in their SCHIP allocations. The revised state reserved allotments for fiscal years 1998 and 1999 that HCFA published in the Federal Register on February 8, 1999, reflect this recalculation. In addition, state SCHIP allocations were originally to be recalculated annually using an average of CPS and Bureau of Labor Statistics (BLS) data from the past 3 years. The Omnibus Appropriation Bill of 1998 required that HCFA use the 1998 allocation data for 1999 to avoid further volatility. Although the allocation formula is the same for both 1998 and 1999, it is applied against a smaller total appropriation in 1999 ($4.295 billion for 1998 and $4.275 billion for 1999). Without further legislation, the CPS and BLS data averaged over the most recent 3 years will be used to calculate the state allotments for fiscal year 2000 and beyond.

[b]Vermont originally submitted a Medicaid expansion plan, which it withdrew in August 1998. A new, stand-alone state plan was approved in December 1998.

Source: HCFA.

Enhanced Federal Match

State SCHIP expenditures draw down federal funds against a state's allotment at a rate that exceeds its current Medicaid matching rate. This enhanced rate results in a national average federal match of 70.22 percent compared with about 57 percent under Medicaid.[23] Thus, a state with the minimum 50-percent Medicaid match receives a 65-percent SCHIP match. Similarly, a state with a 70-percent Medicaid match receives a 79-percent SCHIP match. Assuming that the states match and draw down all available funds, total federal and state SCHIP expenditures would total about $56 billion.

Eligibility Income Limit

In general, title XXI targets children in families with incomes at or below 200 percent of the poverty level—$32,900 for a family of four in 1998.[24] Recognizing the variability in state Medicaid programs, the statute allows a state to expand eligibility up to 50 percentage points above its existing Medicaid eligibility standard.[25] However, Medicaid also allows states to establish their own criteria for measuring income for purposes of determining eligibility, making the $32,900 limit subject to variation, depending upon state determinations.

Uninsured Children's Eligibility

To be enrolled in SCHIP, a child must be uninsured. One exception is for children who were covered by a state program that did not receive a federal financial contribution. Underinsured children with poor benefits or expensive health insurance are not eligible for SCHIP. However, a child with only vision or dental coverage is considered to be uninsured. Children eligible for Medicaid are ineligible for SCHIP.

SCHIP Coordination With Medicaid and Other Private Insurance

Title XXI requirements for coordination with Medicaid and private insurance reflect a twofold concern that (1) children be appropriately enrolled in Medicaid if they are eligible and (2) any coverage provided under SCHIP not displace or crowd out other existing health insurance. To ensure coordination with Medicaid, the states must have a process to ensure that children identified as eligible for Medicaid will be referred to and enrolled in that program. The states must also submit to HHS their

[23]Each state's SCHIP enhanced match is equal to 70 percent of its Medicaid matching rate plus 30 percentage points. However, the enhanced match may not exceed 85 percent. All states receive a minimum allocation of $2 million.

[24]"Poverty level" refers to the federal poverty guidelines, which are used to establish eligibility for certain federal assistance programs. The guidelines are updated annually to reflect changes in the cost of living and vary according to family size. Guidelines are uniform across the continental United States and slightly higher for Alaska and Hawaii.

[25]For example, Alabama covered children aged 15 to 18 up to 15 percent of the poverty level while Washington covered this same group up to 200 percent of the poverty level.

strategy for preventing SCHIP from becoming a substitute for either employer-sponsored coverage or individually purchased insurance.

Family Coverage and Employer Subsidy Options

Title XXI gives the states the option of covering adults in families with children eligible for SCHIP if they can show that it is cost effective to do so and demonstrate that such coverage does not crowd out other insurance. The cost-effectiveness test spelled out in the statute requires a state to demonstrate that covering both the adults and children in a family under SCHIP is no more expensive than covering only the children. A separate option allows a state to cover children whose parents have access to employer-sponsored coverage by paying the parents' share of the cost of covering the children.

Maintenance-of-Effort Requirements

Title XXI specifies two maintenance-of-effort requirements—one for eligibility and another for financing. To ensure that SCHIP funds are used only to provide coverage to children who were not previously eligible for Medicaid, title XXI specifies that state eligibility requirements in effect on March 31, 1997, for Medicaid expansions and June 1, 1997, for stand-alone plans may not be reduced in order to qualify children for the enhanced federal matching rate. Moreover, the states are not eligible for the enhanced matching rate if they reduce their Medicaid financial standards and methodologies below those in effect on June 1, 1997. In addition, Florida, New York, and Pennsylvania were allowed to claim the enhanced federal match for children insured under state-funded programs that formerly received no federal funds; however, they must continue to provide state funds at least equal to their expenditures in 1996.

Waivers and Variances

The statute allows the states to request an exception to title XXI provisions under waiver authority provided to the Secretary of the Department of Health and Human Services (HHS) by section 1115 of the Social Security Act. Section 1115 allows the Secretary to waive certain Medicaid—and now SCHIP—eligibility and funding requirements for demonstrations likely to assist in promoting program objectives.[26] In addition to this general waiver authority, title XXI permits the states to apply for "variances" from two statutory provisions: (1) cost-effective

[26]Past section 1115 demonstrations have made significant contributions to the development of Medicaid policy, such as school-based services for young children. In 1982, Arizona initiated a Medicaid program under a section 1115 waiver that allowed the first statewide Medicaid managed care program. About 17 states now operate some portion of their Medicaid programs under a section 1115 waiver.

family coverage and (2) the inclusion of community-based delivery systems by lifting the 10-percent cap on certain program expenditures.[27]

Reporting Requirements

Title XXI requires various assessments from states that participate in SCHIP. First, each state must report on the operation of its SCHIP program in January of each year for the preceding federal fiscal year, including progress made in reducing the number of uncovered low-income children. By March 31, 2000, the states must submit an assessment of the effectiveness of their SCHIP programs in increasing the number of children with coverage. In addition, by December 31, 2001, HHS must submit to the Congress a report based on evaluations submitted by the states, including any conclusions and recommendations that the Secretary of HHS considers appropriate.

SCHIP Design Choice Has Financial and Programmatic Implications

Important consequences, both financial and programmatic, flow from a state's design choice. In general, a state implementing a stand-alone program has more control over expenditures, enrollment, benefits, and beneficiary cost sharing while Medicaid rules apply to a Medicaid expansion. States expanding Medicaid, however, also gain flexibility under SCHIP. First, they may continue to claim federal contributions at regular federal matching rates for administrative or outreach costs after reaching the statutory cap on such expenditures at the enhanced match. Second, they may be reimbursed for service expenditures at their regular matching rate if they exhaust their allotment. The key features of Medicaid expansions and stand-alone SCHIP programs that flow from title XXI requirements as interpreted by HHS are summarized in table I.2.

[27]HHS uses the term "variances" to distinguish them from exceptions sought under the Secretary's authority to waive title XXI provisions using section 1115.

Table I.2: Key Features of Medicaid Expansions and Stand-Alone SCHIP Programs That Flow From Title XXI Requirements

Feature	Medicaid expansion	Stand-alone
Financial		
Entitlement	Entitlement—federal funds continue at the regular Medicaid matching rate after states exceed their allotment	No entitlement—federal matching funds cease after a state spends its allotment
Nonbenefit-related expenses	When a state reaches the 10-percent expenditure cap on administration, direct services, and enrollment activities, the state's costs can be matched at its lower Medicaid rate	Expenditures on administration, direct services, and outreach are limited to 10 percent of claims for services delivered to beneficiaries
Programmatic		
Benefits	A Medicaid benefits package, including EPSDT, is designed to ensure that children receive all medically necessary services[a]	Benchmark benefits packages use specified private insurance plans as models[b] that may have a different standard of coverage more limited than the EPSDT concept
Cost sharing	Generally, no cost sharing is allowed for children	Cost sharing is permitted for children in families about 150 percent of the poverty level, up to 5 percent of family income. Similar to Medicaid for those below 150 percent
Eligibility rules	Medicaid eligibility rules apply (i.e., income, residency, and disability status)	A state is free to establish its own eligibility rules, taking into account age, geography, residency, disability status, and access to other coverage
Eligibility determination	State agency must determine eligibility	Eligibility determination and other administrative functions can be privatized
Eligibility for children of state employees[c]	Children of low-income state employees are eligible	Children of low-income state employees are eligible only if a state makes no contribution to the cost of employee dependent coverage
Delivery systems	Uses existing Medicaid delivery systems, health plans, and providers	Allows states to develop new contracts with plans and provider networks that may not have previously served Medicaid beneficiaries
Other standards	Medicaid consumer protection and health plan enrollment standards apply	Allows states to establish separate consumer protection and health plan enrollment standards

(Table notes on next page)

[a]Early Periodic Screening, Diagnosis, and Treatment (EPSDT), a required component of the Medicaid benefits package, requires the states to cover treatment for all medically necessary services diagnosed during routine screening. See figure II.1 for a more detailed description of Medicaid EPSDT requirements.

[b]In addition, the packages of state-funded children's health programs in Florida, New York, and Pennsylvania were grandfathered.

[c]Title XXI prohibits the coverage of children "eligible for state employee health benefit plans." This table reflects HCFA's interpretation of SCHIP as it applies to Medicaid expansions and stand-alone programs.

Overview of the SCHIP Review and Approval Process

To qualify for title XXI funds, a state must develop and seek approval for its SCHIP plans from HHS. Subsequent amendments to SCHIP plans also require HHS approval. SCHIP plans must detail how the state intends to use the funds, addressing eligibility, cost-sharing requirements, health benefits, coordination with Medicaid and private insurance, outreach, and other factors. States electing to expand Medicaid were not required to elaborate on program characteristics that were addressed in their existing Medicaid state plans already on file with HHS. In contrast, the development of a state plan for a stand-alone approach understandably requires more documentation. In September 1997, HHS devised a SCHIP template that identified the key information required to review a state plan. As HCFA gained experience with the SCHIP statute, it provided frequent guidance to the states in the form of letters to state Medicaid directors and, on an ongoing basis, shared answers to questions (Q&As) frequently raised by the states. Letters, guidance, and the Q&As were all posted on the Internet.[28] HCFA plans to issue a proposed regulation on the SCHIP statute in 1999.

The statute calls for a prompt federal review of a state's SCHIP plan submission to "determine if the plan substantially complies with the requirements of Title XXI." A plan is approved after 90 days unless HHS specifically disapproves it. However, if additional information is required to complete its review, HHS can stop the clock until a state response is received. The goal of approving SCHIP plans within 90 days differs from the lack of similar statutory standards with respect to section 1115 waivers. Furthermore, HCFA officials told us that title XXI does not allow it to place any conditions on the approval of SCHIP plans—another difference from the broader discretion given to the agency in considering section 1115 waivers. Rather, HHS must either approve or disapprove a state SCHIP plan in total.

[28]These documents are available on the HCFA Web site at www.hcfa.gov.

To expedite the resolution of any policy issues raised during the review process, a steering committee jointly chaired by HCFA and the Health Resources and Services Administration (HRSA) was established within HHS. HCFA is the agency within HHS responsible for managing and monitoring Medicaid as well as the new SCHIP program. Each state is assigned a HCFA project officer who serves as a key focal point during the SCHIP review process.[29] HRSA brings expertise on provider access issues and on outreach. The Office of Management and Budget, the Treasury Department, and the White House have also been involved in developing policy or reviewing SCHIP plans.

[29]The review team within HHS is diverse and includes the Assistant Secretary for Legislation, the Assistant Secretary for Management and Budgeting, the Assistant Secretary for Planning and Evaluation, Intergovernmental Affairs, the Office of Public Health and Science, and the Administration for Children Youth and Families, Agency for Health Care Policy and Research, Centers for Disease Control and Prevention, Indian Health Service, and Substance Abuse and Mental Health Services Administration.

Initial SCHIP Designs Are Evolving as the States Seek to Use Statutory Flexibility

SCHIP design is far from complete. By the end of the first year, nearly all states had submitted SCHIP plans and most had received approval for a Medicaid expansion, a stand-alone program, or a combination of both approaches. For some states, title XXI came at an opportune time—they either had a children's health program in place or had plans under way. For these states, their initial design choices were likely to be either a stand-alone or a combination program. Other states used Medicaid expansions as "placeholders"—minimal expansions of Medicaid to guarantee access to their first year's SCHIP allocation. Placeholder states generally plan additional SCHIP amendments, and HCFA believes that most are likely to incorporate a stand-alone component. A state's design choice had a significant effect on its benefit package and its ability to introduce cost sharing into SCHIP. For Medicaid expansion states, benefits and cost sharing were consistent with those outlined in their state Medicaid plans. States with stand-alone components told us that they were primarily interested in imitating private-sector insurance practices. In general, the benefit packages of such states in our sample will prove adequate for the majority of children but may not address the conditions of those with special needs. States in our sample with a stand-alone component used cost sharing with the goal of achieving utilization control, invoking "personal responsibility," and helping to avoid the displacement of private insurance. Review and approval of cost sharing was particularly complex as states and HCFA attempted to ensure that the appropriate statutory provisions of either Medicaid or SCHIP were properly applied.

SCHIP Design Choices: Snapshot of an Evolving Program

As of April 1, 1999, only 2 states and 1 territory had not yet submitted SCHIP plans to HCFA, and all but 2 of the 53 plans submitted had been approved.[30] HCFA expects that all states will eventually submit a SCHIP plan. The initial design process for the states was driven by the statutorily defined deadline for accessing federal funds and by the more complicated task of developing a stand-alone program. As a result, the initial large number of SCHIP Medicaid expansions does not reflect the ultimate shape of the overall program, and HCFA estimates that a number of states submitted placeholder Medicaid expansions to secure their initial year allotments. The SCHIP programs approved to date reflect the diversity of state approaches and to some extent defy categorization. Thus, some stand-alone programs use Medicaid benefits while most combination programs are largely defined by their stand-alone component rather than their minimal Medicaid expansions. The majority of states in our sample are exploring or have already submitted a plan amendment.

[30]Washington, Wyoming, and the Northern Mariana Islands have not yet submitted plans.

Medicaid Expansions Appear to Dominate Initial SCHIP Plans

Of the 53 SCHIP plans submitted, 27 were expansions of state Medicaid programs, 14 were stand-alone programs separate from Medicaid, and 12 combined a Medicaid expansion with a stand-alone component. SCHIP design choices are outlined in table II.1. As of April 1, 1999, 51 of these plans were approved; American Samoa and Tennessee were still under review.

Table II.1: The States' Approved and Pending SCHIP Design Choices as of April 1, 1999

Design choice	States and territories	Total
Medicaid expansion	Alaska, Ark., D.C., Guam, Hawaii, Idaho, Ill., Ind., Iowa, La., Md., Minn., Mo., Nebr., N.Mex., N.Dak., Ohio, Okla., P.R., R.I., Samoa, S.C., S.Dak., Tenn., Tex., V.I., Wisc.	27
Stand-alone program	Ariz., Colo., Del., Ga., Kans., Mont., Nev., N.Y.,[a] N.C., Oreg., Pa., Utah, Va., Vt.	14
Combination program	Ala., Calif., Conn., Fla., Ky., Mass., Mich., Maine, Miss., N.H., N.J., W.Va.	12

[a]On March 26, 1999, New York submitted a SCHIP plan amendment that includes a Medicaid expansion component. When approved, the state's design will be considered a combination program.

While there currently appears to be a majority of Medicaid expansions, the number of combination programs that have a stand-alone component is expected to increase as state program designs continue to evolve. Thus, as many as 14 SCHIP Medicaid expansions are "placeholders"—that is, minimal expansions in Medicaid eligibility, as small as a 5-percent increase in the income standard—used to guarantee the first year's allocation while allowing time to plan for a stand-alone component. For example, Wisconsin submitted a minimal placeholder Medicaid expansion after prolonged negotiations with HCFA over a more complex and extensive combination program.

Moreover, the number of combination programs with both a Medicaid and stand-alone component should not necessarily be viewed as evidence that the states are embracing a Medicaid approach to SCHIP. Similar to a placeholder plan, the Medicaid component of a combination program often serves a very limited population. For example, Michigan used a Medicaid expansion to standardize its Medicaid income criterion for children of all ages. This allowed the state to establish clear lines of eligibility between its Medicaid and SCHIP stand-alone program; moreover, it serves to reduce confusion over program eligibility for families with more than one child. Indeed, some Medicaid expansions—whether placeholders or part of a combination program—accelerated the

expansion of coverage for children aged 14 to 18 up to 100 percent of the poverty level, an action that federal law already required states to phase in by 2002. For states that used SCHIP to expand Medicaid eligibility in this manner, the combination portion of their SCHIP program disappears in 2002.[31]

In contrast to states that implemented minimal or placeholder plans, a few states—such as Florida, Massachusetts, New York, and Pennsylvania—were well positioned to implement a more robust SCHIP plan in a relatively short period of time. Massachusetts had just received approval for a Medicaid section 1115 waiver program that allowed it to subsidize employer-sponsored insurance. From the state's perspective, title XXI was an opportunity to build on this approach by incorporating an additional funding stream and expanding eligibility even further. Similarly, Florida, New York, and Pennsylvania already had state-funded child health programs—and the Congress recognized their efforts by grandfathering their benefit packages in title XXI. These states were able to establish their SCHIP programs relatively quickly, by basing eligibility on their existing state-funded program enrollment.

SCHIP Basic Design Choices Mask Diverse Approaches

The three basic designs permitted by title XXI—Medicaid expansion, stand-alone, or a combination of both—mask a diversity of approaches. As a result, drawing any conclusion about a state's SCHIP program from these descriptive labels, as summarized in table II.1, can be misleading. Thus, a stand-alone program and a Medicaid expansion can be quite similar if the latter approach is selected by a state already operating its Medicaid program under a section 1115 waiver; such a waiver allows a state to depart from many Medicaid requirements. One state in our sample that elected a stand-alone approach even offers Medicaid benefits, a feature usually associated with Medicaid expansions. Even a comparison of eligibility levels across states can be misleading. Thus, a state that extends coverage to children in families at higher income levels may cover relatively few uninsured children compared with a more modest level of eligibility that may have the potential to enroll hundreds of thousands of uninsured children. In short, the diversity of state Medicaid programs and SCHIP approaches the states have taken make it difficult to generalize across the three designs permitted by title XXI. For example:

[31]Under the Omnibus Budget Reconciliation Act of 1990, the Congress mandated that all children born after September 30, 1983, in families up to 100 percent of the poverty level are eligible for Medicaid. Some states hastened this eligibility by covering children aged 14 to 18 under SCHIP born before this date. By September 2002, these children will age into adulthood and the SCHIP Medicaid expansion component will no longer exist.

- Medicaid expansions encompass very different approaches and levels of eligibility. For example, Rhode Island's Medicaid expansion is based on its existing section 1115 waiver demonstration, which before SCHIP covered children up to age 7 at 250 percent of the federal poverty level and those aged 8 to 12 at 100 percent of the federal poverty level in a mandatory Medicaid managed care program. Under its SCHIP expansion, eligible beneficiaries up to age 18 at 300 percent of the poverty level are given a choice between paying premiums or having copayments attached to applicable services.[32] In contrast, Texas, whose legislature was not in session, submitted a placeholder Medicaid expansion that provides insurance to children aged 15 to 18 in families with incomes from 17 to 100 percent of the poverty level. In addition to this modest expansion and evening out of Medicaid eligibility levels for teens, Texas officials are currently working on a stand-alone amendment to their initial SCHIP plan. State officials told us that they expect to submit the amendment to the state legislature for approval in 1999.
- Stand-alone or combination approaches generally provided the states with increased flexibility in designing a SCHIP program. Stand-alone programs are SCHIP designs that, if a state desires, can be completely separate from the eligibility, benefits, and other regulations that apply under Medicaid.[33] For example, Colorado's stand-alone program is based on a state-funded program that originally provided outpatient but not inpatient benefits to children. Under SCHIP, Colorado's program has been expanded to cover children up to age 17 up to 185 percent of the poverty level, with 1 year of continuous eligibility if the family applies before a child's 18th birthday. California's SCHIP combination plan expanded Medicaid for children aged 14 to 19 from 85 to 100 percent of the poverty level and established (1) an insurance purchasing pool for children with family incomes up to 200 percent of the poverty level and (2) coverage for children under 1 year of age up to 250 percent of the poverty level. California's design of its SCHIP component was intentionally different from Medicaid; officials indicated that by providing coverage through a program resembling an employer-based model, they hoped to acquaint individuals with private insurance and avoid any perceived stigma associated with the state's Medicaid program.

[32]Rhode Island had already begun implementing a coverage expansion up to 250 percent of the poverty level after the maintenance-of-effort date in the statute, allowing the children in the expansion group to qualify for SCHIP. On January 5, 1999, HCFA approved an amendment to Rhode Island's SCHIP plan, expanding coverage up to 300 percent of the poverty level. In keeping with title XXI, no copayments for prenatal, well-baby, or preventive services are required.

[33]Generally speaking, Medicaid expansions under SCHIP must conform to title XIX statutory provisions, whereas stand-alone components of SCHIP programs must conform to title XXI provisions.

- For states that had taken advantage of Medicaid section 1115 waivers to introduce flexibility, stand-alone and combination plans served as a means of building on existing programs, expanding eligibility, and preserving budgetary control. For example, Oregon's stand-alone SCHIP plan operates as an extension of the state's section 1115 waiver program for Medicaid, expanding eligibility to 170 percent of the poverty level. Termed a "Medicaid look-alike," Oregon's program uses a single application and eligibility determination process, provider network, and claims payment system for both SCHIP and Medicaid. Both programs provide the same benefits based upon Oregon's prioritized list of health condition and treatments; however, the stand-alone nature of its SCHIP program allows the state to limit spending by the state by stopping enrollment. Massachusetts' combination approach was designed to provide seamless coverage between the state's Medicaid program, which also operates under a section 1115 waiver, and its new SCHIP combination program for eligible families. The coordination of services and funding streams in Massachusetts is summarized in appendix III, figure III.1.

Many States Have Submitted or Are Exploring SCHIP Plan Amendments

SCHIP design choices to date can be considered a snapshot of a rapidly evolving program, for even as states receive approval for plans, some are already designing what might best be characterized as a second phase. Nationwide, 26 plan amendments have been submitted to HCFA, and 15 of these are already approved as of April 1, 1999. Nine of the 15 states in our sample are exploring or have already submitted one or more plan amendments. Examining the potential for family coverage, possibly through employer-sponsored insurance, and developing stand-alone components to SCHIP are key areas of interest for our sample of states.

Variations in SCHIP Income and Categories of Eligibility

Just as Medicaid eligibility is tied to income and population categories (that is, aged, blind, disabled, families with children), title XXI also contains statutory guidelines regarding income and identifies certain categories of children who are ineligible for SCHIP. With regard to income, SCHIP allows the states to cover children up to 200 percent of the poverty level or 50 percentage points above a state's current Medicaid applicable income level; thus, a state's starting point is highly dependent upon the poverty level previously established in its Medicaid program. Similarly, title XXI bars participation in SCHIP if a child (1) resides in or is an inmate of a public institution, (2) is in a family that is eligible for state employee health insurance, or (3) has existing health insurance coverage. Although the requirements appear to be clear and binding in their exclusions, title

XXI gives the states considerable flexibility in setting income eligibility standards—and some latitude in the treatment of categories of eligibility. For example, neither Medicaid nor SCHIP defines how a state counts income; thus, by excluding certain income (referred to as income disregards), state SCHIP plans encompass an eligibility range of 100 to 300 percent of the poverty level.[34] Furthermore, title XXI's exclusions of categories of children do not apply to Medicaid expansions, which must use Medicaid rules and conditions of eligibility. The states' use of Medicaid section 1115 waivers often fashioned an eligibility system that was more expansive than that of traditional Medicaid, permitting these states to extend eligibility to even higher levels under SCHIP. For states in our sample with Medicaid section 1115 waivers, SCHIP plans tended to be extensions of their Medicaid programs, requiring relatively minor adjustments to incorporate SCHIP into current operations.[35]

States Have Flexibility to Set Income and Resource Standards Under SCHIP

By relying on the flexibility under existing statutes, some states have expanded SCHIP eligibility to an effective rate of up to 300 percent of the poverty level. Connecticut officials originally believed that in order to expand SCHIP eligibility above 235 percent of the poverty level (from their Medicaid level of 185 percent), the state would need to apply for a section 1115 waiver. However, discussions with HCFA resulted in a strategy of using title XXI income disregards to effectively raise the state's eligibility level to 300 percent of the poverty level. Similarly, New York used income disregards as a means of increasing the effective income level to 222 percent of the federal poverty level. Table II.2 shows the SCHIP eligibility by federal poverty level for the states in our sample.

[34]Income disregards are also common in the Medicaid program; title XIX also does not dictate how a state defines income for purposes of eligibility determination. Examples of income disregards include a flat percentage of income and income from sources such as child support.

[35]While states with Medicaid section 1115 waivers expanded their Medicaid operations, many did so through a stand-alone or combination program design. For example, Massachusetts, Oregon, and Vermont all have section 1115 waivers under Medicaid but chose stand-alone or combination SCHIP designs.

Table II.2: Changes in Poverty Level From Medicaid to SCHIP in 15 States

Poverty level and income[a]	State	Program	Poverty level by age			
			<1	1-5	6-14	15-18
High (201%-300%), $32,900-$49,350	Connecticut[b]	SCHIP stand-alone	300%	300%	300%	300%
		SCHIP Medicaid expansion	[c]	[c]	[c]	185
		Medicaid	185	185	185	[c]
	Missouri	SCHIP Medicaid expansion	300	300	300	300
		Medicaid	185	133	100	100
	New York[d]	SCHIP stand-alone	222	222	222	222
		Medicaid	185	133	100	61
	Rhode Island[e]	SCHIP Medicaid expansion	[c]	[c]	300	300
		Medicaid	2-0	2-0	100	[f]
	Vermont[g]	SCHIP stand-alone	300	300	300	300
		Medicaid	225	225	225	225
Medium (151%-200%), $24,675-$32,899	California[h]	SCHIP stand-alone	[c]	200	200	200
		SCHIP Medicaid expansion	250	[c]	[c]	100
		Medicaid	200	133	100	82
	Colorado	SCHIP stand-alone	185	185	185	185
		Medicaid	133	133	100	39
	Florida	SCHIP stand-alone	200	200	200	200
		SCHIP Medicaid expansion	[c]	[c]	[c]	100
		Medicaid	185	133	100	28
	Massachusetts[i]	SCHIP stand-alone	[c]	200	200	200
		SCHIP Medicaid expansion	200	150	150	150
		Medicaid	185	133	133	133
	Michigan[j]	SCHIP stand-alone	200	200	200	200
		SCHIP Medicaid expansion	[c]	[c]	[c]	150
		Medicaid	185	150	150	[f]
	Oregon	SCHIP stand-alone	170	170	170	170
		Medicaid	133	133	100	100
	Pennsylvania	SCHIP stand-alone	200	200	200	200
		Medicaid	185	133	100	39
	Wisconsin[k]	SCHIP Medicaid expansion	[c]	[c]	185	185
		Medicaid	185	185	100	62
Low (100%-150%), $16,450-$24,674	South Carolina[l]	SCHIP Medicaid expansion	[c]	150	150	150
		Medicaid	185	133	100	48
	Texas	SCHIP Medicaid expansion	[c]	[c]	[c]	100
		Medicaid	185	133	100	17

(Table notes on next page)

[a]Percentages of federal poverty level for family of four.

[b]Connecticut covers children up to age 16 under Medicaid at 185 percent of the poverty level.

[c]Not affected by SCHIP.

[d]New York has submitted an amendment to increase the maximum poverty level for its stand-alone program to 230 percent and to add a SCHIP Medicaid expansion for 15-to-18-year-olds up to 100 percent of the poverty level.

[e]Under its section 1115 Medicaid waiver, Rhode Island covered children up to age 7 at 250 percent of the poverty level and those aged 8 to 13 up to 100 percent of the poverty level. Effective May 1, 1997, the state expanded coverage to include children aged 8 to 18 up to 250 percent of the poverty level. Because this expansion was implemented after March 15, 1997, it qualifies as an eligible Medicaid expansion under SCHIP.

[f]Not available.

[g]Vermont's Medicaid program covers uninsured children up to 225 percent of the poverty level. The state received approval in November 1998 to cover underinsured children up to 300 percent of the poverty level through its Medicaid section 1115 waiver. Also, the state's eligibility is for children under age 18 (infant to age 17).

[h]California's SCHIP Medicaid expansion covers children aged 14 to 19 up to 100 percent of the poverty level. The state covers infants only from 200 to 250 percent of the poverty level whose mothers are enrolled in the Access for Infants and Mothers program, which serves families who have no maternity insurance, who have insurance with a high maternity-only deductible, and who do not qualify for no-cost Medicaid.

[i]Massachusetts' SCHIP Medicaid expansion includes children aged 18, an age group of children who were previously not covered under Medicaid.

[j]Michigan's SCHIP Medicaid expansion includes children aged 16 to 18 up to 150 percent of the poverty level. Previously, these children were covered at the poverty level effective for those eligible for Medicaid as medically needy (approximately 60 to 70 percent of poverty). Children aged 15 are covered under Medicaid up to 150 percent of the poverty level.

[k]Initial eligibility in Wisconsin is up to 185 percent of the poverty level. Once an individual is enrolled, eligibility is retained until family income reaches 200 percent of the poverty level.

[l]The nominal poverty level for SCHIP eligibility in South Carolina is 150 percent of the poverty level. Depending on family size and composition, the use of income disregards brings the effective poverty level to between 175 and 200 percent.

The difference in earlier poverty levels of eligibility across state Medicaid programs affected the degree to which the states were able to plan and use their SCHIP allotments. For example, Vermont estimated that its Medicaid program had already reached 89 percent of all children with household income less than the proposed 300-percent income level. A SCHIP program aimed solely at the uninsured would cover only 1,000 additional children. As a result, the state proposed a SCHIP plan that also targeted adults and underinsured children with atypical health care needs. Vermont withdrew its initial application, however, when it became clear that HCFA would not approve these components of its plan for SCHIP funds because they did not

meet statutory requirements. In December 1998, HCFA approved a SCHIP stand-alone program to cover Vermont's remaining uninsured children. SCHIP benefits, however, will be the same as those available to the state's Medicaid beneficiaries. Vermont will use Medicaid rather than SCHIP funds to cover underinsured children up to 300 percent of the poverty level and recently received approval to provide coverage to adults with incomes between 150 and 185 percent of the poverty level under its existing Medicaid section 1115 demonstration waiver.

In contrast, Texas' expansion providing coverage to children aged 15 to 18 from 17 to 100 percent of the poverty level appears, on the surface, to be more modest than Vermont's. However, Texas officials estimate that the state's initial placeholder plan could provide coverage to close to 163,000 children, and they hope to enroll 57,000 during fiscal year 1999. Like Texas, South Carolina had a modest Medicaid expansion, increasing eligibility from 100 to 150 percent. The state began enrolling children before the official start date of SCHIP; the state had enrolled 52,000 children as of September 1998.[36] This enrollment constitutes more than half of the estimated number of low-income uninsured children in South Carolina; furthermore, state officials indicated that this figure does not include an extensive backlog of mail-in applications.

Poor Insurance Coverage Poses Concerns for Some States

As the states refine their initial SCHIP designs, concerns about equity have been raised. Of particular concern are low-income individuals who already have insurance of lesser quality or higher cost than that offered by SCHIP and thus are not eligible for coverage under title XXI. State approaches to SCHIP, as well as variability in the quality of insurance coverage, have posed equity concerns, especially regarding children who have inadequate insurance and state employees who may be ineligible for SCHIP.[37] Title XXI expressly prohibits coverage to individuals who are covered under a group health plan or under health insurance coverage as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HCFA officials noted that HIPAA has a very broad definition of insurance coverage, meaning that individuals with minimal insurance coverage are not eligible for SCHIP.

[36]South Carolina began implementing its SCHIP Medicaid expansion before fiscal year 1998, the first year in which SCHIP funds were available. However, because the expansion was approved after the dates cited in title XXI, the program now operates as a SCHIP Medicaid expansion.

[37]The American Public Human Services Association adopted a resolution in December 1998 urging the Congress to amend SCHIP to enable dependents of low-income state employees to participate in the program.

The HIPAA designation of coverage has posed varying levels of concern for the states. Massachusetts officials told us that insurance reform in their state has helped eliminate "bad" policies—that is, those that provide only minimal coverage. However, other states have expressed concern that the statute does not discriminate between good and poor coverage and thus unfairly penalizes a family who purchases an inadequate insurance policy. Some states would deny immediate SCHIP coverage to such a low-income family, while a family at a similar poverty level who did not purchase insurance would qualify for SCHIP without any restrictions or waiting period. A few states have defined access—that is, whether an individual can obtain insurance through an employer—as the point of eligibility for SCHIP. In this case, while there is no disparity of treatment between insured and uninsured individuals, there is also a smaller pool of individuals eligible for SCHIP. Rhode Island employs a hybrid approach that provides eligibility workers with guidelines regarding affordability of coverage—a policy less than $150 per month for a child or $300 for a family. However, eligibility workers can use their own discretion in deciding if the cost of available coverage is prohibitive for a child or family; in these cases, a worker can deem the individual eligible for SCHIP.

Although title XXI appears to expressly prohibit the states from enrolling children of state employees eligible for its health benefits plan, states' SCHIP design choices have led to some exceptions. A state that selects a Medicaid expansion is subject to Medicaid rules of eligibility, while the SCHIP statute governs any stand-alone approach. Under Medicaid, individuals qualifying for participation in certain eligibility groups (that is, children born before October 1, 1983) cannot be excluded on the basis of their insurance status; hence, Medicaid expansions can include uninsured children of state employees. Thus, for the 27 states with Medicaid expansions, there is no prohibition on uninsured children of state employees who meet the state poverty guidelines for title XXI.[38] In the case of stand-alone or combination programs, however, the statutory restrictions are tighter. If a state contributes nothing to the cost of dependent coverage, then state employees can enroll in SCHIP; nationwide, two states, Mississippi and North Carolina, do not contribute to health benefits for their employees' dependents. Thus, SCHIP eligibility for state employees and their dependents has resulted in different outcomes, depending upon each state's design choice under SCHIP and other special circumstances regarding state employee insurance. Some states and state associations have raised concerns about the state employee prohibition in

[38]Wisconsin officials told us that even though Wisconsin's program is a Medicaid expansion, state employees covered by state employee health insurance are excluded.

SCHIP stand-alone components, pointing out the disparity in treatment across the states and the fact that the prohibition does not apply to federal or other government employees.

The Comparability of Medicaid and SCHIP Stand-Alone Benefit Packages Is Difficult to Ascertain

In contrast to SCHIP programs that are modeled after Medicaid, title XXI allows states with stand-alone programs to impose additional conditions and limits on benefits by authorizing a benchmark benefit package that more closely resembles some employer-based coverage for those implementing a stand-alone approach. For the majority of eligible children, such limits and conditions are not likely to interfere with ensuring adequate diagnosis and treatment. Children with special needs, however, may not receive the full range of services that their conditions might warrant. To guard against this possibility, some states have developed screening tools similar to EPSDT as a means of identifying children with special needs and ensuring that they receive the full range of necessary treatment. Other states have not confronted the problem of these children and, like the Medicaid program, have instituted prior authorization requirements or service limits for certain treatments or services. Finally, the states with stand-alone programs or combination programs with a stand-alone program component in our sample generally included benefits similar to Medicaid but did impose differences in the duration of treatment allowed or the number and amount of services covered.

Stand-Alone Programs Reflect the Full Range of Title XXI Options

Table II.3 describes the four benefit package standards available to states implementing a stand-alone SCHIP program or component—benchmark coverage, benchmark-equivalent coverage, existing comprehensive state coverage, and Secretary-approved coverage. As shown by table II.4, the states in our sample with a stand-alone program used the full variety of options offered under SCHIP. Two states used benchmark coverage—one based on its state employee benefits program and one based on the Federal Employees Health Benefit Program (FEHBP) benchmark option. One state adopted a benchmark equivalent, incorporating the basic and additional benefits cited in title XXI. Finally, three states in our sample had benefit packages that were grandfathered into title XXI, and four states received approval by the Secretary for an alternative benefit package.

Table II.3: SCHIP Benefit Package Standards for Stand-Alone Programs

Coverage standard	Description
Benchmark	FEHBP Blue Cross Blue Shield standard option or coverage generally available to state employees or coverage under the state's health maintenance organization with the largest insured commercial non-Medicaid enrollment
Benchmark equivalent	Basic coverage for inpatient and outpatient hospital, physicians' surgical and medical, laboratory and x-ray, and well-baby and well-child care, including age-appropriate immunizations Aggregate actuarial value equivalent to a benchmark package Substantial (75%) actuarial value for optional prescription drugs and mental, vision, and hearing services
Existing comprehensive state (grandfathered)	Coverage equivalent to state-funded child health programs in Florida, New York, or Pennsylvania
Secretary-approved	Coverage appropriate for targeted low-income children

Table II.4: Basis for Required Scope of Health Insurance Coverage for Ten States With Stand-Alone Programs

Basis[a]	State
Benchmark coverage	Mass., Mich.
Benchmark-equivalent coverage	Colo.
Existing comprehensive state coverage	Fla., N.Y., Pa.
Secretary-approved coverage[b]	Calif., Conn., Oreg., Vt.

[a]Excludes the Medicaid expansion portions of combination programs, which by definition offer benefits identical to a state's Medicaid plan.

[b]Although California and Connecticut use their state employee plans as the basis for coverage, HCFA did not consider this benchmark coverage because both states included additional benefits.

Coverage Requirements for SCHIP Stand-Alone Programs Are Based on Private Sector Standards

Benefit comparisons between Medicaid expansions and SCHIP stand-alone programs are complex because of the numerous services involved, the ability of the states to place limits on covered services, and the availability of EPSDT under Medicaid (see figure II.1). Both Medicaid and the benchmark approaches available to states with stand-alone components include (1) mandatory coverage for a series of basic services for children, such as physician visits, inpatient hospitalization, laboratory and x-ray services, and well-baby and well-child care, and (2) optional coverage for prescription drugs and dental, mental health, vision, and other services. In addition, the states may impose conditions and limits on the benefits offered under a Medicaid expansion or a SCHIP stand-alone program. For example, dental benefits might exclude routine preventive care and cover

only any restoration necessary because of an accident. Or inpatient mental health services may be limited to a dollar amount or a number of days of services.

Figure II.1: Medicaid EPSDT Requirements

EPSDT minimum requirements

- Comprehensive physical and mental health developmental history;
- Comprehensive physical exam;
- Appropriate immunizations for a child's age and health history;
- Laboratory tests, including blood lead level assessment appropriate for age and risk factors; and
- Health education.

EPSDT also requires diagnosis and treatment for

- Defective vision, including eyeglasses;
- Relief of dental pain and infections, restoration of teeth, and maintenance of dental health;
- Hearing defects, including hearing aids; and
- Other conditions discovered through screening, regardless of coverage by the state's Medicaid plan.

However, Medicaid—and therefore Medicaid expansions—use a special standard to determine the appropriate level of services available to children that is based upon a broad definition of medical necessity. In general, Medicaid, through its EPSDT component, requires the states to cover any treatment to cure or stabilize a condition diagnosed during routine screening—regardless of whether the benefit is actually covered under the state's Medicaid program and regardless of any limits placed on the benefit. In contrast, not all private insurance defines covered services this broadly. While the implementation of EPSDT is difficult to measure, federal studies have generally found state efforts to be inadequate. Nonetheless, the EPSDT requirement provides an avenue for legal review and appeal to ensure that children receive necessary services and thus, in theory, guarantees a coverage level beyond that of a state's Medicaid benefit package.

Some SCHIP Stand-Alone Programs Include Screening and Diagnostic Procedures Similar to EPSDT

Some SCHIP stand-alone programs included screening and diagnostic procedures similar to EPSDT, in part as a means to identify children with special health care needs. Connecticut's SCHIP plan contains a screening and referral service intended to provide children with special behavioral or medical needs any extra services they might require. Connecticut officials indicated that the state was interested in a SCHIP benefit package that looked like a commercial insurance model with defined limits on services. However, the officials indicated that experience with Medicaid managed care showed that there were problems in applying a commercial model when serving individuals with extreme health needs. As a result, the state devised an enhanced benefit package for children found to have particular physical or behavioral health needs. For example, a child eligible for SCHIP with behavioral health needs that are not covered under its commercial health maintenance organization (HMO) would receive services through a program developed by the Yale Child Study Center, which provides in-home mental health services.

Florida and Massachusetts also employ screening mechanisms to identify children with special needs. Florida recently received approval for a SCHIP plan amendment that provides approximately 300 children with special needs the opportunity to receive Medicaid benefits. These children have chronic or potentially chronic physical or developmental conditions, and a number of them have serious emotional disturbances or substance dependency. Similar to Medicaid enrollees with similar conditions, children eligible for SCHIP will receive covered services through a capitated managed care arrangement that will be administered by title V.[39] In Massachusetts, children with physical, mental, or developmental disabilities are enrolled in Medicaid, regardless of whether they would otherwise qualify for SCHIP. These children participate in the state's section 1115 waiver for persons with disabilities, receiving treatment and services from fee-for-service providers.

Although providing less extensive coverage than EPSDT, some states have employed other screening mechanisms to attempt to ensure that children receive basic services. For example, Michigan officials told us that their SCHIP stand-alone package includes well-child recommendations by the American Academy of Pediatrics. With the exception of cost-sharing provisions, officials noted that there is little difference between the state's

[39]Title V, the Maternal and Child Health Services Block Grant, offers formula grants that require a state match of $3 in funds or resources for every $4 in federal funds received; a minimum of 30 percent of funds must be used to support programs for children with special health needs. Title V also supports activities under Special Projects of Regional and National Significance and Community Integrated Service Systems.

Medicaid and SCHIP benefit packages. However, Michigan did attempt to improve access to services by increasing physician and dental provider payments in its SCHIP stand-alone component in the hopes of enticing additional provider participation. Although the state's Medicaid program covers dental services, the state recognizes that it has a serious problem regarding access to such services. Michigan officials view the SCHIP payment increases as a test to see if access to covered services actually improves.

Most Stand-Alone Programs Cover Optional Benefits but Vary in the Limits They Impose

The states in our sample with a stand-alone component generally offer the same five optional benefits under their SCHIP programs—namely, prescription drugs and mental health, vision, hearing, and dental services. As shown in more detail in table II.5, states with stand-alone benefit packages covered these benefits but usually with certain exclusions or limits on services. SCHIP limitations on benefits for children represent a departure from the Medicaid program, primarily because EPSDT in Medicaid requires that children with medical needs be afforded services. In general, however, most non-Medicaid SCHIP programs include routine services such as physician services, prescription drugs, and laboratory and radiological services without stated limits. Mental health, substance abuse, ancillary therapies, and other specialized services are generally provided on a more limited basis.

Table II.5: Yearly SCHIP Benefits for Stand-Alone Components in Eight States

Optional service	State	Limits on services
Prescription drugs	California	Covered
	Colorado	Covered
	Connecticut	Covered
	Florida[a]	Covered; generics only unless physician specifies
	Massachusetts	Covered
	Michigan	Covered; generics only unless physician specifies
	New York[b]	Covered; generics only if acceptable to health plan
	Pennsylvania[c]	Covered
Mental health	California[d]	Inpatient 30-day limit; outpatient 20 visits
	Colorado[e]	Inpatient 45-day limit; outpatient 20 visits
	Connecticut[f]	Inpatient 60-day limit; outpatient 30 visits
	Florida	Inpatient 15-day limit; outpatient 20 visits
	Massachusetts	Limits based on medical necessity

(continued)

Optional service	State	Limits on services
	Michigan	Inpatient 365-day limit; outpatient covered
	New York	Inpatient 30-day limit; outpatient 60 visits
	Pennsylvania	Inpatient 90-day limit; outpatient no limits
Vision	California	Covered; one set of glasses or contacts per year
	Colorado	$50 annual maximum for glasses
	Connecticut	Covered; one set of glasses every 2 years
	Florida	Covered; one set of glasses every 2 years
	Massachusetts	Covered; one set of glasses or contacts per year
	Michigan	Covered; one set of glasses every 2 years
	New York	Covered
	Pennsylvania	Covered
Hearing	California	Exams and hearing aids
	Colorado	$800 annual maximum; hearing aids
	Connecticut	Exams; hearing aids covered in supplemental program
	Florida	Routine hearing screening and hearing aids
	Massachusetts	Services for speech, hearing, and language disorders; hearing aids
	Michigan	Exams and hearing aids covered every 36 months
	New York	Covered
	Pennsylvania	Exams and hearing aids
Dental	California	Covered
	Colorado	Treatment of injuries only
	Connecticut	Covered
	Florida	Treatment of injuries only
	Massachusetts	Covered
	Michigan	$600 annual limit
	New York	Covered
	Pennsylvania	Covered

(Table notes on next page)

[a]Benefits for Florida's Healthy Kids program are reflected in the table. The state's Medikids program and the Children's Medical Services Network for children with special health care needs use Medicaid benefits.

[b]New York's benefits reflect expanded coverage of dental, vision care, and other services approved by state legislation after its original SCHIP plan was approved. The state has requested an amendment to the SCHIP plan regarding these benefit changes.

[c]Pennsylvania now requires no limits on optional benefits, and the state will consider this change when renegotiating provider contracts.

[d]California offers additional specialized mental health services for seriously emotionally disturbed children.

[e]Colorado's mental health parity law requires unlimited treatment for ten biologically based illnesses.

[f]Connecticut allows some inpatient days to be converted to outpatient days. Also, children with intensive behavioral health needs are referred to a supplemental behavioral health program for additional services.

The Medicaid and SCHIP benefits of New York and Oregon demonstrate the different approaches the states have taken as well as the specific state circumstances that contributed to their benefit decisions.

- The benefit package from New York's existing state-financed program for uninsured children was grandfathered into the SCHIP program and initially contained limits on services and several exclusions that were generally more restrictive than its Medicaid program. State officials noted that the original goal of its state program was to cover as many children as possible within state budgetary limits. New York originally focused on primary and preventive care and provided very limited benefits for mental health, dental, and hearing services. The state recently passed legislation to amend its SCHIP plan to include dental care, eyeglasses and other vision care, speech and hearing, durable medical equipment, and inpatient mental health, alcohol, and substance abuse services beginning on January 1, 1999, thus narrowing the gap between Medicaid and SCHIP benefits.[40]
- Coverage under Oregon's stand-alone program expressly mirrored the benefits offered under its Medicaid section 1115 waiver.[41] State officials determined through public hearings and testimony that citizens considered Oregon's Medicaid benefit package to be richer than any

[40]On March 26, 1999, New York submitted a SCHIP plan to HCFA regarding these benefit changes.

[41]Through the use of a section 1115 waiver, Oregon redefined its Medicaid benefit package, creating a prioritized list of services and conditions that are eligible for Medicaid reimbursement. Oregon's SCHIP stand-alone benefits package uses the same prioritized list of services and conditions as the state's Medicaid program.

possible benchmark plan, in part because it offers full mental health and preventive dental care.[42]

Cost Sharing: Opportunities and Challenges

Traditional Medicaid does not allow cost sharing for services provided to most children. Thus, the incorporation of cost sharing in both stand-alone SCHIP plans and the Medicaid expansions of several states operating their programs under section 1115 waivers represents a departure from the norm. Most states in our sample with a stand-alone component told us that they included cost-sharing provisions as a way to mirror private insurance. These states generally viewed cost sharing as creating a sense of ownership for beneficiaries. In general, the cost sharing imposed by 11 states in our sample appears to be closer to 1 to 2 percent of income for a family of four with two children than to the 5 percent permitted by title XXI.[43] Indeed, about half of these states impose no cost sharing for families at 150 percent of the poverty level ($24,675 for a family of four). The review and approval of cost-sharing provisions was complex, as both states and HCFA struggled with the application of the appropriate statutory provisions of either Medicaid or title XXI. Compliance with title XXI's 5 percent of family income limit was especially troublesome as the states worked to devise ways to limit the administrative burden imposed in tracking a family's health expenditures. Finally, states with grandfathered benefits learned that the statute did not treat cost sharing as part of their benefit package; ultimately, all three states had to alter their cost-sharing practices to reflect title XXI limits.

Cost-Sharing Provisions Differ for Medicaid and SCHIP

With the exception of preventive services, which are exempt from cost sharing under SCHIP, a state's design choice greatly affects the degree to which families can be asked to contribute to the cost of coverage for their children. Generally, a state with a traditional Medicaid program that elects a SCHIP Medicaid expansion is not allowed to impose premiums on most children or any deductibles, copayments, or other similar charges for children. States operating less traditional Medicaid programs under a section 1115 waiver that had already introduced cost sharing have the option of imposing cost sharing under a SCHIP Medicaid expansion if it is

[42]Under Oregon's section 1115 waiver, EPSDT requirements were waived; however, most EPSDT-mandated services are covered under Oregon's Medicaid program.

[43]Texas commented that the jump from no cost sharing below 150 percent of the poverty level to allowing up to 5 percent of income cost sharing between 150 and 200 percent was "too severe" for such a small change in income (50 percentage points) and suggested that more states would have developed graduated cost sharing at higher levels if the income range had been broader. For example, Texas suggested that cost sharing that started at 0.05 or 1 percent for those under 150 percent of the poverty level would have encouraged incremental cost sharing to higher levels.

consistent with title XXI limits. For SCHIP stand-alone programs, cost sharing at or below 150 percent of the poverty level follows Medicaid limits on premiums, while copayments and other cost sharing must be "nominal." Children in families above 150 percent of the poverty level can be charged premiums or other cost sharing of any amount—as long as the total for all children does not exceed 5 percent of aggregate annual family income.

The two major types of cost sharing—premiums and copayments—can have different behavioral effects on participation in a health plan. Generally, premiums are seen as restricting entry into a program, whereas copayments affect the use of services within the program. Studies of Medicaid programs operating under section 1115 waivers and of state-funded health programs demonstrate that premiums can affect the level of program participation. In particular, one study found that when premiums reach 7 percent of a family's income, participation drops to less than 10 percent of eligible families.[44] Copayments are generally seen as a "brake" on the use of services because they reduce the frequency of physician visits. However, significant cost sharing may cause individuals to defer treatment, resulting in more severe conditions and potentially higher expenses.

States Often Implemented Cost Sharing to Mirror Private Sector Insurance Practices

Thirteen of the 15 states in our sample can impose cost-sharing provisions under SCHIP that are different from Medicaid limits, either by virtue of being a stand-alone component or because of a section 1115 Medicaid waiver.[45] Of those 13 states, all but 2 included cost sharing in their SCHIP plans, as shown in table II.6. Oregon, which asks beneficiaries to contribute to the cost of coverage under its section 1115 waiver, chose not to do so under SCHIP. During negotiations with HCFA, Pennsylvania dropped a $5 copayment for prescriptions that had been part of its previous state-funded children's health insurance program. Eight states are charging both copayments and premiums, while three states are requiring only the latter. A majority of these 11 states have opted to charge a per-child premium, but many have imposed a total limit on the amount of

[44]Leighton Ku and Teresa A. Coughlin, The Use of Sliding Scale Premiums in Subsidized Insurance Programs (Washington, D.C.: The Urban Institute, Mar. 1997).

[45]States with Medicaid expansions whose Medicaid programs do not charge premiums or copayments are barred from imposing cost sharing. Hence, South Carolina and Texas cannot charge copayments under SCHIP.

premiums a family has to pay.[46] For example, in New York, per-child premiums for a family at 160 percent of the poverty level or greater with four children would exceed the allowable maximum premium; thus, the family's premium would be equivalent to three children. Generally, the states in our sample had a similar rationale for imposing cost sharing—to emulate employer-based insurance.

Table II.6: Cost Sharing Under SCHIP in 13 States

Cost-sharing effort	State
No cost sharing	Oreg., Pa.
Premiums and copayments	Calif., Colo., Conn., Fla., Mo., R.I.,[a] Vt., Wisc.
Premiums only	Mass.,[b] Mich., N.Y.

[a]Rhode Island allows individuals to choose between paying premiums or paying copayments.

[b]Massachusetts may provide coverage by subsidizing employer-based insurance; in these circumstances, a family may be charged premiums and copayments.

California officials told us that cost sharing was central to its efforts to create a system that parallels private health insurance. California charges different premiums depending on a family's poverty level, and families who prepay their premiums for 3 months get a fourth month free. Copayments are established by the state's insurance board and are set at $5. California officials told us that cost sharing was a magnet to participation in SCHIP, noting that of the individuals applying for SCHIP who were deemed eligible for Medicaid (and therefore ineligible for SCHIP), only 25 percent gave permission for their applications to be sent to Medicaid.

California was unable to obtain approval for varying levels of cost sharing across different plans because these amounts were higher than those permitted under title XXI. The state had proposed establishing a set premium assistance amount based on the insurance plans offering the lowest cost combination of health, dental, and vision plans for a particular geographic area. Eligible individuals could choose a higher-priced plan but only if they were willing to increase their contribution because the state subsidy would remain the same. Officials cited a twofold reason for this approach: (1) there is an amount above which the federal government and the state should not pay to support insurance costs and (2) SCHIP families deserve to have as many health plan choices as possible. State officials indicated that HCFA was very concerned about bias, believing that families

[46]California, Colorado, Connecticut, Massachusetts, New York, and Rhode Island are charging per-child premiums. Florida, Michigan, Missouri, Vermont, and Wisconsin are charging per-family premiums.

might press themselves to pay higher premiums on the assumption that higher cost meant better coverage. HCFA, in contrast, indicated that the issue was simply that the cost sharing for all but one plan was higher than permitted under the statute. Ultimately, California withdrew this element of its cost-sharing proposal, but state officials said that, as a result, some health plans withdrew from SCHIP participation. California officials characterized the loss of this segment of their SCHIP plan as putting a large hole in their efforts to make SCHIP a path to private insurance. Officials believed that allowing beneficiaries more choice of plans—even those that had a higher cost—was an important educational effort that would afford individuals the opportunity to make informed choices once they were purchasing their own insurance.

Michigan ultimately balanced its interest in modeling its program after employer-sponsored insurance with the desire to ensure that eligible families enroll and use SCHIP. State officials indicated that Michigan wanted its SCHIP to (1) appeal to working families by avoiding any perceived welfare stigma, (2) preserve the ability to alter program design to control costs and expenses, and (3) make it easier for people to make a transition to employer-based insurance. Originally, Michigan required premium and copayments for families above 150 percent of the poverty level. Premiums ranged from $8 to $15 per month, depending upon the number of children, and copayments were generally $5. However, the Michigan state legislature decreased the premium to a flat rate of $5 per family per month and eliminated three $5 copayments. Michigan officials stated that the monthly premium is costly to collect, but it is part of the state's belief that the program should operate like private insurance.

While states with traditional Medicaid programs—such as South Carolina and Texas—are generally not permitted to include cost-sharing provisions in their SCHIP Medicaid expansions, most states with Medicaid section 1115 waivers did incorporate cost sharing consistent with title XXI. For example, Rhode Island's Medicaid section 1115 waiver allows individuals to choose between paying premiums or copayments for eligible children. Missouri and Wisconsin were able to use a Medicaid section 1115 waiver as the basis for their SCHIP programs, and both planned to include cost sharing. For Missouri, cost-sharing provisions were a matter of equity, particularly at higher levels of poverty. Thus, the state has copayments with exemptions for preventive care beginning at 185 percent of the poverty level, and premium assistance amounts are based upon what state employees in Missouri pay for their care. Wisconsin planned to charge

premiums beginning at 150 percent of the poverty level that would total approximately 3 to 3.5 percent of a family's income.

Cost Sharing Under SCHIP Appears to Be Minimal in 15 States

None of the 11 states in our sample required cost sharing that is likely to reach the maximum 5 percent of income permitted by title XXI, as shown in table II.7.[47] To determine the amount of SCHIP cost sharing imposed by states, we estimated copayments for a typical healthy family with two children enrolled in SCHIP. For a family at 150 percent of the federal poverty level, total estimated cost sharing ranged from a low of $60 per year in Michigan (0.2 percent of income) to a high of $864 per year in Wisconsin (3.5 percent of income). Five of the 11 states that imposed cost sharing under SCHIP charged families at this income level nothing to enroll their children. In general, copayments account for a small percentage of the total out-of- pocket costs.

[47]Table II.7 provides our estimate of SCHIP copayments for a family of four consisting of two healthy children between the ages of 6 and 14 years old. Many health services have recommended schedules of usage, but most are exempted for cost sharing under SCHIP. We imputed the type and number of visits for eye, hearing, and dental care and derived estimates for outpatient physician visits and prescriptions (except oral contraceptives) from the National Center for Health Statistics National Ambulatory Medical Care Survey.

Table II.7: Estimated Cost Sharing as a Percentage of Family Income in 11 States

	$24,675 annual income (150% of poverty) 5% limit = $1,234		$30,433 annual income (185% of poverty) 5% limit = $1,522		$41,125 annual income (250% of poverty) 5% limit = $2,056	
State	Estimated cost sharing	Percent of income	Estimated cost sharing	Percent of income	Estimated cost sharing	Percent of income
California	$212	0.9%	$260	0.9%		
Colorado	318	1.3	398	1.3		
Connecticut					643	1.6%
Florida	213	0.9	213	0.7		
Massachusetts[a]	309	1.3	309	1.0		
Michigan	60	0.2	60	0.19		
Missouri	[b]	[b]	54	0.18	888	2.2
New York	[b]	[b]	216	0.7		
Rhode Island	[b]	[b]	68	0.2	68	0.17
Vermont					228	0.6
Wisconsin [c]	864	3.5	1065	3.5		

Note: Blank cells indicate that there is no SCHIP eligibility at this income level.

[a]Massachusetts' SCHIP plan covers adults at some income levels, but adult cost sharing is not subject to the 5-percent-of-income cap and therefore is not included in this estimate.

[b]No cost sharing is required at this income level.

[c]This estimate is based on managed care enrollment where there are no copayments. Wisconsin applies Medicaid-allowable copayments to enrollees in fee-for-service arrangements, but they apply only to an estimated 15 percent of expected enrollees.

Some disparity across income levels exists, depending on how states applied premiums and copayments. Several states in our sample used a single premium level and copayment schedule for all families that did not increase as income increased. This resulted in families with higher incomes paying a smaller percentage of their income for cost sharing in some states, such as Florida, Massachusetts, Michigan, and Rhode Island. In contrast, Colorado's, Wisconsin's, and California's plans ensure that persons at higher income levels pay about the same percentage of family income in cost sharing as those at lower income levels.

Cost Sharing Creates Tracking Requirements for the States

SCHIP cost-sharing provisions gave the states additional flexibility compared with Medicaid but imposed a limit on the amount that they could actually charge. Thus, any cost sharing that was not predictable, such as copayments, created the need for the family, the state, or the

health insurance plans to track spending to ensure that once the maximum level is reached, no further cost sharing is imposed. As noted earlier, 11 states in our sample elected to impose cost sharing, including 9 that charged both premiums and the more-difficult-to-estimate copayments. With respect to tracking copayments, the states worked out a number of approaches, ranging from requiring individuals to keep receipts to mandating that health plans monitor cost sharing.

HCFA's review of Colorado's plan raised the issue of how the state would track family expenditures to ensure that the 5-percent aggregate limit was not exceeded. Working with HCFA, state officials established a method to identify for providers families who are exempt from further copayments. Known as the "shoebox method," the approach requires families to keep track of receipts; when copayments reach the maximum 5 percent of income allowed under title XXI, they notify the state, which places a sticker on the health card to indicate their exemption from further copayments.

Massachusetts also adopted the shoebox method to track family expenditures but with the added complexity of incorporating this methodology into its premium assistance program for employer-sponsored insurance. The state originally set premium assistance levels at 1 to 2 percent of family income and believed that this would ensure that no family exceeded the 5-percent cost-sharing limit. However, because levels of cost sharing vary across different employer-sponsored plans, HCFA raised concerns that families might exceed the limit. To resolve this issue, Massachusetts adopted the shoebox method. The state now plans to inform families of the 5-percent limit as they are determined eligible for the program. Once a family submits proof of expenses totaling 5 percent of family income, the state notifies the health plan and requests that further copayments be billed to the Massachusetts SCHIP. State officials describe this process as administratively difficult because of the number and variety of health plans with which employers contract and for which the state might have to generate copayments.

In contrast, Connecticut placed the burden of tracking family expenditures on the health plans. Connecticut's SCHIP plan included state legislation that cites a maximum annual aggregate cost sharing of $650 for children in families with income levels between 186 and 235 percent of the poverty level and $1,250 for families from 236 to 300 percent of the poverty level. These annual limits equate to around 2 to 4 percent of aggregate family

income. Participating health plans are charged with tracking family payments to ensure that spending does not exceed the required amount.

States With Grandfathered Benefit Packages Had to Change Cost-Sharing Provisions

States with grandfathered benefit packages—Florida, New York, and Pennsylvania—had to alter their cost-sharing provisions in order to conform to SCHIP statutory requirements. Florida was required to lower several copayment amounts and its premiums for subsidy families in order to meet limits included in the federal legislation. While title XXI does allow the states to petition the Secretary to approve an alternative cost-sharing schedule, Florida chose not to pursue this option. State officials indicated that there was tremendous internal pressure to implement title XXI within state-imposed deadlines; as a result, they were concerned that a waiver process might draw out the review of their plan. Pennsylvania wanted to continue to charge a $5 copayment for prescriptions, a provision that was part of its state-funded children's program. Like Florida, state officials interpreted title XXI as including this copayment in the grandfathered benefits package. Ultimately, the state removed this copayment from its plan as a result of the review process.

Incorporating New York's long-standing children's health program into SCHIP provisions was challenging for state officials. New York's state-funded program was started in 1990 and was based on a partnership between government and private insurers to provide subsidized private health insurance coverage to children. New York had cost-sharing provisions that HCFA determined were not in compliance with title XXI requirements, the most controversial being a $25 penalty for inappropriate emergency room use that HCFA considered to be in excess of the nominal charge permitted. New York officials stated that they had numerous discussions with HCFA regarding the $25 charge; their approved plan included a $10 copayment, but state officials told us that they plan to drop all copayments in a subsequent plan amendment. As with Colorado and several other states, HCFA raised the issue of how New York planned to track annual aggregate expenditures. New York officials estimated that a child at 150 percent of the poverty level would have to visit a physician daily for a period of 1 year in order to exceed the 5-percent cap. Thus, from the state's perspective, a tracking system was unnecessary. HCFA indicated that a way was needed to demonstrate that the statutory requirement was being met. New York initially placed the administrative burden of tracking expenditures on the health plans. However, the state legislature removed all copayments, including inappropriate emergency room use, effective January 1, 1999. State officials indicated that this was

done at the request of insurers who believed that the administrative burden of collecting $2 and $3 copayments would be far greater than the revenue collected.

Early State Efforts to Use SCHIP Family Coverage and Employer Subsidy Options

Having secured approval for their fiscal year 1998 SCHIP allocations, a growing number of states are exploring two options permitted by the statute: (1) family coverage that includes the adults in families as well as the children and (2) an employer buy-in that helps families gain access to available employer-based insurance for their children by using SCHIP funds to pay the employee share of the cost of dependent coverage. The statutory requirement that the cost effectiveness of covering adults as well as children in a family be demonstrated underscores the need for some type of subsidy. Although the two options are distinct, family coverage appears to be impossible to achieve without the subsidy inherent in most employer-based coverage: Because some employers subsidize a share of the cost of providing coverage to workers, an employer buy-in can help meet the statute's cost-effectiveness test by limiting SCHIP outlays. As of April 1, 1999, only Massachusetts and, to a lesser degree, Wisconsin had received approval for family coverage under SCHIP, demonstrating cost effectiveness by relying on an employer buy-in option. However, achieving family coverage through an employer buy-in can further complicate plan approval and implementation because of the complex benefit and cost-sharing requirements imposed by title XXI. HCFA has so far declined to use its section 1115 authority to facilitate state family coverage goals by waiving title XXI requirements. HCFA believes that it is inappropriate to use this demonstration authority to waive title XXI requirements before a state's implementation of its SCHIP program. In part, this stance reflects a concern about not undermining the statutory goal of covering uninsured children.

Family Coverage Under SCHIP Requires External Subsidy

Although the goal of SCHIP is to provide uninsured children with health insurance coverage, a state can elect to cover the entire family—both the parents or custodians and their children—if it is cost effective to do so. The cost-effectiveness test for family coverage specifies that the expense of covering both adults and children in a family must not exceed the cost of covering only the children. Under these circumstances, cost effectiveness appears possible only when the cost to SCHIP of covering a family is subsidized, such as by employer contributions. Massachusetts and Wisconsin received approval of their title XXI family coverage proposals by relying on an employer buy-in—a distinct and challenging SCHIP option. (See figure III.1.) Under an employer buy-in, benefits must be equivalent to one of the SCHIP benchmark packages, and cost sharing for a child cannot exceed the statute's limit of 5 percent of family income.

Figure III.1: Massachusetts' SCHIP

Massachusetts' coverage of low-income individuals is based on a Medicaid section 1115 waiver, approved by HCFA in April 1995 and the state legislature in 1996. The waiver covers children younger than 19 and their parents, individuals with disabilities, and long-term unemployed adults with incomes at or below 133 percent of the poverty level. Perhaps one of the most complex plans, Massachusetts weaves Medicaid and SCHIP funds to provide coverage to children and adults, using poverty level and access to insurance as key determinants of the funding stream that will be applied to an individual or family unit. SCHIP continues provisions of the section 1115 waiver up to 200 percent of the poverty level.

Under the SCHIP Medicaid expansion component, services are extended to 150 percent of the poverty level for children (including those with disabilities) and 200 percent for pregnant women and infants. At 151 to 200 percent of the poverty level, Massachusetts implements a family assistance program that subsidizes family contributions to employer-based insurance coverage. A child's eligibility for SCHIP determines which funding stream–Medicaid or SCHIP–is used. The following examples illustrate how SCHIP funds are used.

- For children in families with access to employer-sponsored health insurance that meets benchmark and title XXI requirements, the family contributes 1 to 2 percent of its gross income toward premiums for employer-sponsored family coverage. Assuming cost-effectiveness, the state provides any additional premium assistance required above the family's contribution.
- For children in families that do not have, or do not have access to, employer-sponsored health insurance, the family contributes not more than 2 percent of its gross income to participate in a benchmark benefit package similar to that of Medicaid (excluded are nonemergency transportation, long-term care, and EPSDT).

Medicaid funds are available for premium assistance if a low-income family has already availed itself of employer-sponsored insurance or if the employer-sponsored benefits package is less generous than the SCHIP stand-alone and thus is not equivalent to a title XXI benchmark package.

Massachusetts was the first of two states to receive approval for family coverage. State officials believe that HCFA's 1995 approval of a section 1115 waiver permitting an employer buy-in for their traditional Medicaid program greatly facilitated their family coverage cost-effectiveness test. Massachusetts' as well as Wisconsin's cost-effectiveness test for family coverage built upon the employer subsidy inherent in most coverage provided through the workplace, thus minimizing the state subsidy of the cost of parental coverage. Because HCFA conditions the employer buy-in on a firm's payment of at least 60 percent of the cost of family coverage, the state's subsidy of the remaining 40 percent of the premium is less than the full cost of covering children under its Medicaid program. Under title XXI, an employer's coverage must be actuarially equivalent to a SCHIP benchmark package. For Massachusetts, HCFA agreed to a state certification of comparability based on a benefit-by-benefit comparison of coverage in lieu of a time-consuming and expensive actuarial test for each

employer plan. Thus, the use of the employer buy-in option to cover families was facilitated by HCFA's flexibility on the comparability of employer-offered benefits with those of SCHIP. HCFA said that this approach was a commonsense way to implement the statutory requirement, given the costly nature of actuarial assessments. Despite HCFA's flexibility, Massachusetts officials characterized the agency's approval of family coverage as a compromise. Uninsured families with access to employer-sponsored coverage are eligible for SCHIP, but low-income families who may be struggling to afford coverage through their employers are eligible for a buy-in only with title XIX money.

HCFA has found other cost-effectiveness tests proposed by the states to be inconsistent with the title XXI statute. For example, HCFA rejected an effort to establish cost effectiveness by comparing family coverage under title XXI to the cost of a commercial rate for child-only coverage.[48] In preliminary discussions with HCFA, another state interested in family coverage suggested comparing the costs of SCHIP managed care coverage for an entire family to Medicaid fee-for-service costs to cover children. In our discussions with HCFA, officials characterized this type of test as hypothetical. A HCFA official told us that the agency has not yet issued any guidance on family coverage in order to remain open to creative state ideas for meeting the SCHIP cost-effectiveness test.

Some States Cover Families by Using Title XIX Funds for Adults

Some states wishing to cover the parents of children eligible for SCHIP have been able to do so by using title XIX funds. In general, adults do not qualify for Medicaid coverage unless they are in families with children or are aged, blind, or disabled. After the enactment of SCHIP, Missouri simultaneously negotiated a Medicaid section 1115 waiver to cover parents with title XIX funds and a SCHIP Medicaid expansion for the children of such families using title XXI funds. State officials indicated that their goal was to connect children and families into one seamless program with two different funding streams. While noting that including adults in their title XIX waiver greatly complicated the review process for SCHIP, state officials indicated that family coverage was an important state goal. Missouri's Medicaid approach commits the state to spending beyond its SCHIP allotment if necessary, a situation that other states may find less palatable.

Connecticut is working to implement family coverage using Medicaid funding. The state intends to use section 1931 of the Social Security Act, a

[48]These types of cost-effectiveness comparisons are difficult because very few health insurance plans cover only children. See Health Insurance for Children: Private Individual Coverage Available, but Choices Can Be Limited and Costs Vary (GAO/HEHS-98-201, Aug. 5, 1998).

provision of the welfare reform law that creates a new eligibility category for parents and allows states to apply income and resource disregards to qualify higher-income adults.[49] The state will receive its regular Medicaid matching rate for these parents. Connecticut has not decided whether this coverage will extend to families with income above 100 percent of the poverty level.

Vermont and Wisconsin Sought Relief From Title XXI Requirements

HCFA has worked with the states to find other ways to achieve their goal of covering adults in families with children. For states such as Missouri that are not opposed to using both the title XIX and title XXI funding streams, the goal of covering families is achievable. For other states, however, ensuring that the goals of title XXI and their own goals were consistent with each other has proven more problematic. The initial plans that Vermont and Wisconsin submitted demonstrate the difficulty of building flexibility into a program that is an overlay of Medicaid. These two states were interested in section 1115 waivers of SCHIP requirements to reconcile the requirements of title XIX and title XXI. Thus far, HCFA has refused to consider the use of section 1115 to waive SCHIP requirements.

Vermont's and Wisconsin's Family Coverage Proposals

Before SCHIP, Vermont covered uninsured adults up to 150 percent of the poverty level and children up to 225 percent. Vermont wanted to use a SCHIP Medicaid expansion that would amend its Medicaid section 1115 waiver program to cover (1) uninsured and underinsured children with family income up to 300 percent of the poverty level and (2) uninsured adults with dependent children with family income up to 185 percent of the poverty level. According to HCFA, family coverage under title XXI must address the "family unit." Thus, if a child is already receiving Medicaid benefits, a parent can qualify only for Medicaid, not SCHIP. This situation resulted in a coverage gap for parents with family income above 150 percent of the poverty level whose children were already being served by Medicaid.[50] Although this interpretation prevented Vermont from covering lower-income parents, the state could have included higher-income adults in families with children under SCHIP where crowd-out is of greater concern.

[49]Jocylen Guyer and Cindy Mann, "Taking the Next Step," Center on Budget and Policy Priorities, Washington, D.C., Aug. 20, 1998.

[50]Concerns regarding the family unit were never resolved; thus, the validity of the cost-effectiveness test submitted by Vermont was never fully tested.

Vermont also wanted to include underinsured children whose coverage is prohibited by title XXI. Because of earlier coverage expansions, the state estimates that there are fewer than 2,500 remaining uninsured children. At the same time, many children in the state have poor coverage. Consequently, the state proposed using a portion of its title XXI allocation on underinsured children to cover dental and vision care and other benefits not available to them. Vermont withdrew its initial SCHIP plan and has since received approval for a stand-alone program to cover uninsured children up to 300 percent of the poverty level. The state will use Medicaid funds to improve coverage for underinsured children and some parents. Finally, the state has since covered the adults it originally sought to insure under SCHIP through an amendment to its section 1115 waiver program using regular Medicaid funds.

Wisconsin applied for a section 1115 waiver under Medicaid to cover parents and proposed implementing a stand-alone SCHIP program for children to limit expenditures to the amount of its allotment.[51] The state wanted to maintain budgetary control over SCHIP program expenditures while rationalizing coverage for low-income, working families, most of whom did not have access to health insurance. Conceptually, Wisconsin's proposal covered the same individuals as programs in Massachusetts and Missouri. However, because Wisconsin's approach had the effect of splitting the family unit into two different funding streams (an enhanced matching rate under title XXI and a regular matching rate under title XIX), the proposal did not comply with the federal budget neutrality provisions required of all section 1115 demonstrations. These provisions require that unless the expansion is funded through program savings, the children must be covered under Medicaid in order for the parents to be covered under regular Medicaid.

Wisconsin ultimately received approval for a revised SCHIP plan by switching from a stand-alone to a Medicaid expansion design. With regard to family coverage, Wisconsin has two approaches, one that operates under regular Medicaid and one under SCHIP. Under regular Medicaid, the state uses a section 1115 waiver of title XIX to cover parents up to 185 percent of the poverty level. For a small number of parents who have access to employer-sponsored insurance, Wisconsin believes that they will be able to meet the title XXI cost-effectiveness test and use SCHIP funds to provide coverage for both parents and their children. Wisconsin's cost-effectiveness test is similar to that of Massachusetts, comparing the

[51]Although Wisconsin did not want to create a new entitlement, the state planned to use its Medicaid benefit package and allow family income for those in the program to increase up to 15 percent over the original 185 percent of the poverty level without affecting their eligibility for coverage.

cost of the premium assistance for a commercial plan against the cost of covering children in its SCHIP Medicaid expansion. However, state officials believe that SCHIP coverage of parents is likely to be minimal, since they can look only at plans in which the employer subsidizes 60 to 80 percent of the premium costs. Finally, Wisconsin plans to control overall expenditures in both title XIX and title XXI programs by creating an enrollment threshold. The state plans to continuously monitor enrollment and, in the event it is close to exceeding its state budget, officials plan to submit a waiver amendment to lower the income eligibility level for both Medicaid and SCHIP. HCFA has committed to responding quickly on any amendments submitted by Wisconsin, providing an informal response within 60 days and a formal response within 90 days.[52]

HCFA Questions the Timing of Requests for Section 1115 Waivers

In September 1997, shortly after the enactment of SCHIP, HCFA informed the states that "it would be reasonable for states to have experience in operating their new Title XXI programs before designing and submitting demonstration proposals. Without experience in implementing Title XXI, it would be very difficult for HCFA to review and evaluate the merits of any waiver proposal."[53] In elaborating on this statement, HCFA underscored that the purpose of section 1115 waivers is to test innovative approaches requiring research designs—not to waive statutory provisions that the states find objectionable. HCFA intends to require that the states have 1 year of operational experience with their SCHIP programs and complete an evaluation before requesting a section 1115 waiver. Without first implementing a SCHIP program, a state lacks the requisite baseline from which to measure change. Finally, HCFA takes seriously SCHIP's goal of providing insurance to uninsured, low-income children, a goal that it does not want to see circumvented by the waiver process.

HCFA believes that it is inappropriate to use section 1115 to waive title XXI requirements before a state implements a SCHIP program—a policy that reflects the demonstration nature of section 1115 waivers and a concern about not undermining the statutory goal of covering uninsured children. States and advocacy groups contend that there is no longer any merit in postponing the use of such waivers now that most states have secured their fiscal year 1998 SCHIP allocations.

[52]In the event that the state decreases its income eligibility, children and adults already enrolled in Wisconsin's program will maintain their eligibility under Medicaid and SCHIP. Thus, the enrollment threshold will apply only to new applicants.

[53]HCFA, "Dear State Letter," Sept. 12, 1997.

Established to test program innovations, section 1115 allows the Secretary of HHS to approve demonstrations likely to assist in promoting program objectives. Past demonstrations have made significant contributions to the development of Medicaid policy. Title XXI stipulates that the provisions of section 1115 of the Social Security Act relating to demonstration authority "shall apply in the same manner as they apply to a state under title XIX." According to HCFA, the section 1115 waiver authority applies equally to Medicaid expansions and stand-alone programs and is broad. Thus, it allows the Secretary to waive many of the numerous provisions related to Medicaid state plan requirements and to provide matching funds for items and services not normally covered under Medicaid. This authority has been used to expand eligibility, mandate the enrollment of beneficiaries in managed care, and modify benefits or cost sharing for certain populations.[54]

States and some advocacy groups would like HCFA to begin allowing the states to tailor their SCHIP programs through the use of section 1115 waivers. Citing a study that suggests that children are more likely to be insured when their parents are also offered health benefits, they contend that family coverage is consistent with SCHIP.[55] Some states also view an employer buy-in as consistent with efforts to prevent the substitution of public programs for employer-provided health insurance. Ultimately, the use and approval of section 1115 waivers under SCHIP will require a judgment regarding the consistency between state goals and the intent of title XXI.

[54]As of December 1998, 17 states operate their Medicaid programs under such a waiver. These demonstrations must be budget neutral and must incorporate research hypotheses.

[55]Kenneth E. Thorpe and Curtis S. Florence, "Covering Uninsured Children and Their Parents: Estimated Costs and Number of Newly Insured," The Commonwealth Fund, New York, N.Y., July 1998.

Innovative State Outreach Strategies Are Critical to the Success of SCHIP

Many states, including the 15 in our sample, are developing innovative outreach strategies to widely publicize SCHIP and to provide families with applications and program information.[56] Some states have adopted sophisticated media campaigns to market SCHIP like a product, a development attributed in part to the greater likelihood that targeted children have working parents. Outreach strategies have worked to minimize the burden on both the beneficiary and the state by eliminating onerous documentation requirements, which in turn allows the introduction of shorter application forms. States with a large number of low-income immigrants are also implementing outreach efforts geared toward these populations. Finally, some states are implementing measures to help them evaluate which outreach strategies are the most effective—for example, school-based initiatives, local community designed efforts, or general media campaigns. While it is too early to judge the success of their outreach efforts, some states are reporting that the publicity is attracting not only children eligible for SCHIP but also far greater numbers of those who are eligible for Medicaid but not enrolled. Although title XXI recognizes the importance of outreach, it also limits the amount of federal matching funds that are available. Including outreach within the prescribed limit has been problematic for some stand-alone programs with significant start-up costs.

SCHIP Emphasizes Outreach Within Prescribed Limits

As a new program, title XXI underscores the importance of identifying and enrolling eligible children by requiring each state to include an outreach strategy in its SCHIP plan. Despite this emphasis on outreach, however, the statute also limits outreach spending and certain other spending to 10 percent of a state's actual expenditures on benefits. Thus, the statute ties outreach expenditures directly to enrollment. For states such as New York, with state-funded children's programs that predated SCHIP and thus populations already receiving services, the spending limitation on outreach has not been a particular problem. It has, however, been problematic for other states with a stand-alone SCHIP component that are incurring start-up costs and lack the enrollment necessary to fully claim their outreach expenditures. A state that implements a Medicaid expansion, however, may continue to claim a federal match for such

[56]In their Medicaid outreach efforts, many states have been cognizant of barriers to enrollment that include confusion over eligibility, lack of program knowledge, complex eligibility rules, belief that participation is not necessary when children are healthy, potential stigma, and language and cultural barriers to participation. To overcome these barriers, the states have applied strategies under Medicaid that are also relevant to their SCHIP efforts. For more detailed information on the barriers to Medicaid enrollment, see Medicaid: Demographics of Nonenrolled Children Suggest Outreach Strategies (GAO/HEHS-98-93, Mar. 20, 1998).

expenditures at the regular Medicaid matching rate after the 10-percent cap is reached.

In addition to the title XXI requirement that each state include an outreach strategy in its SCHIP plan, other BBA provisions gave the states additional tools to facilitate the enrollment and coverage of children in both Medicaid and SCHIP.[57] One option known as "presumptive eligibility" allows the states to extend immediate Medicaid or SCHIP coverage to children until a formal determination of eligibility is made. Under this option, a "qualified entity" may use preliminary information to presume that a child is eligible for benefits if the family income does not surpass the state's applicable income eligibility levels.[58] A second option allows the states to provide beneficiaries with continuous eligibility in their Medicaid or SCHIP programs for up to 12 months without an eligibility redetermination. The continuous eligibility option may reduce the difficulties associated with intermittent program eligibility and coverage stemming from changes in a family's financial circumstances.

Since the enactment of SCHIP, HCFA has also emphasized the importance of effective outreach strategies. It issued guidance to the states in January and September 1998 that reviewed the outreach options already available to them under Medicaid as well as new strategies for reaching and enrolling targeted children. Additionally, in February 1998, the President signed an executive memorandum establishing a multiagency effort to enroll uninsured children in SCHIP. In response, the Vice President announced new approaches that federal agencies are taking to identify and enroll targeted children. Finally, the President's fiscal year 2000 budget is proposing to expand the use of a special $500 million Medicaid outreach fund, originally earmarked for state costs associated with outreach for children losing welfare. This proposal, if passed, will allow the states to use the fund for outreach activities geared to all uninsured children, not just those affected by the delinking of Medicaid from welfare.

While every state SCHIP plan contains a strategy to reach targeted children, two states have expressed concern that SCHIP funding limitations on

[57]Although the BBA is silent on the application of these provisions to SCHIP, HCFA has permitted the states to pursue these options.

[58]Under BBA, "qualified entities" are health care providers of items and services under the state's Medicaid plan (including the Indian Health Service and Tribal and Urban Indian health care providers) as well as entities that make eligibility determinations for Head Start; the Special Nutritional Program for Women, Infants, and Children (WIC); and child care subsidies under the Child Care and Development Block Grant. After a child has been determined to be presumptively eligible by a qualified entity, the child's family is then required to apply for the program formally by the last day of the month following the month in which the presumptive eligibility determination was made.

outreach contradict these efforts. Under title XXI, a state may receive federal matching funds for certain expenditures to the degree that they do not exceed 10 percent of the state's total expenditures for health benefits under SCHIP. The capped expenditures include costs relating to the administration of the program, outreach, and certain other health-related activities. Essentially, the goal of the 10-percent cap is to preserve as much SCHIP funding as possible to pay for health insurance for children.

Including program administration and outreach within this cap, however, has been problematic for some states as they develop and implement their SCHIP plans. In particular, some states with a stand-alone component have found the 10-percent cap difficult to work with, given the magnitude of start-up costs and low enrollment in the early stages of their programs. For example, California officials noted that while the cap may be reasonable once a program is under way, it is impossible to stay within the 10-percent limit while conducting outreach and other activities that precede actual service delivery. As a result, California has committed significant unmatched state start-up funds. Colorado officials also indicated that the 10-percent limit is problematic because of the state's smaller population and low initial enrollment, but it may be more viable once the program is established and service expenditures increase. Both states noted that the legislation's inclusion of outreach within the 10-percent cap is counter to presidential efforts for increased outreach, as discussed above. HCFA has tried to be flexible in addressing state concerns, suggesting for example that a state withhold claims for administration and outreach until there is sufficient program enrollment. Moreover, the President's fiscal year 2000 budget includes a provision to establish an additional 3-percent allowance for outreach that would continue to be tied to expenditures.

While the stand-alone components of California's and Colorado's programs have experienced difficulties with the 10-percent limit, other states with similar approaches have not. This may be, in part, because of the individual states' starting points or baselines. For example, New York is rolling over enrollment from its state-funded program and expects to spend between $15 million and $16 million on health care services each month; thus, the state will have a significant basis from which to draw down the federal match for outreach costs. States without similar, significant SCHIP expenditures will have more difficulty recouping the cost of their outreach efforts during the early phase of the program.

Outreach Strategies Focus on Publicity, Simplification, and Targeting

The development of effective and appealing marketing has become a priority under SCHIP. In addition to implementing approaches suggested by HCFA, some states have developed unique strategies to publicize SCHIP and to change community perceptions that had previously hindered Medicaid enrollment. Outreach measures also encompass efforts to simplify state eligibility procedures, streamline program applications, and opt for the presumptive and continuous eligibility provisions. Some states are also focusing on the diverse and specialized needs of the populations they intend to reach, such as immigrants. Lastly, while it may be too early in the program to identify the most effective outreach strategies, some states are implementing measures to help them identify the efforts that appear to be the most successful.

Publicizing SCHIP

To overcome the informational barrier to enrollment, the states have initiated a variety of methods to publicize SCHIP. Their approaches include multimedia campaigns, direct mailings and widespread distribution of applications, community involvement, and corporate participation. In addition to disseminating information about available programs, some states have taken steps, even before the enactment of SCHIP, to address the Medicaid stigma issue in an attempt to improve perceptions of publicly sponsored health insurance programs. As the Congress may have expected and some states have already experienced, the publicity about SCHIP has already resulted in the enrollment of additional children in Medicaid.

Media Campaign

To publicize SCHIP, the states are using media such as posters, newspapers, billboards, radio, and television. In SCHIP advertisements, the states typically provide toll free numbers and, in some instances, Web site addresses to assist potential enrollees in receiving an application or other information about the program. All the states, including those in our sample, have some sort of media campaign in their SCHIP programs, but the approaches vary significantly, depending on their budgets and community needs.

For instance, California is advertising statewide in English and Spanish on television and radio. Additionally, the state is using billboard and transit advertisements, posters, pamphlets, and other promotional materials in ten languages. California is spending $9 million on traditional media out of its $21 million outreach budget. Michigan reported that it will spend $750,000 on a professional media campaign that includes television, radio, and print media. The state plans to have a base level of media coverage

throughout the year that will increase at certain times, such as at the beginning of a new school year.

Distribution of Program Information and Applications

Other efforts to inform the public about the states' SCHIP programs involve the widespread distribution of SCHIP applications and materials through schools, the mail, and other avenues. (See figure IV.1 for excerpts from Michigan's SCHIP application.) Fourteen of the 15 states in our sample reported that they would be using the local school systems in their outreach efforts. Although South Carolina mailed more than 500,000 copies of its bright yellow application, accompanied by a letter from the governor, within the first few months of its program, a state official reported that the distribution of applications throughout the state school system proved to be the most effective so far. SCHIP program materials are also being placed in other organizations such as child care centers, Head Start programs, child support enforcement agencies, community action programs, refugee resettlement programs, family preservation and support programs, and Social Security offices.

Figure IV.1: Materials From Michigan's SCHIP Application

SCHIP Application Cover

Excerpts From SCHIP Application

Additionally, some states are identifying and targeting families who are likely to have eligible children by coordinating with other programs. For example, Florida plans to send information directly to families who receive food stamps. Other distribution strategies include mailing information to families who fall below a certain income threshold as determined by the SCHIP program. Thus, Connecticut is planning a direct mail campaign to all families with incomes below 300 percent of the poverty level.

Community Involvement

The states are developing outreach approaches in concert with local organizations such as churches and social service agencies that are familiar with the community and understand its needs. Community-based organizations are able to disseminate information on SCHIP by word of mouth, often a more effective tool than government officials. The following states in our sample are involving community-based organizations for outreach in innovative ways:

- California is enlisting the assistance of community-based groups such as parent-teachers associations, YMCAs, and religious organizations and other entities such as insurance agents and tax preparers. The state approached tax preparers as a group that may be able to identify children eligible for SCHIP because many low-income families do not prepare their own tax returns. After state-provided training, these groups help inform potential SCHIP and Medicaid enrollees about the program and assist families in completing application forms. To compensate them for their effort, the state pays a $50 "application assistance fee."[59] State officials indicated that as of September 1998, approximately 40 percent of California's applications had been "assisted."
- Massachusetts is using social service agencies, religious and civic leaders, and schools to conduct outreach activities. The state will provide "minigrants" varying from $10,000 to $15,000 to community-based organizations that facilitate the enrollment of hard-to-reach populations.
- New York and South Carolina have found that grassroots efforts and community organizations are also effective in publicizing the availability of SCHIP. These organizations are distributing information and reaching parents in nontraditional locations such as adult learning centers, tenant organizations, and beauty salons (New York) and movie theaters and laundromats (South Carolina). Both states are also using ministers and local churches to pass out information to congregations.

[59]Originally, the state proposed an application assistance fee of $50 but lowered the amount to $25 when the state began to implement SCHIP. In November 1998, the state restored the fee to $50 to boost lower-than-expected enrollment in its SCHIP program. HCFA indicated that the increase to $50 is under review.

Corporate Partnerships

The states are also finding other ways to use the private sector to spread the word about SCHIP. Michigan's stand-alone program is working with Kmart stores throughout the state that have agreed to display SCHIP applications at their "community issues" bulletin boards. Publicity will also be strategically placed near displays of school clothes and in the pharmacy section of the stores. Michigan is also working with the Meijers supermarket chain in Grand Rapids. While the store does not allow displays, it will include SCHIP information in a shopping guide that is mailed to two million families. California has placed its toll free SCHIP telephone number on grocery bags and coupons. Additionally, the state has obtained corporate sponsorships with local supermarkets and drug stores. California officials believe that corporate partnerships will complement the state's paid media advertising strategy. Other private sector initiatives transcend state boundaries. For example, Bell Atlantic is establishing and operating a toll free telephone number nationwide to assist families in reaching enrollment centers. Additionally, Pampers, the diaper company, will provide this toll free number and other information about health insurance options to first-time mothers.

Addressing the Stigma Issue

SCHIP has refocused attention on the Medicaid-welfare stigma issue and state efforts to overcome this potential barrier to participation in publicly sponsored health insurance programs. Before the heightened outreach efforts under title XXI, some states had already endeavored to project a more positive image of their medical assistance programs. The most visible effort was to re-invent a program with a new name. Oregon Medicaid was rechristened the "Oregon Health Plan" when its section 1115 waiver was approved in 1993; the state's SCHIP stand-alone program also operates under that name. In contrast, California has not changed the name of its Medicaid program; its SCHIP stand-alone program is called "Healthy Families" while Medicaid continues as Medi-Cal. Other stand-alone programs with names distinct from Medicaid include the MIChild program in Michigan and the Florida Healthy Kids program.

Other approaches to destigmatizing Medicaid include advertising SCHIP as a program intended for working families, using an alternative enrollment site or mechanism that eliminates the need to submit an application at a local welfare office, and issuing identification cards for program participants that are free of any perceived "welfare stigma." For example, South Carolina, a Medicaid expansion state, is considering issuing an identification card that closely resembles private health insurance

identification cards.[60] The state has also removed almost all mention of Medicaid from its application form. State officials say that most applicants do not realize that they are applying for Medicaid for their children. In Oregon, there are no unique Medicaid or SCHIP identification cards. Instead, each beneficiary receives a card from the health insurance plan he or she chooses—one identical to the card issued to an individual with employer-sponsored health insurance.

Some states are concerned about perceived stigma attached to their Medicaid programs and believe that families will prefer to enroll their children in their state's stand-alone programs, which appear to be more like private health insurance programs. For example, Florida has suggested that some families might even falsify their incomes to avoid enrolling in Medicaid. California reports that 75 percent of SCHIP applicants who are found eligible for Medicaid refuse to allow the state to refer their applications to Medicaid. In addition to the perceived stigma that the states believe endures among recipients, a few states in our sample told us that Medicaid has a negative image among some providers who are unwilling to serve beneficiaries. Thus, Michigan Medicaid offers dental benefits but has few participating dentists, although this may be in part the result of low Medicaid reimbursement rates. To attract dentists to its SCHIP stand-alone program, the state has raised the rates. While this potentially creates a two-tiered system in terms of dental access, the state is waiting to determine whether more dentists participate and the delivery of services increases.

Simplifying Eligibility Determination and Enrollment Procedures

In a September 1998 letter to the states, HCFA acknowledged the need for safeguarding program integrity in order to ensure that only those who are eligible receive program benefits. Nevertheless, HCFA maintained that burdensome application and enrollment processes are a substantial impediment to successful enrollment in both SCHIP and Medicaid. In an earlier report, we found that among three states, almost half of Medicaid application denials were for procedural reasons, such as incomplete documentation.[61] While simplification measures are being taken under

[60]Plans for an identification card have been postponed until after the state completes modifications to solve the year 2000 computer problem.

[61]See Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People (GAO/HEHS-94-176, July 11, 1994).

SCHIP, some states were already streamlining both their Medicaid eligibility rules and enrollment procedures.[62]

Streamlining the Eligibility and Application Process

To overcome the barrier of a long, complicated SCHIP eligibility determination process, the states are (1) eliminating burdensome eligibility tests, (2) shortening the length of applications, (3) using joint SCHIP-Medicaid applications, and (4) opting for a period of continuous eligibility.

Eliminating Burdensome Eligibility Tests. Dropping an asset test reduces the complexity of the eligibility determination process for families and, in some cases, the documentation requirements. In our 15-state sample, 12 states have eliminated the asset test from their SCHIP applications. (See table IV.1.) Some states are also allowing families to report their own incomes with verification by the state as follow-up. Additionally, some states are reducing verification and documentation requirements that exceed federal requirements. For example, Rhode Island has significantly reduced the number of documentation requirements that were in place when Medicaid and welfare eligibility were linked.

[62]According to the Center on Budget and Policy Priorities, as of November 1998, 41 states had shortened their Medicaid applications, 36 states allowed individuals to apply by mail, and 40 had simplified their Medicaid eligibility process by eliminating an asset test. Center on Budget and Policy Priorities, Steps States Can Take to Facilitate Medicaid Enrollment of Children (Washington, D.C.: Nov. 1, 1998).

Table IV.1: Eligibility and Enrollment Initiatives in 15 States

	No asset test	Combined SCHIP-Medicaid application	Continuous eligibility[a]	Presumptive eligibility under SCHIP[b]
California	X	X	X	
Colorado		X	X	
Connecticut	X	X	X	X
Florida	X	X	X	
Massachusetts	X	X		X
Mississippi	X	X	X	X
Missouri	X	[c]	X	X
New York	X	X	X	X
Oregon		X	X	
Pennsylvania	X		X	
Rhode Island	X	[c]	X	
South Carolina	X	[c]	X	
Texas		[c]		
Vermont	X	X		
Wisconsin	X	[c]		

[a]Florida, Oregon, and Rhode Island have continuous eligibility for 6 months; all other states that have continuous eligibility extend it for 12 months.

[b]May be applied to separate stand-alone programs or Medicaid expansions under SCHIP.

[c]Medicaid expansion states that must use the same application for SCHIP and Medicaid.

Shortening Applications. State efforts to simplify eligibility procedures gave them the opportunity to consider the use of shorter SCHIP applications. Florida, Missouri, and South Carolina reduced their applications to a single page, front and back. Missouri, in particular, was able to shorten its application by narrowing it to health coverage only, removing other social services from that particular form. Massachusetts' SCHIP application consists of four pages with four supplements that may apply to the applicant, depending on specific circumstances such as the presence of a disability, access to insurance, an absentee parent, and immigration status. In late 1998, California decided to shorten its application form after considerable criticism of its 28-page booklet, which includes a 12-page application with separate forms for the state's stand-alone program, Medicaid, and a Medicaid program for pregnant women. California officials explained that the form, while lengthy, was designed to avoid the inappropriate enrollment of children and to

minimize follow-up information. In response to adverse feedback about the onerous nature of the application, the state developed a revised four-page joint application for its Medicaid and stand-alone SCHIP programs.

Combining SCHIP and Medicaid Applications. In addition to shortening the form, nine states in our sample are using a single application for SCHIP and Medicaid.[63] This approach not only simplifies the application process for families but also reduces paperwork for the states. Additionally, joint SCHIP-Medicaid applications help the states accomplish seamless coverage for children who may move between programs when their family circumstances change. For instance, Connecticut is marketing its stand-alone and Medicaid programs together under a new name and has developed a four-page application for both programs. The state opted for a joint application under one program name to create an application process that masks for potential enrollees the fact that there are two separate programs.

Providing Continuous Eligibility. Because Medicaid beneficiaries were often subject to frequent eligibility redeterminations and interrupted Medicaid benefits when their income fluctuated, some states are opting to provide up to 12 months of continuous eligibility in an effort to prevent coverage interruptions. As noted earlier, the BBA allowed the states to guarantee a longer period of Medicaid coverage, regardless of changes in a family's financial status or size. HCFA indicated that since the BBA is silent on the application of this provision to SCHIP, the agency allows it. Eleven of the 15 states in our sample have implemented continuous eligibility ranging from 6 to 12 months.

Streamlining the Enrollment Process

The states are simplifying the enrollment process for families with children in several ways. These include using the mail, telephone, and Internet for enrollment; offering additional enrollment sites; reducing the time it takes to process applications; and introducing other innovative enrollment initiatives.

Allowing Mail-in, Telephone, and Internet Enrollment. By introducing mail-in applications, some states are eliminating the need for applicants to

[63]Pennsylvania does not have a joint SCHIP-Medicaid application, but its referral procedure allows the review of either form, without the applicant having to submit a new application. For example, if an applicant to Medicaid is not eligible, the form is automatically referred to SCHIP. Because the SCHIP application does not include all information needed for Medicaid, the state contacts applicants whose SCHIP forms are referred to Medicaid to complete a review; an applicant does not have to fill out a new form.

take time off from work as well as any transportation costs and stigma associated with visiting a social services office. Some states are also extending the use of the mail-in option to eligibility redeterminations. Some are also exploring other options to further simplify the submission of Medicaid and SCHIP applications, such as accepting applications by telephone or facsimile. In Colorado, applications are available over the Internet for families to fill out and mail in.[64] This approach may be particularly effective for community-based organizations that assist families with enrollment since many low-income families may not have access to a computer at home.

Adding Enrollment Sites. To help applicants, some states are increasing the number and type of sites where enrollment can take place. Locating eligibility workers in places other than welfare offices to help families with the initial processing of applications is commonly referred to as outstationing. Outstationing sites may be located where workers frequently come into contact with families such as schools, child care centers, churches, Head Start centers, WIC sites, local tribal organizations, and Social Security offices. Outstationing is an increasingly important strategy, given that welfare offices no longer play the key role that they did when welfare and Medicaid were more closely linked.

Expanding Enrollment Sites With Presumptive Eligibility. Some states are using presumptive eligibility to increase the number of enrollment sites. Presumptive eligibility allows a child to receive coverage under Medicaid or SCHIP immediately, without the delays associated with the normal application process. In addition to traditional Medicaid providers, other entities such as WIC agencies, Head Start programs, and agencies that determine eligibility under the Child Care and Development Block Grant can "presume" eligibility for services until a formal application is submitted and reviewed. Five states in our sample have chosen to use presumptive eligibility in their SCHIP programs.

Reducing Enrollment Time. Some states are shortening the time it takes to process an application once it reaches the appropriate SCHIP or Medicaid office. For example, the goal of California's stand-alone program is to complete eligibility determinations 3 days after a completed application is submitted. The state also plans to commence coverage 10 days after an application is deemed complete. Before the enactment of SCHIP, Massachusetts developed a computer program to determine Medicaid

[64]The actual submission of applications over the Internet is available only to community agencies that have been trained to use the system.

eligibility. The state's data entry approach to determining eligibility reduced the processing time from 3 weeks to 3 days. Massachusetts characterized the development of computerized enrollment as time consuming and expensive but worthwhile.

Making Other Innovative Enrollment Initiatives. Some states are streamlining their enrollment processes by instituting a follow-up system to contact families that do not complete the application process for various reasons. For example, Massachusetts is attempting to initiate follow-up with families and to take their applications over the telephone. Other efforts to ensure that families do not "fall between the cracks" include the development of an effective referral system between the SCHIP office, the state Medicaid agency, and other federal and state entities that frequently come in contact with low-income families. For example, Connecticut's enrollment vendor records daily the number of Medicaid referrals made. Additionally, the state has developed a tracking system to follow referrals once they reach the state's Department of Social Services. Other state efforts to simplify enrollment procedures for families include offering telephone interviews or providing transportation vouchers to assist them in reaching the eligibility office for a face-to-face interview. Some states are extending their office hours so applicants are not required to take time off from work to apply.

Targeting Outreach to Specific Populations

Research indicates that Hispanics, U.S.-born children of foreign parents, and immigrant children are more likely than others to be uninsured despite being eligible for Medicaid. Given these statistics and the renewed efforts under SCHIP to actively recruit the uninsured, states with large Hispanic or foreign-born populations are implementing outreach strategies geared toward reaching them.[65] Some states are offering multilingual applications and program materials and toll free telephone lines in appropriate languages. California is providing applications and materials in ten languages: English, Armenian, Cambodian, Cantonese, Farsi, Hmong, Laotian, Russian, Spanish, and Vietnamese. Colorado and Rhode Island are also providing SCHIP materials in both English and Spanish. Additionally, some states are increasing the number of multilingual eligibility workers and staff able to provide program information and answer applicants' questions.

[65]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires immigrants who arrive on or after August 22, 1996, to be in the United States for 5 years before receiving any federal means-tested benefits such as Medicaid and SCHIP.

The diversity of these targeted populations has also influenced the states' efforts to market SCHIP. For example, Colorado officials noted that different marketing approaches may be necessary to meet the needs of Native American and Hispanic people living in rural areas. The state is also working with the Colorado Migrant Health Program to develop specific outreach activities for migrants statewide. Texas officials similarly noted that its outreach efforts vary by region and by the ethnic population being targeted. In Houston, there is a large southeast Asian immigrant population, and outreach in this area must be culturally and linguistically sensitive. Additionally, Texas officials noted that they must identify the medium that is most effective within a particular group; for example, individuals in areas of the state that border Mexico may be more responsive to television advertisements than to print media.

Despite targeted outreach efforts, some states remain concerned that hard-to-reach populations will continue to be underserved by both Medicaid and SCHIP. Michigan officials noted that citizen children of foreign-born parents may be particularly difficult to reach because of family fears that information will be shared with the Immigration and Naturalization Service (INS) or other federal agencies and may jeopardize their ability to remain in the United States. California is concerned that INS and State Department rules have caused its current enrollment figures to suffer because of fear among immigrants that participation will adversely affect not only their ability to legally stay in the country but also their ability to sponsor other family members coming to the United States. California officials have requested but not received an answer from INS regarding whether the receipt of SCHIP or Medicaid benefits would result in the beneficiary's being considered a "public charge." INS uses the term "public charge" to describe immigrants who are or will be dependent on public benefits.[66] While HCFA sent a letter to state Medicaid directors on December 17, 1997, stating that aliens legitimately receiving Medicaid benefits were not indebted to the state, INS has not clarified this issue with formal guidance.[67] California officials believe that the state will continue to experience difficulty reaching targeted immigrant children until INS

[66]An alien who is likely to become a public charge may be prevented from entering the United States. For aliens already in the United States, deportation may result. Current statutes and regulations do not specify whether the receipt of Medicaid benefits would result in someone's being considered a public charge.

[67]The HCFA letter from Sally Richardson also informed states that the "Medicaid program has no authority to collect repayments of benefits from current or former beneficiaries except in cases where those benefits were fraudulently received or an overpayment has occurred." While the State Department specifically identified WIC as a program that should not be considered when making public charge determinations, neither the State Department nor INS has addressed the receipt of past, present, and future Medicaid benefits.

issues a clear written statement that the lawful receipt of Medicaid and SCHIP benefits will not be considered in public charge determinations.

Mechanisms to Identify Effective Outreach Strategies

Because only 19 states and territories have more than 6 months of implementation experience, it is still too early to identify the most successful outreach strategies. Some states, however, are establishing mechanisms to help them better target their outreach activities. For example, Colorado's SCHIP application contains a question that asks how applicants heard about the program and where they received the application. Those calling in for information are also asked similar questions. In the early stages of South Carolina's program, the state placed different-colored applications at various locations such as schools, providers, and churches in order to determine where each application originated. A South Carolina official indicated that the majority of applications came from schools, allowing the state to better focus its outreach efforts.

Although a state may find that specific outreach approaches are more effective than others, New York's experience suggests that the level of expenditure may also be an important factor. State officials told us that its state-funded children's health program allocated a small amount of money for marketing and outreach—less than 10 percent of the appropriation. After New York increased its funding of marketing and outreach under SCHIP, new monthly enrollment jumped to 19,000 children in July 1998, compared with 2,000 just 1 year earlier.

It Would Be Premature to Draw Conclusions From Preliminary Enrollment Data

In April 1999, HCFA reported estimated SCHIP enrollment of 982,000 children. The data are based on a combination of state-written submissions and oral reports and generally reflect enrollment as of December 31, 1998, for 42 states and territories with operational SCHIP programs. The states estimate that enrollment will reach 2.5 million children by September 2000. Although the states were required to report SCHIP enrollment data to HCFA by January 31, 1999, some did not meet the first reporting deadline. In addition to year 2000 computer problems, the time that the states committed to program start-up contributed to reporting delays. HCFA worked with the states on compiling and verifying the data for accuracy before releasing it to the public. (See table IV.2.)

Table IV.2: Preliminary Enrollment Estimates for States and Territories as of December 31, 1998

States and territories[a]	Months in operation	Estimated enrollment
Medicaid expansion		
Alaska	None	None
American Samoa	None	None
Arkansas	3	3,000
District of Columbia	3	400
Guam	None	None
Hawaii	None	None
Idaho	15	2,900
Illinois	11	30,300
Indiana	15	25,000
Iowa	6	6,000
Louisiana	2	3,500
Maryland	6	9,400
Minnesota	3	Less than 100
Missouri	4	23,900
Nebraska	8	5,500
New Mexico	None	None
North Dakota	4	600
Ohio	11	85,300
Oklahoma	13	17,500
Puerto Rico	11	20,000
Rhode Island	8	2,900
South Carolina	5	44,500
South Dakota	6	1,700
Tennessee	None	None
Texas	6	39,000
Virgin Islands	9	None reported
Wisconsin	None	None
Stand-alone program		
Arizona	2	3,600
Colorado	8	17,400
Delaware	None	None
Georgia	2	4,000
Kansas	None	None
Montana	None	None
Nevada	3	2,700
New York	8	270,700
North Carolina	3	26,800

(continued)

States and territories[a]	Months in operation	Estimated enrollment
Oregon	6	10,400
Pennsylvania	7	68,400
Utah	5	5,000
Vermont	3	400
Virginia	2	2,100
Combination program		
Alabama	11	20,600
California	10	63,100
Connecticut	6	6,900
Florida	9	60,500
Kentucky	6	5,500
Maine	6	5,200
Massachusetts	15	42,100
Michigan	8	11,600
Mississippi	6	3,500
New Hampshire	8	200
New Jersey	10	29,600
West Virginia	6	300
Total		**982,000**

[a]The Northern Mariana Islands, Washington, and Wyoming had not submitted SCHIP plans as of April 1, 1999.

Despite the availability of these estimates, it is still too early to assess the effect of state outreach efforts from any enrollment figures. Differences in implementation schedules, preparedness, and eligible populations complicate any comparison across states. For example, California created a new stand-alone program that began enrollment in July 1998. In contrast, Florida, New York, and Pennsylvania rolled over enrollees from their previously state-funded children's programs. Many states in our sample told us that a significant number of persons applying for SCHIP have been determined to be eligible for Medicaid, approximately two eligible for Medicaid for every one eligible for SCHIP in both Massachusetts and Michigan. Thus, SCHIP enrollment figures do not reflect the simultaneous progress made in enrolling uninsured children into Medicaid. Finally, another important factor influencing the enrollment growth rate is that many states' program designs are still evolving and do not fully use their SCHIP allotments. While SCHIP is likely to be judged by enrollment, this factor should not be viewed as the sole indicator of the program's success.

Other considerations in determining SCHIP's effectiveness include whether enrolled children actually visit the doctor, receive the appropriate preventive and treatment services, and improve their overall health.

Despite Divergent Views, the States Are Taking Steps to Avoid Crowd-Out

State and federal efforts to avoid crowd-out reflect some of the divergent views regarding the significance of this phenomenon as well as differences over whether effective tools exist that could dampen or deter crowd-out. The concern over crowd-out—that is, the substitution of newly created public coverage perceived to be less costly or more generous for already existing health insurance—is underscored by title XXI's statutory mandate for close coordination between SCHIP, private health insurance, and Medicaid. The concern is twofold:

- for existing private health insurance, that individuals will drop their employer-based or individually purchased coverage or that employers will effectively reduce their health coverage for employees and,
- for Medicaid, that children who are currently eligible but not enrolled may be attracted to SCHIP by new state outreach efforts or that the states may enroll children eligible for Medicaid in SCHIP to take advantage of the enhanced federal matching rate.[68]

The states responded to the coordination mandate with a variety of measures to address the potential crowd-out of both Medicaid and private insurance. To ensure that SCHIP does not become a substitute for Medicaid, most states with a stand-alone component are using joint applications and must first screen for Medicaid and enroll any children found eligible for that program. With regard to private insurance, state crowd-out mitigation tools for SCHIP mirror strategies adopted in other state-funded health insurance programs and suggested by researchers.

Targeted Families' Access to Other Insurance Underlies Concern About Crowd-Out

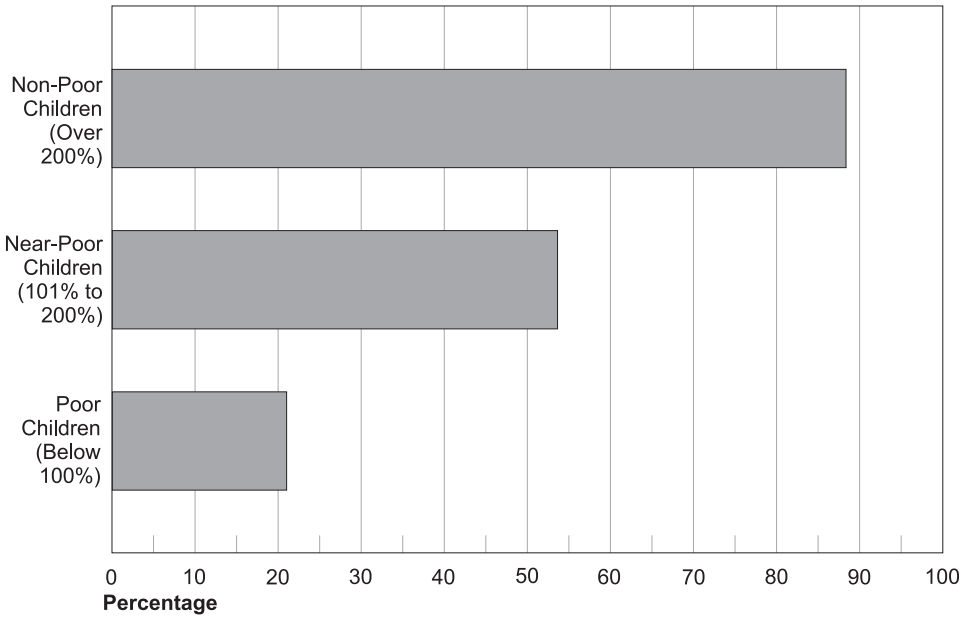
Quantifying the potential extent and effect of crowd-out under SCHIP is difficult, in part because the results of previous crowd-out studies cannot be directly used to predict SCHIP crowd-out experience. Most studies examining previous public health insurance expansions focused on Medicaid populations quite different from those eligible for SCHIP and not subject to crowd-out prevention strategies. National studies found crowd-out occurring at higher levels than did state-focused studies—15 to 17 percent compared with 5 to 7 percent. Another complication is the problem of separating the effect of public insurance expansions from other insurance trends occurring at the same time. Finally, no studies have determined which of the many existing crowd-out prevention measures are the most successful and under what state conditions they should be applied.

[68]On concern about whether employers may reduce their premium contributions or provide less service coverage, see David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" The Quarterly Journal of Economics, 111:2 (1996), pp. 391-430.

Despite these uncertainties, researchers believe that private insurance is more likely to be substituted when public programs serve individuals at higher income levels, who are more likely to have access to and are able to afford some level of employer-sponsored or individually purchased insurance.[69] Congressional concern about SCHIP's potential for crowd-out also arises from the higher incomes of targeted families with children—between 100 and 200 percent of the poverty level—who often are referred to as near-poor or low-income working families. One study highlights the potential for crowd-out among the near-poor. As shown in figure V.1, the report found that more than twice as many near-poor children as poor children were covered by private insurance. Underscoring the potential for crowd-out, ten states in our sample cover children living in families with incomes at 200 percent of the poverty level or greater (see appendix II, table II.2). While children in families with higher incomes will be more likely to have, or to have access to, employer-based dependent insurance, these families also may be attracted to the lower-cost public programs if they find the purchasing power of their wages declining and their premiums increasing.

[69]See Deborah J. Chollet, Michael Birnbaum, and Michael J. Sherman, Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience (Washington, D.C.: Robert Wood Johnson Foundation, Oct. 1997), p. 17, and O'Brien and Feder, How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?

Figure V.1: Children With Employer-Sponsored or Other Private Insurance by Federal Poverty Level, 1996



Note: Insured status does not include coverage under Medicaid, CHAMPUS, or Medicare.

Source: Percentages derived from Kenneth E. Thorpe and Curtis S. Florence, Covering Uninsured Children and Their Parents: Estimated Costs and Number of Newly Insured (New York: The Commonwealth Fund, July 1998); tabulations taken from the March 1997 CPS.

Estimates of possible crowd-out as well as views on the importance attached to crowd-out differ. The Urban Institute's projection of crowd-out ranges from 22 to 36 percent of SCHIP enrollees.[70] In analyzing the SCHIP legislation, CBO offered a long-term assessment that 40 percent of ultimate SCHIP participants would have had some other form of insurance coverage. CBO based its projection on both a review of crowd-out under earlier Medicaid eligibility expansions and the anticipated reaction of labor markets to SCHIP. Over time, CBO concluded, labor markets will adapt to the existence of federal subsidies, with low-income workers receiving more compensation in the form of wages and less in the form of health

[70]The Urban Institute estimated that if 20 percent of families dropped their employer's dependent coverage to enroll children in SCHIP, then about 36 percent of all new SCHIP participants would be substituting their private insurance for public coverage. If 10 percent dropped coverage, then the crowd-out would amount to 22 percent of the new SCHIP children. See Lisa Dubay, Session 5: Exploring Potential for "Crowd Out" Under CHIP, presentation at the Agency for Health Care Policy and Research Workshop entitled CHIP: Implementing Effective Programs and Understanding Their Impacts, Portland, Oregon, Sept. 1998.

insurance. In fact, CBO analysts suggested that some displacement of private insurance is inevitable in the trade-off between the SCHIP goals of stable insurance coverage for children and crowd-out prevention. Under this scenario, if children who move in and out of private insurance based on their families' changing jobs and incomes were to qualify for consistent coverage under SCHIP, then their previous private insurance is crowded out. However, these children gain more reliable access to health coverage and a greater likelihood of receiving both preventive and primary health care, leading to improved health status.

According to a January 1998 telephone survey of 450 businesses conducted by the Maternal and Child Health Policy Research Center, most companies are unlikely to make significant changes in the health coverage they offer to employee dependents as a result of SCHIP.[71] The availability of new public insurance for low-income children would persuade 7 percent of those surveyed to stop offering dependent health insurance coverage. Another 5 percent said they would consider dropping coverage, while 12 percent would not drop coverage but would increase the cost or decrease the value of dependent health insurance. When the employers likely to drop coverage were informed that children would have to wait 3 months to be eligible for public coverage, the number willing to eliminate coverage fell from 7 to 3 percent. Only 1 percent of businesses would drop coverage if the waiting period was 6 months, and none of the employers would drop coverage if children had to wait 12 months for new public insurance.

In addition, a number of studies indicate that the effect of some crowding out of private insurance may be less negative than expected. While some researchers believe that crowd-out leads to problems in ensuring that public dollars serve targeted populations, and may actually increase the cost of public insurance programs, analyses by the Urban Institute show that the costs of crowd-out from the expansions of the late 1980s and early 1990s did little to increase overall Medicaid costs and suggest that

[71]The survey was conducted as part of a larger study of employer-based coverage of dependent children. The sample consisted of an equal distribution of small, medium, and large businesses and was regionally stratified. Small businesses had 10 to 99 employees, medium-sized businesses had 99 to 1,000 employees, and large businesses had more than 1,000 employees. The sample included a significant proportion of businesses most likely to employ low- and moderate-wage workers. See Fox and McManus, The Potential for Crowd Out Due to CHIP.

crowd-out will not siphon off a significant portion of SCHIP funds.[72] Moreover, some states have pointed out that prohibiting insured children from participating in SCHIP does not take into account the quality of their existing insurance coverage, which may be much more limited than either Medicaid or the SCHIP benchmark plans. For example, Alabama officials said the state is "rife with poor coverage," including catastrophic plans with large deductibles that provide no incentive for preventive care. Finally, some researchers who attempted to estimate the extent of crowd-out suggested that there may be benefits in the health improvements gained when expanded public insurance that encourages the use of preventive care substitutes for private coverage.[73]

HCFA Focuses Crowd-Out Scrutiny on High-Risk SCHIP Designs

While title XXI requires the states to address crowd-out, the Congress provided no direction to HCFA or the states on how to do so. In fact, title XXI somewhat limits the states' ability to employ higher cost-sharing or benefit limitations, tools used previously to prevent crowd-out. As we noted in appendix II, the states must follow either Medicaid or SCHIP restrictions on cost sharing, depending on the state plan design and a child's family income level. However, several states, including Arkansas and Nevada, have indicated a preference for gradually increasing cost-sharing levels for children in families with higher incomes. They suggest that SCHIP's limits on cost sharing for higher-income families make their contributions artificially low compared with those in the private market. Thus, the limit may reduce incentives to keep private coverage. The states are required to use one of several benchmark benefit packages outlined in title XXI. For some states with employer-based coverage less generous than SCHIP coverage, the relative richness of these benchmark packages contributes to the crowd-out concern.

As a consequence of title XXI's limited direction on crowd-out, HCFA's guidance to the states was based on the available research and has evolved as the agency has gained more experience in reviewing state plans. On February 13, 1998, the agency issued guidance for states that elected to provide coverage directly through a stand-alone program or a Medicaid expansion and issued separate requirements for states electing to subsidize employer-sponsored group health plans. Regarding the former,

[72]See David M. Cutler and Jonathan Gruber, "The Effect of Medicaid Expansions on Public Insurance, Private Insurance, and Redistribution," American Economic Review, 86:2 (1996), pp. 378-83; Chollet, Birnbaum, and Sherman, Deterring Crowd-Out in Public Insurance Programs; Robert Wood Johnson Foundation October 1997 Monograph; and John Holahan, "Crowding Out: How Big a Problem?" Health Affairs, 16:1 (1997), pp. 204-6.

[73]David M. Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," Health Affairs, 16:1 (1997), pp. 194-200.

HCFA imposed no specific crowd-out mechanisms; rather, it indicated that the states, especially those with higher income eligibility levels, must address the crowd-out of private insurance in some manner. The states were put on notice that HCFA would later review their crowd-out efforts and might require them to alter their plans if crowd-out proved to be a problem. Because HCFA believes that there is greater potential for substitution when states attempt to subsidize employer-based coverage, the guidance spells out a specific five-point mandate for states that pursue this option. Their SCHIP programs must incorporate provisions that are "substantially equivalent" to the following:

- adopting a 6-to-12-month waiting period during which children must have no existing insurance;
- allowing subsidies only where the employer covers at least 60 percent of the employee cost;
- demonstrating cost-effectiveness of family coverage, where the cost is no greater than the cost of covering the children alone;
- ensuring that the employer pays the highest level of premium possible; and
- requiring a crowd-out study to help demonstrate cost-effectiveness.

As indicated in HCFA's guidance, the most scrutiny was directed toward programs with eligibility at higher poverty levels and those proposing or considering employer subsidies. HCFA officials told us that any Medicaid expansion that raises income eligibility to higher levels will also be held to crowd out prevention requirements. However, HCFA officials told us that during SCHIP plan review, the agency was sensitive to the states' different needs and circumstances. For example, the states chose different time periods for their waiting periods and will design their own crowd-out studies.

Crowd-Out Strategies Reflect State Design Choices and Experience

Among the 15 states in our sample, strategies to avoid crowd-out varied, depending on program design and poverty level eligibility standards. Title XXI allows all participating states to impose a waiting period, but generally only states that select a stand-alone approach may use cost sharing or the SCHIP benefit design to discourage crowd-out. Unless operating with a section 1115 waiver, states that elect to expand Medicaid must offer the Medicaid benefits package and may not introduce cost sharing for most children. State strategies also differed depending on their level of concern regarding crowd-out, which for some was influenced by previous experience with a state-funded children's health insurance program. At issue for some states was the level of crowd-out that could be

considered acceptable and, thus, not serious enough to address. While several states said that they developed their crowd-out strategies because of local concern, others included prevention measures only as a result of the legislative mandate or HCFA's review. In general, states covering children at higher income levels tend to have more aggressive crowd-out strategies

State Views About Crowd-Out Range Widely

The SCHIP plans of 13 of the 15 states in our sample included strategies that were intended, either directly or indirectly, to help prevent crowd-out. Each of these 13 states' SCHIP programs had income eligibility levels greater than 150 percent of the poverty level.[74] In South Carolina and Texas, the Medicaid expansions were at poverty levels low enough (150 percent and 100 percent, respectively) that significant crowd-out was not considered likely.

States in our sample ranged from exhibiting a deep concern about crowd-out to a conviction, in part based on previous experience, that crowd-out was unlikely to be a problem. For example, Missouri, a Medicaid expansion state raising its eligibility level to 300 percent of the poverty level, had serious concerns about crowd-out and instituted broad-ranging preventive measures, including a 6-month waiting period and cost sharing. In a unique provision, the state required children whose family incomes are between 225 and 300 percent of the poverty level to wait 30 days after enrollment before using health care services. State officials believe this will prevent people from "shopping for health care" only when they are ill.

Several other states agreed to mitigation plans or crowd-out studies only after discussion with HCFA. Connecticut's crowd-out provision—a 6-month waiting period without employer-sponsored insurance—was a response to federal concerns and was developed by studying the tactics of other states and charting a middle course between what others states had chosen. Connecticut officials said that the state built "flexibility" into its prevention strategies by establishing ten exceptions to its waiting period requirement and increasing the waiting period to 12 months if crowd-out

[74]A July 1998 HCFA report also shows that states with higher eligibility levels had more comprehensive crowd-out prevention components. Of the 23 states profiled, the 15 with higher income levels planned waiting periods or studies. The remaining eight states planning only to monitor the situation were covering children with family incomes at or less than 150 percent of the poverty level.

proves to be a serious problem.[75] Most states with waiting periods also allow some exceptions, although in most of the states in our sample they are not as extensive as in Connecticut. Connecticut also coordinates with employers to review 20 percent of its applicants to ensure that they do not have insurance or did not drop available insurance coverage.

States Most Often Choose a Waiting Period as a Prevention Strategy

The crowd-out strategy adopted most often by the states in our sample was to impose a waiting period, as shown in table V.1.[76] The assumption is that parents will not want currently covered children to go without health insurance for several months and, as a result, will be discouraged from dropping private coverage. California initially has selected a 3-month waiting period that will be increased to 6 months if the state finds that it is covering substantial numbers of children previously covered under employer-sponsored plans. In contrast, Rhode Island implemented crowd-out provisions in 1994 when it received approval to expand eligibility and operate its Medicaid program under a section 1115 waiver. The state continued to require a 12-month waiting period when it expanded the program to incorporate SCHIP and requires applicants to be not only uninsured but without access to affordable insurance before applying for SCHIP.[77] All four states conducting studies to determine whether SCHIP programs either resulted in or increased crowd-out will impose some type of waiting period if the studies find that sufficient crowd-out exists.

[75]Exceptions include the loss of employment for reasons other than voluntary termination, a change to a new employer that does not provide a dependent coverage option, and discontinuation of health benefits to all employees by the applicant's employer.

[76]Notably, even Medicaid expansion plans were allowed to implement waiting periods. A HCFA official said that imposing a waiting period on the "targeted low-income children" eligible under SCHIP does not violate Medicaid entitlement rules because the eligibility focus is on the child's income level rather than on the Medicaid eligibility categories. In effect, SCHIP Medicaid expansions can require eligibility criteria for children different from those of regular Medicaid programs.

[77]Rhode Island describes affordable coverage as costing less than $150 per month for premiums for an individual or less than $300 per month in premiums for a family.

Table V.1: Crowd-Out Strategies in 15 States

Strategy	State
Waiting period with no insurance	
1 month	Vt.
3 months	Calif., Colo., Wisc.
6 months	Conn., Mich., Mo., Oreg.
12 months	R.I.
Crowd-out study and implement waiting period or limits to access if needed	Fla., Mass., N.Y., Pa.
Cost-sharing (premiums or copayments)[a]	Calif., Mo., N.Y., Wisc.
Compare SCHIP enrollment to private coverage	Mass., Mich., Pa., Wisc.
State insurance regulation	Calif.

[a]Texas noted plans to use cost sharing in proposed phase II components to prevent crowd-out. Neither Texas' nor South Carolina's Medicaid expansion imposes cost sharing.

Two of these states, Florida and New York, had found low levels of substitution in studies of their previous state-funded children's health programs and questioned how much priority they should place on the issue. Pennsylvania did not have a previous crowd-out study but also disagreed with the importance attached to crowd-out during the review of state SCHIP plans. In the end, all three states finally complied with HCFA's request to include prevention components in their plans. HCFA expressed concern that the existing evaluations might poorly predict SCHIP substitution effects because children targeted under SCHIP had higher incomes than those already in their state-funded programs. Under the agreement reached with HCFA, Florida will conduct a crowd-out study after 6 months of enrollment and will add a 3-month waiting period if crowd-out is greater than that found previously. Florida officials also decided to fully study and reevaluate crowd-out after 36 months of operation. New York agreed to study crowd-out for 9 months and impose a waiting period or restrictions for children with access to insurance if more than 8 percent of SCHIP enrollment is attributed to crowd-out. New York also had argued that a waiting period "penalized" children for actions taken by a parent or employer to drop private coverage. For example, the state was opposed to making a child with asthma wait 6 months for care. Finally, after studying both Florida's and New York's mitigation plans, Pennsylvania agreed to take crowd-out action if at least 12 percent of SCHIP enrollment is the result of crowding out of private insurance.

While 11 states in our sample required participants to pay either premiums or copayments, only 4 characterized their cost-sharing provisions as intended to prevent crowd-out (see appendix II, table II.6). Cost sharing helps narrow the cost difference between public and private insurance, reducing the likelihood that lower out-of-pocket costs for SCHIP will attract individuals with existing insurance. In addition to using waiting periods and cost sharing, some states are using other methods to prevent crowd-out. A few states asserted that eliminating or limiting dental coverage within benefits packages may make a plan less attractive to families with existing insurance. Several states indicated that they plan to periodically check their SCHIP enrollment with private insurers to identify and disenroll or deny coverage to persons who have private coverage or have recently dropped it. For example, Pennsylvania provides SCHIP benefits through five state grantees—a health maintenance organization and four subsidiaries of large health insurance providers. These grantees will compare SCHIP applicants' names with the names of their commercial subscribers to determine whether they have other coverage. Michigan is considering whether to contract with Blue Cross and Blue Shield to compare its applicants with their commercial enrollees and with Medicaid. This venture would allow the state to review coverage for about 75 percent of people with health insurance in Michigan. To protect its public programs, California passed insurance regulations that prohibit insurance agents from referring children covered by employee plans to the state's stand-alone program.[78] The state also makes it an unfair labor practice for an employer to either refer a covered employee to SCHIP or change the employee's coverage or cost sharing to induce enrollment in the state program.

Several state officials expressed concern that HCFA did not use consistent standards among states for crowd-out studies. HCFA officials acknowledged that crowd-out scrutiny evolved as they gained more review experience. Agency representatives said that they intentionally did not set specific crowd-out study standards in order to consider each state's previous crowd-out research and its expectations of SCHIP's effect. For example, New York's previous study, which was conducted when the state provided only outpatient care and not the hospitalization included in the SCHIP expansion, found only a 2-percent crowd-out effect. HCFA, however,

[78]In addition to California, Rhode Island had previously enacted legislation that prohibits employers from dropping coverage for lower-income employees who might be eligible for publicly funded programs while maintaining insurance coverage for higher-income employees. The law includes civil penalties and extends a federal requirement that applies only to employers who choose to bear the financial risk of offering coverage themselves to firms that rely on an insurance company to bear the risk.

believed that the expansion of both the poverty level and benefits under New York's SCHIP stand-alone would increase crowd-out. After negotiations, the state agreed that an 8-percent crowd-out effect would trigger prevention measures. In contrast, Florida's study had indicated a 10-percent crowd-out effect under its previous state program. Therefore, HCFA officials said, Florida's waiting period should be triggered if the same level, or higher, crowd-out occurs with its SCHIP program.

States Face Crowd-Out Scrutiny If They Explore Employer-Based Options

Although HCFA views crowd-out as particularly worrisome for states that elect to subsidize employer-based insurance, some states and analysts view such subsidization as helping preserve employer-based coverage. As of April 1, 1999, only Massachusetts and Wisconsin had received approval for the employer-subsidy option under their SCHIP programs, although several other states have expressed interest in this option for future SCHIP amendments. Massachusetts believes that the incentives for employees to drop workplace coverage are removed with its premium assistance program; the SCHIP stand-alone program covers low-income families with access to employer insurance who have not enrolled, while the state's section 1115 Medicaid waiver can assist those who already pay for employer coverage. State officials said that their challenge will be to educate families that they do not have to drop existing employer coverage in order to be eligible for premium assistance. Massachusetts is more concerned about the response of employers that may have an incentive to reduce their premium contribution, thereby increasing the public subsidy, or to drop dependent coverage entirely. The state will conduct a survey of employers to track contribution levels and other state insurance trends. If it finds evidence of employer-connected crowd-out practices, Massachusetts will attempt to develop corrective action plans. California, which is planning to submit an employer subsidy amendment, told us that keeping children in their parents' employer-based insurance programs ameliorates crowd-out by providing an affordable option to families. With the SCHIP subsidy, families are able to buy the previously unaffordable dependent coverage offered at their workplace.

Coordination Requirements Seek to Limit SCHIP's Crowding Out of Medicaid

Title XXI reflects a concern that SCHIP might substitute for traditional Medicaid coverage. The states might have an incentive to enroll children who are eligible for Medicaid in SCHIP, since the federal financial match is higher for the new program. Children's advocates were concerned that children who are eligible for Medicaid and are incorrectly enrolled in a stand-alone program would have less generous benefits or would find themselves dropped from coverage when or if SCHIP funding ended,

because the program, unlike Medicaid, is not an entitlement. As a result, state coordination efforts were mandated to ensure that children who qualify for Medicaid are enrolled in that program rather than in a SCHIP program and that their applications are fully processed for Medicaid when they are not eligible for SCHIP. HCFA's plan review process led some states to upgrade their screening strategies to check children first for Medicaid eligibility and to create closer links between stand-alone and Medicaid programs.

The possibility of SCHIP substitution is highlighted by the large numbers of children who are eligible for Medicaid now but have no health insurance. Nearly one-fourth of the children who currently are eligible are not enrolled. For example, California has estimated that while it has 400,000 children eligible for its stand-alone program, another 600,000 children are eligible but not enrolled in its Medicaid program. Children who are eligible for Medicaid but not enrolled may be likely to apply for SCHIP programs if they are attracted by the new outreach efforts that the states have developed to attract children and their families eligible for SCHIP. CBO estimated that nationwide the "outreach effect" of SCHIP will increase Medicaid spending by $2.4 billion over the first 5 years of SCHIP enrollment because of an increased enrollment of 460,000 children eligible for Medicaid each year.[79]

Title XXI contains three provisions aimed at preventing SCHIP from substituting for Medicaid coverage. First, the states must include assurances in their program plans that they will develop Medicaid coordination strategies. Second, statutory maintenance-of-effort provisions for Medicaid eligibility apply to both Medicaid expansion and SCHIP stand-alone plans. States with stand-alone components cannot adopt income and resource methodologies for children eligible for Medicaid that are more restrictive than those in effect on June 1, 1997. Medicaid expansion programs cannot use the SCHIP enhanced match rate for any child who would have been eligible for Medicaid under standards in effect on March 31, 1997. Finally, any child who applies for SCHIP must be screened for Medicaid and then enrolled if found eligible. Missouri officials listed the strong coordination requirements in the legislation as a factor that supported the decision to fold SCHIP into an application for a section 1115 waiver and an expanded Medicaid program.

[79]Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies (GAO/HEHS-98-93, Mar. 20, 1998).

HCFA's approach during plan review was to query states closely and require assurances that they would plan to screen and enroll applicants eligible for Medicaid. HCFA asked 8 of our 15 sample states for more information about how they intended to meet the screening and enrolling requirement, and a few states amended or revised their planned screening processes to meet HCFA's standards. In response to HCFA's review, for example, Pennsylvania developed a common application form and initial Medicaid screening to ensure Medicaid enrollment. Colorado had developed a nonautomated screen to prevent children eligible for Medicaid from enrolling in its previously state-funded insurance program. Because HCFA did not consider the screen adequate for SCHIP, the state hired a Medicaid consultant to create a new computer-based program to screen applicants. Even with this computerized method, Colorado officials characterized the screening process as time-consuming and administratively costly.

States Find That Their Screens for Medicaid Eligibility Meet the Title XXI Mandate

Coordination with Medicaid is easy for a Medicaid expansion state because SCHIP is administratively part of its Medicaid program. In contrast, some stand-alone programs went to significant time and expense to create new administrative structures and find ways to connect them with Medicaid. The most practical way for states with stand-alone components to meet the legislative mandate to screen and enroll is to check first for Medicaid eligibility. The states in our sample with stand-alone components have all included screening for Medicaid eligibility as the first step in the eligibility determination process. They are also using a joint application form for both programs, which simplifies the process. All but 2 of the 48 states whose applications had been submitted to HCFA by October 8, 1998, were using or planning to use a single application for regular Medicaid and SCHIP-related applicants.[80]

Some states are also using a single agency or entity to screen and track referrals for both programs or are developing a coordination plan if two offices are involved. For example, Connecticut and Michigan use a private contractor to accept applications for both the expanded Medicaid and the new stand-alone programs and to forward appropriate applications to the state Medicaid eligibility agency. Connecticut's Single Point of Entry Servicer screens all applications and, if a family appears to be eligible for Medicaid, sends its application to the Department of Social Services (DSS) for final eligibility determination. The contractor keeps daily logs of

[80]HCFA reported that Colorado, Florida, Montana, Nevada, and North Carolina, all with stand-alone components, are not using joint applications. However, Colorado and Florida indicated in interviews that they are using joint applications, while North Carolina had adopted a joint application by April 1, 1999.

referrals to DSS, and the state has a tracking system to follow referrals once they reach the DSS office. In Colorado, the stand-alone administrator and Medicaid office developed an agreement that each will forward applications for children who appear to qualify for the other's program. Other states, including California and New York, compare SCHIP participant lists against Medicaid enrollment files to ensure that children are not already covered.

As anticipated under the enabling legislation, several states have found a significant number of children who are eligible for Medicaid as initial applicants for their new SCHIP programs. Connecticut has found that approximately 8,000 of the 11,000 children determined to be eligible since SCHIP's implementation are eligible for Medicaid, including the SCHIP Medicaid expansion component. The remaining 3,000 are in the state's stand-alone SCHIP component. New York officials believe that anywhere from 20 to 40 percent of the approximately 170,000 children already in its existing state program will be found to be eligible for Medicaid. New York's request for retroactive funding for its state-turned-SCHIP program was denied because its state-funded program lacked an extensive Medicaid screening and enrollment process and because its program did not meet the title XXI premium and cost-sharing limits. HCFA indicated that it will not include expenses for children eligible for Medicaid in a payment for health expenses retroactive to October 1997. New York has requested an "indefinite continuance" of its appeal, which is before an administrative law judge. Others have reported finding applicants inflating income in order to qualify for SCHIP rather than Medicaid or refusing to continue the application process, once they are deemed ineligible for SCHIP, to avoid Medicaid enrollment.

As SCHIP programs evolve, coordination plans may be complicated by the income volatility many low-income families experience from fluctuation in their paychecks and changing employment. Periodic reviews of SCHIP eligibility will result in states shifting any children found eligible for Medicaid out of SCHIP and into title XIX. This suggests that at redetermination of eligibility, there could be significant movement in and out of stand-alone and Medicaid programs. The changes may result in either health care coverage lapses as children move into and out of programs or situations in which states use SCHIP funds to cover individuals whose changed income has made them ineligible. The states may offset these problems by choosing to allow continuous eligibility for up to 12 months for participants in both Medicaid and SCHIP programs. Eight of the 15 states in our sample use 12 months of continuous eligibility for SCHIP

programs, while 3 have a 6-month allowance. Additionally, California has instituted a 1-month bridge eligibility transition period from Medicaid to the stand-alone SCHIP program to give those who lose Medicaid eligibility time to enroll in the SCHIP program while continuing to receive health coverage. Michigan allows children who become eligible for Medicaid because of high medical expenses to remain enrolled in SCHIP to ensure continuity of care. Finally, HCFA officials noted that if a family's financial circumstances changed, making its children eligible for Medicaid, it could request that the children be switched from SCHIP to Medicaid.

Key SCHIP Design Characteristics in 15 States as of February 1999

State	FY 1998 SCHIP allocation (millions)	Initial design	Eligibility[a]		Stand-alone coverage basis[b]
			Maximum income	% of federal poverty level	
California	$854.6	Combination	$32,900	200%	Secretary-approved coverage
Colorado	41.8	Stand-alone	30,433	185	Benchmark equivalent
Connecticut	34.9	Combination	49,350	300	Secretary-approved coverage
Florida	270.2	Combination	32,900	200	Existing state coverage
Massachusetts	42.8	Combination	32,900	200	Benchmark
Michigan	91.6	Combination	32,900	200	Benchmark
Missouri	51.7	Medicaid expansion	49,350	300	
New York	255.6	Stand-alone	36,519	222	Existing state coverage
Oregon	39.1	Stand-alone	27,965	170	Secretary-approved coverage
Pennsylvania	117.5	Stand-alone	32,900	200	Existing state coverage
Rhode Island	10.7	Medicaid expansion	49,350	300	
South Carolina	63.6	Medicaid expansion	24,675	150	
Texas	561.3	Medicaid expansion	16,450	100	
Vermont	3.5	Stand-alone	49,350	300	Secretary-approved coverage
Wisconsin	40.6	Medicaid expansion	32,900	200	

Cost-sharing practice	Potential amendment: Coverage	Potential amendment: Stand-alone component	Eligibility and enrollment simplification[c]	Crowd-out strategy[d]	Enrollment[e]
Premiums, copayments	Employer buy-in for children		No asset test, continuous eligibility	Waiting period, cost sharing, insurance regulation	63,100
Premiums, copayments	Family		Continuous eligibility	Waiting period	17,400
Premiums, copayments	Family		No asset test, presumptive eligibility, continuous eligibility	Waiting period	6,900
Premiums, copayments	Employer buy-in for children		No asset test, continuous eligibility	Crowd-out study	60,500
Premiums, copayments	None		No asset test, presumptive eligibility	Crowd-out study, compare enrollment with private data	42,100
Premiums	Family		No asset test, presumptive eligibility, continuous eligibility	Waiting period, compare enrollment with private data	11,600
Premiums, copayments	None	None	No asset test, presumptive eligibility, continuous eligibility	Waiting period, cost sharing	23,900
Premiums	None		No asset test, presumptive eligibility	Crowd-out study, cost sharing	270,700
None	Family		Continuous eligibility	Waiting period	10,400
None	None		No asset test, continuous eligibility	Crowd-out study, compare enrollment with private data	68,400
Premiums, copayments	Family	None	No asset test, continuous eligibility	Waiting period	2,900
None	None	None	No asset test, continuous eligibility	None	44,500
None	None	Planning	None	None	39,000
Premiums, copayments	None		No asset test	Waiting period	400
Premiums, copayments	None	None	No asset test	Waiting period, cost sharing, compare enrollment with private data	None

[a]Maximum income is for a family of four at that poverty level. States may increase eligibility up to 50 percentage points above current Medicaid eligibility levels or to 200 percent of the federal poverty level. Some states do not consider certain portions of income, thereby effectively increasing eligibility level above 200 percent.

[b]For a description of benchmark coverage options, see appendix II.

[c]For a description of state approaches to simplifying eligibility and enrollment, see appendix IV.

[d]For a description of state strategies to prevent the substitution of SCHIP for either Medicaid or private health insurance, see appendix V.

[e]States generally reported enrollment to HCFA as of December 31, 1998. (See appendix IV.)

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

Ms. Kathryn G. Allen
Associate Director
Health Financing and Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

Enclosed are the Department's comments on your draft report entitled, "Children's Health Insurance Program: State Approaches Are Evolving." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided extensive technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano
for June Gibbs Brown
Inspector General

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Children's Health Insurance Program: State Approaches Are Evolving"

The Department appreciates the opportunity to comment on the draft report by the U.S. General Accounting Office (GAO). This report provides valuable information to Federal and State policy-makers, advocacy groups and other interested parties on the status (as of January 1999) of implementation of the new State Children's Health Insurance Program (CHIP), with particular emphasis on 15 States that had been approved before January 1999.

The Department is pleased with GAO's finding that the States and the Federal Government have made considerable progress in implementing CHIP. In the year and a half since the program was enacted, the Department's Health Care Financing Administration (HCFA) has approved 51 CHIP plans (as of March 31, 1999.) We approved the first State plan, for Alabama, in January 1998--just 5 months after the legislation was signed. Of those 51 CHIP approvals, 14 create or expand a separate State CHIP program, 25 expand existing Medicaid programs and 12 use a combination of these two approaches. States and Territories have told HCFA that these programs have the potential to provide coverage for up to an estimated 2.5 million children by Fiscal Year (FY) 2000.

The Department agrees with GAO's finding that although CHIP plans were evenly divided as of January 1999 between Medicaid expansions and programs with a separate State CHIP component, the State design choices for CHIP will continue to evolve and more States will eventually include a separate, non-Medicaid component in their programs. The diversity of State approaches highlighted in the GAO report demonstrates the considerable flexibility that the law gives States to design programs that meet their unique needs. The Department also agrees with GAO's conclusion that since a number of State plans are not fully operational, it is too soon to evaluate the outcomes of the program. Nevertheless, we are actively working with our regional offices and the States through monitoring and technical assistance to assure that States will be able to accurately reflect the outcome of their programs over time. The HCFA Administrator recently sent a letter to the States stressing the need for States to file requested data in a timely manner.

As noted in the GAO report, a number of States have submitted and many more intend to submit amendments to their initial programs. As of March 31, we already have approved 13 amendments for eligibility expansions or program changes. Another 10 such amendments are under review. We believe that most States will eventually expand eligibility for children up to 200 percent of the Federal poverty level (FPL). Half of the

approved CHIP plans already expand coverage to above 200 percent of the FPL.

It is correct that the statutory requirements for CHIP present challenges for States wishing to adopt family coverage and subsidize employer-sponsored coverage. However, these requirements are also intended to offer important protections to enrollees, particularly in the areas of benefits and cost-sharing. We also believe that family coverage and employer buy-in together with providing coverage to the underinsured are likely to become more visible issues in the next year. As most States have secured their CHIP allotments with at least a "place-holder" plan as of March 1999, the Department shares GAO's view that they will begin to explore using some of the flexibility provided in the statute to achieve broader goals. For example, a number of States have indicated their interest in subsidizing the premium for purchase of employer-sponsored coverage. While this approach is complicated and has issues that are difficult to address, we will continue to work closely with States to develop appropriate resolutions. For example, HCFA recently sponsored a meeting with several key States to both address employer-sponsored coverage and to develop models that States considering this approach could use.

The Department has been impressed with the innovative outreach activities undertaken by the States to provide the public with information about the program as well as to simplify and streamline enrollment. As GAO shows, States have undertaken many different strategies to identify and enroll children. Outreach is key to the success of the program. We are working with States to gather and share outreach success stories and to help States address enrollment issues. We also recognize that States may need more funding for outreach because of the limit of a 10 percent cap on administrative expenditures. The President's FY 2000 budget includes proposals to allow States to spend additional funds on outreach. We will continue to work with States and to provide even more support as they enhance outreach efforts to identify eligible children and to ensure that these children receive appropriate care.

In addition, the President established the Interagency Task Force on Children's Health Insurance Outreach (Task Force) in February 1998, including eight Federal agencies. The Task Force published a report in June 1998 that proposed a coordinated outreach effort to identify and enroll uninsured children in CHIP and Medicaid. For example, the Department of Agriculture will be providing child health insurance information to all of their Agriculture extension service offices; the Social Security Administration is distributing posters and information to all of their local offices; and the Department will distribute information to all of their community and migrant health centers as well as Indian Health Service clinics. The Task Force will actively promote these efforts and will submit an updated report to the President in June on each agencies' innovative activities. A national media campaign was developed using radio and television to enhance States' efforts to increase enrollment. This includes the promotion of the national toll-free number, 1-877-KidsNow, a part of the "Insure Kids Now" initiative which includes

launching a new website, developing a series of public service announcements, and initiating other Federal outreach efforts.

We are also taking lessons learned from early successes in States and sharing them widely. We have issued two letters to States providing guidance on how to simplify and streamline the eligibility process. This guidance included a simplified model application form that can be used as a joint CHIP and Medicaid application. The HCFA is expanding its website to facilitate sharing outreach innovations. We have held several outreach conferences around the Nation to identify more innovative and successful strategies used by State and local communities. In addition, HCFA is sponsoring, with the Health Resources and Services Administration, a series of focus groups and technical advisory panels to share successful outreach innovations that States develop.

Finally, the Department agrees with GAO's assessment that the range of States' crowd out strategies demonstrates differing views among States about the importance of crowd out. The statute is clear that States must have strategies to ensure that CHIP does not substitute for existing coverage--public or private. To ensure that funds are used for uninsured children as required by the statute, we have worked with States on their CHIP plans to prevent crowd out. We are also working with States to gather information on the extent of crowd out in their programs and to identify the most effective strategies for measuring and preventing crowd out.

The Department looks forward to consulting with GAO as we work to achieve the objectives of CHIP in the future.

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