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Congressionally Mandated Evaluation of the State Children's Health Insurance Program

Final Cross-Cutting Report on the Findings from Ten State Site Visits

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EXECUTIVE SUMMARY

In August 1997, Title XXI of the Social Security Act was signed into law, creating the State Children's Health Insurance Program (SCHIP), an ambitious federal-state initiative aimed at extending health insurance coverage to many of the nation's estimated 10 million low-income uninsured children. Approximately $40 billion in federal funds was made available for fiscal years 1998 through 2007. Two years after the creation of SCHIP, Congress mandated an independent federal evaluation of the program as part of the Balanced Budget Refinement Act (BBRA) of 1999. The legislation specified that 10 states be included in the evaluation, for the purposes of assessing the effectiveness of alternative outreach strategies, the coordination of SCHIP with Medicaid, and the effects of cost-sharing on retention, among other issues. Mathematica Policy Research, The Urban Institute, and MayaTech Corporation have teamed to conduct the evaluation, which comprises both quantitative and qualitative analytical components.

During the first two years of the evaluation, case studies of the 10 study states—California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas—represented the major activity of the qualitative assessment. The case studies were designed to provide an in-depth understanding of why states designed SCHIP programs as they did, how the programs were implemented, the challenges faced in implementation, and the perceived outcomes of these efforts. The case studies were also designed to inform the quantitative components of the evaluation and help researchers better analyze and interpret survey findings. This report represents the final product of the case study component of the evaluation, and summarizes the findings from site visits conducted between May 2001 and January 2002.

Overview of SCHIP Programs in the 10 Study States

The 10 study states each responded rapidly to the optional authority granted them by Title XXI; seven had submitted SCHIP plans to the Health Care Financing Administration (now called the Centers for Medicare & Medicaid Services, or CMS) within six months of the passage of the Balanced Budget Act of 1997 (BBA), and only Louisiana, North Carolina, and Texas were somewhat slower in submitting their initial state plans. All of the states implemented at least the initial phases of their SCHIP initiatives during 1998. The responses by the study states are quite consistent with how states reacted across the nation to the creation of SCHIP.

The BBA provided states with three options for increasing coverage under SCHIP: expanding Medicaid, creating a new insurance program separate from Medicaid, or implementing a combination of both. Our 10 study states include examples of each approach: Louisiana and Missouri enacted Medicaid expansions; Colorado and North Carolina created separate programs; and California, Florida, Illinois, New Jersey, New York, and Texas each chose to adopt combination approaches. This distribution of program types is somewhat different from that seen nationally, where roughly one-third of the 50 states and the District of Columbia implemented Medicaid expansions; while roughly two-thirds created separate programs, either alone or in combination with Medicaid expansions.

The upper-income eligibility thresholds ultimately adopted by the study states vary considerably—from 185 percent of the federal poverty level (FPL) in Colorado and Illinois, to

350 percent of the FPL in New Jersey. Before SCHIP, the average income threshold for children in these states was 111 percent of the FPL. After SCHIP, this average income threshold increased to 232 percent of the FPL, an increase of 121 percentage points. This increase in children's average income thresholds is somewhat higher than the average increase across all 51 states.

Among our 10 study states, four had the highest numbers of low-income uninsured children in the nation in 1997—California, Florida, New York, and Texas—and the other six were above average on this measure. Not surprisingly, therefore, our study states also reflect higher-than-average SCHIP enrollment.

Factors Influencing Policy and Program Design Choices

State officials interviewed for our case studies cited a number of factors as contributing to their swift response to Title XXI. These included the availability of enhanced federal matching funds, bipartisan support for children's health insurance expansions, and strong economies in the states at the time. In addition, in Colorado, Florida, and New York, state-funded child health insurance programs were already in place when Title XXI was created, thus state officials were also driven by the financial incentive to capture new federal matching funds to support existing programs. Our case studies found that a range of environmental factors influenced state officials' decisions regarding what type of children's insurance program to adopt. In both Louisiana and Missouri, for example, we learned that state officials chose to expand Medicaid because it was seen as efficient, permitting the states to build on existing administrative infrastructures; it offered the optimal benefits package for children; and was viewed positively by state legislators as a well-run program.

Case study respondents in the eight states that elected to create separate SCHIP programs, either alone or in combination with Medicaid expansions, identified a very different set of influencing factors. The environment in these states typically included:

- Political resistance to significant expansion of Medicaid because it is a federal entitlement program;
- Legislative and/or gubernatorial dislike of the Medicaid program and its "uncontrollable" budget;
- Provider dislike of Medicaid, usually arising from low payment rates; and a
- Perception that consumers were resistant to Medicaid, attaching a stigma to the program and its welfare-based eligibility process, which was described as onerous, complex, and intrusive.

Officials in these states viewed Title XXI as an opportunity to test (or continue) new models of health insurance patterned after private insurance, to build new partnerships between government and the private sector, and to design systems that were distinctly different from the Medicaid/welfare models of the past.

Outreach

States enacting SCHIP aggressively publicized the availability of new health insurance coverage for children through outreach. As the study states assessed alternative strategies, most concluded that multi-pronged approaches that involved both broad, statewide marketing to create a strong “brand identity” for their programs were needed, as well as more targeted, community-based efforts to attract “hard-to-reach” families.

In marketing SCHIP to families with uninsured children, the study states undertook a fairly consistent set of strategies. In most cases, they created program names that project positive images or brand identities (e.g. *Child Health Plus, Healthy Families, KidCare*), launched television and radio advertising campaigns (often targeting ethnic media outlets), distributed and posted a range of promotional print materials, worked with health plans to promote SCHIP and/or Medicaid, established one or more toll-free information hotlines, and created websites describing the program.

Community-based outreach was described as a more direct means of talking to families about the importance of coverage, discussing program eligibility rules and application procedures, and correcting misconceptions about SCHIP and Medicaid. Often, such outreach was seen as the only way states could reach the “hard to reach” ethnic minorities, and working families with no experience in public programs. Through a variety of means, a broad array of local organizations were funded to provide “application assistance,” in the hope that trusted individuals and organizations in the community would connect with parents and persuade them to enroll their children in coverage.

State and local officials interviewed for this study expressed varying degrees of satisfaction with their SCHIP outreach. Generally, case study participants praised the two-pronged approach involving statewide media marketing coupled with community-based efforts. Over time, it appears that several states became more sophisticated and effective in conducting statewide marketing, refining their advertising based on input solicited from consumer focus groups. Even more consistently, we heard that community-based outreach was considered critical to successful SCHIP implementation, that giving local citizens and coalitions the freedom to be creative and design outreach suited to their neighborhoods built “buy in” and commitment to the effort, and that the provision of funding to support application assistance programs gave community-based organizations a direct tool for helping families to enroll their children.

States with separate programs also reported on persistent challenges they faced in marketing SCHIP jointly with Medicaid. Foremost, perhaps, is family resistance to Medicaid. According to state officials in California, Colorado, Illinois, New Jersey, New York, and Texas, some parents with uninsured children are unwilling to enroll their uninsured children in Medicaid due to negative prior experiences with the program’s enrollment process and the association of Medicaid with welfare and poverty. Among immigrant families, the persistent fear of “public charge” and the belief that participation in Medicaid could disrupt their (and their children’s) citizenship applications, was another challenge noted in California, Florida, New Jersey, New York, and Texas.

Enrollment and Retention

The early implementation phase for SCHIP witnessed massive efforts by the states to simplify their procedures for enrolling children into coverage. Specifically, every state in our study developed a joint application form for its SCHIP and Medicaid programs (with page lengths ranging from 2 to 8), and eliminated the requirement for a face-to-face interview with a SCHIP program eligibility worker, permitting SCHIP applications to be submitted by mail; eight of the 10 states dropped the assets test from the SCHIP eligibility process; and six of the 10 extended 12-month continuous eligibility to children. Most states in our study also embraced the notion that families should be provided assistance, when needed, in the SCHIP/Medicaid application process—eight of the 10 study states adopted and funded a variety of assistance mechanisms, creating both telephone-based and in-person assistance capacity in communities throughout their states.

The federally required "screen and enroll" process—whereby states with separate programs must review applicants' potential eligibility for Medicaid before granting them SCHIP coverage—proved challenging for most, but not all, of the study states with separate programs. Often, difficulties grew out of the fact that separate SCHIP programs enacted significantly simpler eligibility rules and procedures than their Medicaid counterparts, creating "disconnects" between the programs and complications surrounding the need to determine children's eligibility multiple times according to differing program rules. Frequently, though, Medicaid programs eventually adopted most of SCHIP's simplification strategies, resulting in streamlined access for children in both programs.

Our study showed that retaining eligible children, and policies to simplify children's renewal of ongoing coverage, received little attention during the SCHIP developmental process and the early years of implementation. Three years into their programs, several of the study states were experiencing challenges in *keeping* children covered. By 2002, however, states were taking steps to streamline the SCHIP renewal process, including designing shorter and simpler renewal application forms, permitting renewal applications to be submitted through the mail; preprinting renewal applications with information already submitted by families on their initial applications; and reducing the need to resubmit documents verifying income and other family characteristics. The simplest system we saw was the State of Florida's "passive" renewal, whereby children are automatically re-enrolled into *KidCare* unless parents inform state officials that the personal and income information sent to them on preprinted renewal applications has changed.

Crowd Out

During the early development of SCHIP, there was considerable concern among state policymakers that SCHIP would lead to a substitution of government-sponsored health insurance for existing employer-based coverage, a phenomenon referred to as "crowd out." In response, officials devised a number of strategies to prevent its occurrence. The major strategy considered was to impose a waiting period, during which children must be uninsured before being allowed to enroll in SCHIP.

Ultimately, seven of the ten study states adopted waiting periods—ranging from two to six months—although two states subsequently eliminated them, and one shortened the length of its waiting period. To ensure that waiting periods did not adversely effect children who had lost insurance for reasons beyond their families' control, numerous "exceptions" to waiting periods

were adopted, including: if a child's loss of insurance is caused by a parent's loss of employment, or a change of employment to a job that lacks dependent coverage, or expiration of COBRA coverage. In addition, many of the states created exceptions for parents who had opted, prior to the creation of SCHIP, to purchase high-cost health insurance beyond their means, or who purchased policies that that were seriously limited in scope, leaving their children "underinsured." The State of North Carolina went so far as to create a blanket exemption for children with special health care needs, assuming that the coverage the state was offering under SCHIP would be both broader in scope, and less costly, than employer-based insurance.

The dominant view across the study states was one of little concern about crowd out. There was a clear perception among most state officials, legislative staff, and advocates that neither consumer- nor employer-based crowd out was occurring at significant levels, and that waiting periods were an effective deterrent to crowd out.

Benefits

States choosing to implement SCHIP through an expansion of Medicaid must extend the full Medicaid benefit package to SCHIP enrollees. However, those adopting separate programs have greater flexibility to adopt more limited benefits, as long as they meet or exceed minimum coverage "benchmarks" outlined in the Title XXI statute. Upon SCHIP's passage, one of the most persuasive arguments among advocates in support of adopting Medicaid expansions was that the move would extend to children the broadest possible benefits and the protections dictated by Medicaid's EPSDT rules. However, policymakers in many of our study states resisted the idea of adopting the Medicaid benefit package, and opted instead to make the SCHIP benefit package more like packages offered in the commercial market, or to the package available to state employees.

The eight states in our study with separate programs chose a variety of benchmarks for their benefits packages, however, half chose the state employee health benefits plan. All the states with separate programs made enhancements beyond the required benchmark coverage. New York made the largest number of enhancements, adding coverage of vision, dental, and hearing services, as well as coverage of outpatient substance abuse and mental health treatment, over-the-counter medications, and durable medical equipment. The most common enhancements were the addition of vision and substance abuse treatment services, mental health care, and durable medical equipment. Smaller numbers of states also added coverage for dental, hearing, orthodontia, therapy services, and over-the-counter drugs.

The benefits packages in the study's separate programs are quite comprehensive. Few services are omitted entirely; the most common exclusions are for personal care services, non-emergency transportation, intermediate-care facilities for the mentally retarded (ICF/MR), and residential substance abuse treatment services. Colorado, Florida, and New Jersey are unique in that they are the only states in the nation to have excluded preventive dental services from their SCHIP package at some point and for at least some enrollees. Separate SCHIP benefit packages also place limits (dollars or days/visits) on the amount of coverage provided for certain services.

Without exception, SCHIP benefit packages were considered adequate and very generous by case study participants in all ten states. Furthermore, SCHIP coverage across the ten states was consistently described as at least as good as, and often considerably better than, private insurance. While coverage in the two Medicaid expansion programs is obviously considered

more generous than private insurance, this same opinion was often held of separate programs. Key informants in all of the study states, including child advocates, identified very few cases where children needed care that was not covered, and state officials have received few complaints from families about coverage limits. The most notable complaints lodged against states' coverage occurred in those with limited dental coverage (although coverage of dental services is optional in separate programs).

Service Delivery Systems, Utilization, and Access

Most of our study states set out to make risk-based managed care the cornerstone of their SCHIP delivery systems. With the exceptions of Illinois, Louisiana, and North Carolina (where managed care infrastructures are limited), states typically began with a goal of implementing risk-based managed care statewide for SCHIP. Managed care was embraced by state officials for a number of reasons: it was described as the most cost-efficient approach to delivering services; as a vehicle for improving delivery systems for low-income children; as a means of modeling delivery arrangements after those found in private insurance markets; and as an opportunity to test new approaches for delivering care that were not feasible within the larger Medicaid program.

Contextual and environmental factors related to existing state Medicaid programs greatly influenced the development of SCHIP delivery systems in all ten states. In most cases, states attempted to align SCHIP and Medicaid delivery systems as much as possible, while also extending managed care to a larger number of counties, including rural ones, where Medicaid managed care had never been implemented. In most of the eight states with risk-based managed care, the majority of health plans participate in both Medicaid and SCHIP. When the same plans participate, families reportedly have an easier time transitioning from one program to another.

SCHIP managed care arrangements often differ from those of Medicaid in their use of population and/or service carve-outs. In most of the states we studied, carve-outs are used less frequently in SCHIP than they are in Medicaid; that is, states have tended to include all (or more) populations and services within managed care systems and health plans' responsibilities. Dental care arrangements also differ across the states we studied. As with other services, the use of managed care arrangements is more common for dental care in SCHIP than in Medicaid.

In the states using managed care, payment arrangements between states and health plans vary under SCHIP, with several states negotiating rates individually with health plans, and three setting rates based on historic Medicaid data. Because SCHIP is a relatively new program, most states used Medicaid cost and utilization data to set or evaluate health plan capitation rates. After adjusting for population and service differences, however, case study respondents generally reported that plan payment rates were roughly comparable for Medicaid and SCHIP in Colorado, New Jersey and Texas, and slightly higher under SCHIP than Medicaid in California, Florida, and New York. With regard to fee-for-service payments, state officials reported that provider fees are the same for SCHIP and Medicaid in roughly half the states, but tend to be slightly higher for SCHIP in the other half.

Overall, access to care under SCHIP was described as good, especially in urban areas. This was often attributed to the widespread use of managed care arrangements, which have reportedly helped increase both the supply of participating providers and the number of children with a primary care "medical home." In at least one of our fee-for-service states—North Carolina—access was also described as quite good, given providers' willingness to participate in the program.

Access challenges were, however, reported in some of the study states. In a minority of the states, some health plans and providers have pulled out of both SCHIP and Medicaid because they found payment rates too low. Provider shortages and limited provider participation appear to be bigger problems in the rural areas of several of our study states, especially those with limited managed care infrastructure; these problems were reported for both Medicaid and SCHIP. Longstanding shortages of certain services remain under SCHIP, as well as Medicaid, including shortages of pediatric subspecialty and dental care providers. Notably, though, the use of managed dental care arrangements was thought to have improved access to dental care in California, Florida, and New York.

Cost Sharing

States implementing Medicaid expansions under SCHIP must follow Medicaid's rules, which generally prohibit cost sharing without special waiver authority. States implementing separate programs, however, may impose cost sharing as long as the cumulative, annual cost-sharing burden under SCHIP for any one family does not exceed five percent of the family's annual income, and copayments are not required for preventive services. Because cost-sharing provisions are relatively new in publicly-funded health insurance programs, there is great interest in understanding the approaches that states adopt, as well as how they affect enrollment, utilization, retention, and other outcomes.

Cost sharing was typically considered an important and positive program element in the study states permitted to include such provisions in their SCHIP programs. In seven states with separate programs, case study participants believed that: cost sharing modeled on private insurance would provide a "bridge" to help families transition from public to private coverage; help make SCHIP look like private insurance, rather than a form of welfare; and promote personal responsibility and reinforce the value of health coverage. In several states, there was also strong sentiment that it was appropriate for higher-income families to contribute to the cost of coverage.

Cost-sharing policies vary from state to state, but include annual enrollment fees, monthly premiums, copayments, and deductibles. Within each category, states use differing income guidelines to determine who is subject to cost sharing; set premiums or enrollment fees on a per-child or per-family basis; impose fees at different levels; and have differing administrative rules governing the payment process and how to handle families who fail to keep up with cost-sharing obligations.

These differing policies, not surprisingly, lead to wide variations in the proportions of families that are subject to premiums and enrollment fees—from 100 percent in California, Florida, and Texas, to 5 percent in Missouri, with 40 percent paying premiums in New York and roughly one-third doing so in North Carolina.

In states requiring payment of premiums or enrollment fees, most case study respondents (including child advocates) reported that cost sharing has not posed a barrier to enrollment.[1] Premium amounts are typically considered reasonable, and premium requirements were described as making the program more appealing to some families. As an informant in one state put it, "I think that if we had made this program free, families would have probably been more skeptical of it, or dismissed it as welfare." Compared with the cost of alternative private-sector options, premium levels adopted by most states are considered quite affordable. In all states, case study respondents reported that copayments are considered reasonable, and even desirable, in some cases. Respondents generally noted that families appeared happy to make copayments and that this type of cost sharing had not had a negative influence on service use.

Colorado and North Carolina were the only states among those we studied where objections to premiums and enrollment fees, respectively, were consistently voiced. Colorado experienced particular problems with its cost sharing policies when variable enforcement of premium collections led to considerable negative publicity and a drop in program enrollment.

Parental Coverage and Premium Assistance Programs

Some states expressed interest early on in adopting strategies that would allow them to cover low-income parents, as well as children, under SCHIP, or that would allow them to leverage employer-based and other insurance packages available to some families by subsidizing the cost of such coverage, often referred to as "premium assistance." Although CMS resisted allowing parental coverage waivers during the program's first two years, they issued guidance in July 2000 that clarified the conditions under which they would grant approval of state applications to test such strategies. At the time of our study, New Jersey was the only state operating both a family coverage waiver and a premium assistance program.

Financing and Fiscal Outlook

The legislation that established SCHIP made available approximately $40 billion in federal funds to states for 10 years, starting in fiscal year 1998. Allotments to the states are based primarily on two factors: the number of children (both low-income and low-income, uninsured children), as estimated in the Current Population Survey; and state health care costs. States that exceed their given year's allotment are able to draw on unspent funds from other states' allotments. The 1998 allotments provided to the 10 study states tended to be larger than the national median, and California, Texas, Florida and New York received respectively the four largest amounts in the country. Between them, the 10 states received 57.5 percent of the federal funds apportioned nationwide in 1998.

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[1]Once again, case studies were conducted from May 2001 to January 2002. Since that time, some states have changed their cost sharing policies.

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Under Title XXI policy, states receive an Enhanced Federal Medical Assistance Percentage for SCHIP—greater, in other words, than the Federal Medical Assistance Percentages provided under Medicaid. Under this system, the state share of costs was established at 70 percent of what states pay under Medicaid. Federal matching rates paid to the 10 study states ranged from 65 percent to 79.37 percent at the time of our study. To obtain federal funds, states must contribute matching funds. To match the federal share with state funds, the 10 states use two sources for funding: state appropriations and tobacco settlement funds. Nine states draw upon general state appropriation monies, and five on tobacco settlement funds. One state—New York—uses provider assessments to obtain the state share of SCHIP costs.

Spending patterns in SCHIP varied across the 10 states we visited. New York, North Carolina and Missouri had spent their full FFY 1998 federal allotment by the time the three-year spending period for the funds had ended, thus qualifying them for additional redistributions from the pool of funds unexpended by the other 37 states and the District of Columbia.

State officials and legislators varied in their perception of the fiscal outlook for SCHIP in their respective states, from positive to uncertain. Of note, the four states visited between November 2001 and January 2002 all expressed the greatest amount of concern, often in the aftermath of the early phases of the economic downturn.

Coordination of SCHIP and Medicaid

A fundamental feature of Title XXI is that it gave states a choice regarding how they could expand children's health coverage. About one-third of the states elected to expand through Medicaid, while two-thirds chose to create separate programs, either alone or in combination with smaller Medicaid expansions. For those states expanding Medicaid, coordination between Title XXI and Title XIX was not an issue—the two programs, by definition, were integrated. However, states creating separate programs were required to coordinate SCHIP and Medicaid coverage and operations, and faced numerous challenges in coordinating the two, sometimes very different, programs. Coordination issues arose mostly with regard to three program areas: enrollment and retention; outreach and marketing; and service delivery and access.

The policy areas of enrollment and retention posed the greatest coordination challenges in states with separate SCHIP and Medicaid programs. While state programs have typically introduced new policies to simplify SCHIP enrollment procedures, they often did less to simplify Medicaid rules and procedures. As a result, in four states—California, Colorado, New York, and

Texas—there were differences in eligibility, enrollment and redetermination procedures between SCHIP and Medicaid. These differences were described as very confusing for families, sometimes resulting in inappropriate interruptions or even losses of coverage, and were observed as presenting the most challenging administrative and coordination problems for states.

State outreach also gave rise to coordination challenges. The eight study states with separate programs typically designed marketing campaigns to promote public awareness of SCHIP, while also implementing ambitious community-based initiatives to recruit "hard-to-reach" families with uninsured children at the local level. The programs were given catchy sounding names and marketing campaigns presented positive and colorful images of healthy mothers, infants, and children, using upbeat slogans like "Growing Up Healthy," "A Healthier Tomorrow Starts Today" and "Better health for your children, peace of mind for you." Importantly, however, six of the eight study states with separate programs did *not* prominently promote Medicaid in their marketing materials. According to case study participants, these arrangements arose for a variety of reasons; some state officials said that Medicaid was not aggressively promoted for fear of "turning off" families who might hold negative opinions of Medicaid, either because of previous negative experiences with the Medicaid enrollment process or, among immigrant Hispanic families, due to fear that Medicaid enrollment may adversely affect their or their child's ability to obtain citizenship.

Key informants at the state and local level had mixed opinions about the appropriateness of single-program marketing. Some were pragmatic, believing that the states would attract more families by promoting a new and "baggage-free" product, while taking comfort in the likelihood that these efforts would also succeed in reaching families with Medicaid-eligible children. Others, however, were philosophically opposed to and offended by this approach because it promoted SCHIP in a very positive light, while effectively maintaining Medicaid in a secondary, perhaps less positive light.

The extent to which SCHIP and Medicaid delivery systems are aligned is a significant aspect of coordination between the two programs, that largely determines whether children who move between the two programs receive seamless and integrated health care. In cases where SCHIP and Medicaid programs in a given state share the same (or similar) provider networks, children are more likely to receive continuous care from the same provider regardless of which program is paying the bills. If SCHIP and Medicaid programs use significantly different networks, then children and families may be much more likely to experience disruptions in their relationships with caregivers and their continuity of care. This issue is especially important for "mixed coverage" families (that is, those with children covered by each of the programs), who might face the prospect of having different children enrolled in different health plans, receiving care from different providers.

Overarching Conclusions and Lessons Learned

The years since the creation of SCHIP have witnessed considerable change in publicly funded health systems for children—all states have implemented Title XXI initiatives; the average income eligibility threshold for subsidized coverage of children has nearly doubled to 214 percent of the federal poverty level; and, as of December 2002, approximately 3.7 million children were insured by SCHIP. These trends are well reflected among the ten states included in this evaluation.

Overall, our study states experienced significant enrollment growth during the first three years of SCHIP. Program sizes vary considerably across our sample, driven by both the overall population size in the states and the number of low-income uninsured children residing there. California, Florida, New York, and Texas represented the four largest SCHIP programs in the nation, with enrollment of between roughly 246,000 and 479,000 children; while Colorado, Illinois, Louisiana, Missouri, New Jersey, and North Carolina each enrolled fewer than 100,000 children. Overall, enrollment in our study states makes up a large share of the national total. State officials mostly reported a high level of satisfaction with their enrollment achievements.

The evidence to date is that SCHIP is a successful program. It is popular among legislators, advocates, and providers; is becoming well known among consumers at least in part due to the aggressive mass media and community-based outreach that states have conducted; is simple to enroll in, as a result of states' extensive simplification efforts; covers benefits that are considered broad and comprehensive; and requires cost sharing that most case study participants believe is affordable and does not pose a barrier to enrollment or service use. Families' access to primary medical care, once they are enrolled, is thought by case study respondents to be quite good (though access to dental care and specialty services in not very good). Although worsening economic and budget conditions in the states may have negative consequences for SCHIP, it appears that, at least for the short term, the future of the program is secure.

I. INTRODUCTION

In August 1997, Title XXI of the Social Security Act was signed into law, creating the State Children's Health Insurance Program (SCHIP), an ambitious federal-state initiative aimed at extending health insurance coverage to many of the nation's estimated 10 million low-income uninsured children.[1] Approximately $40 billion in federal funds was made available for fiscal years 1998 through 2007, allotted to the states based on a formula that considers both the number of low-income uninsured children residing in each state, and each state's health care costs relative to other states. Two years after the creation of SCHIP, Congress mandated an independent federal evaluation of the program as part of the Balanced Budget Refinement Act (BBRA) of 1999.[2] The legislation specified that 10 states be included in the evaluation, for the purposes of assessing the effectiveness of alternative outreach strategies, the coordination of SCHIP with Medicaid, and the effects of cost-sharing on retention, among other issues.[3] Mathematica Policy Research, The Urban Institute, and MayaTech Corporation have teamed to

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[1]Alan Weil. "The New Children's Health Insurance Program: Should States Expand Medicaid?" Washington, DC: The Urban Institute, Issue Brief Series A, no. A-13, October 1997.

[2]Wooldridge, J. et al. Design Report: "Congressionally Mandated Evaluation of the State Children's Health Insurance Program." Mathematica Policy Research and The Urban Institute, report submitted to DHHS, November 30, 2001.

[3]One of the first tasks of the evaluation was to conduct a rigorous selection process for identifying states to include in the study. The process, described in detail in the evaluation Design Report, resulted in the selection of the following states: California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas.

conduct the evaluation, which comprises both quantitative and qualitative analytical components.[4]

During the first year of the evaluation, case studies of the 10 study states represent the major activity of the qualitative assessment. The case studies were designed to provide an in-depth understanding of why states designed SCHIP programs as they did, how the programs were implemented, the challenges faced in the implementation, and the perceived outcomes of these efforts. The case studies will also inform the quantitative assessments included in the evaluation and help researchers better analyze and interpret findings.

This report synthesizes the findings from the 10 state case studies, which were conducted between May 2001 and January 2002. (A detailed summary of our case study design and methodology is included in Appendix A.) Chapter II presents background and contextual information about the study states, describing how SCHIP programs and policies were developed. Chapters III through XI follow with detailed assessments of the states' experiences implementing SCHIP by addressing, in turn, the issues of outreach; enrollment and retention;

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[4]In the legislation establishing SCHIP (the Balanced Budget Act of 1997), Congress mandated that states evaluate the effectiveness of their SCHIP programs and that the Department of Health and Human Services submit a report to Congress by December 31, 2001, based on the states' evaluations. Recognizing this statutory requirement—as well as the need for a more detailed assessment of the performance of the SCHIP programs, the Health Care Financing Administration (name later changed to the Centers for Medicare & Medicaid Services, or CMS), which was charged with administering SCHIP, contracted with Mathematica Policy Research (MPR) to examine enrollment in SCHIP, expenditures, and service use, drawing on the Medicaid Statistical Information System, and the Statistical Information Management System. The evaluation also is reviewing the literature on the effects of SCHIP and synthesizing results from the mandatory state evaluations of their programs and state annual program reports. The CMS evaluation will look at outreach and enrollment processes in eight states using case study site visits and focus groups of enrollees. The study also includes a review of trends in the numbers of uninsured children before and after SCHIP implementation, using data from the Current Population Survey and the National Health Interview Survey.

crowd out; benefits; service delivery systems, utilization, and access; cost sharing; parental coverage and premium assistance programs; financing and fiscal outlook; and the coordination of SCHIP and Medicaid. Chapter XII concludes the report with a summary of cross-cutting conclusions and lessons learned by the states.

II. OVERVIEW OF SCHIP PROGRAMS IN THE TEN STUDY STATES

Seven of the 10 study states responded rapidly to the optional authority granted them by Title XXI. Within six months of the passage of the Balanced Budget Act of 1997 (BBA), California, Colorado, Florida, Illinois, Missouri, New Jersey, and New York had each submitted SCHIP plans to the Health Care Financing Administration (HCFA),[5] and all these states but Missouri had begun implementing their programs by April 1998. Louisiana, North Carolina, and Texas were somewhat slower in submitting their initial state plans—doing so between April and July 1998—but each implemented at least the initial phases of their SCHIP initiatives during 1998 (see Table 1). The responses by our study states are quite consistent with how states reacted across the nation to the creation of SCHIP—within six months of the passage of the BBA, 18 states had submitted plans to HCFA and four had been approved; by the first anniversary of the law, 48 states had submitted plans and 41 had received federal approval; and by the end of 1999, every state and the District of Columbia had approved plans in place.[6,7,8]

The BBA gave states three options for providing coverage under SCHIP: expanding Medicaid, creating a new insurance program separate from Medicaid, or implementing a combination of both. Our 10 study states include examples of each approach: Louisiana and Missouri enacted Medicaid expansions; Colorado and North Carolina created separate programs; and California, Florida, Illinois, New Jersey, New York, and Texas each

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[5]In 2001, the agency was renamed the Centers for Medicare & Medicaid Services (CMS).

[6]Ian Hill. "Charting New Courses for Children's Health Insurance." *Policy and Practice,* vol. 58, no. 4, December 2000.

[7]Ullman, Frank, Ian Hill, and Ruth Almeida. *CHIP: A Look at Emerging Programs.* Washington, DC: The Urban Institute, September 1999.

[8]Centers for Medicare & Medicaid Services, website, www.hcfa.gov

TABLE 1: SCHIP STATE PLANS: DATES OF SUBMISSION, APPROVAL AND IMPLEMENTATION

		Dates of Approved Submission			
State	Program Name	Program Type	Submitted	Approved	Implemented
California	*Healthy Families*	Combination	11/19/97	3/24/98	3/1/98 (Medicaid expansion) 7/1/98 (Separate program)
Colorado	*Child Health Plan Plus*	Separate	10/14/97	2/18/98	4/22/98
Florida	*KidCare*	Combination	12/4/97	3/6/98	4/1/98
Illinois	*KidCare*	Combination	12/31/97 11/10/98	4/1/98 3/30/00	1/1/98 (Medicaid expansion) 8/12/98 (Separate program)
Louisiana	*LaCHIP*	Medicaid	7/31/98	10/20/98	11/1/98
Missouri	*MC+ for Kids*	Medicaid	9/2/97	4/29/98	7/1/98 children 2/1/99 parents
New Jersey	*FamilyCare*	Combination	2/6/98	4/27/98	2/1/98 (Medicaid expansion) 3/1/98 (Separate program
New York	*Child Health Plus*	Combination	11/5/97	4/1/98	4/15/98
North Carolina	*Health Choice*	Separate	5/14/98	4/14/98	10/1/98
Texas	*TexCare*	Combination	4/1/98 6/23/99	6/15/98 11/8/99	7/1/98 (Medicaid expansion) 4/3/00 (Separate program)

SOURCES: Centers for Medicare & Medicaid Services (CMS), *California Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfsca.htm

National Governor's Association. State Children's Health Insurance program Plan Summaries. California S-CHIP Plan Summary. website http://www.nga.org/cda/files/CASCHIP.pdf

Centers for Medicare & Medicaid Services (CMS), *Colorado Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfsco.htm

Centers for Medicare & Medicaid Services (CMS), "Louisiana Title XXI Program Fact Sheet." CMS website http://www.hcfa.gov/init/chpafsla.htm

Centers for Medicare & Medicaid Services (CMS), "Missouri Title XXI state Plan Summary Fact Sheet." website http://www.hcfa.gov/init/chpfsmo.htm. "Missouri Statewide Health Reform Demonstration Fact Sheet. web site http://www.hcfa.gov/medicaid/1115/ mofact.htm. "The State Of Missouri 1915(b) Program." web site http://www.hcfa.gov/medicaid/1915b/ mo03fs.htm

Centers for Medicare & Medicaid Services (CMS), *New York Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfsny.htm. New York Governor's Press Office, *Child Health Plus Expansion Means Healthier Kids.* Press Release June 18, 1998. Department of Health and Human Services, *HHS Approves Changes In New York SCHIP Program*, HHS News, July 12, 2001.

Centers for Medicare & Medicaid Services (CMS), *Florida Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfsfl.htm.

TABLE 1 *(continued)*

Centers for Medicare & Medicaid Services (CMS), *New Jersey Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfsnj.htm.

Centers for Medicare & Medicaid Services (CMS), *North Carolina Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfsnc.htm.

Centers for Medicare & Medicaid Services (CMS), *Illinois Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfsil.htm.

Centers for Medicare and Medicaid Services (CMS), *Texas Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfstx.htm

chose to adopt combination approaches.[9] This distribution of program types is somewhat different from that seen nationally—16 states, or roughly one-third of the 50 states and the District of Columbia, have implemented Medicaid expansions under SCHIP; while 35 states, roughly two-thirds, have created separate programs, either alone or in combination with Medicaid expansions.[10]

As illustrated in Table 2, the upper-income eligibility thresholds ultimately adopted by the study states vary considerably—from 185 percent of the federal poverty level (FPL) in Colorado and Illinois, to 350 percent of the FPL in New Jersey. Before SCHIP, the average income threshold for children in these states was 111 percent of the FPL. After SCHIP, this average income threshold increased to 232 percent of the FPL, an increase of 121 percentage points. This increase in children's average income thresholds is somewhat higher than the average increase across all 51 states—nationally, the average income threshold for children was 121 percent of poverty before SCHIP, and 214 percent after SCHIP, an increase of 93 percentage points.[11,12]

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[9]On October 1, 2002, each of these programs, with the exceptions of Illinois, New Jersey, and New York, became "separate" state SCHIP programs, as opposed to "combination" programs, as the federal mandate for phasing in poverty-level Medicaid coverage of children under age 19 born after September 30, 1983 was complete. Thus, these states' initial Title XXI efforts, which accelerated the phase-in of Medicaid coverage for children between the ages 15 and 19 living in families with incomes below poverty were subsumed within Title XIX, as of October 2002. In New York, however, a further expansion of Medicaid under Title XXI to all children under age 19 living in families with incomes below 133 percent of poverty was approved by CMS, so the state remains a "combination" program.

[10]Centers for Medicare & Medicaid Services, website, www.cms.hhs.gov

[11]Average income eligibility thresholds for children were generated by determining the income eligibility threshold for children of all ages up to age 19, summing the income thresholds, then dividing by 19.

[12]Ullman, Frank, Ian Hill, and Ruth Almeida. *CHIP: A Look at Emerging Programs,* Washington, DC: The Urban Institute, September 1999.

TABLE 2: SCHIP ELIGIBILITY EXPANSION AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL

	Income Eligibility Levels							
	Infants		Ages 1 to 6		Ages 6 to 15		Ages 16 to 19	
State	Medicaid Expansion %	Separate Program %	Medicaid Expansion %	Separate Program %	Medicaid Expansion %	Separate Program %	Medicaid Expansion %	Separate Program %
California	N.A.[a]	201 to 250	N.A.[a]	134 to 250	N.A.[a]	101 to 250	86 to 100	101 to 250
Colorado	N.A.[b]	134 to 185	N.A.[b]	134 to 185	N.A.[b]	101 to 185	N.A.[b]	38 to 185
Florida	186 to 200	N.A.	N.A.	134 to 200	29 to 100	101-200	29 to 100	101 to 200
Illinois	200	N.A.	N.A.	133 to 185	100 to 133	133 to 185	46 to 133	133-185
Louisiana	134 to 200	N.A.[c]	134 to 200	N.A.[c]	101 to 200	N.A.[c]	11 to 200	N.A.[c]
Missouri	186 to 300	N.A.[c]	134 to 300	N.A.[c]	101 to 300	N.A.[c]	101 to 300	N.A.[c]
New Jersey	N.A.	185 to 350	N.A.	133 to 350	100 to 133	133 to 350	41-133	133-350
New York	186 to 250	N.A.	134 to 250	N.A.	N.A.	101 to 250	88 to 100[d]	101 to 250
North Carolina	N.A.[b]	185 to 200	N.A.[b]	133 to 200	N.A.[b]	100 to 200	N.A.[b]	100 to 200
Texas	N.A.[a]	186 to 200	N.A.[a]	134 to 200	N.A.[a]	101 to 200	19 to 100	101 to 200

NOTES: Income less than the lower income eligibility band represent the Medicaid standards for children in effect March 31, 1997.

N.A. = Not applicable.

[a]In California and Texas, children under 16 years in Medicaid were already covered to 100 percent of the Federal poverty level and the Medicaid expansion under SCHIP does not apply.'

[b]In Colorado and North Carolina, there is no Medicaid expansion.

[c]Louisiana and Missouri do not operate a separate children's health insurance program.

[d]An expansion up to 133 percent has been approved but will not be implemented until April 2002.

TABLE 2 *(continued)*

SOURCES:

Centers for Medicare & Medicaid Services (CMS), California Title XXI Program Fact Sheet. CMS website http://www.hcfa.gov/init/chpfsca.htm; State of California. State Child Health Plan under Title XXI of the Social Security Act: California's *Healthy Families* program. November 18, 1997 website http://www.dhs.cahwnet.gov/org/Director/healthy_families/ stplan.pdf

Donna Cohen Ross and Laura Cox, *Making It Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey.* Kaiser Commission on Medicaid and the Uninsured, October 2000.

Centers for Medicare & Medicaid Services (CMS), "Eligibility Standards in the 50 States and District of Columbia," January 2001.

Louisiana Department of Health and Hospitals (DHH), *Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act, 2000*, March 22, 2001.

Centers for Medicare & Medicaid Services (CMS), "Eligibility Standards in the 50 States and District of Columbia (01/01/01)."

Louisiana DHH, "More Children Now Eligible for Health Insurance," January 9, 2001.

State of Missouri, Department of Social Services, Missouri's Children Health Insurance Program Evaluation." Submitted to the Health Care Financing Administration, March 31, 2000.

American Academy of Pediatrics, *Improving Access to Children's Health Insurance in New York*. AAP: 2000 website: http://www.aap.org/advocacy/chi2/ny.pdf

Centers for Medicare & Medicaid Services (CMS), *Texas Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/ chpfstx.htm

Centers for Medicare & Medicaid Services (CMS), *Illinois Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/ chpfsil.htm

Centers for Medicare & Medicaid Services (CMS), *North Carolina Title XXI Program Fact Sheet.* CMS website http://www.hcfa.gov/init/chpfsnc.htm

State of Florida. Florida KidCareProgram: *Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Health Cre Financing Administration*. July 2000. Medicaid standards based on: "The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999." CMS web site http://www.hcfa.gov/init/enroll99.pdf.

Centers for Medicare & Medicaid Services (CMS), "Eligibility Standards in the 50 States and District of Columbia" January 2001.

Among our 10 study states, four had the highest numbers of low-income uninsured children in the nation in 1997—California, Florida, New York, and Texas—and the other six were above average on this measure. Furthermore, uninsured children comprised between 20 percent (in New York) and 35 percent (in Texas) of all low-income children in these 10 states, all figures equal to or above the national average.[13] Not surprisingly, therefore, our study states also reflect higher-than-average SCHIP enrollment. According to state data, our sample includes the four states with the largest SCHIP enrollment in the nation—New York, California, Texas, and Florida, with approximately 480,000, 476,000, 433,000, and 246,000 children participating, respectively. The remaining six states had considerably smaller programs—New Jersey (approximately 80,000 children); Missouri (approximately 75,000); Illinois (65,000); North Carolina (60,000, but 72,000 at its peak), Louisiana (56,000 children); and Colorado (37,000 children)—but each still fell above the national median.[14]

A. FACTORS INFLUENCING POLICY AND PROGRAM DEVELOPMENT IN THE STUDY STATES

State officials interviewed for the case studies cited a number of factors contributing to their swift response to Title XXI. These included the availability of enhanced federal matching funds,[15] bipartisan support for children's health insurance expansions, and strong economies in the states at the time. In addition, in Colorado, Florida, and New York (and to a lesser extent, Texas), state-funded child health insurance programs were already in place when Title XXI was

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[13]Catherine Hoffman and Mary Pohl, *Health Insurance Coverage in America: 1999 Data Update.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, December 2000.

[14]Vernon K. Smith, *CHIP Program Enrollment: December 2000.* Kaiser Commission on Medicaid and the Uninsured: September 2001.

[15]To obtain federal funds under Title XXI, states must contribute matching funds at rates that are 70 percent of their state share under Medicaid.

created, thus state officials were also driven by the financial incentive to capture new federal matching funds to support existing programs.

Our case studies revealed that a range of existing environmental factors influenced state officials' decisions regarding what type of SCHIP program to adopt. State SCHIP and Medicaid officials, governors' staff, state legislators and their staffs, providers, and child advocates gave several reasons why states pursued either the Medicaid or the separate program route. In both Louisiana and Missouri, for example, we learned that state officials chose to expand Medicaid because:

- Expanding Medicaid was seen as efficient, permitting the states to build on existing administrative infrastructures, thus allowing more rapid and less expensive start-up;
- Medicaid offered the optimal benefits package for children, much richer than most packages covered by private insurance; and
- The Medicaid program was viewed positively by state legislators and considered to be run well by respected, competent managers.

In Missouri, additional factors influenced the choice of a Medicaid expansion. First, the program had implemented a major Medicaid managed care initiative in 1995 that was well received by insurers and providers, and thus was enjoying improved relations with these stakeholders. In addition, in the months prior to passage of the BBA, state officials had completed intensive plans to expand Medicaid eligibility for children and families under a Section 1115 demonstration; so it made sense to integrate these plans with Title XXI to obtain the enhanced match.

In both Louisiana and Missouri, key informants told us that consumers tended to attach less stigma to the receipt of Medicaid coverage than is sometimes reported in other states—in Missouri, this was attributed to the popularity of the MC+ managed care program; in Louisiana, state officials pointed to the fact that Medicaid had delinked its eligibility processes from those of cash assistance and food stamps five years earlier, resulting in a more positive view of

Medicaid among consumers. Combined, these factors led policymakers to conclude that creating a SCHIP program by expanding Medicaid made sense and held significant potential for efficiently insuring a large number of previously uninsured children.

Key informants in the eight states that elected to create separate SCHIP programs, either alone or in combination with Medicaid expansions, identified a very different set of influencing factors. The environment in these states typically revealed:

- Legislative and/or gubernatorial resistance to significant expansion of Medicaid because it is a federal entitlement program and, as such, has an "uncontrollable" budget;
- Provider dislike of Medicaid, usually arising from payment rates that they perceived as too low, resulting in chronic access to care problems for children and families; and
- A perception that consumers were resistant to Medicaid, attaching a stigma to the program and its welfare-based eligibility process, which was described as onerous, complex, and intrusive. In several states, consumer resistance to Medicaid also resulted from a significant fear of "public charge" and the potential that participation in Medicaid might negatively influence immigrant families' applications for citizenship.[16]

Officials in these states viewed Title XXI as an opportunity to test (or continue) new models of health insurance patterned after private insurance, to build new partnerships between government and the private sector, and to design systems that were distinctly different from the

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[16]The welfare reform legislation enacted in 1996 included provisions that altogether banned immigrants who arrived in the United States after August 22, 1996 from receiving Medicaid and other federal means-tested public benefits for a period of five years from the time of their entry. However, in many families, some members—those who arrived on or before August 22, 1996 and those who were born in the U.S. and, thus, are citizens—may be eligible for Medicaid even though others in the family are excluded. Although guidance issued by the Immigration and Naturalization Service (INS) has clarified that receipt of Medicaid (except long-term care) and SCHIP is not counted when determining "public charge" status in immigration proceedings, fear persists among immigrant families that Medicaid participation by some members might undermine the renewal of a "green card" or prevent a green card holder who goes abroad from re-entering the U.S. These fears—which arose from well-publicized incidents in the 1990s of INS officials wrongly requiring green card-holders who were returning to the U.S. to reimburse the government for services received in Medicaid as a condition of reentry—may continue to affect enrollment decisions by immigrant families.

Medicaid/welfare models of the past. In Colorado, Florida, and New York, which had preexisting state-funded children's health insurance programs (*Child Health Plan, Healthy Kids,* and *Child Health Plus,* respectively), officials and advocates had learned how popular separate programs, designed along the lines of mainstream private insurance, could be among working families who had little or no prior experience with government programs. In these states, there was little question that SCHIP would be used to expand upon the existing state programs. In California and Texas, officials were well acquainted with providers' dissatisfaction with Medicaid and the negative attitudes many families held toward the program. They viewed SCHIP as a potential "bridge" between Medicaid and private insurance. States with separate programs were not alone in their desire to make SCHIP more like private insurance; one of the Medicaid expansion states we studied—Missouri—used a Section 1115 demonstration to adopt premiums and copayments to promote personal responsibility, and waiting periods to deter families from dropping private coverage to sign up for SCHIP.

In Illinois and North Carolina, state officials followed a somewhat different path. Both states saw strong, opposing forces supporting Medicaid expansion as well as the creation of separate programs. In the end, compromises were reached in each state whereby separate programs were elected, but essentially designed as Medicaid "look alikes." That is, separate SCHIP programs in Illinois and North Carolina have been very closely patterned after existing Medicaid programs with the major difference between the two being SCHIP's lack of an entitlement to coverage for children.

Although six of the eight states creating separate programs also adopted Medicaid expansions, the Medicaid portions of their Title XXI initiatives were small in comparison to the separate components. In California, Florida, New York, and Texas, Medicaid expansions simply comprised accelerations of the federally mandated phase-in of poverty-level coverage for children under age 19, and enabled the states to capture enhanced federal matching dollars for

children who would be have been covered by Title XIX within three years.[17] In New York and Texas, especially, the Medicaid components of SCHIP received relatively little attention during program design and implementation. In Texas, the Medicaid expansion was explicitly described as a "placeholder" that locked in the state's access to the FY 1998 federal allotment while policymakers designed the separate program for children in families with higher incomes. In Florida, after accelerating poverty-level coverage for adolescents, officials also expanded eligibility for infants under Medicaid, raising the upper income threshold from 185 to 200 percent of poverty. The exceptions were Illinois and New Jersey (and later, New York), which went beyond simply accelerating poverty-level coverage for adolescents and used SCHIP to equalize Medicaid coverage for children of all ages at 133 percent of poverty.

While eight of the 10 case study states created separate SCHIP programs, six of these states either assigned responsibility for the programs' administration to the state Medicaid agency or created new divisions for SCHIP administration within the Medicaid agency.[18] Thus, in eight of the 10 states in our study, the agencies administering Medicaid are also responsible for managing SCHIP. The only exceptions are California (where the quasi-governmental Managed Risk Medical Insurance Board (MRMIB) was directed to run the *Healthy Families* program), and Florida (where the not-for-profit Florida Healthy Kids Corporation runs the major portion of the state's separate program). Even in these states, however, Medicaid agencies play major roles. In California, the California Department of Health Services was given responsibility for the outreach effort for the joint *Healthy Families/Medi-Cal for Children* initiative. And in Florida, the Agency for Health Care Administration oversees not only the Medicaid portion of SCHIP,

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[17]New York subsequently received approval to further expand Medicaid coverage to children of all ages in families with incomes below 133 percent of poverty.

[18]Colorado, Illinois, New Jersey, New York, North Carolina, and Texas.

but also the *MediKids* component which provides Medicaid "look alike" coverage for children ages one to five.

Many of the study states also chose to contract out important administrative functions. That is, it was explicit policy in California, Colorado, New York, and Texas to contract with private sector organizations (including managed care plans) for such functions as marketing, application assistance, application processing, health plan enrollment, premium collection, and operating toll-free consumer hotlines.

B. ORGANIZATION OF THE REMAINDER OF THE REPORT

In the following chapters, we continue our synthesis of findings from the 10 state case studies and describe the policies adopted by SCHIP programs and their experiences implementing them. In turn, the chapters address the following major policy areas:

- Outreach
- Enrollment and retention
- Crowd out
- Benefits coverage
- Service delivery and access
- Cost sharing
- Family coverage and premium assistance programs
- State financing
- Coordination of SCHIP and Medicaid

Within each chapter, discussion is divided into three parts—first, we discuss the relevant debates and developmental processes that occurred during the SCHIP programs' design phases; second, we identify the specific state policies and program strategies that were adopted; and third, we discuss states' experiences implementing these programs.

III. OUTREACH

A. BACKGROUND AND POLICY DEVELOPMENT

The creation of SCHIP as Title XXI of the Social Security Act in summer 1997 was a notable event. Not since the launch of Medicaid in 1965 had the federal government sponsored such a large, subsidized health insurance program, and Congress's appropriation of $40 billion for the program's first 10 years demonstrated lawmakers' hope that SCHIP would extend coverage to a large portion of our nation's 10 million uninsured children. It was implicit, therefore, that states enacting SCHIP would aggressively publicize the availability of new health insurance coverage for children. More explicit was the initial guidance issued by HCFA that required states to describe in their state plans their outreach strategies. Still, believing that the majority of program funds should underwrite the provision of care, SCHIP's drafters required that states spend no more than 10 percent of their total expenditures on administrative activities, including outreach.

Every state in our study, like those across the country,[19] responded to these directives by undertaking unprecedented levels of outreach. Even those states enacting Medicaid expansions under SCHIP adopted a range of strategies for making families aware of the new coverage, the importance of health insurance for children, and the availability of various forms of assistance for enrolling their children in care.

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[19]Ian Hill, "Charting New Courses for Children's Health Insurance," *Policy and Practice,* vol. 58, no. 4, December 2000.

B. PROGRAM AND POLICY CHARACTERISTICS

As the study states assessed alternative strategies for outreach, most concluded that multi-pronged approaches that involved broad, statewide marketing to create a strong "brand identity" for their programs were needed, as well as more targeted, community-based efforts to attract "hard-to-reach" families. Of particular note, most states' outreach efforts also incorporated application assistance, thus giving "outreach" a clear and measurable objective of enrolling children into SCHIP.

The strategies adopted by the ten study states and their experiences implementing them are described in detail below and summarized in Table 3.

1. Statewide Marketing Efforts

In marketing SCHIP to families with uninsured children, the study states undertook a fairly consistent set of strategies. In most cases, they created program names that project positive images or brand identities, launched television and radio advertising campaigns, distributed and posted a range of promotional print materials, worked with health plans to promote SCHIP and/or Medicaid, established one or more toll-free information hotlines, and created websites with various program information. Each of these efforts is discussed in more detail below.

- ***Program Names.*** As a first step in their efforts to market SCHIP, states created new names for their programs. Reflecting a desire to project an attractive and appealing brand identity and, in some states, explicitly to "reinvent" the image of public insurance, officials from our study states selected names such as *HealthyFamilies* (in California), *Child Health Plus* (in New York), *KidCare* (in Florida, Illinois, and New Jersey), *LaCHIP* (in Louisiana), *HealthChoice for Children* (in North Carolina), and *TexCare* (in Texas). State officials described these program names as "not sounding like" government programs and, in Louisiana, *LaCHIP* was described as part of the state's effort to "forge a new identity" for its Medicaid program.

  Only in Missouri did the process of naming the SCHIP program follow a different course. There, after heated debate, state officials elected to build on the name recognition that had been established for the Medicaid program's managed care initiative, *MC+,* and called their SCHIP effort *MC+ for Kids.* Advocates and others

TABLE 3: STATE SCHIP OUTREACH STRATEGIES

	Statewide Marketing						Community-Based Marketing	
State	New Name	TV And/Or Radio	Print Materials	Health Plans	Hotline	Website	Grants/ Contracts with CBOs	CBOs Involved with Application Assistance
California	✓	✓	✓	✓	✓	✓		✓
Colorado	✓	✓	✓	✓	✓	✓	✓	✓
Florida	✓	✓	✓		✓	✓	✓	
Illinois	✓	✓	✓		✓	✓	✓	✓
Louisiana	✓	✓	[c]		✓	✓	[a]	[b]
Missouri	✓		✓	✓	✓	✓	[a]	[b]
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓
New York	✓	✓	✓	✓	✓	✓	✓	✓
North Carolina	✓	✓	✓		✓	✓		
Texas	✓	✓	✓	✓	✓	✓	✓	✓

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES: CBO = Community-based organization

[a]Local and county government organizations receive free printed materials and actively market SCHIP and Medicaid.

[b]Local organizations do not perform direct application assistance. Eligibility determination remains the responsibility of county social services departments.

[c]Louisiana uses radio advertising in a limited number of urban markets.

have found this title problematic in part because it has confused consumers in those parts of the state that do not have managed care, and because it does not convey a clear identity as a child health insurance program.

- ***Television and Radio Advertising.*** In seven of the 10 study states, television and radio advertising, broadcast either statewide or to particular neighborhoods and/or ethnic markets, were central components of outreach. Key informants in California, Colorado, Florida, Illinois, New Jersey, New York, and Texas typically described multiple goals for such marketing, including creating a strong identity and promoting name recognition for SCHIP, raising families' awareness of the program and the importance of health insurance for children, and persuading parents to follow up by enrolling their children into SCHIP. State campaigns initially embraced broad slogans, including "Growing Up Healthy" (in New York) and "A Healthier Tomorrow Starts Today" (in California), and used bright colors and images of diverse children to promote their programs. In New Jersey and New York, the states' Governors were featured prominently in several ads, urging parents to sign their children up for *NJKidCare and Child Health Plus,* respectively.

  We did not observe such extensive mass media efforts in either Louisiana or Missouri—the two states in our study with Medicaid expansions. In these states, key informants reported less political and financial support for the conduct of visible, high-profile marketing of Medicaid, and in Louisiana radio ads were broadcast only in selected urban markets. In North Carolina, the separate *HealthChoice* program was not publicized widely through mass media (although a limited number of television and radio public service announcements were broadcast in counties with low enrollment). The state's Outreach Committee believed that a more grass-roots, community-based outreach strategy would be more effective and less costly.

- ***Print Materials.*** In every state we visited, print materials represented a core tool of SCHIP outreach and marketing efforts. Colorful and attractive application forms, brochures, posters, and fact sheets typically were designed and distributed to a broad range of local entities, including schools, health departments, WIC clinics, hospitals, Head Start and preschool programs, child care agencies, churches, and other community-based organizations. Billboards were often placed in communities where lots of low-income uninsured families live.

  Attempts to target specific racial and ethnic groups were common. In every state, program applications were printed in English and Spanish. Spanish-language versions of brochures and posters were also common in most states. In California and Florida, state officials developed *Fotonovelas*—comic book-style magazines presenting stories about families needing health care and insurance for their children—and have found them to be an especially popular vehicle for promoting SCHIP to Hispanic families.

- ***Working with Health Plans.*** Six of 10 states used managed care health plans as partners in conducting SCHIP outreach although the extent to which they relied on plans varied considerably. Officials described feeling torn between the desire to take advantage of plans' marketing expertise and the need to minimize the potential for

marketing abuses. In most instances, they have enlisted health plans' assistance, but carefully regulate how plans can participate. In California, Colorado, Missouri, New Jersey, and New York, for example, plans must submit all television, radio, and printed marketing materials to the state for review and approval before use. They are permitted to publicize SCHIP and Medicaid and their role as providers in these programs, but their logos must typically be less prominent than those of the state programs they are promoting. Plans may not directly contact potential enrollees, discuss health plan choice or enrollment in their promotions, or imply that they *are* the program or the only plan providing care under the program. As will be discussed in the next chapter, health plans in a more limited number of states have had their roles expanded to include providing application assistance to families with potentially eligible children.

- ***Toll-Free Hotlines.*** Every state in the study established one or more toll-free hotlines to provide parents with additional information about SCHIP. Hotline numbers typically are prominently featured in television, radio, and print advertisements. Most often, hotline operations have been contracted out to vendors, whose multi-lingual staffs are available to field questions from interested parties. In Texas, it was originally intended that hotline staff would take applications over the phone. Over time, however, heavy call volume has resulted in these staff more often simply answering callers' questions about the program and mailing out applications to parents requesting them. In Florida, the existing *Healthy Kids* hotline (established for the pre-SCHIP state-funded program) was expanded to serve as the main *KidCare* hotline. It, too, was soon overwhelmed by call volume, so responsibility for the hotline was transferred to the Department of Health and additional hotlines were introduced to handle different components of the program.

- ***Websites.*** Every state we studied had created a website for its program. Most commonly, these websites were designed with consumers in mind, providing electronic versions of brochures, fact sheets, and even program applications (in California, Florida, Illinois, Louisiana, Missouri, New Jersey, North Carolina, and Texas). In some states, websites were also intended to serve the needs of policymakers, state and local program managers, and researchers, and included more detailed information on policies and procedures, as well as various program data (in California, Colorado, Florida, New Jersey, New York, and Texas).

2. Community-Based Outreach

Community-based outreach was a critical complement to statewide media marketing in California, Colorado, Florida, Illinois, New Jersey, New York, and Texas; it comprised the core outreach strategy in Louisiana, North Carolina, and Missouri. Whereas statewide outreach was viewed as a way to raise awareness and boost name recognition of SCHIP, community-based outreach was described as a more direct means of talking to families about the importance of

coverage, discussing program eligibility rules and application procedures, and clarifying misconceptions about SCHIP and Medicaid. Often, such outreach was seen as the only way states could reach the "hard to reach" ethnic minorities, immigrant families afraid of "public charge," and working families with no experience in public programs. Through a variety of contracts, grants, and special appropriations, monies have been extended to a very broad array of local organizations in support of community-based outreach, in the hope that "trusted voices" in the community would be successful in connecting with parents and persuading them to enroll their children in coverage. Importantly, these groups were frequently charged with assisting families with completing program applications and were trained to do so. State-specific examples of community-based strategies follow:

- ***California*** implemented two strategies to support community-level outreach and enrollment assistance. First, "outreach contracts" were extended to community-based organizations (CBOs) across the state (72 individual organizations in the first funding round, and 25 community collaboratives, as well as 26 school-based organizations, in the most recent round), to enable them to hire staff to engage in community-wide education, partnership building with other organizations, and door-to-door and telephone outreach and enrollment assistance. Second, the state trained nearly 24,000 individuals, affiliated with 3,600 "enrollment entities," to serve as Certified Application Assistors who seek out families with uninsured children and enroll them in *Healthy Families* and/or Medi-Cal. In return, for each family whose children are enrolled, these assistors receive a $50 "finder's fee."

- In ***Colorado***, the state's outreach and enrollment contractor—Child Health Advocates—has networked with a broad array of local partners, including schools, hospitals, Community Health Centers, local health departments, local social services agencies, and WIC clinics to distribute program materials and promote SCHIP to the families they serve. In addition, 82 of these organizations have received training and certification as Satellite Eligibility Determination sites and assist families in completing *Child Health Plan Plus* applications.

- Most of ***Florida's*** effort to find and assist *KidCare*-eligible children occurs at the local level under the direction of regional outreach coordinators. In addition to promoting awareness and making applications available, the regional outreach projects focus on helping families complete program applications and navigate the enrollment process (although no direct compensation is provided for application assistance). While particular outreach strategies vary from region to region, common approaches include participating in health fairs, meeting with groups of parents and providers, and distributing applications, brochures, posters, fliers and other materials

in various community locations. Dating back to its *Healthy Kids* roots, school-based outreach continues to be central to local *KidCare* outreach. As it has done for years, the Florida *Healthy Kids* Corporation directs efforts to distribute applications and other promotional materials to students at the beginning of each school year. School districts are partners in this effort and help with the distribution of materials and by fielding questions from parents.

- Beginning in late-1999, ***Illinois*** awarded $1.6 million in outreach grants to 29 community agencies to conduct *KidCare* outreach in immigrant, rural, minority, and other communities needing attention. The following year, an additional $500,000 was awarded to support targeted outreach efforts. Such an approach supports the state's philosophy that local contacts, spreading the word from within communities, is the best way to reach Illinois' large rural and immigrant populations, as well as working families without previous experience with public aid programs. State outreach staff, in concert with community organizations, have formed partnerships with chambers of commerce, farm bureaus, and local resource centers to ensure that staff are aware of the program and have *KidCare* outreach materials available. The state has placed a high priority on reaching working families and devised many employer-based outreach strategies, including building relationships with large corporations, trade organizations, and unions, in order to inform employers and employees alike about *KidCare.* As will be discussed in the next chapter, in order to bridge outreach with enrollment, Illinois also trained and certified *KidCare* Application Agents (KCAAs) in over 1,400 sites who are eligible to receive a $50 "technical assistance payment" for each applicant they succeed in assisting to enroll.

- In ***Louisiana***, state officials asked each of the state's nine Department of Health and Hospitals (DHH) regional offices to develop an outreach plan for their regions, encouraging staff to devise creative strategies that would work in the communities they serve. Each office has done so, eagerly "buying into" *LaCHIP* and aggressively marketing the program by distributing applications and brochures through schools and health fairs, outstationing eligibility staff at hospitals and other health care provider sites, placing articles in local newspapers, and contacting and promoting SCHIP with employers, among other strategies. In its most ambitious effort, DHH worked with its sister Department of Education, the National School Lunch Program, and the state *Covering Kids* initiative to conduct back-to-school campaigns in 1999, 2000, and 2001. The effort entailed, among other activities, sending *LaCHIP* brochures home with every child, along with their applications for the Free/Reduced-Price School Lunch Program.

- In ***Missouri***, state officials have broadly distributed program materials, posters, brochures, and applications to local schools, social services offices, hospitals and health centers, health department clinics, and a range of CBOs. In addition, the state trained 3,000 individuals to serve as "ambassadors" for *MC+ for Kids*, spreading the word to CBO staff, clients, and others in the community. Finally, piggybacking on an existing initiative, Medicaid officials have integrated SCHIP promotional efforts with the activities of eight Community Partnerships, multi-agency consortia charged with addressing the needs of children in the areas of health, mental health, public safety, and juvenile justice, among others.

- In ***New Jersey,*** state officials made a concerted effort to promote *NJKidCare* to the state's Hispanic population which, at 13 percent, is proportionally the ninth largest in the U.S. In 1999, the state awarded $375,000 in grants to five organizations to increase awareness of *NJKidCare* among Hispanics in North Jersey. Funds were used to develop culturally appropriate outreach and education materials and to hire bilingual outreach workers to conduct community outreach events and assist families with applications. This collaboration with community agencies was a key part of the state's efforts to address the "public charge" issue. As one state official explained, "You need to get the appropriate people in the community to dispel the myths."

- In ***New York***, managed care health plans represent one of the state's key "arms" in the community; since *Child Health Plus's* inception, health plans have served as partners in marketing the program and enrolling children. More recently, the state launched its Facilitated Enrollment initiative, which gave grants to 32 "lead agencies," representing county health departments, county social services departments, perinatal networks, hospital associations, rural health networks, and senior citizen centers, to develop partnerships with "literally hundreds" of other local organizations in their communities to conduct outreach to families and assist them in enrolling in SCHIP and Medicaid.

- ***North Carolina's*** key outreach strategy was to give responsibility to local, volunteer coalitions, given the state's significant regional variations and traditions of local governance. Each of North Carolina's 100 counties was asked to form a coalition which would design and implement outreach efforts. Aside from relatively small, one-time grants from the state ($200,000, in all, was distributed statewide), the coalitions have been self-funded. Typically, county Departments of Social Services or Health have spearheaded coalition formation and have invited providers, health-based organizations, and community groups to join. The efforts of local coalitions have been bolstered by RWJF-funded *Covering Kids* projects in five counties that were described as "laboratories" for testing new outreach approaches, and by six minority-focused outreach projects underwritten by a grant from the Duke Endowment (targeting American Indians, African Americans, and Hispanics). Together, local efforts have typically engaged in such activities as developing and distributing outreach materials; making presentations to local councils, associations, businesses and providers; raising awareness in the schools; working with local media to produce public service announcements; and placing application forms in community sites, such as providers' offices, schools, public libraries, and child care centers.

- In ***Texas,*** a regional procurement process was implemented that permitted the state's eight regional Health and Human Services Commission offices to solicit proposals and award contracts to support local-level outreach and application assistance across the state. In all, 50 CBOs received contracts, including faith-based charities, community action agencies, county health departments, hospital partnerships, health provider groups, and other grassroots organizations. Typically, these CBOs have networked with other interested organizations in their communities, conducted training on *TexCare* eligibility rules and application procedures, and organized regional outreach and enrollment efforts.

Community-level outreach efforts were often complemented by states' support for Medicaid outreach using TANF/1931(b) monies. (i.e., monies that were allocated to states as part of welfare reform to support targeted Medicaid outreach of families who were leaving welfare). Most states distributed these monies to county departments of social services to support efforts to inform former welfare recipients of the availability of continued Medicaid coverage for them and their children. In Louisiana, for example, *LaCHIP* materials were distributed to families enrolled in the state's food stamp program. In Los Angeles, the County Department of Social Services built partnerships with community organizations, publicizing *Healthy Families/Medi-Cal for Children*, and outstationing eligibility workers at hospitals and clinics throughout the county, under its Child Medicaid Enrollment Project.

C. IMPLEMENTATION EXPERIENCES

State and local officials interviewed for this study expressed varying degrees of satisfaction with the outreach efforts they have carried out for SCHIP. Generally, key informants in seven states—California, Colorado, Florida, Illinois, New Jersey, New York, and Texas—praised the two-pronged approach involving statewide media marketing coupled with community-based efforts. We repeatedly heard the opinion expressed, from diverse individuals, that the two approaches were complementary—that broader marketing succeeded in getting families' attention, sparking initial interest in SCHIP, and building "brand recognition" over the long run; while community-based efforts, staffed by "trusted voices" from the neighborhood, provided the crucial ability to contact families directly, discuss the program in detail, answer questions and clarify misconceptions, and ultimately assist families with completing program applications. In New Jersey, state officials concluded that their media campaign was *too* successful—after enrollment soared in response to the introduction of parental coverage under the state's *FamilyCare* expansion, state officials decided to end all media outreach at the end of 2000. Toll-

free hotlines were also seen as critical back-ups to broader marketing, providing families with a resource from which to obtain further information about the program, as well as a tool with which state officials could gauge the effectiveness of alternative outreach strategies. In New Jersey, a study conducted by the state's media consultant found that close to half the families who called the state hotline learned of the state SCHIP program through television or radio advertising, and one-quarter through print advertising.

Of note, in both Louisiana and Missouri, state and local officials expressed frustration that there was no prominent mass-media component to their states' strategies. Although community-based efforts in these states were believed to be highly effective, officials felt that they faced significant challenges in informing families of the program in the absence of broader media efforts to raise awareness. This was not the case in North Carolina, however, where virtually all key informants interviewed for the study were content with having their outreach focus almost exclusively on community-based efforts, and did not feel that media would have helped the state reach more children.

Over time, it appears that several states became more sophisticated and effective in conducting statewide marketing, refining their advertising based on input solicited from consumer focus groups. In both Texas and California, for example, initial campaigns were described as "too generic" and "limited." Second-generation SCHIP advertising however, has included specific "price points" (that is, actual dollar figures charged as premiums) and avoided vague references to "affordable coverage" while including more detailed descriptions of available benefits, clearer statements about children being eligible regardless of their parents' citizenship status or participation in "welfare," and testimonials from satisfied parents. In Colorado, Florida, and New Jersey, officials avoided the use of phrases like "free care" because it devalued the program in the eyes of parents, and "health care for low-income children" so that working families would not be "turned off" by advertisements. In Florida, officials found the

phrases “For Parents, One Less Worry” effective. The targeting of particular ethnic groups was a feature of campaigns in several states—California described how it placed advertisements on numerous Spanish-speaking radio stations in various markets across the state; and Texas incorporated the well-known Hispanic nursery rhyme sung by mothers to their sick children—“Sana Sana”—into some of its radio and TV ads.

Even more consistently, we heard that community-based outreach was considered critical to the successful implementation of SCHIP programs, that giving local citizens and coalitions the freedom to be creative and design outreach suited to their neighborhoods built “buy in” and commitment to the effort, and that the provision of funding to support application assistance programs gave community-based organizations a direct tool for helping families to enroll their children.

New York officials are convinced that health plans play a critical role in promoting SCHIP and boosting program enrollment, and feel confident that they can control and guard against abuses that might arise from inappropriate plan behavior. Of all our study states, New York was the most aggressive in its use of health plans as marketing partners for *Child Health Plus.* While the state reviews and approves all plan promotional materials, health plans are encouraged to be aggressive in marketing and are permitted to reach out to and assist families in completing applications for SCHIP and Medicaid. One of the key marketing images used by New York—that of child “angels” perched upon fluffy clouds against a blue-sky backdrop—was originally designed by the largest health plan participating in *Child Health Plus.* Other states, however, still take an “arm’s length” approach to involving health plans, limiting the extent to which they can directly contact and enroll families. Such policies frustrated health plan officials who were eager to be more involved and were convinced that state officials were “blowing a big opportunity” to capitalize on their marketing expertise.

States also reported outreach strategies they believed were less successful. For example, officials in both Colorado and Louisiana said that distributing program brochures, flyers, and applications at health fairs, community events, and open houses at schools resulted in little interest and sustained followup by parents. Interestingly, in California, local outreach agencies described how some organizations which they had viewed as "obvious partners" sometimes resisted getting involved—for example, both WIC agencies and faith-based organizations reportedly were often uninterested in participating in *Healthy Families* outreach. For these groups, as well as many schools and school districts, "persistence and education" were required to forge successful outreach partnerships, according to local officials in California.

Officials in Illinois had a very different experience. There, aggressive outreach was targeted to WIC agencies, and the state Office of Family Health made "enrollment in *KidCare*" a performance measure for WIC clinics. In response, between September 2000 and October 2001, the number of WIC children who were not enrolled in *KidCare* dropped from roughly 47,000 to 20,000. Illinois, however, experienced mixed results with school-based outreach. Schools are "where the kids are…but not where the parents are," said one official, and local application assistors reported that outreach events in the Chicago Public Schools yielded frustratingly low attendance by parents. Yet efforts to use the school lunch enrollment list to link potentially-eligible children with application assistance has been somewhat more effective in the state. Of course Florida officials stand firmly behind school-based outreach; using school districts as the focal point for contacting families, distributing materials, and enrolling children has been the centerpiece of the state's program since its inception.

At the time of our site visits, officials in most states were optimistic that SCHIP outreach efforts would be sustained. Six of our 10 study states were satisfied with the amount of funding that had been devoted to outreach to date, and only two states—Colorado and Illinois—told us that the 10 percent federal cap on administrative spending had constrained their outreach efforts.

At the time of our site visits, political support for the programs was quite strong, and in that context, outreach was seen as an important ongoing process for recruiting families into coverage and helping them remain in coverage.

Among our study states, and nationally, at the time of our site visits, North Carolina was the only state to have imposed a cap on enrollment. Not surprisingly, this development had a chilling effect on outreach. When enrollment was frozen in January 2001, the intensity of outreach was deliberately reduced at the state level and, for the most part, at the local level as well. The freeze was described as "very painful" and "devastating" by outreach staff. One local official commented that "…it took the wind out of me completely, it was awful." Interestingly, even after the enrollment cap was lifted in October 2001, outreach efforts continued to be implemented "at a low level." According to one coalition member who spoke of their reluctance to launch another big effort, "…if we get more children enrolled, it might result in another freeze."

States with separate programs also reported on persistent challenges they faced in marketing SCHIP jointly with Medicaid. Foremost, perhaps, is family resistance to Medicaid. According to state officials in California, Colorado, Illinois, New Jersey, New York, and Texas, some parents with uninsured children are unwilling to enroll their uninsured children in Medicaid due to negative prior experiences with the program's enrollment process and the association of Medicaid with welfare and poverty. Among immigrant families, the persistent fear of "public charge" and the belief that participation in Medicaid could disrupt their (and their children's) citizenship applications, was another challenge noted in California, Florida, New Jersey, New York, and Texas. Consumers' negative opinions of Medicaid, growing from both of these factors, were reported to limit the effectiveness of state and local efforts to broadly promote "health insurance," and families that are favorably disposed toward SCHIP were often reported as being conversely resistant to Medicaid. In Colorado and Texas, these attitudes persuaded

community organizations to market SCHIP to the exclusion of Medicaid—"we can get our foot in the door with SCHIP, and then talk about Medicaid when we have to"—a sentiment expressed by many informants. In California, where all promotional materials display the joint logo of *Healthy Families/Medi-Cal for Children*, strategies are more mixed, with some CBOs and plans marketing the programs jointly, and others avoiding the mention of Medi-Cal to avoid "losing families' interest right out of the blocks." Advocates understood these dynamics, but were convinced that outreach for health insurance should jointly promote SCHIP and Medicaid.

Importantly, however, family resistance to Medicaid was not reported to be a problem in several other of our study states. In Louisiana, Missouri, and North Carolina, various factors contributed to this situation, including the fact that enrollment systems had been greatly simplified (in Louisiana and North Carolina), Medicaid and "welfare" eligibility determination had been separated years earlier (Louisiana), and managed care initiatives had been smoothly implemented and well received by providers and consumers alike (in Missouri). Equally important, in the states that did describe strong family resistance to Medicaid, local outreach and enrollment staff commonly reported that they were able to discuss families' fears, clarify misconceptions, and persuade parents to enroll their children. This critical success is discussed in more detail in the next chapter.

IV. ENROLLMENT AND RETENTION

A. BACKGROUND AND POLICY DEVELOPMENT

During each state's design phase for SCHIP, officials focused considerable attention on simplifying enrollment procedures. Described as an extension of aggressive outreach, simplified enrollment was designed to enable families to easily sign up for coverage in response to a program promotion. For states creating separate programs, streamlined enrollment was also seen as consistent with these programs' broader goal of modeling themselves on private insurance. As one New York official said, "…signing up for private coverage is usually easy…the same should apply for SCHIP." In the Medicaid expansion programs we studied, as well, considerable political support emerged for simplifying eligibility rules and procedures. In Missouri, for example, a user-friendly enrollment system was seen as critical for attracting higher-income families unfamiliar with government programs.

The vast majority of states in our study embraced the notion that families should be provided assistance, when needed, in the SCHIP/Medicaid application process. Eight of our 10 study states adopted and funded a variety of assistance mechanisms, creating both telephone-based and in-person assistance capacity in communities throughout their states.

The federally required "screen and enroll" process—whereby states with separate programs must review applicants' potential eligibility for Medicaid before granting them SCHIP coverage—proved challenging for most, but not all, of the study states with separate programs. Often, difficulties grew out of the fact that separate SCHIP programs enacted significantly simpler eligibility rules and procedures than their Medicaid counterparts, creating "disconnects" between the programs and complications during "screen and enroll." Frequently, though, as will be discussed below, we also observed SCHIP simplification strategies "spilling over" to Medicaid and resulting in streamlined access for children in both programs.

It also became clear during the study that the issue of retention, as well as policies to simplify children's renewal of ongoing coverage, had received little attention during either the SCHIP developmental process or the early years of implementation. Three years into their programs, several of the study states were experiencing challenges in *keeping* children covered.

B. PROGRAM AND POLICY CHARACTERISTICS

1. Eligibility Policies and Enrollment Processes

The study states have adopted a variety of policies aimed at keeping the SCHIP application process simple. Specifically, every state developed a joint application form for its SCHIP and Medicaid programs (with page lengths ranging from 2 to 8); every state eliminated the requirement for a face-to-face interview with a SCHIP program eligibility worker, permitting SCHIP applications to be submitted by mail; eight of the 10 states dropped the assets test from the SCHIP eligibility process; and six of the 10 extended 12-month continuous eligibility to children.[20] (See Table 4.) However, only three of the states—Florida, New Jersey and New York—adopted presumptive eligibility for SCHIP enrollees.

To varying extents, simplification has also reduced the documentation that parents must submit with their children's SCHIP applications. As detailed in Table 5, the majority of the study states requires applicants to submit verification of income (although Missouri, for a time, permitted families to "self-declare" their income). However, seven states have done away with the requirement to verify children's ages; four do not require verification of income deductions; eight do not require documentation of state residency; five do not require verification of immigrant status; and all but two states have done away with the requirement to submit social

[20]In addition, both Missouri and New York, while not guaranteeing continuous coverage for 12 months, do follow a 12-month eligibility redetermination cycle. Families are required, during that time, to notify the state if any changes in income or family structure occur that may affect their eligibility status.

TABLE 4: SCHIP AND MEDICAID SIMPLIFICATION STRATEGIES

State	Simplification Strategies										
	Joint Application	No Face-to-Face Interview		No Assets Test		12-Month Continuous Eligibility		Presumptive Eligibility		Retroactive Eligibility	
	(Length)[a]	SCHIP	Medicaid[b]	SCHIP	Medicaid[b]	SCHIP	Medicaid[b]	SCHIP	Medicaid[b]	SCHIP	Medicaid[b,c]
California	✓(4)	✓	✓	✓		✓	✓			[e]	✓
Colorado	✓(8)	✓	✓	✓		✓				✓[e]	✓
Florida	✓(2)	✓	✓	✓	✓		✓[i]	✓[h]	✓[h]	✓	✓
Illinois	✓(2)	✓	✓	✓	✓	✓	✓			✓[e]	✓
Louisiana	✓(2)	✓	✓	✓	✓	✓	✓			✓[c]	✓
Missouri	✓(2)	✓	✓								✓
New Jersey	✓(4)	✓	✓	✓	✓			✓[g]	✓		✓
New York	✓(2)	✓		✓	✓		✓	✓	[f]		✓
North Carolina	✓(2)	✓	✓			✓	✓				✓
Texas	✓(2)	✓	[j]	✓		✓	✓[d]				✓

SOURCES: Centers for Medicare & Medicaid Services (CMS), Framework For State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: California. March 2000 website: http://www.hcfa.gov/init/caeval98.pdf

Kaiser Commission on Medicaid and the Uninsured. Comparison of Medi-Cal and Healthy Families Programs in California. October 2000.

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Centers for Medicare & Medicaid Services (CMS), Framework for Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act: New York State November 2000. CMS website, http://www.hcfa.gov/init/charny99.pdf

Centers for Medicare & Medicaid Services (CMS). Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: Texas. March 2000 website: http://www.hcfa.gov/init/txeval98.pdf

State of Florida. *Florida KidCare Program: Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Health Care Financing Administration*. July 2000.

Donna Cohen Ross and Laura Cox, *Making It Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey.* Kaiser Commission on Medicaid and the Uninsured, October 2000.

Centers for Medicare and Medicaid Services (CMS), Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: North Carolina. March 2000 website: http://www.hcfa.gov/init/nceval98.pdf

TABLE 4 *(continued)*

NOTES:

[a]The numbers of pages in the application form are shown in the table. The application package also includes instructions, of varying length.

[b]Children's programs under Title XIX.

[c]Retroactive to up to 3 months prior to date of application.

[d]Continuous eligibility under Medicaid in Texas is for 6 months, not 12.

[e]Retroactive to date of application.

[f]Presumptive eligibility for children was approved in the 1998 New York Health Care Reform Act, but it has not been implemented.

[g]Except for plan D.

[h] Florida's Title XXI legislation contains language permitting presumptive eligibility under Healthy Kids, MediKids and Children's Medical Services, but the Governor has ordered that these provisions not be implemented.

[i]12-months of continuous eligibility is only extended to children under age 5; all other children receive 6 months of continuous coverage.

[j]In January 2002, Texas repealed the requirement for a face-to-face interview for children applying for Medicaid.

TABLE 5: VERIFICATION REQUIRED FROM APPLICANTS TO SCHIP AND MEDICAID

State	Verification Requirements													
	Income		Age		Deductions		Assets		State Residency		Immigration		SSN[e]	
	SCHIP	Medicaid[c]	SCHIP	Medicaid[c]	SCHIP	Medicaid[c]	SCHIP	Medicaid[c]	SCHIP	Medicaid[c]	SCHIP	Medicaid[c]	SCHIP	Medicaid[c]
California	Net	Net	✓	✓	✓	✓	NA		✓	✓	✓	✓		✓
Colorado	Net	Net				✓	NA	✓				✓		✓
Florida	Gross	Net					NA	NA						
Illinois	Gross	Net				✓	NA	NA			✓	✓	✓	✓
Louisiana	Net	Net			✓	✓	NA	NA			✓[b]	✓[b]		
Missouri	Gross	Gross	[a]	[a]	NA	NA	NA		[a]	[a]	✓[b]	✓[b]	[a]	[a]
New Jersey	Gross	Net	✓	✓	✓	✓	NA	NA			✓[b]	✓[b]		
New York	Gross[d]	Net	✓	✓	NA	✓	NA	NA	✓	✓		✓	NA	✓
North Carolina	Net	Net					✓	✓					✓	✓
Texas	Net	Net		✓	✓	✓	NA	✓		✓		✓		✓

SOURCES: Donna Cohen Ross and Laura Cox, *Making It Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey.* Kaiser Commission on Medicaid & the Uninsured, October 2000.

Centers for Medicare & Medicaid Services (CMS), *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: California*. March 2000 website: http://www .hcfa.gov/init/caeval98.pdf

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Centers for Medicare & Medicaid Services (CMS), *"Application and Enrollment Simplification Profiles: Medicaid for Children and SCHIP."*

Centers for Medicare & Medicaid Services (CMS), "*Framework for Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act: New York State"* November 2000. CMS website, http://www.hcfa.gov/init/charny99.pdf

Centers for Medicare & Medicaid Services (CMS), *Framework For State Evaluation Of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: Texas*. March 2000 website: http://www.hcfa.gov/init/txeval98.pdf

Centers for Medicare and Medicaid Services (CMS), Framework for State Evaluation of Children's Health Insurance Plans Under Title XXI of the Social Security Act, 1999: *North Carolina.* March 2000 website: http://www.hcfa.gov/init/nceval98.pdf

State of Florida. *Florida KidCare Program: Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Health Care Financing Administration*. July 2000.

NOTES:

SSN = social security number

NA = not applicable

Blank indicates that self declaration is sufficient (i.e., no written/printed verification is required.

[a]Verified using state databases.

[b]For applicants who are non-citizens.

[c]Children's programs under Title XIX.

[d]Self-declaration is permitted as a last resort, when no income verification can be provided.

[e]Note that this is the verification of SSN, the actual number is not collected for the application, NA indicates that the SSN is not required.

security numbers of children. Of the two states that retain an assets test for SCHIP—Missouri and North Carolina—only North Carolina requires families to submit documentation of their assets; in Missouri, families do not have to submit asset documentation.

Although most states have also simplified Medicaid rules and procedures, typically they have gone less far in doing so, compared to SCHIP (see Table 4). For example, while every state permits SCHIP applications to be completed entirely by mail, at the time of our site visits two states—New York and Texas—still required a face-to-face interview for applicants referred to Medicaid.[21] Furthermore, while eight of the 10 study states have eliminated assets tests for SCHIP, only five have done so for Medicaid. Only half of the study states extend continuous eligibility to children under both SCHIP and Medicaid, but even these policies are not always consistent across the two programs. For example, Texas extended 6 months of continuous coverage to Medicaid enrollees, while extending 12 months of continuous coverage SCHIP enrollees.[22] Medicaid programs are consistently more generous than SCHIP programs in retroactive coverage policy—Medicaid programs, by law, must extend eligibility retroactively to 90 days prior to the date of application. The SCHIP statute does not have such a provision so most programs, like private insurance, simply begin eligibility after an application has been approved, or back-date coverage to the date of application.[23]

Medicaid programs have also been less likely to reduce verification requirements compared to SCHIP programs in the same states (see Table 5). Under Medicaid, the study states often

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[21]In New York, this face-to-face interview can occur with a qualified "Facilitated Enroller" and does not have to take place with a county social services worker. In Texas, the face-to-face interview requirement under Medicaid was repealed in January 2002.

[22]As part of the same Medicaid simplification bill that eliminated the face-to-face interview requirement, Texas also extended the Medicaid continuous eligibility period to 12 months effective January 2002.

[23]Missouri, under its Section 1115 demonstration, is the only study state that does not provide retroactive coverage to Title XIX enrollees.

require applicants to submit verification of children's ages, income deductions, assets, residency, immigration status, and social security numbers, but less often impose such requirements on SCHIP applicants.

The study states used multiple avenues for enrolling children in SCHIP and Medicaid. These methods are displayed in Table 6 and are summarized below.

- ***Mail.*** Every state in our study now permits the SCHIP application process to be completed entirely by mail. Invariably, this policy was adopted to make the process more convenient for parents and to avoid resistance that might arise from requiring parents to meet face-to-face with an eligibility worker in a social services office. While eight of the 10 study states permit the mail-in application to be used for determining both SCHIP and Medicaid eligibility, New York and Texas required, at the time of our site visits, that a face-to-face interview take place for those children who apply for, or are referred to, Medicaid.[24]

- ***Community-Based Application Assistance.*** In six of the 10 study states, officials have created community-based assistance systems to help families complete program applications. In three cases, grant and/or contract monies have been extended to community organizations through competitive procurements, permitting them to hire staff dedicated to application assistance (as seen with Outreach Contractors in California and Texas, and Facilitated Enrollers in New York). In five states, individuals and community organizations are paid a retroactive "finder's fee" for every successfully submitted application (as seen with Certified Application Assistors in California, Satellite Eligibility Determination sites in Colorado, *KidCare* Application Agents in Illinois, application assistors in New Jersey,[25] and Medicaid Application Centers in Louisiana). In both New York and California, managed care plans and their marketing staff are permitted to serve as application assistors.

[24]Once again, policies in both New York and Texas have changed since our site visits. New York now permits community-based facilitated enrollers to conduct the required face-to-face interviews, and Texas completely eliminated the requirement for such an interview from the Medicaid application process, effective January 2002.

[25]Given rapidly rising enrollment, New Jersey discontinued paying "finder fees" to agencies providing application assistance, as well as its grant program to support these agencies' start-up costs. This effort ended in June 2001 after two years of operation.

TABLE 6: AVENUES FOR SUBMITTING SCHIP AND MEDICAID APPLICATIONS

State	Process									
	Mail-In Application[b]		Community-Based Enrollment		Phone Application[c]		Internet Application[c]		County Social Services	
	SCHIP	Medicaid[a]	SCHIP	Medicaid[a]	SCHIP	Medicaid[a]	SCHIP	Medicaid[a]	SCHIP	Medicaid[a]
California	✓	✓	✓	✓			✓[e]		✓	✓
Colorado	✓	✓	✓	✓			[f]		✓	✓
Florida	✓	✓					✓[g]		✓	✓
Illinois	✓	✓	✓	✓	✓	✓			✓	✓
Louisiana	✓	✓	✓	✓					✓	✓
Missouri	✓	✓			✓	✓			✓	✓
New Jersey	✓	✓	✓	✓					✓	✓
New York	✓[d]		✓	✓					✓	✓
North Carolina	✓	✓							✓	✓
Texas	✓		✓	✓	✓		✓		✓	✓

SOURCES: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES:

[a]Children's programs under Title XIX.

[b]Therefore no face to face interview required.

[c]Signature required either electronically or as a hard copy.

[d]A face to face is required, but with a facilitated enroller.

[e]In a pilot phase at the time of the site visit. Shortly to be introduced on a county by county basis.

[f]Under development at the time of the site visit.

[g]Florida, at the time of our visit, was pilot-testing an Internet-based application form in 5 sites.

- ***Telephone Assistance.*** Instead of funding community organizations, Missouri chose to establish seven regional "phone centers" to provide application assistance. All the state's outreach materials display a toll-free hotline number, and parents calling the hotline have their call routed to the phone center nearest their community. Phone Center staff can take applications over the phone or simply mail application forms to interested parents. In Texas, the same capacity was created with the state's vendor, Birch & Davis; in practice, however, this state's hotline staff typically have sent blank applications out to families, as opposed to completing applications over the phone. In North Carolina, parents can receive assistance over the phone from staff of any of the states' 100 county Departments of Social Services. The same arrangement is established in Illinois. In New Jersey, however, while hotline staff are available to answer questions, they do not fill out applications on behalf of callers.

- ***Internet.*** Some states have also begun to explore using the Internet to facilitate SCHIP and Medicaid enrollment. While Colorado's program has been designing such a system since its inception, California and Texas have pilot-tested Internet-based applications and are currently introducing their systems in selected counties. In California, the "Health-E Application" initially will be used by Certified Application Assistors and Outreach Contractors as they assist families with their applications. Texas' "E-Z App" is available to consumers who wish to complete their applications on line.

- ***County Departments of Social Services.*** Finally, in each of the states we studied, families can apply for coverage through more traditional means—with local social services workers in county "welfare" offices, or with eligibility staff outstationed at public clinics and hospitals. In states with separate programs, initiating an application in this way typically results in families completing the longer Medicaid (or multi-program) application and in eligibility for the entire family being reviewed. Ultimately, however, it can lead to a referral to SCHIP for children found to be living in families with incomes or assets above Medicaid limits. County staff we interviewed typically do not help families complete SCHIP application forms; rather, they refer families to SCHIP, and may or may not provide them with a blank application form. In New Jersey, however, local social services staff will forward a child's application to the vendor responsible for determining SCHIP eligibility. In states with Medicaid expansions, applications begun through county social services agencies are considered for both SCHIP and Medicaid eligibility.

To ensure that children eligible for Medicaid are extended that entitlement, and to guard against SCHIP "crowding out" Medicaid, states are required to review every application for potential Medicaid eligibility before granting any child coverage under SCHIP. In the two study states with Medicaid expansion programs (Louisiana and Missouri), and in one with a separate program (North Carolina), screen-and-enroll is relatively simple: social services staff in county

offices, phone centers, and application centers review all applications and determine which program each child is eligible for. In the seven other states with separate programs, screen-and-enroll can be considerably more complicated. Most often, this is because states have given responsibility for SCHIP eligibility determination to an entity other than the state or county social services agency that retains responsibility for Medicaid eligibility determination. Thus, states typically had to devise referral mechanisms to transfer applications back and forth between these entities. In California and Texas, state officials have contracted with vendors to act as "single points of entry" into SCHIP and Medicaid. That is, all applications in these states are mailed to the vendors, who then conduct screen-and-enroll reviews. The vendors process SCHIP-eligible applicants but transfer the applications of children who appear to be Medicaid eligible to county social services offices in the child's county of residence. Illinois' process works in a similar manner, except that state program staff work in the "central processing unit" rather than contracted vendor staff.

New Jersey and Colorado have also contracted with vendors to serve as a central processing unit for *NJFamilyCare* and *Child Health Plan Plus* applications, respectively, but place state or county social services workers on site at the vendors to handle applications of children deemed Medicaid eligible. Florida, which uses staff of the not-for-profit Healthy Kids Corporation to process *KidCare* applications, has also chosen to co-locate county social services staff to process Medicaid-eligible children. Both states believe that this approach saves a lot of time and reduces the potential for problems to arise out of referrals back and forth between vendors and counties.

In New York, no single point of entry exists. Instead, Facilitated Enrollers and their "lead agencies" conduct screen-and-enroll and make referrals to county social services offices in much the same manner as described above. And North Carolina stands alone among our study states with separate programs in that all application processing continues to be handled at the local level, in county Departments of Social Services. County staff review the simplified applications

first for Medicaid eligibility, then for *Health Choice* eligibility, and process enrollment for both programs in house.

While the various processes used in study states may sound straightforward, they have often proven complex in practice, as will be discussed below in the "Implementation Experiences" section.

2. Eligibility Redetermination Policies and Processes

We found that eligibility redetermination processes for SCHIP were similar in eight of the 10 study states. Most states in our study either offer 12-month continuous eligibility or follow a 12-month redetermination cycle under SCHIP. Typically, computer-generated letters are mailed to families at the beginning of a child's tenth month of eligibility, notifying parents that it is time to renew their child's coverage. These letters often are accompanied by a blank program application (or renewal) form, and parents are asked to complete the form and resubmit documentation of certain items. If families do not respond to these initial notices, reminder notices usually are sent out at month 11. In addition, vendor, state, county, CBO, or health plan marketing staff (depending on the state) make two or three attempts to contact families (by phone or mail) before the end of the child's period of coverage. If families submit their renewal packets on time, they are reviewed for continued eligibility (and referred to Medicaid if family income has dipped to Medicaid-eligible levels). If families fail to submit their applications and materials, their children are disenrolled.

Missouri and Florida were the only states that varied significantly from this approach. In Missouri, county social services offices were described by state officials as "chronically understaffed;" therefore, eligibility redetermination is not conducted on a routine, systematic, or timely basis. Rather, staff prioritize redeterminations, focusing first on families where changes are known to have occurred (for example, adolescents aging out of the program), and on families

more likely to experience a change in income or family circumstances (including, we heard, families in lower income groups and those with certain types of jobs). Meanwhile, a child's enrollment continues uninterrupted until staff have time to conduct a redetermination.

In Florida, officials have adopted a more formal "passive" redetermination approach for *KidCare*. There, families are sent a pre-printed renewal application two months before the end of the child's 12-month eligibility period. The form is printed with family and income information that was provided by parents on the initial application. Parents are simply asked to review the information and correct any items that have changed. If parents do not respond by resubmitting their forms, state officials assume that their children remain eligible and continue their enrollment. Since all families in Florida are required to pay monthly premiums in order to maintain their children's eligibility, if premium payments are current state officials can presume that the families are still in the state and interested in continuing their participation with the program.

States have taken various steps to streamline the SCHIP renewal process (see Table 7). The "passive" system in Florida (described above) was, by far, the simplest for families among our study states. More generally, in every state we visited, renewals can be completed entirely by mail. In California, Florida, Illinois, New Jersey, and Texas, computer systems produce "preprinted" renewal applications, populating the form with information gathered from the initial application. In these states, parents are asked to indicate where changes have occurred, and to submit updated verification for those items that have changed. California, North Carolina, and Texas have also reduced verification requirements for eligibility redetermination, requiring the resubmission of income and other verification only if these items have changed during the previous 12 months. Louisiana officials reported that they have recently developed a shorter and simpler renewal form for *LaCHIP* that they believe will be easier for families to complete.

TABLE 7: REDETERMINATION FORMS, REQUIREMENTS, AND PROCEDURES FOR SCHIP AND MEDICAID

State	Characteristic									
	Mail-In Redetermination		Pre-Printed Form		Same Form As Application		Income Verification Required[a]		Other Verification Required	
	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid
California	✓	✓	✓			✓	[a]	✓	[a]	✓
Colorado	✓	✓			✓		✓	✓		✓
Florida	✓		✓							✓
Illinois	✓	✓	✓	✓			✓	✓		
Louisiana	✓	✓					✓	✓		
Missouri	✓	✓					✓	✓		
New Jersey	✓	✓	✓				✓	✓	[a]	[a]
New York	✓				✓	✓	✓	✓	[a]	✓
North Carolina	✓	✓			✓	✓	[a]	[a]	[a]	[a]
Texas	✓		✓			✓	[a]	✓	[a]	✓

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES:

[a]Verification required only if circumstances have changed.

As was the case with initial application procedures, however, states' eligibility redetermination rules and procedures for SCHIP were often observed to be simpler than those used for Medicaid. First, redetermination forms for Medicaid were often described as longer and more complicated than those for SCHIP (in four states, the same, full-length application form that was used initially to determine Medicaid eligibility is also used for eligibility renewal). Furthermore, while all states permit renewals to be completed by mail for SCHIP, New York and Texas require that face-to-face interviews be conducted when redetermining eligibility for Medicaid. In addition, while five states preprint their renewal applications for SCHIP, only one of our study states—Illinois—also does so for Medicaid. In seven of the eight states with separate programs, Medicaid also requires the resubmission of verification of family income, and commonly, children's ages, social security numbers, residence, and immigration status. In those states' separate programs, verification of items beyond income are only required when information has changed.

C. IMPLEMENTATION EXPERIENCES

Table 8 presents enrollment totals for children in SCHIP (and, for comparison purposes, in Medicaid) in each of our study states as of September 2001. Program sizes vary considerably across our sample—California, Florida, New York, and Texas represented the four largest SCHIP programs in the nation, with enrollment of between roughly 246,000 and 479,000 children; while Colorado, Illinois, Louisiana, Missouri, New Jersey, North Carolina, enrolled fewer than 100,000 children. In every state, SCHIP program enrollment is dwarfed by that of Medicaid for children.

Overall, our study states experienced significant growth during the first three years of SCHIP, as seen in Figure 1, but trends vary across the states. Whereas California, Colorado, Florida, Illinois, Louisiana, and Missouri experienced relatively steady growth, Texas'

TABLE 8: SCHIP AND MEDICAID ENROLLMENT

State	SCHIP Enrollment (2001)[a]	Medicaid[b] Child Enrollment (FFY2001)
California	475,795	3,169,060
Colorado	36,536	202,166
Florida	79,994	1,190,510
Illinois	64,817	952,915
Louisiana	56,227	499,771
Missouri	75,221	538,423
New Jersey	79,994	436,335
New York	479,973	1,573,767
North Carolina	60,211	685,285
Texas	432,745	1,526,365

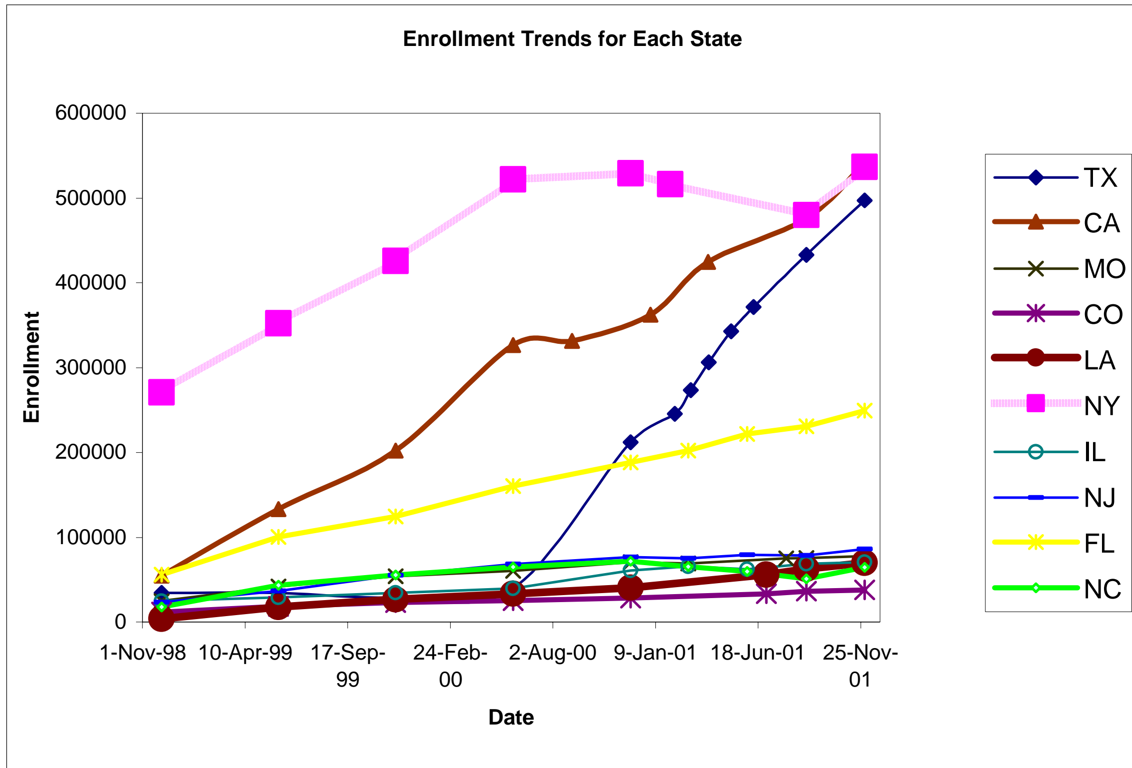
SOURCE: SCHIP: State administrative data; Medicaid: Kaiser Family Foundation. State Health Facts Online. Medicaid enrollment figures, www.cms.hhs.gov/medicaid/msis/msis99sr.asp.

NOTES:

[a]Point-in-time data for most recent month available, which is September 2001 for all states except Florida (December 2001), Missouri (August 2001), Louisiana (July 2001), Illinois (December 2001)

[b]Children's programs under Title XIX. Children ever enrolled during fiscal 2000.

FIGURE 1: ENROLLMENT TRENDS FOR EACH STATE



enrollment dramatically increased with the implementation of its Phase 2 *TexCare* program in April 2000, and New York had begun to see a decline in total enrollment by 2001. In New Jersey, with the implementation of *FamilyCare* in the Fall of 2000, enrollment of parents of SCHIP enrollees skyrocketed, however child enrollment continued to grow at a slow, but steady rate. North Carolina's enrollment peaked in January 2001 at roughly 72,000 children. At that point, an enrollment cap was imposed and enrollment dropped to 51,000 as disenrollment due to attrition reduced the program rolls. During the same period, state officials continued to accept applications, placing more than 35,000 children on the state's waiting list. After the cap was lifted in October 2001, enrollment quickly climbed to 60,000 by December of that year.

Figure 2 illustrates the extent to which these states enrolled their self-identified "target" populations.[26] Here, too the experiences varied considerably. Two states actually exceeded their target enrollment at some point during the course of our study—Texas, enrolling 110 percent of its target by December 2001, and North Carolina, enrolling 101 percent by January 2001, before implementing its aforementioned enrollment cap—and New York had reached 99 percent of target enrollment by December 2001. In contrast, New Jersey and Illinois enrolled the smallest proportions of their estimated target populations—31 and 37 percent, respectively. California, Colorado, Florida, Louisiana, and Missouri each enrolled between 55 and 86 percent of their target populations of children by the end of 2001.

State officials mostly reported a high level of satisfaction with their enrollment achievements. They were pleased with the extent to which they had simplified enrollment systems, and with the way outreach efforts had succeeded in building strong recognition of the

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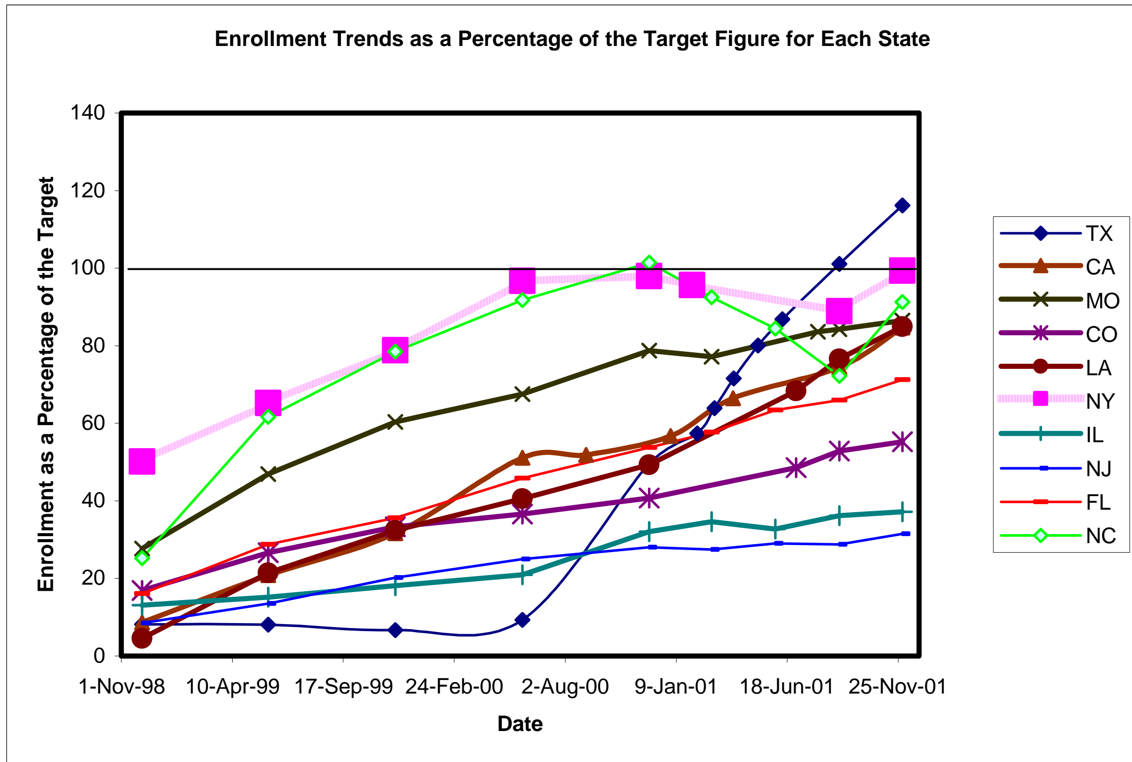
[26]Importantly, these targets do *not* represent the total number of low-income uninsured children eligible for SCHIP in each state; also, states employed different assumptions when creating these targets. The targets do, however, reflect policymakers' goals for their programs and the benchmarks against which they judged whether they were achieving their goals.

FIGURE 2: ENROLLMENT TRENDS AS A PERCENTAGE OF THE TARGET FIGURE FOR EACH STATE



programs and persuading large numbers of families to enroll their children in coverage. In a number of states, community-based application assistors, working in a variety of settings, were credited as the crucial ingredient in achieving high enrollment. In some states, however, there was less satisfaction with enrollment progress. A synthesis of comments from key informants in the study states appears below.

- In ***California***, state officials, advocates, and local-level enrollers consistently believed that the state had rebounded well after a shaky start. The launch of *Healthy Families* was marred by the state's use of a 28-page "short" form which was universally criticized as unworkable. However, state officials, working closely with advocates and other stakeholders, had developed a dramatically simpler, four-page form by early 1999, and had designated its vendor, EDS, as the "single point of entry" for all applications. Together, these improvements helped increase enrollment beginning in late 1999. In addition, informants pointed to steady expansion and growth in funding for community Outreach Contractors and Certified Application Assistors as critical in reaching "hard to reach" groups and improving the state's ability to enroll Hispanic children, who now comprise roughly 70 percent of all enrollees, a figure estimated to be commensurate with the share of Hispanic children in the low-income population.

- ***Colorado*** was the only state in our sample where informants were consistently less pleased with enrollment growth. While key informants viewed the SCHIP eligibility process as dramatically simplified, they also cited a number of factors that had suppressed enrollment, including a complicated joint application form (revised and improved during 2001), inconsistencies in SCHIP and Medicaid rules, sometimes problematic relationships between SCHIP and county social services agencies, and a premium structure that may have caused considerable consumer resistance to the program, especially in light of the state's existing low-cost Indigent Care Program (discussed in more detail in the cost-sharing chapter of this report).

- In ***Florida***, while enrollment levels have steadily grown, a number of advocates and providers were concerned that the state was not accessing its full federal allotment and pointed to a number of factors that delayed full implementation, including: the extended period of time it took for the *Healthy Kids* component to be implemented in every county; enrollment freezes that occurred in some counties that experienced difficulty coming up with required local matching funds; initially limiting enrollment in the *MediKids* component to a 3-month open-enrollment period, as opposed to permitting enrollment year round; and backlogs in application processing that occurred when the Healthy Kids Corporation was inundated with applications at the start of the state's large-scale outreach campaign. Still, with the creation of a significantly simplified initial application process, a fairly seamless screen-and-enroll system, and passive renewal, Florida has achieved impressive enrollment and retention results.

- In ***Illinois***, restructuring eligibility and enrollment policies for both *KidCare* and Medicaid have collectively resulted in a system with which key informants were very pleased. Simplification strategies include the creation of a 2-page joint SCHIP/Medicaid application, reduction of verification requirements to income only, permitting applications to be submitted by mail, and the funding of KidCare Application Agents at the local level to assist parents with completing program applications. This final strategy was praised, in particular, for improving the quality of application submissions; application approval rates jumped from 30 to 85 percent after KidCare application agents began assisting families with the process. Remaining concerns, however, center on the fact that local Departments of Human Services retain responsibility for processing the applications of children who appear Medicaid eligible; this arrangement has contributed to both logistical challenges in transferring applications back and forth between the central unit and the counties, and confusion on the part of parents who thought they were enrolling for *KidCare,* but were contacted by county "welfare" offices when their children were determined Medicaid eligible.

- In ***Louisiana***, enrollment has consistently met state targets. Children's enrollment in Medicaid (both Title XIX and Title XXI) rose by 138,111 between the implementation of *LaCHIP* and the end of 2000. This enrollment growth was generally attributed to simplification of the application form and process. Enrollment rose appreciably with the implementation of *LaCHIP* and the debut of the one-page mail-in application form and again when the state reduced verification requirement for *LaCHIP* and Title XIX children's Medicaid programs in July 2000. Most respondents believe that the state's system of community-based application assistance, which existed prior to *LaCHIP*, has also contributed to enrollment growth, by providing the kind of personal assistance that some families need to complete the application accurately. The one remaining barrier cited by respondents was the state's income verification requirements. At the time of our visit, close to one-quarter of the applications received by the central processing office were missing the required proof of the prior month's income.

- ***Missouri*** has experienced high enrollment levels despite a limited publicity campaign and complex enrollment processes, attesting perhaps to the strength and effectiveness of local outreach in getting the word out about the program. Key informants also attributed the state's success to its phone centers, which streamline and facilitate enrollment. Its enrollment successes notwithstanding, there is some concern that enrollment rates are too low in some areas, leading advocates to push for a presumptive eligibility component under *MC+*. In addition, an important caveat to Missouri's enrollment story is that most enrollment to date has been among children at lower income thresholds; some key informants suggested this might be due to requirements for children in higher income households that they pay premiums and wait 6 months to enroll after leaving private insurance.

- In ***New Jersey***, steady but unspectacular enrollment under *KidCare* provided little warning of the demand that would surface when the state implemented parental coverage under *FamilyCare.* While roughly 74,000 children had been enrolled during the first two and one-half years of implementation, combined child/parent enrollment tripled to 230,000 by November 2001, just six months after the adoption

of parental coverage. Nearly all of this increase was among parents, as child enrollment only grew to 80,000 by this date. Because of this spike in enrollment, New Jersey halted its statewide, media outreach campaign and discontinued its payment of $25 "bounties" to community-based organizations that provided application assistance. Neither of these steps caused much concern among key informants, however, as it was reported that the program had already established a strong identity across the state, and bounties were only paid to a very small proportion of the community groups that were involved with helping families. Unlike some states in our study, a large proportion of families continue to choose to apply through county social services offices, and local officials described a process that had been restructured to be more "consumer friendly."[27]

- In ***New York***, state officials believe that increasing enrollment takes time and have identified the advantage they had over most states in building SCHIP on a state-funded initiative that had been in place for six years prior to the enactment of SCHIP. These officials, along with most other informants we interviewed, felt that health plans had been very successful partners in outreach and enrollment. With careful oversight and monitoring by the state, these plans had aggressively identified and enrolled eligible children. With the addition of Facilitated Enrollment in mid-2000, New York was also able to address previous challenges in conducting accountable screen-and-enroll efforts.

- ***North Carolina***, creative, locally-based outreach and a simple, seamless application process that serves both SCHIP and Medicaid were credited with achieving strong rates of enrollment. Key informants described the county welfare process as "reinvented" with the implementation of *HealthChoice,* and family resistance to traditional county offices and systems was reported to have significantly declined after the state's processes were reformed. These steps have also led to significant increases in Medicaid enrollment, as some counties reported that as many as half of all SCHIP applicants end up enrolled in Title XIX. Still, the many positive experiences under *HealthChoice* were offset by the negative reports of the impact of the enrollment freeze.

- In ***Texas***, enrollment grew rapidly beginning in April 2000, coincident with the launch of Phase 2 of its SCHIP initiative—the separate program, *TexCare*. In just 18 months, Texas enrollment grew to nearly the level of enrollment in California and New York. State officials attribute this success to two years of careful planning of outreach and enrollment strategies that drew heavily on the input of consumers, advocates, and other stakeholders interested in expanding insurance coverage for children, as well as observations of strategies that had worked in other states. Despite this positive recent trend, Texas was still criticized by some for taking two years to implement its separate program, leaving many children uninsured during its planning phase.

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[27]Effective June 2002, New Jersey capped enrollment of parents under *FamilyCare.* The freeze did not effect parents already enrolled at the time, but precluded the enrollment of any new parents.

As implied above, another positive finding of our study is that eligibility reforms implemented under SCHIP have "spilled over" to Medicaid in several ways. First, in every state in the study, SCHIP either stimulated the creation of shorter, simpler "joint" application forms or it reinforced existing simplification efforts. These efforts were described as greatly benefiting families whose children ultimately enroll in Medicaid as well. Furthermore, we saw several examples, such as California, where simplification strategies adopted by separate SCHIP programs—for example, permitting applications to be submitted by mail, dropping assets tests, reducing verification requirements, and guaranteeing 12 months of continuous eligibility—were also adopted by Medicaid programs in the interest of aligning the rules of the two programs (even though these policies had been resisted by the state for years before the creation of SCHIP). And, in Texas, dramatic differences between SCHIP and Medicaid eligibility rules—including a more complicated form, an assets test, more extensive verification requirements, no continuous eligibility, and the requirement of a face-to-face interview with social services staff—helped spur support for passage of a Medicaid simplification bill. Beginning in late 2001, Texas' Medicaid eligibility rules were aligned with those of SCHIP, with an assets test remaining as the key difference between the programs.

In a more subtle, but equally important, way key informants indicated that SCHIP has stimulated changes in the culture and operations of traditional social services ("welfare") programs. In both Louisiana and Missouri, efforts to delink Medicaid from welfare eligibility systems predated Title XXI but were further expanded in the aftermath of SCHIP, in an effort to create more user-friendly systems for consumers. A similar effect was seen in North Carolina, where county social services offices were given responsibility for processing the state's new joint application, whether received by mail or submitted by parents in person. And in each of the other states with separate programs, social services systems were working hard to facilitate families' access to coverage, as opposed to denying such access. Especially in high-density

population centers like Los Angeles County and the boroughs of New York City, we heard local eligibility staff make such observations as: "…we've had a real culture shift here. No longer are we supposed to keep everybody out; we're supposed to help them get in!"

Still, despite the considerable progress being made in streamlining children's enrollment, SCHIP and Medicaid eligibility systems continue to be criticized by a wide array of key informants; and many barriers to enrollment persist. For example:

- ***Even with simplified forms, reduced verification requirements, and the widespread availability of application assistance for parents, many parents submit incomplete applications.*** In some cases, this was blamed on the fact that SCHIP and Medicaid rules continue to differ within many states, resulting in unnecessarily long joint applications (that must take account of both programs' rules) and causing confusion among parents. For advocates, in particular, this was evidence that SCHIP and Medicaid application procedures were still "too complex." Rates of "incompletes" varied dramatically from state to state, with a rate of 70 percent reported in California and 35 percent in Texas. Interestingly (and, perhaps, discouragingly), some informants in California and Louisiana told us that incomplete rates were the same regardless of whether or not the parent had received application assistance. Both California and Texas were excited by the potential of their Internet-based applications to significantly improve families' rates of submitting full and complete applications.

- ***In most states with separate programs, screen-and-enroll procedures were described as complex and confusing for families.*** Once again, this often was attributed to differences between SCHIP and Medicaid rules that frequently require eligibility to be determined twice. Beyond differences in policy, however, most prominent problems surrounded the logistics of sharing information between "single point of entry" vendors and county departments of social services. Depending on where an application is initiated, screen-and-enroll may require vendors to "deem" or refer applications to their social services counterparts, or vice versa. Due to differing eligibility rules (and confusion over how rules for one program may or may not apply to the other), we heard that applications are often sent back and forth between vendors and social services offices several times. The vendor in California was referred to as "a black hole" by several social services staff for its inability to track the status of applications. Colorado enrollers were concerned that large numbers of children referred to Medicaid were "falling through the cracks"—again, because the state did not have a system with which to track applications. The vendor in Texas was viewed somewhat more favorably for its technological ability to both track applications (by bar codes) and to electronically transfer "images" of applications to county offices.

A model that seemed to address this problem was observed in the States of Florida and New Jersey. In these states, state or county Medicaid eligibility staff are co-located at the entity responsible for processing mail-in applications.[28] Children observed to be potentially Medicaid eligible are simply forwarded to co-located staff who process them on site. Notably, problems with screen-and-enroll were absent in North Carolina, where the system has been structured so that county social services offices determine eligibility for both programs.

- ***Retroactive "finder's fees" were sometimes criticized as an ineffective way to pay community-based application assistors.*** Despite considerable praise voiced for community-based application assistance efforts, those states that pay agencies retroactive "finder's fees" for successfully enrolled children were sometimes criticized by community groups, for a variety of reasons. Certified Application Assistors (in California), Satellite Eligibility Determination sites (in Colorado), *KidCare* Application Agents (in Illinois), Medicaid Application Centers (in Louisiana), and application assistors (in New Jersey) receive fees ranging from $50 in Illinois and California (which raised the fee from $25 during the program's first year), to $25 in New Jersey, to either $15 or $12 in Colorado (depending on whether applications were submitted electronically or by mail), to $14 in Louisiana. Regardless of the fee level, however, community-based organizations in each of these states (except Illinois) often reported that fees were insufficient to cover the time and costs involved in assisting families with applications. Furthermore, satisfaction with the arrangements was undermined in California by slow payment by the state's vendor, and in New Jersey where local groups reported that the fees generated bitter competition for enrollees in some communities. In contrast, community groups tended to voice support for receiving up-front grants or contracts to support application assistance activities, since these arrangements enabled the community groups to add capacity by hiring new staff.

- ***State eligibility data systems were also criticized for their inability to track applications through the process and report precise figures on SCHIP and Medicaid interactions.*** While every state strongly believed that Medicaid enrollment of children had increased as a result of SCHIP outreach and enrollment efforts, few states in our sample could quantify this claim with precise program data.

- ***Changes in culture, approach, and attitudes in county social services departments have occurred in many localities, but many counties have been "slow to give up their welfare mentality and practices."*** In some states (for example Missouri, New Jersey, and North Carolina) county "welfare" offices were described as having evolved into more user-friendly sites where families felt comfortable applying for health coverage. In Louisiana, county Medicaid offices were made completely separate from county welfare offices. However, informants in Colorado, California, New York, and Texas spoke of the considerable variation in practices between counties, with some cooperatively working with community application assistors, and

[28]Colorado also began co-locating state Medicaid eligibility staff at its CHP+ enrollment center in February 2002, after the time of our site visit.

others seemingly resentful that other groups were getting involved with eligibility-determination activities. We also heard of instances where counties' eligibility review procedures differed, despite uniform state policy. In Colorado, for example, we heard that different counties required different kinds and amounts of verification materials from families, and also used different sources for determining the value of automobiles during assets' reviews. These problems contributed to difficulties with screen-and-enroll, and perpetuated some families' negative feelings toward welfare and Medicaid vis-à-vis SCHIP.

- ***Family resistance to Medicaid, strong in several states, appears to be undermining states' broader efforts to achieve high enrollment in public insurance programs.*** Family resistance to Medicaid was reportedly strong in half of the 10 states we studied—California, Colorado, Illinois, New York, and Texas—all states with separate SCHIP programs. "Medicaid stigma" was most often ascribed to families' previous negative experiences trying to enroll for assistance in county welfare offices. We heard reports of families feeling "…intimidated by local DSS offices," and of being "treated rudely." In addition, in California and Texas, resistance was attributed to deeply entrenched fears of "public charge" among immigrant Hispanic families believing that participation in Medicaid would affect their or their children's citizenship. This problem was manifest most clearly during screen-and-enroll activities. In California, New York, and Texas, we repeatedly heard that families were drawn to SCHIP and attracted to its promise of health coverage for children, but "turned off" if their children were found to be Medicaid-eligible. Quotes of local enrollers and advocates included, "…families simply don't want Medicaid and would rather be uninsured," "…the program carries so much negative baggage," "…parents are not afraid of SCHIP, but they're terrified of Medicaid," and "…families have begged us to stay on SCHIP and even offered to pay premiums to do so."

  The success of community-based enrollers in persuading these families to sign their children up for Medicaid was mixed. In New York, we heard encouraging reports from Facilitated Enrollers, who were able to convince the majority of the families with whom they worked to follow through with Medicaid enrollment for their children. (There, fears of public charge seem to have largely dissipated, perhaps due to New York's decision to use state funds to cover immigrant and non-citizen children in *Child Health Plus.*) In California and Texas, however, fear of public charge has been "very slow to fade." From one Application Assistor in California, we heard "…I lose 90 percent of the children that I find Medicaid-eligible…they simply walk away." The fact that 43 percent of parents check the box on the *Healthy Families/Medi-Cal for Children* application form that indicates they do not want their application forwarded to DSS, was described as further evidence of the presence of Medicaid stigma and the fear of public charge. In Texas, we were told that only 25 percent of families referred to Medicaid ultimately enroll with the program.

  Once again, it is important to point out that in the other half of our study states, state and local officials have apparently succeeded in reducing, or largely eliminating families' resistance to Medicaid. Through simplified enrollment procedures and formal delinking application systems for health care and other forms of public aid, Florida, Louisiana, Missouri, New Jersey, and North Carolina have found that

> families tend to attach little or no negative feelings to interactions with local social services offices.[29]

The picture regarding SCHIP retention, and whether or not problems with retention were undermining enrollment, was inconsistent across the study states. While it is not clear what rate of retention should be expected under SCHIP, in at least five of the study states—Colorado, Illinois, Louisiana, North Carolina, and New York—disenrollment rates among SCHIP children had begun to worry key informants. State officials in Colorado, Illinois, Louisiana, and North Carolina reported disenrollment rates of approximately 40 percent. In New York, state officials and health plan administrators reported that they were "losing children at redetermination almost as fast as we can sign them up." This is consistent with New York program data showing recent declines in enrollment (recall Figures 1 and 2) a reversal attributed by key informants to problems with retention. Disenrollment rates were described as ranging from 30 to 40 percent of all children coming up for renewal, depending on the health plan children were enrolled in. Plans that had redeployed much of their marketing staffs to focus on eligibility redetermination and made aggressive attempts to contact families at renewal reported more success, achieving retention rates of roughly 75 percent. In New Jersey, retention rates appeared a bit better—83 percent in FY 2000.

In two of the other study states, there was less information about reenrollment rates. In California, data systems cannot report on the outcomes of eligibility redeterminations; thus, a precise retention figure was unavailable.[30] In Texas, officials had had little experience with

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[29]Nationally, participation rates among eligible children are higher in the Medicaid program than in SCHIP (Dubay et al., 2002)

[30]State officials recently analyzed their data and found that for every 100 children who enroll in *Healthy Families,* 76 remain on the program one year later—an apparent retention rate of 76 percent.

eligibility renewal at the time of our visit, since *TexCare's* Phase 2 was only 14 months old. In Missouri, retention was not a concern, since local social services offices continue children's enrollment indefinitely until staff are able to "catch up" on redetermination. There, state officials reported a disenrollment rate of just 2 to 3 percent. Similarly, Florida's passive renewal system has been found to result in disenrollment rates of less than five percent in most months.

While limitations of data collection and reporting systems often make precise measurements impossible, state data suggest that nearly as many children lose SCHIP eligibility at redetermination because they never complete the renewal process as lose coverage because they are found to be no longer eligible for the program. For example, in both Colorado and Louisiana, 40 percent or more of children who lose coverage at redetermination do so because their renewal applications are either never submitted or are submitted incomplete. In California, an estimated two-thirds of children are disenrolled for "potentially avoidable reasons," including never receiving renewal applications from families and children who are disenrolled for nonpayment of premiums. Presumably, the parents of some of these children do not renew SCHIP because they have gained access to private coverage—a positive outcome—but key informants believed it unlikely that this explained the majority of such disenrollment, yet state data systems were unable to determine precise reasons for disenrollment.

From this evaluation, it can be observed that the states in our study have made great strides in simplifying eligibility, and that they appear to be achieving strong enrollment under SCHIP. Yet challenges remain with eligibility redetermination and retention, and coordination with Medicaid.

V. CROWD OUT

A. BACKGROUND AND POLICY DEVELOPMENT

During the development of SCHIP, many policymakers were concerned that the program would lead to "crowd-out," or the substitution of government-sponsored health insurance for existing employer-based coverage. How should such substitution be prevented? The major strategy considered was to impose a waiting period, a period of time during which children must be uninsured before being allowed to enroll in SCHIP. While many policymakers viewed this strategy as necessary for discouraging parents from dropping their children's private group insurance and joining SCHIP, others feared it could potentially erect a barrier for children needing better health coverage, or could lead to more gaps in insurance coverage. These tradeoffs generated considerable debate in seven of the ten study states.

In Missouri, legislators were so concerned that the program's high-income threshold (300 percent of the federal poverty level for children) would stimulate crowd out that they approved the Medicaid expansion only with a waiting period. In New Jersey, concern about the potential for significant crowd out led the state to require a 12-month waiting period for children eligible for the separate child health program. In North Carolina, crowd out was debated more than any other issue. Democrats felt a waiting period would be an unfair barrier to enrollment, while Republicans felt one would ensure that the program would cover the children most in need. In the end, a six-month waiting period was imposed, however, after six months, this period was reduced to two months. The question of whether or not to include a waiting period was also a crucial issue in Texas. Conservatives argued that the potential for substitution would increase the higher the state moved its upper-income eligibility threshold, and that Texas' SCHIP income threshold should be held at 150 percent of poverty. Liberals, on the other hand, argued that the state's income threshold should be higher—200 percent—and realized that agreeing to a waiting

period to deter crowd out might be a reasonable trade-off. In the end, a deal was struck—Texas expanded eligibility to 200 percent of poverty and a three-month waiting period was included. Legislators and officials in California, Colorado, and Louisiana also debated the merits and problems of crowd out, eventually including a waiting period.[31]

In contrast, crowd out was not a much-debated issue in three study states. In two, Florida and New York, the lack of concern arose from prior experience of running a separate state child health insurance program. In New York State, for example, administrators and legislators felt confident that crowd out had not surfaced as a problem during the six years of the state-funded *Child Health Plus* program. Nevertheless, federal officials at CMS were still concerned that crowd out could occur, especially among families with incomes above 200 percent of poverty. Therefore, in the absence of active crowd-out prevention strategies, CMS required the state to monitor crowd out, and implement a waiting-period if crowd out was found to exceed a threshold of 8 percent over any nine-month period. A similar situation arose in Florida. The state's prior experience with the *Healthy Kids* program gave them no reason for concern. But in their Title XXI submission, the state agreed to assess whether crowd out was occurring under *KidCare*. If they were to find evidence of crowd out, the state agreed they would implement a three-month waiting period in the *Healthy Kids* portion of the program. In Illinois the lack of debate about crowd out arose from a belief, held mainly by Republican legislators, that a waiting period would create an inequity for those families that met SCHIP's income eligibility, but had "done the right thing" by previously purchasing available coverage for their children. In response to this concern lawmakers proposed the *Kidcare Rebate* program, a state-only funded premium assistance program that policymakers believed would help families maintain private coverage

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[31]California also wrote into its statute the possibility of increasing the waiting period from three to six months if crowd out emerged as a significant problem.

(by helping to pay families a portion of their premiums) and reduce the potential that they might drop it to enroll in Medicaid or SCHIP.

Of note, Louisiana had to drop its waiting period in January 2001 after CMS issued a new SCHIP rule. The rule stated that eligibility-related substitution provisions, such as periods of uninsurance, were inconsistent with the entitlement nature of Medicaid; thus states with Medicaid expansion programs (with no section 1115 waivers) could not impose waiting periods.

There were other changes to state crowd out policies during the first five years of implementation. For example, North Carolina exempted children with special health care needs from the state's two-month waiting period in October 2000, a choice legislators made because they felt the waiting period to be an unfair penalty for parents who had made "sacrifices to insure their children," and then were effectively disbarred from the broader, less costly *Health Choice*. Later, in January 2002, the waiting period was eliminated for all children owing to the perceived lack of crowd out in the state. In January 1999, New Jersey, too, shortened its waiting period to six months as a result of reduced fears about crowd out, and introduced more exemptions as the program developed over time.

B. PROGRAM AND POLICY CHARACTERISTICS

When it came to choosing strategies to deter crowd out, states predominantly favored imposing waiting periods. As shown in Table 9, seven of the ten study states originally selected this option, although two states have since eliminated them, and one waiting period has been shortened.

Although states saw waiting periods as important crowd-out prevention strategies, officials feared that they could unfairly prevent certain groups of children from participating in the

TABLE 9: STATE SCHIP POLICIES TO DETER CROWD OUT

STATE	Waiting Period (No. indicates length in months)	Monitoring	Application Question(s)	Cost-Sharing	Imposing Obligations on Employers and/or Insurers	Other
California	3		✓	✓	✓	
Colorado	3		✓	✓		Limitation of benefits package
Florida	-	✓	✓			“Open enrollment” period
Illinois	3	✓	✓		✓	Premium assistance program
Louisiana	-[a]		✓			
Missouri	6		✓	✓		Verifying Insurance Status Against a Database of Private Coverage / Price Quotes
New Jersey	6[b]		✓	✓		Limitation of benefits package; Premium assistance program
New York	-	✓	✓	✓		
North Carolina	2[c]		✓	✓		
Texas	3		✓			
Number of States Using Policy	**6**	**3**	**10**	**6**	**2**	**5**

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES:

[a]Until January 2001 Louisiana had a 3-month waiting period.

[b]Until January 1999 New Jersey had a 12-month waiting period.

[c]Until January 2002 North Carolina had a 2-month waiting period (and for the first 6 months of the program the waiting period had been 6 months).

program, namely: (a) children who had lost coverage for reasons beyond their families' control; (b) children whose parents had opted, prior to the creation of SCHIP, to purchase high-cost health insurance beyond their means (including parents of children with special health care needs); or (c) income-eligible children who were "underinsured," a status applied to individuals who possess insurance that is either very expensive or very limited in scope. As a result, the following exceptions to waiting periods were implemented by the study states to allow such children into the program:

- In all the states with waiting periods, if a child's loss of insurance within the span covered by the waiting period is not voluntary, due to parents' loss of employment, a change to employment that lacks dependent coverage, or expiration of COBRA coverage

- In four of the states, if the child is "underinsured," or had been paying for high-cost insurance. Specifically, these include:

  - In California, children who have been covered by individual,[32] rather than group, policies
  - In Colorado, children whose parents are paying more than 50 percent of the premium costs for employer-sponsored coverage
  - In New Jersey, children in families with incomes at or below 200 percent of FPL who have been covered by an individual policy
  - In Texas, children whose parents are paying premiums amounting to more than 10 percent of total family income

As illustrated in Table 9, states also instituted other measures to deter crowd out and to reinforce the waiting period. All the ten study states chose to include questions on the application form about applicants' health insurance status. This is considered an anti-crowd-out strategy because it is a screening mechanism for the waiting period—parents who state that their children have been covered by insurance within the waiting period are automatically denied, and states believe that the process deters families from dropping coverage. The questions broadly take the

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[32]The federal statute already exempts such children from waiting periods.

same form in every state, asking if the child already has health insurance, if they have had coverage in the past "*x*" months, or if the child has lost this coverage and, if so, why.

In New York State, questions on the application form are used to monitor crowd out, in order to satisfy federal officials' requirement. Parents must answer detailed questions when applying for C*hild Health Plus*, that allow the state to tabulate:[33]

1. The number of children who have had health insurance in the previous six months
2. The number, of those, that had this insurance through an employer
3. The numbers of those who dropped that insurance for any of the following reasons:

- The employer discontinued offering dependent coverage or is no longer contributing toward a premium for dependent coverage
- The premium was increased beyond a level that was affordable to the family;
- *Child Health Plus* was judged to be a more affordable alternative
- *Child Health Plus'* benefits were judged to be better
- The parent was no longer working for the employer who offered health insurance

Two states, Illinois and Florida, also include application questions specifically to monitor crowd out. Six states specified cost-sharing as an anti-crowd-out measure. Although not implemented primarily to deter crowd out, officials in these states believe that cost sharing deters families wishing to substitute SCHIP for private insurance by creating an economic disincentive.

Four states adopted less commonly used strategies to deter crowd out, as detailed below:

- In Colorado and New Jersey, state officials believed that making the benefit package under SCHIP more like private insurance (and not as broad as Medicaid) would help limit the parents' attraction to the program over their current private coverage.
- In Illinois the primary anti-crowd-out strategy was the implementation of a state-only premium assistance program, *Kidcare Rebate*. New Jersey also sees its premium assistance strategy as a crowd-out prevention strategy.

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[33] A. Westpfahl and I. Hill, "Has the Jury Reached a Verdict? States' Early Experiences with Crowd Out Under SCHIP." The Urban Institute: June 2001

- In Missouri, the health insurance status of the applicant is verified against a database of private coverage, a provision aimed at reinforcing the waiting period. Also, applicants who fall within the higher (premium-paying) income group (226 to 300 percent of poverty) are first required to obtain and provide price quotes from two private insurers for the cost of dependent coverage to ensure that lower-cost alternatives for coverage do not exist. In order to prevent families with access to what could be deemed "affordable" coverage from enrolling in SCHIP, those who obtain quotes for less than $290 per month are prohibited from enrolling.[34]
- In California, insurance agents and insurance companies are prohibited from referring dependents to *Healthy Families* when they already have employer-sponsored coverage. They are also prohibited from changing the extent and price of their coverage in a way that might encourage employees to switch to *Healthy Families*. Unlike the former strategies, which are designed to influence consumer behavior, this strategy is aimed at preventing "employer-based" crowd out, to deter employers who already offer insurance from directly encouraging families to instead enroll their children in SCHIP. Another strategy that has the effect of minimizing employer-based crowd out is in Illinois, where state insurance law prohibits employers from dropping coverage for only some of its employees.

C. IMPLEMENTATION EXPERIENCES

The dominant view across the study states was one of little concern about crowd out. There was a clear perception among most state officials, legislative staff, and advocates that neither consumer- nor employer-based crowd out was occurring at significant levels. Louisiana was the one exception, where some state officials and local informants in New Orleans reported that crowd out was a concern. In addition, in four states, we heard anecdotes about specific cases of crowd out occurring in certain sites.

Notably, at the time of our site visits, only one of the states (New York) was able to back up these perceptions with hard data of actual crowd out. As shown in Table 10, between four and six percent of children enrolled in New York's *Child Health Plus* indicated that they had

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[34]The affordability threshold is adjusted periodically.

TABLE 10: PREVENTED OR ACTUAL CROWD OUT IN THE TEN STATES

State	Prevented Crowd Out (Children Denied Coverage Because They Have/Have Had Private Insurance)	Actual Crowd Out
California	4.8%	NA
Colorado	1-3%	NA
Florida	10-11%	NA
Illinois	No data	NA
Louisiana	1% (prior to 2001)	NA
Missouri	1.6-3.2%	NA
New Jersey	No data	NA
New York	NApp	4-6%
North Carolina	1-3%	NA
Texas	4%	NA

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTE: NA = Not available.

NApp = Not applicable.

health insurance coverage in the six months prior to their application, and had dropped it for voluntary reasons.[35] Another state without a waiting period, Florida, also monitored crowd out, asking whether applicants had insurance coverage at any time during the 12 months preceding enrollment in KidCare, and whether the family currently had access to employer-sponsored coverage. Strictly speaking this survey, conducted by the Florida Institute for Child Health Policy, only revealed a high-end estimate of "potential" crowd out, since families may have lost coverage prior to enrolling in KidCare. Figures suggest that roughly 10 percent of KidCare families surveyed in 1999 had had prior coverage in the preceding 12 months, and in FY2000 about 11 percent of children were insured when they applied.

In the other states with waiting periods, questions on the application provided data on the number of parents stating either that their children have existing coverage (in which case they are

[35]The data obtained from monitoring are subject to the accuracy of the applicants in self-reporting previous coverage. There is concern that there may be systematic underreporting of insurance coverage by applicants, leading to biased downward estimates of crowd out.

denied), or had had employer-sponsored coverage within the waiting period. In these states, officials tended to use these figures to indicate that the potential for crowd out in their states was low, since the numbers actually represent "prevented" crowd-out cases. Table 10 shows that between 1 and 4.8 percent of children applying for SCHIP in California, Colorado, Missouri, North Carolina and Texas were denied coverage for having private insurance within the waiting period.[36] State administrators in two states presented additional evidence that crowd out was not occurring. In North Carolina, when the waiting period fell from six months to two there was no surge of enrollment, as some people expected, indicating that families were not taking advantage of a shorter waiting period to drop existing coverage. Likewise, there was no surge in enrollment when the waiting period was reduced from 12 to six months in New Jersey.

Most informants believed that the waiting periods deter crowd out because families are unwilling to allow their children to go without health insurance while waiting to obtain SCHIP. We learned that state and local officials actively discouraged parents from taking this step. The large majority of staff assisting parents with applications consistently stated that they discouraged applicants from dropping their children's private insurance in order to enroll in SCHIP. In the six states with waiting periods, assistors told clients it was ill-advised to drop coverage for even a short period of time. Some also pointed out that families run the risk of losing all coverage if they drop their private insurance, do not qualify for SCHIP, and then attempt to re-enroll in their group coverage with an existing condition. In New York, which does not have a waiting period, enrollers warned families that if they dropped private coverage, a waiting period might be introduced. In Illinois, which has a three-month waiting period, *Kidcare*

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[36]There are no current data for Louisiana, in part because the application questions do not necessarily reveal whether families dropped coverage before they applied. When the waiting period was in place, reportedly one percent of applications were denied coverage for possessing insurance within the waiting period.

Application Agents noted that some families ask whether they should drop their private coverage to enroll in SCHIP, but application agents said they were generally able to convince families to maintain their coverage and apply for the Rebate program.

In Illinois, in fact, the absence of significant crowd out was attributed to the *Kidcare Rebate* program. According to key informants, some families eligible for the Rebate program decided to continue to bear the cost of coverage and enroll in Medicaid as wrap-around coverage. In three other states, Florida (which has no waiting period), North Carolina and Colorado, the absence of crowd out was attributed by key informants to the fact that only a very small proportion of low-income workers have access to employer sponsored coverage, and if they do, it is prohibitively expensive.

Louisiana was the one state in our sample where crowd out was perceived as a problem. According to eligibility workers, the number of children dropping insurance increased after the waiting period was dropped. An assistor at Children's Hospital, in New Orleans, for example, said that among the families she has helped, as many as one in five has dropped coverage in order to apply for *LaCHIP*. Application assistors indicated, too, that many families whose children are denied coverage because they have existing coverage simply drop the coverage and reapply. "Prohibitively expensive" employer-sponsored coverage is the apparent driving force behind this trend.

Despite the widespread perception that rates of crowd out were low in all but one of the study states, staff assisting parents with applications in several states did tell us of cases of consumer- and employer-driven crowd out at the local level. Most often, high (and often rising) insurance costs were identified as the reason why consumers dropped private insurance. In addition, the richer benefits package available under SCHIP, compared with employer-sponsored

coverage, was a factor that some suspected caused parents to switch coverage to SCHIP. For example:

- In **New York,** informants in Cortland County, a rural area, reported that self-employed workers in a rural area are dropping high-cost but limited packages in order to enroll in SCHIP, a situation a state public health official suggested would increase throughout the state "if health plans continue to reduce the amount of benefits for children with special health care needs." On the employer side, Cortland County informants also reported that "employers have definitely encouraged employees to take SCHIP."

- In an agricultural region of **California,** informants told us that underinsurance apparently is driving families away from employer-sponsored coverage and into SCHIP, despite the presence of a three-month waiting period. In light of this, local health plan and outreach staff expressed the desire that waiting periods be dropped—or exceptions be made—in order that more underinsured children could enroll in SCHIP. In contrast, another health plan employee stated that the waiting period should be extended to six months, while another feared that crowd out "could become more of a problem after Healthy Families is extended to parents."

- In **Missouri,** high-cost insurance was also perceived as a problem, although others believed that families were in fact able to afford private coverage, but were dropping it to enroll in SCHIP. There were also anecdotes of employers dropping dependent coverage.

- In **Texas,** although there were no reports of significant consumer-led crowd out at the local level, health plans officials said that they suspected that it was occurring among parents who wanted to access the richer benefits package available under SCHIP. On the employer side, one informant described having heard of employers in the Rio Grande Valley who were no longer offering dependent coverage and/or were "encouraging" their employees to seek coverage for their children under SCHIP.

The exemptions implemented in three states, to allow children covered by high-cost policies to switch to broader, less expensive coverage under SCHIP, were viewed overall as "equitable and fair." The impact of the exemptions on enrollment was not clear in California or Colorado, but in Texas "literally thousands" of families were reported to be qualifying for coverage under the "10 percent of income" exception. And in all states, informants perceived crowd out arising from parents dropping very expensive or limited private coverage as "not a bad thing" (Louisiana), "reasonable" (New York), and "OK" (California and Texas).

VI. BENEFITS

A. BACKGROUND AND POLICY DEVELOPMENT

Generally speaking, while states with Medicaid expansion programs must extend the full Medicaid benefit package to SCHIP enrollees, those with separate programs have greater flexibility, within guidelines specified in the Title XXI legislation, to provide coverage of fewer benefits. Specifically, states with separate programs must ensure that the SCHIP benefit package meets or exceeds minimum coverage parameters outlined in Title XXI, by adopting one of the following options:

- Benchmark coverage equivalent to the Blue Cross/Blue Shield preferred provider option offered under the Federal Employee's Health Benefit Program (FEHBP), the state employee health benefit plan, or coverage offered by the HMO with the largest commercial, non-Medicaid enrollment in the state;
- Coverage that is actuarially equivalent to any of the above benchmarks (and that meets coverage requirements specified in Title XXI);
- Grandfathered coverage provided through pre-SCHIP state programs available only to Florida, New York, and Pennsylvania; or
- Other coverage approved by the Secretary of DHHS.

Upon the passage of Title XXI, one of the most persuasive arguments among advocates in support of adopting Medicaid expansions under SCHIP was that Medicaid extends to children the broadest possible benefits.[37] Legislation passed as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) strengthened Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions, by defining the benefit more clearly and, most important, by requiring states to provide (rather than simply arrange for):

> "such other necessary health care, diagnostic services, treatment, and other measures described in [the list of covered services] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan."[38]

In essence, the OBRA-89 provisions give Medicaid-eligible children coverage for any medically necessary service. To meet the new EPSDT requirements, some states modified their Medicaid state plans and related administrative systems to include additional benefits and/or eliminate limits for children. Other states decided to address limits and exclusions on a case-by-case basis. (Hill et al., 1991)

Because of the unparalleled coverage provided through EPSDT, there is great interest in how states with separate programs have designed their benefit packages under SCHIP. In every state, there was a clear recognition that the Medicaid benefit package offered the broadest possible coverage—referred to by some as "the gold standard" or "Cadillac coverage." Some states saw this as a good thing, while others viewed Medicaid coverage as too generous, and preferred to adopt coverage that would more closely resemble products available through private health insurance. In the two Medicaid expansion states we studied—Louisiana and Missouri—benefits issues influenced the debates greatly in one, and only marginally in the other. In Louisiana, a state-appointed task force pushed for a Medicaid expansion specifically because they thought coverage provided through available benchmark plans would be too limited, especially for children with special health care needs. Debates in Missouri focused more on ensuring that the expansion would target children lacking access to affordable insurance, than on the benefit package per se. Furthermore, although Missouri could have modified the Medicaid

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[37]Ian Hill, "Charting New Courses for Children's Health Insurance," *Policy and Practice,* vol. 58, no. 4. December 2000.

[38]42 C.F.R. Section440.230(c)

package for SCHIP because it implemented its expansion program through Section 1115 research and demonstration authority, the state only chose to eliminate coverage for non-emergency transportation services.[39] Beyond this, there was surprisingly little discussion of further limiting benefits.

To varying degrees, six of the eight study states with separate programs (California, Colorado, Florida, New Jersey, New York, and Texas) resisted the idea of adopting the Medicaid benefit package, and opted instead to make the SCHIP benefit package more similar to packages offered in the commercial market. In California and Colorado, there were also equity-related concerns; policymakers did not want the SCHIP benefit package to be more generous than options available to state employees and those covered by typical private insurance packages. In Florida and New York, pre-existing state child health insurance programs were given "grandfathered" status; that is, the statute pre-approved their existing benefits coverage, and this fact helped both states solidify decisions to adopt separate programs under SCHIP.

In Illinois and North Carolina, however, benefits-related debates were quite different from those in the other study states. Rather than aiming to mirror private coverage, these states tried to make coverage under their separate SCHIP programs as close to Medicaid's as possible. Policymakers, and in North Carolina the provider lobby, recognized the importance of broad benefits for low-income children and did not see this policy area as one where limitations should be pursued.

[39] Program designers in Missouri made this one change because so few private insurance options offer this transportation benefit and because higher-income families brought in under the expansion would have better access to alternative types of transportation.

B. PROGRAM AND POLICY CHARACTERISTICS

The eight states in our study with separate programs chose a variety of benchmarks for their benefits packages, and each made enhancements to the benchmarks beyond what was required. In California, North Carolina, and Texas, the benchmarks were the state employee health benefits plans. Colorado modeled its SCHIP package on the Standard and Basic Health Benefit Plan required for use in the state's small employer market. As mentioned above, Florida and New York started with the packages previously used in their state-only *Healthy Kids* and *Child Health Plus* programs. However Florida ultimately adopted three different packages for the three distinct components of its program—for the youngest enrollees ages 1 to 5, enrolled in the *MediKids* component, policymakers chose to extend Medicaid equivalent benefits; children ages 6 to 19 in the *Healthy Kids* component receive the more limited package of benefits that was "grandfathered" by statute; and children with qualifying chronic illnesses and disabilities are enrolled in the *Children's Medical Services* component and receive the enhanced coverage established for that program. New Jersey, as well, selected different benchmarks for different program components—for kids under 200 percent of poverty, an enhanced version of the standard Blue Cross/Blue Shield PPO Option for the Federal Employees Health Benefit Plan is used; but for children in higher-income families, the plan offered by the HMO with the largest non-Medicaid enrollment is used, a package that compares more closely with typical private insurance. Finally, Illinois offers benefits to all its enrollees that come closest to being considered Medicaid "look alike;" that is, policymakers chose to extend the full Medicaid package to SCHIP enrollees, save for coverage of abortions, services provided under Medicaid Home and Community Based Services Waivers, and the open-ended protection offered by Medicaid's EPSDT benefit.

As mentioned above, all the states with separate programs made enhancements beyond required benchmark coverage. (Features of the benefit packages adopted by the eight separate state programs are summarized in Tables 11A, 11B, and 11C.) New York made the largest number of enhancements to its plan, despite its grandfathered status, adding coverage of vision, dental, and hearing services, as well as coverage of outpatient substance abuse and mental health treatment, over-the-counter medications, and durable medical equipment. The most common enhancements (made by four states) were the addition of vision and substance abuse treatment services. Three states added coverage for mental health and durable medical equipment. Coverage was also added for dental, hearing, orthodontia, therapy services, and over-the-counter drugs by smaller numbers of states. California added retroactive coverage for screening EPSDT services provided to children whose doctors refer them to SCHIP and who are found eligible for Medicaid.

If we conclude that Medicaid provides children with, in essence, coverage for any service considered medically necessary, then coverage in the eight separate programs is, by definition, not as generous as in the two states with Medicaid expansions. Still, a review of the benefits packages in the study's separate programs reveals that they are quite comprehensive. As shown in Table 11B, few services are omitted entirely, and the services excluded are those that typically would be excluded from private insurance packages. The most common exclusions are coverage for personal care services and non-emergency transportation (each omitted in four states), and care in intermediate-care facilities for the mentally retarded (ICF/MR) and residential substance abuse treatment services (in three states). Other services excluded by more than one state

TABLE 11A: BENEFIT PACKAGES FOR SEPARATE STATE PROGRAMS: ENHANCEMENTS MADE TO THE BENCHMARK PLAN

		Services Added								
State	Benchmark Plan	Vision	Dental	Hearing	OT, PT, ST[b]	Substance Abuse Treatment	Mental Health Treatment	Over-the-Counter Medication	Durable Medical Equipment/ Medical Supplies	Other
California	SEHBP[a]	✓	c	c	c	c	c	c	c	EPSDT[c] CSHCN services[d]
Colorado	Standard plan for small employer market	✓	✓[e]	c	c	✓	c	nc	✓	
Florida	Grandfathered *Healthy Kids* program	c	✓	c	c	c	c	nc	c	
	Medi-Kids Secretary-Approved	c	c	c	c	✓	✓	nc	✓	
Illinois[e]	Secretary-Approved	c	c	c	c	c	c	c	c	c
New Jersey B and C	FEHBP	✓	✓	✓	✓	✓	✓	nc	✓	home health, chiropractic services
D	Largest HMO	✓	nc	c	c	c	c	nc	c	
New York	Grandfathered *Child Health Plus* program	✓	✓	✓	c	✓	✓	✓	✓	
North Carolina	SEHBP[a]	✓	✓		c	c	c	nc	c	
Texas	SEHBP[a]	c	c	c	✓	✓	✓	nc	c	

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES: NA: Not Applicable

TABLE 11A *(continued)*

✓ = Added benefit not contained in benchmark package
c = Already covered in benchmark package
nc = Not covered
EPSDT = Early and periodic screening, diagnosis, and treatment
CSHCN = Children with special healthcare needs

[a]State Employee Health Benefit Plan.

[b]Occupational therapy, physical therapy, and speech therapy.

[c]California's SCHIP program provides retroactive coverage of EPSDT screening services provided to children referred to and found eligible for SCHIP.

[d]Services for children with special health care needs are carved out of the benefit package, as they are under the state's Medicaid program.

[e]Illinois' SCHIP is secretary-approved and therefore has no benchmark, the benefit package replicates Medicaid benefits.

[f]Colorado adopted dental coverage in February 2002 after our site visits were conducted.

TABLE 11B: BENEFIT PACKAGES FOR SEPARATE STATE PROGRAMS: SERVICES NOT COVERED BY SCHIP

	Services Excluded								
State	Preventive Dental	Orthodontia	Family Planning Contraceptive Services	Long-Term Care	Over-the-Counter Medication	Personal Care	Substance Abuse Treatment	Transportation	Case Management
CA	c	nc	c	ICF/MR	c	nc	Residential	c	c
CO	nc	c	c	ICF/MR	nc	nc	Residential	Non-emergency	c
FL Healthy Kids	c	nc	c	nc	nc	nc	c	Non-emergency	nc
IL	c	c	c	c	c	c	c	c	c
NJ Plan B & C	c	c	c	c	c	nc	c	Non-emergency	Covered only for chronically mentally ill
Plan D	Excluded for children over 12	Excluded for children over 12	c	nc	nc	nc	c	nc	nc
NY	c	nc	c	ICF/MR Nursing facility Hospice care	c	c	c	Emergency Non-emergency	nc
NC	c	c	c	c	nc	c	c	c	c
TX	c	c	nc	Nursing facility	nc	c	Residential Inpatient	c	c

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES: c = Already covered in benchmark package
nc = Not covered

TABLE 11C: BENEFIT PACKAGES FOR SEPARATE STATE PROGRAMS: SERVICES LIMITED UNDER SCHIP

	Service Limits						
State	Prescription Drugs	Preventive Dental	Restorative Dental	Medical Supplies/ DME[a]	OT, PT, ST[b]	Substance Abuse Treatment	Mental Health Treatment
CA	Varying limits	Varying limits	Varying limits	Covers diabetic supplies; no coverage for therapeutic footwear	60 days	Detoxification services and 20 outpatient visits	30 inpatient days and 20 outpatient visits
CO	Unlimited	Not covered	Not covered	$2,000 limit; diabetic supplies not covered	30 visits	Unlimited for inpatient and 20 visits for outpatient	45 inpatient days and 20 outpatient visits
FL (Healthy Kids)	Unlimited	Unlimited	Unlimited	Unlimited	24 outpatient and 60 inpatient visits	37 inpatient days and 40 outpatient days	30 inpatient days and 40 outpatient days
IL	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
NJ							
Plans B & C	Unlimited	Unlimited	Unlimited	Unlimited	60 days of therapy per year	Unlimited	Unlimited
Plan D	Unlimited	Not Covered	Not Covered	Not Covered	60 consec. days per illness. ST only for treating disease, injury, defects	Detox. Only. Rehab not covered	20 outpatient days and 35 inpatient days
NY	Varying limits	Varying limits	Varying limits	Covers only commodes, walkers, diabetic supplies, and wheelchairs	Short-term PT and OT	30 inpatient days and 60 outpatient visits	30 inpatient days and 60 outpatient visits
NC	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
TX	Unlimited	Varying limits	$300 limit	$20,000 limit; diabetic supplies not counted against cap	Unlimited	14 days detoxification and crisis stabilization; 60 days partial hospitalization 12-week limit rehabilitation	45 inpatient days and 60 outpatient visits

TABLE 11C *(continued)*

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES: Information on limits for some services was taken from Hill, Lutzky and Schwalberg, "Are We Responding to Their Needs? States' Early Experiences Serving Children with Special Health Care Needs Under SCHIP," Washington DC: The Urban Institute, May 2001.

[a]Durable Medical Equipment.

[b]Occupational therapy, physical therapy, and speech therapy.

include orthodontics, and over-the-counter medications. New York also excludes hospice care and emergency transportation.[40]

Colorado, Florida, and New Jersey are unique in that they are the only states in the nation to have excluded preventive dental services from their SCHIP package at some point and for at least some enrollees. New Jersey's exclusion is only for children ages 12 and above who are enrolled in its Plan D, which covers children in families with incomes between 201 and 350 percent of poverty. (Children in families with incomes below 200 percent receive full dental coverage.) In Colorado, state officials used tobacco-settlement funds to add dental coverage in February 2002. Prior to early 2000, Florida (like Colorado) was the only state not covering dental benefits under SCHIP. Beginning that year, however, dental was added to the package. State officials reported during our site visit that they expected dental coverage to be in place, statewide, by mid- to late-2002.

Separate SCHIP benefit packages, like private insurance, can place limits (dollars or days/visits) on the amount of coverage provided for certain services. Among the separate programs we studied, four place limits on restorative dental care and durable medical equipment and supplies, five limit mental health services, three limit preventive dental, four limit therapy services, and five place limits on the amount of outpatient substance abuse services that can be received in a year (see Table 11C). While some service limits (such as the $300 limit on restorative dental care in Texas) affect a wide range of children, most of the limitations have a much greater potential to affect children with special health care needs. The services most commonly subject to limits were medical supplies and DME, rehabilitative therapies, and behavioral health services. Colorado, for example, limits coverage for durable medical

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[40]Key informants described the omission of emergency transportation services in New York as an oversight; efforts were underway at the time of our site visit to add this service to the SCHIP benefit package.

equipment to $2,000 per year, which is less than half the cost of a typical power wheelchair covered by Medicare. Colorado's children's health insurance program is currently working with its Title V program to develop a strategy to better address the needs of children with greater medical needs.

Given that the nature of service gaps and limits in the study's separate programs have the greatest potential to affect children with special health care needs, it is noteworthy that four of the eight states have taken steps to help ensure that these vulnerable children receive the services they need. As noted above, Illinois has adopted Medicaid "look-alike" coverage; thus, with the exception of EPSDT-like open-ended coverage, children in *KidCare* enjoy Medicaid's breadth of coverage. In North Carolina, state officials formed a workgroup during the design phase of SCHIP and worked hard to identify a model that could extend comprehensive care to children with special health care needs. At one point, it appeared the state would move in the same direction as Illinois and adopt Medicaid "look-alike" coverage. However, ultimately, the decision was made to adopt the state employee benefit package as benchmark coverage, enhance this coverage by adding benefits such as dental and vision care, and then to create a special set-aside fund that would be used to underwrite services for children with special health care needs that were not covered by the benchmark. Florida and California, rather than adopting enhanced benefits per se, refer children with special needs to their Title V-managed *Children's Medical Services* and *California Children's Services* systems, respectively, to receive specialized care. (These service "carve outs" will be discussed in more detail in the next chapter.)

C. IMPLEMENTATION EXPERIENCES

Without exception, the SCHIP benefit packages were considered adequate or very generous by key informants in all ten states, including those with separate programs. Furthermore, SCHIP coverage across the ten states was consistently described as at least as good as, and often considerably better than, private insurance. While, coverage in the two Medicaid expansion programs is considered much more generous than private insurance, this same opinion was often held of separate programs. In California and Texas, for example, informants noted that dental, hearing, and vision service coverage is better under SCHIP than in most private insurance options, and that SCHIP has less onerous cost-sharing provisions. In Texas, SCHIP coverage also is considered better than private options for behavioral health and physical, speech, and occupational therapies. The SCHIP package in Colorado is well regarded because it is comparable to packages offered by local employers. Key informants in all of the study states, including child advocates, identified very few cases where children needed care that was not covered, and state officials have received few complaints from families about coverage limits.

The most notable complaints lodged against states' coverage occurred in those with limited dental coverage. In Colorado, most informants believed that SCHIP's lack of coverage for preventive dental care was a problem, and that adding this benefit would provide an additional incentive for parents to enroll their children into coverage. In Florida, key informants expressed similar opinions. Fewer complaints were lodged in New Jersey, however, where limited coverage only affects those children in higher-income families and where benchmark coverage for the Plan D component is comparable to private insurance which also commonly omits dental

coverage. New York plans to address the gap in its benefit package by adding coverage for emergency transportation in the near future.[41]

Interestingly, there were some informants in almost every state that expressed concern that the SCHIP benefit package may actually be "too generous." They raised concerns that SCHIP coverage exceeds what many others can access on the private market, and that such generous coverage could set the stage for adverse selection if those in need of greater care are disproportionately attracted to SCHIP.

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[41]In the 2002 legislative session, despite large state budget deficits, New York did add coverage of emergency transportation under *Child Health Plus.*

VII. SERVICE DELIVERY SYSTEMS, UTILIZATION, AND ACCESS

A. BACKGROUND AND POLICY DEVELOPMENT

Most states in our study sample set out to make risk-based managed care the cornerstone of their SCHIP delivery systems. With the exceptions of Illinois, Louisiana, and North Carolina, where managed care infrastructures are limited, the states we studied typically began with a goal of implementing risk-based managed care statewide for SCHIP.[42] Managed care was embraced by state officials for a number of reasons: it was described as the most cost-efficient approach to delivering services, and thus an effective way to leverage limited SCHIP dollars; as a vehicle for improving delivery systems for low-income children; as a means of modeling delivery arrangements on those often found in private insurance markets; and in some states, as an opportunity to test new approaches for delivering care that were not feasible within the larger Medicaid program.

Contextual and environmental factors related to existing state Medicaid programs greatly influenced the development of SCHIP delivery systems in all ten states. For example, Missouri and New Jersey were able to build upon managed care delivery systems successfully launched for Medicaid several years earlier. In both states, the Medicaid program was viewed favorably by many plans, providers, and state legislators, so using it for SCHIP was a natural choice. In California, Colorado, New York and Texas, state officials sought to align SCHIP and Medicaid delivery systems to the greatest extent possible, while also extending managed care to a larger number of counties, including rural ones, where Medicaid managed care had never been implemented. In Florida, SCHIP and Medicaid delivery system alignment was not a leading

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[42]At the time of our site visit, Louisiana was planning a statewide expansion of its primary care case management (PCCM) program.

priority, as the existing state-funded *Healthy Kids* component (which contracted with one capitated health plan in each county in which the program operated) had taken on quite a different look from Medicaid's managed care system (which contracted with multiple capitated plans in several counties, but also relied heavily on its Primary Care Case Management program (PCCM)—*MediPass*—throughout the state*);* there was little support for the idea of changing either system.

Three of our 10 study states had very limited managed care infrastructure in place, and thus it was unrealistic to consider using risk-based arrangements for SCHIP. Louisiana did not use capitated arrangements under Medicaid at all, and had only implemented its PCCM program—CommunityCARE—in 20 of the state's 64 parishes, serving only six percent of the Medicaid population. Similarly, North Carolina had contracted on a risk basis with an HMO in only one county—Mecklenberg—and implemented PCCM arrangements in the remainder of the state. Meanwhile, Illinois, too, had only contracted with health plans in the Chicago/Cook County area under Medicaid, using fee-for-service arrangements throughout the rest of the state. Thus all three of these states have developed systems that rely primarily or exclusively on fee-for-service (or "managed" fee-for-service) arrangements for serving SCHIP enrollees, although only Illinois and Louisiana use the same network of providers for both SCHIP and Medicaid, while North Carolina does not place any restrictions on who can provide services to SCHIP enrollees.

B. PROGRAM AND POLICY CHARACTERISTICS

Features of SCHIP delivery systems in the study states are summarized in Table 12. As noted above, eight out of 10 states implemented mandatory, risk-based managed care arrangements for SCHIP in at least the more populated urban areas of their states. In Florida and New Jersey, such arrangements are used statewide; in New York, capitated plans are under

TABLE 12: SCHIP SERVICE DELIVERY SYSTEM FEATURES

PROPORTION OF STATE COVERED BY MANDATORY RISK-BASED MANAGED CARE ARRANGEMENTS

	Number of Counties in State	Number of Counties with Mandatory Risk-Based Managed Care Arrangements in SCHIP	Number of Counties with Mandatory Risk-Based Managed Care Arrangements in Medicaid
CA	58	43	22
CO	64	38	38
FL	67	67(Healthy Kids) 13(Medi-Kids)	None
IL	101	None	None
LA	64	None	None
MO	115	37	37
NC	101	None	None
NJ	21	21	21
NY	62	61	14
TX	254	84	In 50 urban counties, enrollees must select an HMO or PCCM

PROPORTION OF PROGRAM PARTICIPANTS IN MANDATORY RISK-BASED MANAGED CARE ARRANGEMENTS

	SCHIP	Medicaid
CA	Nearly 100%	52%[a]
CO	Roughly 66%	Roughly 40%[b]
FL	100% (Healthy Kids) ~25% (MediKids)	None
IL	None	None
LA	None (6-7% in PCCM)	None
MO	58%	41-44%[c]
NC	None	None
NJ	100%	100%
NY	Nearly 100%	25%[b]
TX	58%	32%[b]

NUMBER OF CAPITATED MANAGED CARE PLANS SERVING PROGRAM ENROLLEES

	SCHIP	Medicaid	Both SCHIP and Medicaid
CA	26	26	22
CO	6	5[e]	5[d]
FL	15 (Healthy Kids) 13 (MediKids)	13	5
IL	None	5	
LA	None	None	N.A.
MO	9	9	9
NC	None	4	
NJ	5	5	5
NY	30	30	28
TX	12	12	6

SPECIAL ARRANGEMENTS IN RURAL AREAS

	SCHIP	Medicaid
CA	EPO	FFS
CO	EPO	PCCM
FL	EPO	PCCM
IL	FFS	FFS
LA	Limited PCCM; FFS	Limited PCCM; FFS
MO	FFS	FFS
NC	FFS	FFS, PCCM
NJ	No special arrangements	No special arrangements
NY	PCCM (one county)	FFS
TX	EPO	PCCM

TABLE 12 *(continued)*

POPULATIONS AND SERVICES CARVED OUT FROM MANAGED CARE					
	CSHCN/SSI	Behavioral Health	Dental	Prescription Drugs	Other[e]
CA	SCHIP and Medicaid				
CO					
FL	SCHIP and Medicaid[f]				
IL	N.A.	N.A.	N.A.	N.A.	N.A.
LA	N.A.	N.A.	N.A.	N.A.	N.A.
MO		SCHIP and Medicaid			SCHIP and Medicaid
NC	N.A.	N.A.	N.A.	N.A.	N.A.
NJ		SCHIP and Medicaid			SCHIP and Medicaid
NY	Medicaid		Medicaid (option)	Medicaid (option)	
TX	Medicaid	Medicaid	SCHIP and Medicaid	SCHIP and Medicaid	

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES: CSHCN = Children with special health care needs; SSI = Supplemental security income

N.A. = Not applicable.

[a]"Medi-Cal Managed Care," Medi-Cal Facts, No.8. Oakland, CA: the Medi-Cal Policy Institute, March 2000.

[b]September 2001 GAO report, Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care.

[c]From the State of Missouri Department of Social Services, Division of Medical Services. As of June 2001, pregnant women, children, and their caregivers were covered under 1915(b) managed care program.

[d]Although Colorado requires all SCHIP plans to participate in Medicaid, one of the SCHIP plans meets the Medicaid participation requirement indirectly through another SCHIP/Medicaid plan of which they are part owner. The two plans share the same provider network; under SCHIP, the parent plan manages care directly, while under Medicaid, care is managed through its subsidiary plan.

[e]Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) services, environmental lead assessments, bone marrow and organ transplants, protease inhibitors, sexual assault and child abuse assessments, and abortion services.

[f]Children with special health care needs are "carved out" of Healthy Kids and MediKids, and enrolled in a specialized managed care network (CMS) that operates as another SCHIP component.

contract in all but one rural upstate county; in California, these arrangements are in place for SCHIP in all but 15 rural counties; and in Texas, risk-bearing HMOs operate in 84 counties encompassing the state's numerous urban centers where roughly 70 percent of *TexCare* enrollees reside. In California, Florida, New Jersey, and New York, nearly all SCHIP participants are enrolled in risk-based managed care. In Colorado, Missouri, and Texas, participation rates are between 60 and 70 percent because risk-based arrangements are not available in many rural areas within these states. In Illinois, Louisiana, and North Carolina, as indicated above, almost all children receive care through fee-for-service arrangements.

In most of the states we visited, managed care arrangements employed by states built on systems already in place for Medicaid, although, in many, managed care's reach is more extensive in SCHIP than in Medicaid. In California and Texas, for example, mandatory risk-based arrangements operate in many more counties for SCHIP than for Medicaid, and the proportion of program participants enrolled in such arrangements under SCHIP is twice as high as under Medicaid. In New York, three times as many counties and an equally larger proportion of participants are enrolled in risk-based managed care for SCHIP than for Medicaid. In Colorado, managed care arrangements have been implemented in the same counties for SCHIP and Medicaid, and there is close to full alignment among health plans participating in the two programs, although the proportion of program participants enrolled in such arrangements is slightly greater in SCHIP than in Medicaid. In New Jersey, there is complete alignment between the SCHIP and Medicaid managed care systems—health plans participating in one program must also participate in the other—and enrollment into managed care is mandatory for both programs as well. In Missouri, managed care's reach is comparable for SCHIP and Medicaid, which is expected since this Medicaid expansion state utilizes the Medicaid delivery system for SCHIP.

In the three states that rely primarily on fee-for-service arrangements, two explicitly use the existing Medicaid delivery system—Louisiana (like Missouri, a Medicaid expansion); and Illinois (where, since the Medicaid benefit package was being used, policymakers decided that it would be simplest to also use Medicaid-participating providers). In North Carolina, however, SCHIP uses a somewhat different set of providers than are used in Medicaid. Here, during the program's design phase, physician groups succeeded in persuading policymakers that there should be no explicit network for SCHIP. Rather, they argued that any willing provider should be permitted to participate if he or she desires. Because North Carolina decided to use the State Employee Health Benefit Package as its benchmark it also decided to partner with the state agency responsible for administering the package for state employees, and its contractor, Blue Cross/Blue Shield of North Carolina, for all claims processing and adjudication. In essence, this has extended to SCHIP enrollees a very similar network as is currently available to state employees, that is, the Blue Cross/Blue Shield network.

In most of the eight states with risk-based managed care, the majority of health plans participate in both Medicaid and SCHIP. When the same plans participate, families reportedly have an easier time transitioning from one program to another. In four states, plan participation is the same (Colorado, Missouri, and New Jersey), or very similar (New York) in the two programs. The SCHIP authorizing legislation in Colorado and New Jersey specifically requires that plans participating in SCHIP also participate in Medicaid, which helped ensure alignment between the two programs.[43] In New York, the only difference is that one large New York City plan participates in SCHIP but not in Medicaid.

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[43]One of the six SCHIP plans in Colorado is able to meet its Medicaid participation requirement through its affiliation with another plan.

Distinctions between plans participating in Medicaid and SCHIP are larger in California, Florida and Texas. In California, although the same number of plans participate in each program, eight plans (four per program) participate in one program but not the other, and managed care systems differ considerably across the two programs. Moreover, the SCHIP program in California operates managed care in many more counties than the Medicaid program does, and whereas contracts with plans are statewide for SCHIP, managed care systems and contracting arrangements vary greatly across counties for Medicaid. In part because SCHIP is more streamlined and utilizes managed care throughout the state, California was able to secure SCHIP contracts with three large commercial insurers (Blue Cross, Blue Shield,[44] and HealthNet) that participate in Medicaid only in selected counties or, in the case of Blue Shield, do not participate in Medicaid at all. Key informants in California noted that these "mainstream" health plans are very popular among families because they offer very broad networks of providers throughout the state. Enrollees transitioning from SCHIP to Medicaid, however, might not have access to the same plans and providers. The lack of alignment between SCHIP and Medicaid managed care plans is perhaps greater in Texas, where only six of the 12 participating Medicaid plans submitted bids to participate in SCHIP. These six plans, along with six others that do not participate in Medicaid, have networks dominated by traditional safety net providers. In Texas, plans with larger commercial lines of business typically did not bid on SCHIP because they judged it would not be profitable. Some of these plans had already struggled as participating Medicaid plans and saw SCHIP as "more of the same." In Florida, perhaps, the largest differences between SCHIP and Medicaid were observed. Of the various *KidCare* components, the *Healthy Kids* program continues to use mostly commercial, fully-capitated

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[44]Blue Cross and Blue Shield operate as separate entities in California.

HMOs for service delivery; the *MediKids* component (a Medicaid "look-alike" for children ages one to five) uses Medicaid-participating HMOs and enrollment in these plans is mandatory in counties where there is a choice of more than one plan; and the *CMS* program, with the creation of *KidCare,* became a capitated program through which the state Department of Public Health receives a fixed per-member-per-month fee for each child with special health care needs and must manage all care for these children within that budget. In Medicaid, however, there is no mandatory enrollment into HMOs; roughly 75 percent of Medicaid enrollees choose to receive care through the PCCM program—*MediPass.* While nearly the same number of plans participate in SCHIP and Medicaid (15 and 13, respectively), only five plans participate in *both* programs.

Although a few states have secured significant contracts with mainstream commercial insurers under SCHIP, managed care enrollment in four of the seven study states with primarily risk-based managed care systems is concentrated in plans with strong links to traditional safety net providers. As discussed above, SCHIP managed care enrollment in Texas is exclusively in these types of plans. In New York, 70 percent of SCHIP enrollment is with plans that participate only in Medicaid or SCHIP, and safety net providers play a large role in the provider networks for these plans. Roughly half of the SCHIP managed care enrollment in Colorado is with a plan formed by community health centers and safety net hospitals. In New Jersey, enrollment is heavily concentrated in health plans that serve only Medicaid and SCHIP recipients. In Florida, Missouri, and California, however, a larger share of SCHIP managed care enrollment is in largely commercial plans.

Medicaid and SCHIP delivery systems are more likely to be similar in urban areas, where both programs operate the same types of managed care arrangements, than in rural areas. The clearest distinctions were observed in those areas of the states where managed care's reach is

greater in SCHIP than in Medicaid. In areas where delivery system features differ, provider participation in SCHIP is considered comparable to and, in some cases, better than in Medicaid. SCHIP's more extensive use of managed care was described as giving participants in some areas access to a larger and/or better selection of providers—either because the program image was more appealing to providers or payment was better.

In rural areas of the seven states that use risk-based managed care systems, we observed distinct differences between the delivery systems designed for SCHIP and those in place for Medicaid. New models for delivering care in rural areas have emerged in several states. California, Colorado, and Texas each operate some form of exclusive provider organization (EPO) in rural communities.[45] Access to providers reportedly is better in areas with these organized networks than under Medicaid fee-for-service arrangements, both because SCHIP has attracted more providers (in some cases by paying higher fees), and because the programs are able to provide families with a list of participating doctors from whom to select a primary care physician, rather than leaving families on their own to find a doctor willing to accept their insurance. California also recently launched a program to stimulate innovative delivery models in rural areas. Health plans and providers have competed to obtain special funding to develop and test new approaches for serving Alaska Natives, American Indians, and forestry, fishery, and migrant workers. Some ideas being explored to bring specialty care to rural areas are: extending clinic hours, using mobile vans, and using telemedicine.

SCHIP managed care arrangements also differ from Medicaid in their use of population and/or service carve-outs. In most of the states we studied, carve-outs are used less frequently

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[45]In Colorado, the network began prior to SCHIP, to serve mainly rural areas; but it has since become statewide. Under SCHIP, network providers also serve as primary care providers for SCHIP participants until the HMO enrollment process is complete.

in SCHIP than they are in Medicaid; that is, states have tended to include all (or more) populations and services within managed care systems and health plans' responsibilities. In California, however, SCHIP contracts with health plans exclude specialty care services for children with qualifying special health care needs, and plans refer these children to county-based specialty health and mental health systems for these services, where providers are reimbursed directly by the state on a fee-for-service basis. (These children continue to receive their primary care through the mainstream health plan.) In Florida, rather than carving services out of health plan contracts, there is a population carve out. Specifically, children with qualifying chronic conditions and disabilities are referred to the *CMS* program component where they can receive *all* their care—primary, acute, specialty, and support—through the specialty network developed for the *CMS* program. Health plan contracts in Missouri (SCHIP and Medicaid) include carve-outs for certain behavioral health care services and a small number of other specialized services (listed in Table 12). In Texas, SCHIP contracts exclude dental care and prescription drugs while Medicaid contracts exclude not only dental care and prescription drugs, but also behavioral health services. In New York, SCHIP contracts with health plans include the full scope of benefits whereas the state's Medicaid contracts in New York exclude children with special health care needs on SSI, and plans have the option to provide dental care and prescription drugs.

Dental care arrangements differ across the states we studied. As with other services, the use of managed care arrangements is more common for dental care in SCHIP than in Medicaid. Health plans are responsible for dental care under SCHIP in New York and Missouri, (where plans typically subcontract with dental managed care organizations to meet this obligation). In California's and Florida's SCHIP programs, the states contract directly with five and three managed dental care plans, respectively, to provide coverage to SCHIP enrollees. Illinois, as well, contracts with a dental managed care organization to serve *KidCare* enrollees. Texas had

also hoped to secure contracts with dental plans, but when none applied, they carved dental care out of health plan contracts and pay for dental care directly on a fee-for-service basis.

In the states using managed care, payment arrangements between states and health plans vary under SCHIP, with several states negotiating rates individually with health plans (California, Florida, Missouri, and New York) and three setting rates based on historic Medicaid data (Colorado, New Jersey, and Texas). Because SCHIP is a relatively new program, most states used Medicaid cost and utilization data to set or evaluate health plan capitation rates. As plans have gained more experience serving SCHIP enrollees, some states have begun using actual cost data from plans to reassess rates when contracts come up for renegotiation. It is difficult to directly compare SCHIP and Medicaid plan payment rates because the programs cover different population groups and different services. After adjusting for population and service differences, however, key informants generally reported that plan payment rates were roughly comparable for Medicaid and SCHIP in Colorado, New Jersey and Texas, and slightly higher under SCHIP than Medicaid in California, Florida, and New York. Plans in California and New York also noted that the contracting process is more streamlined with SCHIP than with Medicaid. (In Missouri, a Medicaid expansion program, the same rates are paid to plans.)

Payment arrangements between health plans and their network providers also vary considerably both within and across states. Some health plans pay providers on a capitated basis, while others pay fee-for-service rates. When health plans utilize capitation arrangements, they most often do so for routine primary care, but pay fee-for-service rates for specialty and ancillary services. Specific arrangements vary, however, with some plans offering partial-risk contracts or restricting capitation to urban and/or larger-volume providers. Outside managed care areas, providers are usually paid directly by the state on a fee-for-service basis; but, in some EPO regions, providers receive a partial capitation payment for primary care and care coordination

services. Fee-for-service rates and provider capitation payments under SCHIP are sometimes tied to existing Medicaid fee schedules, and at other times payments are enhanced by health plans in order to increase provider participation. Although it is difficult to generalize, we heard that providers in managed care arrangements typically are paid at levels comparable to Medicaid.

With regard to fee-for-service payments, state officials reported that provider fees are the same for SCHIP and Medicaid in Louisiana, and in the fee-for-service regions of Illinois, Missouri, and Texas, but tend to be slightly higher for SCHIP in California, Colorado, and New York. In North Carolina, fees were described as higher under SCHIP than Medicaid for some services, most likely an outgrowth of the program's close affiliation with Blue Cross/Blue Shield.

C. IMPLEMENTATION EXPERIENCES

Overall, access to care under SCHIP was described as good, especially in urban areas. This was often attributed to the widespread use of managed care arrangements, which have reportedly helped increase both the supply of participating providers and the number of children with a primary care "medical home." Informants in California, Florida, Missouri, New York, and Texas characterized access as better in managed care regions of the state compared to areas with fee-for-service arrangements, even in areas with long-standing provider shortages. In some states, health plans also played an influential role in getting state legislatures to approve rate increases for health plans and providers under Medicaid; this, in turn, helped states and plans recruit more providers to SCHIP and Medicaid. Where Medicaid programs use managed care arrangements that were similar to those used by SCHIP—most often in urban areas—access to care was also described as good for Medicaid enrollees. In at least one of our fee-for-service states—North Carolina—access was also described as quite good, given providers' willingness to participate in the program.

Beyond this general characterization, however, some access challenges were reported in the study states. In Texas, for example, one health plan pulled out of both SCHIP and Medicaid because it found payment rates too low, and physicians in some areas are dropping out of the programs, some because of low payment rates and some because they are opposed to managed care. A similar situation was also emerging in New Jersey where a number of health plans had stopped participating in SCHIP and Medicaid. Provider resistance to managed care was also cited as a factor contributing to access problems in the more rural regions of Colorado, Missouri, and Texas. In several states, we also heard that providers participating in Medicaid and SCHIP limit the number of people they serve, causing access problems even in more densely populated urban regions. Finally, in the three states with behavioral health carve-outs (California, Missouri, and New Jersey), problems were sometimes reported regarding coordination across the different systems.

Provider shortages and limited provider participation appear to be bigger problems in the rural areas of several of our study states, especially those with limited managed care infrastructure. These problems were reported for both Medicaid and SCHIP. In Louisiana, provider shortages and low participation rates were a problem in most areas of the state before SCHIP, and they may actually have worsened since the onset of SCHIP. Some providers in rural areas of the state have stopped participating in Medicaid and SCHIP because reimbursement is too low and because rates have often fluctuated over the past several years. Provider shortages and low participation rates were also described as problematic in many rural regions in Missouri, Texas, and Colorado. Still, as mentioned earlier, California, Colorado, Florida, and Texas have used SCHIP to implement managed care models in rural areas that reportedly have improved access compared with the fee-for-service delivery systems used by

Medicaid. And in the rural regions of Illinois and North Carolina, while some provider shortages exist, access was still generally described as good.

Longstanding shortages of certain services remain an issue under SCHIP, as well as Medicaid. Informants in every study state noted shortages in some areas of pediatric subspecialty care, especially behavioral health services for children. Informants in almost every state noted concerns about access to dental care; shortages of dentists willing to treat Medicaid and SCHIP patients are a major concern in Illinois, Louisiana, Missouri, and North Carolina and in some rural upstate areas in New York. Notably, though, the use of managed care arrangements was thought to have improved access to dental care in California, Florida, and New York.

Findings were mixed with regard to service use by SCHIP enrollees and how it compares with service use by Medicaid enrollees. The two Medicaid expansion programs had examined utilization rates and found they were largely comparable for SCHIP and Medicaid enrollees, although in Louisiana, the state reported that utilization of emergency room and inpatient hospital services has been lower for SCHIP than for Medicaid. In Missouri, state officials reported that utilization is comparable for SCHIP and Medicaid enrollees; but utilization in both programs has been greater than expected, due primarily to greater use of prescription drugs. In North Carolina, *HealthChoice* enrollees had utilization rates similar to those of children enrolled in commercial Blue Cross/Blue Shield plans. In other states, discussions with health plans shed some light on utilization. Health plans in California and New York reported that utilization rates among SCHIP enrollees are significantly lower than those of their Medicaid counterparts. In Texas, however, plans reported that children in SCHIP are using more services than children on Medicaid, and attribute this both to pent-up demand and to the fact that SCHIP enrolls children

with special health care needs into managed care while these children are largely in fee-for-service arrangements under Medicaid.

For the most part, the health plan representatives we interviewed seemed satisfied with the SCHIP capitation rates they receive, although some noted that rates were too low when they first started with the program. Significant concerns about health plan payment rates surfaced primarily in Texas, where SCHIP payments (based on historic Medicaid costs) reportedly do not adequately reflect the costs of serving children with special health care needs. Because other states have experienced lower or comparable utilization rates under SCHIP than under Medicaid, capitation payments may have been adequate to cover the costs of serving SCHIP enrollees. In New Jersey, complaints from health plans largely focused on the capitation they receive to serve parents. However, several health plans in California and New York noted that they were "doing quite well," given enrollees' low utilization of services. In Florida, where children with special health care needs are "carved out" of *Healthy Kids* and *MediKids* and served through the *CMS* system, health plans were pleased not to be incurring the high costs of caring for this population.

In over half of the study states, however, we heard complaints about physician payment levels. Providers in several states noted that the rates they receive from health plans (in managed care regions) and from the state (in fee-for-service regions) under SCHIP are just as bad as those of Medicaid; as one informant put it, basing SCHIP rates on Medicaid "was the wrong place to start." Although SCHIP has helped bring about fee increases in some states, many providers still reported that SCHIP and Medicaid payments do not cover their overhead costs. Low payment levels have reportedly contributed to serious provider shortages in parts of Texas, Louisiana, Colorado, and Missouri. Informants in Texas warned that low payments, combined with large enrollment levels, have set the stage for "an impending access crisis," adding that access concerns are "the Achilles heal of SCHIP and Medicaid." Informants in other states also

expressed concerns that access under SCHIP may erode without substantial increases in provider reimbursement.

The case studies did not reveal the same level of dissatisfaction with provider fees in Florida, Illinois, and New Jersey. In North Carolina, physicians were reportedly very happy with the rates they are paid under *HealthChoice.*

VIII. COST SHARING

A. BACKGROUND AND POLICY DEVELOPMENT

States using SCHIP to expand Medicaid must follow Medicaid's cost-sharing rules, which generally prohibit the use of cost sharing without special waiver authority.[46] States implementing separate programs, however, are allowed to require cost sharing as long as it meets federal requirements. Specifically, the cumulative, annual cost-sharing burden under SCHIP for any one family cannot exceed five percent of the family's annual income, copayments may not be imposed for well-baby or well-child care or related preventive and diagnostic services, and families with lower incomes may not be charged more than families with higher incomes.[47] Because cost-sharing provisions are relatively new in publicly-funded health insurance programs, there is great interest in understanding the approaches that states adopt, as well as how they seem to be affecting enrollment, utilization, retention, and other outcomes.

Cost sharing was typically considered an important and positive program element in the nine study states permitted to use such provisions in their SCHIP programs (the eight states with separate SCHIP programs and Missouri, which was permitted to do so through its Section 1115 demonstration). Although state leaders in Missouri originally had planned an expansion that would not include cost sharing, they became convinced early in the design phase that cost sharing would be necessary to gain legislative approval, particularly given the high income threshold proposed for SCHIP (300 percent of the federal poverty level).

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[46]Nominal cost sharing is permitted for children who qualify under Medicaid's medically needy provisions.

[47]In addition, American Indians and Alaska Natives are exempt from all cost-sharing requirements.

Proponents of cost sharing offered several reasons for finding such provisions appealing. In seven states with separate programs, key informants believed that cost sharing modeled on private insurance would provide a "bridge" to help families transition from public to private coverage. In California, Colorado, Florida, New Jersey, New York, North Carolina, and Texas, this emphasis on making SCHIP look like private insurance was seen as yet another way to promote the program as health insurance, rather than a form of welfare. In several states (Missouri, New Jersey, New York, and Texas), there was strong sentiment that it was appropriate for higher-income families to contribute to the cost of coverage. To differing degrees, proponents in each state also believed that cost sharing would promote personal responsibility and help reinforce the value of health care coverage.

There were lively debates over whether or not to impose cost sharing in Illinois and North Carolina. In both states, there were strong forces both for, and against, cost sharing. In Illinois, some Republican members of the Governor's Task Force advocated for the creation of a separate program modeled as closely on private insurance as possible, and were adamant in their belief that cost sharing should be part of that vision. Requiring participants to pay premiums and copayments would encourage them to value the program and help them "transition to private coverage," they said. Similar sentiments were expressed by conservative legislators in North Carolina, though the Governor's task force in this case recommended minimal or no cost sharing. The compromises reached in these states were somewhat different. In Illinois, Democrats and advocates succeeded in their push to require only copayments (and not premiums) for the poorest of enrollees (those with family incomes between 133 and 150 percent of poverty), while Republicans succeeded in their efforts to require premiums for families above 150 percent of poverty. In North Carolina, cost sharing was only included for those families with incomes over

150 percent of poverty; nominal copayments were set; and premiums were ruled out in favor of a one-time enrollment fee per child to keep the program administratively simple.

B. PROGRAM AND POLICY CHARACTERISTICS

Cost-sharing policies vary from state to state, as summarized in Table 13. The four types of cost sharing used by the study states fall into the following categories: (1) annual enrollment fees, (2) monthly premiums, (3) copayments, and (4) deductibles. Within each category, states use differing income guidelines to determine who is subject to cost sharing; and set premiums or enrollment fees on a per-child or per-family basis; impose different enrollment fees, premiums, copayments, and deductibles (subject to federal limits on outlays per family); and have differing administrative rules governing the payment process and how to handle families who fail to keep up with cost-sharing obligations. States' cost-sharing policies have not been static; rather, most states have modified the provisions since they began, making it difficult to distinguish themes or patterns.

Three of the study states (Colorado, North Carolina, and Texas) charged all or some families an annual enrollment fee, while seven (California, Florida, Illinois, Missouri, New Jersey, New York, and Texas) charged monthly premiums at the time of our site visits. The levels of income at which cost sharing begins varied by state. Three of the study states required these fees from families with incomes between 100 percent and 150 percent of FPL—California charged monthly premiums between \$4 and \$14, depending on family size; Florida charged a \$15 per family premium on all enrollees; while Texas charged a \$15 per family annual enrollment fee. Nine states either continued or began to impose premiums and enrollment fees on families with incomes above 150 percent of FPL, as summarized below:

TABLE 13: COST SHARING PROVISIONS

A. ENROLLMENT FEES AND PREMIUMS						
	Annual Enrollment Fees		Premiums		Conditions Attached to Payment of Premiums?	
	Annual Enrollment Fee?	Amount of Annual Enrollment Fee	Any Premiums?	Monthly Premium Amounts	Grace Period	Black Out Period
California	No	--	Yes	<150% FPL: One child: $4; $7[a] Two children: $8; $14[a] 151-250% FPL: One child: $6; $9[a] Two children: $12; $18[a] 3+ children: $18; $27[a]	60 days	6 months
Colorado	Yes	<150% FPL: None 151-185% FPL: One child: $25 2+ children: $35	No[b]	--	--	--
Florida	No	--	Yes	MediKids Florida Healthy Kids CMS Network: $15 per family	30 days	60 days
Illinois	No	--	Yes	<150% FPL: None 151-185% FPL: One child: $15 Two children: $25 3+ children: $30	60 days	3 months
Louisiana[c]	No	--	No	--	--	--
Missouri	No	--	Yes	<225% FPL: None 226-300% FPL: based on income and family size between $55 and $218	90 days	6 months[d]
New Jersey	No	--	Yes	134-150% FPL (Plan B): None 151-200% FPL (Plan C): $15 per family $25 one parent $35 two parents 201-250% FPL (Plan D): $30 per family	30 days	None

A. ENROLLMENT FEES AND PREMIUMS						
	Annual Enrollment Fees		Premiums			
					Conditions Attached to Payment of Premiums?	
	Annual Enrollment Fee?	Amount of Annual Enrollment Fee	Any Premiums?	Monthly Premium Amounts	Grace Period	Black Out Period
				251-300% FPL (Plan D): $60 per family 301-350% FPL (Plan D): $100 per family		
New York	No	--	Yes	<160% FPL: None 161-222% FPL: One child: $9 Two children: $18 3+ children: $27 223-250% FPL: One child: $15 Two children: $30 3+ children: $45 >250% FPL: full premium varies by plan average $115/month	30 days	None
North Carolina	Yes	<150% FPL: None >150% FPL: $50	No	--	--	--
Texas	Yes	<150% FPL: None >150% FPL: $15	Yes	<150% FPL: None 151-185%: $15/family 186-200%: $18/family	60-90 days	3 months

B. COPAYMENTS AND DEDUCTIBLES						
	Any Copayments?	Emergency Room Visits Copay Amount	Medical Office Visits Copay Amount	Prescription Drugs Copay Amount	Any Deductibles?	Deductible Amount
California	Yes	All incomes: $5[e]	All incomes: $5[e]	All incomes: $5[e]	No	--
Colorado	Yes	<100% FPL: None 101-150%: $5 151-185%: $15	<100% FPL: None 101-150%: $2 151-185%: $5	<100% FPL: None 101-150%: $1 151-185% $3-5	No	--
Florida	Yes	MediKids: None Florida Healthy Kids: Inappropriate Use Fee: $10	MediKids: None Florida Healthy Kids: $3	MediKids: None Florida Healthy Kids: $3	No	--

B. COPAYMENTS AND DEDUCTIBLES

	Any Copayments?	Emergency Room Visits Copay Amount	Medical Office Visits Copay Amount	Prescription Drugs Copay Amount	Any Deductibles?	Deductible Amount
Illinois	Yes	<150%FPL:None 151-185%FPL: Inappropriate Use Fee: $25	<133%FPL:None 134-150%FPL: $2 151-185%FPL: $5	<133%FPL:None 134-150%FPL: $2 151-185%FPL: $5 $3 generics	No	--
Louisiana	No	--	--	--	No	--
Missouri	Yes	None	<185% FPL: None 186-225%: $5 226-300%: $10	<225% FPL: None 226-300%: $9	No	--
New Jersey	Yes	134-150%FPL: None 151-200%FPL: $10 201-350%FPL: $35	134-150%FPL: None 151-200%FPL: $5 201-350%FPL: $5	134-150%FPL: None 151-200%FPL: $5 (brand name drugs) $1 (generics) 201-350%FPL: $5	No	--
New York	No	--	--	--	No	--
North Carolina	Yes	<150%FPL:None 150-200%FPL: $20	<150%FPL:None 150-200%FPL: $5	<150%FPL:None 150-200%FPL: $6	No	--
Texas	Yes	<150% FPL: $5 151-185%: $25 186-200%: $35 ($100 annual family cap)	<150% FPL: $2 151-185%: $5 186-200%: $10	<150% FPL: $1-2 >150% FPL: $5 generic; $10 other	Yes	186-200%FPL: Inpatient: $200 Outpatient: $50[f]

SOURCE: Information obtained during site visits conducted between May 2001 and January 2002.

NOTES: N.A. = not applicable.

Black-out period = amount of time following disenrollment that a participant must wait before they are allowed to reenroll in the program.

[a]Lower amount is for families who opt to participate in a Community Provider Plan (which involves safety net providers).
[b]Premiums were eliminated and replaced by enrollment fees in October 2000.
[c]As a Medicaid expansion state without a Section 1115 demonstration, Louisiana could not require cost-sharing.
[d]As of August 2001, the state had not yet acted on this provision to disenroll any family for nonpayment of premiums.
[e]Up to $250 annual limit (excluding vision and dental).
[f]Texas has since dropped its deductibles.

- California's sliding-scale monthly premium ranges from $6 to $27 for families with income between 151 percent and 250 percent of FPL, depending on family size;

- Colorado's annual fee ranges from $25 to $35 for families with income between 151 percent and 185 percent of FPL, depending on family size;

- Florida's $15 monthly premium applies to families of all incomes;

- Illinois charges between $15 and $30 per month depending on family size, for families with incomes between 151 and 185 percent of poverty;

- Missouri imposes no fees on families until earnings rise above 225 percent of FPL, charging monthly premiums ranging from $55 to $218 for families with income between 226 percent and 300 percent of FPL, depending on income and family size.

- New Jersey has four tiers of premiums which vary by family size (ranging from $15 to $100 per family), and by income (for families with incomes between 151 and 200 percent of poverty, 201 and 250 percent of poverty, 251 and 300 percent of poverty, and 301 and 350 percent of poverty);

- New York's sliding-scale monthly premium ranges from $9 to $45 for families with incomes between 161 percent and 250 percent of FPL, depending on family size;

- North Carolina charges its one-time $50 enrollment fee (per child, up to $100 per family) on families of any size with income between 150 and 200 percent of poverty;

- Texas' per family annual premiums range from $15 to $18 for families with incomes between 150 percent and 200 percent of FPL.

These differing policies, not surprisingly, lead to wide variations in the proportions of families that are subject to premiums and enrollment fees—from 100 percent in California, Florida, and Texas, to 5 percent in Missouri, with 40 percent paying premiums in New York and roughly one-third doing so in North Carolina.

Florida, New York, and North Carolina allow families to buy into SCHIP. In Florida and New York, families with incomes above 200 percent of poverty may purchase coverage by paying for the full cost of coverage. In North Carolina, families with incomes between 200 and 225 percent of poverty whose children are disenrolled because their income rises above 200 percent are permitted the option of purchasing ongoing coverage under *HealthChoice*. In these

states, the premium amounts vary; in Florida, buy-in premiums range from $68 to $153 per child per month, depending on the county and whether or not dental coverage is elected; in North Carolina, the premium is just under $121; and in New York, buy-in premiums vary by health plan, but average $115 per month per family.

Missouri made a significant change in its premium program in 2001. Beginning July 1, 2001, the monthly premium went from a fixed amount of $80 per family to a sliding-fee scale ranging from $55 to $218, depending on income and family size. The change made premiums more comparable to the full cost of coverage under the state employee health benefit plan, as required by the state's authorizing legislation.

Three states in our study (California, New York and Texas) require initial payments to be submitted with the SCHIP application, as a condition of eligibility. Colorado, Florida, Illinois, Missouri, New Jersey, and North Carolina wait to invoice families for the annual fee or initial premium payment until after eligibility is determined but payment must be received before enrollment takes effect. In states with premiums, families are invoiced monthly, and typically receive at least one reminder notice if payment is not received by the stated due date. Both Texas and California allow families to pay premiums in advance for multiple months, but only California provides an incentive to do so—families paying for three months in advance get their fourth month of coverage free; and, to facilitate premium payment, California allows families to make their premium payments at any Rite Aid drugstore.

Every state with a premium or annual fee component offers a grace period of between 30 and 90 days before action is taken to disenroll families for nonpayment. With the exception of New Jersey, New York and North Carolina, families disenrolled because of nonpayment are subject to a "blackout" period ranging from three to six months before they are permitted to reenroll. In New Jersey, New York and North Carolina, families disenrolled for nonpayment of

premiums may reenroll at any time, once payments are brought up to date. In New York's case, this policy has raised concerns about potential adverse selection; some health plan officials we interviewed believe that some families avoid paying monthly premiums when their children are healthy, and allow their coverage to lapse until their children need care.

Eight of the ten study states impose copayments on selected services; specific copayment amounts vary but are roughly similar across states and are considered comparable to, or lower than, those imposed by many private insurers. With the exception of emergency room copayments in New Jersey, North Carolina, and Texas (where the copay is $25, or $35 for families in the higher-income groups) and Illinois (where $25 is charged if the visit is deemed "inappropriate"), copayment amounts typically are no more than $5 or $10 per visit or prescription. California imposes the same $5 copayment for each type of service and for families in all income groups. Texas extends copayment requirements to all families, utilizing a tiered arrangement that imposes higher copayment amounts on families in the higher-income groups. Missouri, New Jersey, and Colorado base at least some copayments on family income, and exempt families in the lowest-income groups. Providers are expected to collect copayments at the point of service. Whether or not health plans deduct copayment amounts from the fees they pay providers varies from plan to plan and from state to state. In all states with copayments, providers are not permitted to deny service for refusal to pay; we heard that some providers write off copayments as "a cost of doing business." New York eliminated copayments when it introduced premiums during the conversion of its state-funded program to SCHIP.

At the time of our site visit, Texas was the only state in the nation to incorporate deductibles into its SCHIP program. Families with incomes above 185 percent FPL were required to meet deductibles of $200 for inpatient and $50 for outpatient hospital care.[48]

C. IMPLEMENTATION EXPERIENCES

In states imposing premiums or enrollment fees, the vast majority of informants we interviewed (including child advocates) reported that cost sharing has not posed a barrier to enrollment; there were some notable exceptions, however, as described below. Premium amounts are typically considered reasonable, and premium requirements were described as making the program more appealing to some families. As an informant in one state put it, "I think that if we had made this program free, families would have probably been more skeptical of it, or dismissed it as welfare." Compared with the cost of alternative private-sector options, premium levels adopted by most states are considered quite affordable. Front-line staff in Texas have heard families describe the premium as "too good to be true," and "the deal of the century."

Some key informants in Missouri believe that the state's premium amounts could be a barrier to enrollment, although premiums apply only to families with incomes above 226 percent FPL. Premium levels are higher in Missouri than in any of the other study states, and they have recently increased for many families. It is not clear whether the small number of enrollees in this segment of the program (five percent of total enrollment) is an indication that premiums are less affordable, that families are not aware of the program, or that the need for the program is less among families at these higher incomes. The buy-in premium component in New York, which also has a higher premium ($115) and applies to families with higher incomes (above 250 percent FPL), constitutes a small part (two percent) of total SCHIP enrollment in that state.

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[48]This policy has since been dropped.

Colorado and North Carolina were the only states among those we studied where objections to premiums and enrollment fees, respectively, were consistently voiced. Colorado, however, experienced particular problems with its premium program, including a substantial drop in enrollment following negative publicity about the program. When Colorado initially implemented SCHIP, it required all families to pay premiums, including those with incomes between 100 percent and 150 percent of FPL (a lower threshold than used by most states). The monthly premiums ranged from $9 to $30, with families in the 100 to 150 percent FPL group required to pay $9 per month for one child and $15 for two or more children.[49] Unlike other states, however, Colorado's program did not include provisions to penalize families for nonpayment of premiums. Lacking adequate enforcement tools, delinquency rates escalated over time. After the state comptroller threatened to send overdue accounts to collection agents, public opinion of the program dropped so much that ultimately the state abandoned the premium program and replaced it with an annual enrollment fee. The state also decided not to impose the enrollment fee on families with incomes below 150 percent FPL. During this period, rumors about families' accounts being sent to collection agents dampened enrollment considerably, and it took many months for enrollment growth rates to return to prior levels. In addition, the availability of free or low-cost care through a well-known indigent care program operating in the most populous regions of the state was reported as influencing families' perceptions of whether SCHIP offered a "good deal," especially for families in the lowest income groups.

Other states report that only small percentages of families who must pay premiums are being disenrolled for nonpayment. To strengthen its ability to take action against families who fail to pay, Missouri received approval from HCFA in January 1999 to disenroll families after four or

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[49]These premiums were comparable to what families at these income levels pay in California.

more instances of nonpayment. To date, however, the state has taken no action to disenroll any families through this authority.

In all states, key informants reported that copayments are considered reasonable, and even desirable, in some cases. Respondents generally noted that families appeared happy to make copayments and that this type of cost sharing had not had a negative influence on service use. Informants in several states noted that even higher copayment amounts, especially for emergency room care, might help reduce inappropriate utilization. While this problem did not appear to be widespread, we heard about some families who were not meeting their copayment obligations. This seemed to happen more often in areas where families are accustomed to accessing free care through programs for the medically indigent. Providers had varying views of unpaid copayments. While some reported absorbing the cost when copayments aren't paid, others in one state saw this as another reason to limit their SCHIP caseload. In several states, we heard that providers with a tradition of providing charity care often resist collecting cost sharing from their patients.

One consistent finding across our study states was that cost-sharing components are not considered "revenue makers." State officials report that premium programs cost more to administer than the dollars collected, especially given the cost of monthly invoicing, payment processing and reminder systems. Costs may decrease as states explore using payroll deduction systems, quarterly or semi-annual billing cycles with incentives, and other systems to reduce administrative costs. Despite the high cost, however, states still find cost-sharing components desirable because of the positive image they seem to engender for the program among participants, policymakers, and the general public.

IX. PARENTAL COVERAGE AND PREMIUM ASSISTANCE PROGRAMS

A. BACKGROUND AND POLICY DEVELOPMENT

Some states expressed interest early on in adopting strategies that would allow them to cover low-income parents, as well as children, under SCHIP, or that would allow them to leverage employer-based and other insurance packages available to some families by subsidizing the cost of such coverage, often referred to as "premium assistance." Although CMS resisted allowing parental coverage waivers during the program's first two years, they issued guidance in July 2000 that clarified the conditions under which they would grant approval of state applications to test such strategies.

Different rules govern premium assistance programs. The initial regulations governing premium assistance programs reportedly posed barriers for many states; revisions in the final regulations (and most recently, guidance issued under the Health Insurance Flexibility and Accountability—HIFA—Initiative) have made it easier for states to implement programs to subsidize employer-based coverage with SCHIP funds. At the time of our site visits, six states nationally had been given approval to cover low-income parents under SCHIP (Arizona, California, Minnesota, New Jersey, Rhode Island, and Wisconsin), and four states had received approval to use SCHIP funds to support premium assistance programs (New Jersey, Massachusetts, Mississippi, and Wisconsin). One state, Illinois, had a state-only funded premium assistance program that works alongside its SCHIP program.

B. PROGRAM AND POLICY CHARACTERISTICS

1. Parental Coverage

According to guidelines issued by CMS in July 2000, states desiring parental coverage waivers under SCHIP must first demonstrate that they are already covering children up to 200

percent FPL, enrolling children statewide without any waiting lists, and adequately promoting enrollment and retention of children in SCHIP and Medicaid. States were also expected to show that these coverage expansions to parents would make lower-income parents eligible for coverage prior to making higher-income parents eligible.[50] Also, since no additional funds are provided to finance expansions to parents, states with separate state programs must ensure that the cost of covering children and parents does not exceed the state's SCHIP allotment.[51]

New Jersey is the only state in our study that had implemented a SCHIP Section 1115 demonstration program for parents at the time of the site visits. The program, *FamilyCare,* was approved by CMS on January 18, 2001, though it had been in operation for five prior months using only state funds. The early interest in covering parents in New Jersey grew from the state's long history of providing coverage for childless adults and non-qualifying aliens with state-only dollars. The state wanted to maximize federal funds but, without an expansion, anticipated losing about $10 million in 1998 SCHIP matching funds at the end of FFY 2000, and a larger amount the following year. The state also had available tobacco settlement dollars to supply the state match.

FamilyCare covers parents with incomes between 134 and 200 percent of the FPL and pregnant women with incomes between 185 and 200 percent of the FPL. Under the expansion, the state also used state funds to cover three additional eligibility groups: childless single adults and couples (insured or uninsured) who are eligible for the state's General Assistance program;

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[50]Embry Howell, Ruth Almeida, Lisa Dubay and Genevieve Kenney. "Early Experience with Covering Uninsured Parents Under SCHIP." Washington, DC: The Urban Institute. *Assessing the New Federalism* Brief No. A-51. May 2002.

[51]When a Medicaid expansion program expands coverage to parents under SCHIP, they may use Title XIX funds when the SCHIP allotment runs out and receive federal funds at the regular Medicaid matching rate.

childless single adults and couples (uninsured) with incomes at or below 100 percent of the FPL; and legal immigrants who would qualify for Title XIX- or Title XXI-funded coverage but for the fact that they entered the U.S. less than five years ago and are therefore ineligible for federally-funded assistance. The program also includes a premium assistance program to subsidize eligible families' participation in employer-sponsored group health plans (described in more detail below in the premium assistance section).

To encourage enrollment, the state launched a statewide media campaign and mailings to General Assistance recipients and parents of Medicaid and *KidCare* enrollees. They also implemented a limited presumptive eligibility program for adults that allowed them to receive hospital and FQHC services and related pharmacy coverage during the period of presumptive eligibility.

When measured in terms of enrollment, expansion of SCHIP to parents has been very successful in New Jersey—155,000 parents enrolled in *FamilyCare* within 16 months of implementation. As a result, the funds put aside by the state to cover services provided during the presumptive eligibility period were soon exhausted, so presumptive eligibility was ended for adults in April 2001. The cost-sharing requirements for the program are viewed by advocates and outreach workers as fair, and the benefits package adequate or better.

At the time of our site visits, two other states, California and Louisiana, were both awaiting decisions on Section 1115 demonstration applications to expand coverage to parents (and, in Louisiana, to pregnant women) under SCHIP. California submitted its application to CMS in December 2000, requesting approval to use SCHIP funds to cover parents of SCHIP-enrolled children with incomes between 100 and 200 percent FPL, as well as parents with incomes below 100 percent FPL who do not qualify for Medicaid because of excess assets. In November 2001, while still awaiting approval, Governor Davis asked the state legislature to delay the parental

coverage expansion to July 2003 because he was concerned about a budget shortfall. But on January 29th 2002, CMS approved California's waiver request to cover parents.[52]

In July 2001, Louisiana submitted a proposal to use SCHIP funds to cover parents with family incomes under 100 percent FPL (mostly parents of children covered under Title XIX) and pregnant women with incomes between 185 percent and 200 percent FPL. Louisiana also needs approval from its legislature of the enrollment targets and its plans for covering the state's share of the expansion costs.[53]

In both California and Louisiana, similar reasons were given by key informants for pursuing these expansions:

- First, informants believed that parents of Medicaid- and SCHIP-eligible children would be more likely to enroll their children if coverage was also available to them.
- Second, they felt that when parents themselves are covered, they are more likely to seek appropriate care for their children.
- Finally, the expansion to parents would allow the state to access a greater portion of its federal SCHIP allotment.

In Louisiana, the expansion for pregnant women was seen as a way to reduce future program costs by preventing poor birth outcomes and childhood disabilities.

Missouri and New York already had approval to cover low-income parents under Medicaid Section 1115 research and demonstration programs. Missouri sought approval to cover parents under SCHIP when it submitted its SCHIP plan in 1997; but when that request was denied, the state revised the proposal to cover parents under Title XIX. New York's Title XIX parental

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[52]Due to large state budget deficits, California has put implementation of its parental coverage policy on indefinite hold.

[53]At the time of this writing, Louisiana had not yet implemented parental coverage under SCHIP.

coverage program was approved in June 2001. In both states, parents covered under the demonstrations are not parents of SCHIP-eligible children, because the income thresholds are lower for the Medicaid demonstrations than they are for SCHIP.[54] At the present time, neither state thought it would be feasible to extend coverage to parents under SCHIP; New York cannot do so because it has, in recent years, spent its full Title XXI allotment each year, and Missouri did not have the financial capacity to support additional expansions at the time of our visit. Both states were also facing challenges concerning confusion about the different rules governing eligibility for children and parents. In Missouri, different income thresholds for parents and children have confused families and front-line eligibility staff, adding to the burden on outreach and enrollment staff. New York's program had just gotten underway, but local staff we met with expressed concern that this same type of confusion could arise, along with the added volume of applications from parents. California anticipates facing similar problems since the income threshold for its parent component will be lower than the threshold for children (at 200 versus 250 percent FPL). No such problems were reported in New Jersey, where income thresholds for parents and children were the same.

The study states that expressed no interest in family coverage expansions said that the reason was either insufficient funds—North Carolina and Florida—or that policymakers preferred the premium assistance option—Illinois, Colorado and Texas.

2. Premium Assistance Programs

In theory, premium assistance programs offer a potentially low-cost method of providing dependent or family coverage by leveraging available employer-sponsored and other private health insurance options. To operate a premium assistance program, states must demonstrate

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[54]Missouri's program includes a small number of parents of SCHIP-eligible children.

that costs under the program do not exceed the costs the state would incur if it were to provide direct coverage. Furthermore, the initial guidelines limited the arrangements states could subsidize to those in which the employer contributed at least 60 percent of the cost of coverage. Another constraint was states had to cover any cost sharing in excess of that imposed under the regular SCHIP program, and that the benefit package offered through the alternative source had to be at least as generous as the package provided to SCHIP participants that the state covers directly. When benefit gaps existed, states were required to provide "wraparound" coverage. Waiting periods were also required for higher income families to prevent the substitution of public for private coverage, which would happen if employers reduced or eliminated their premium contributions or families opted to drop dependent coverage with an employer in order to enroll their children in SCHIP.

In response to complaints from many states that the initial regulations were too limiting, CMS eliminated the percentage contribution language from the final SCHIP regulations issued in January 2001 (as many states argued, the employer contribution must still be significant for the cost effectiveness standard to be met), allowed states to establish "reasonable" exceptions to the waiting period, and clarified how states can meet the benefit package standards when employer packages don't comply with the SCHIP statute.

Among the study states, only New Jersey had implemented a premium assistance program using federal SCHIP funds. The program is part of *FamilyCare*, and subsidizes eligible families participating in employer-sponsored group health plans. The proposal to implement a premium assistance program was submitted to CMS as part of the state's Section 1115 demonstration proposal for parental coverage. In the proposal, the state asked to be allowed to subsidize premiums for families who had access to employer-based coverage in which the employer paid at least 50 percent of the cost. Although this went against the CMS rule that employer

contributions had to be 60 percent, the proposal was approved. (Shortly afterwards, CMS dropped the requirement for minimum employer contributions.) Enrollment in the premium assistance program began on July 1, 2001, but as of May 2002, only 296 people in 88 families had enrolled. The low enrollment was attributed to delays in the receipt of application and enrollment records from the enrollment broker, the lack of current information about families' access to employer-sponsored insurance, and the need to wait for open enrollment periods for families to enroll in the coverage offered by their employers. New Jersey officials have found that their premium assistance program has very high administrative costs, relative to its direct coverage program. Still, they believe that once more people are enrolled, it will prove cost effective.

At the time of our site visit, Illinois' premium assistance program did not use federal SCHIP funding, but worked within the structure of SCHIP and played an important role in the dynamics of *KidCare*. The program, *KidCare Rebate*, subsidizes premiums for children with employer-sponsored insurance in families with incomes between 133 and 185 percent FPL. Policymakers in Illinois pursued the development of the program in order to address two related concerns. First, legislators, largely Republicans, were unhappy about the federal requirement that children must be uninsured to qualify for SCHIP. They believed this requirement created an equity disparity for families that met SCHIP's income eligibility, but were ineligible for coverage because they had "done the right thing" and purchased coverage prior to SCHIP's enactment. Second, there was apprehension about crowd out, and policymakers believed that subsidizing families' existing employer-sponsored insurance would help induce parents to maintain private coverage rather than dropping it to enroll their children in Medicaid or SCHIP. Policymakers, however, chose not to implement Illinois' premium assistance program with SCHIP funds

because they viewed the federal regulations as too burdensome. The program therefore draws only on state funds.

KidCare Rebate was implemented in October 1998 in conjunction with the *KidCare Share* and *Premium* Programs. Parents of children who already have insurance, or access to insurance, apply for the program by completing a separate one-page form, which is included as the last page of the *KidCare* application. There is no minimum employer contribution requirement and no benefit benchmark (although the employer coverage must provide hospital and physician care). As of December 2001, 5,754 children were enrolled in *Rebate*, approximately 4 percent of *KidCare* enrollment. Although a modest number, it is sizeable relative to other states which have SCHIP-funded premium assistance programs. Of note, *KidCare Rebate* provides subsidies only for children's coverage, not for parents, a situation unique amongst premium assistance programs. Although at present there is no interest in extending the *Rebate* program to parents, a proposal was submitted to CMS in November 2001 to provide parental coverage through the Medicaid and SCHIP-funded *KidCare* programs.

Three of the other study states have either taken steps toward or shown an interest in developing a premium assistance program: Florida, Colorado and Texas. In Florida, support for public-private partnerships among legislators and the Governor meant there was interest from the very start in leveraging employment-based insurance for families with access to such plans. In 1999 the state submitted a SCHIP amendment to add a premium assistance component to *Healthy Kids*. In the amendment, the state, aware that many Florida businesses do not offer employees dependent coverage, requested CMS to grant an exception to the (then in effect) federal rule that employers contribute at least 60 percent of the premium costs. In its place, Florida officials proposed a two-tiered contribution requirement—one for large employers and one for small employers. After a lengthy debate with federal CMS officials, the proposal was

turned down. There is, however, still interest in premium assistance in Florida, but only if it also includes reduced cost sharing for employers, as is allowable under current SCHIP rules.

Colorado also originally envisioned a second phase to its SCHIP program that would include a premium assistance component. The state explored the idea further during 2000 but concluded that federal rules at that time would make the program infeasible to implement. Although the regulations have since changed, the state is now facing serious fiscal constraints that prevent it from pursuing the program. Texas also expressed some interest in a premium assistance program; in summer 2001, the state legislature gave the SCHIP agency authority to explore and pursue this option further.

None of the other study states have seriously considered adding a premium assistance component to their SCHIP programs. In Louisiana, such an option was not considered viable because many employers do not offer dependent coverage and because the lack of large employers in the state would make a premium assistance program very costly to administer.

X. FINANCING AND FISCAL OUTLOOK

A. POLICY DEVELOPMENT AND PROGRAM CHARACTERISTICS

The legislation that established SCHIP made available approximately $40 billion in federal funds to states for fiscal years 1998 through 2003. From FY 1998 to FY 2001, states had access to slightly more than $4 billion per year. Allotments to the states are based primarily on two factors. One is the number of children, both low-income and low-income, uninsured children, as estimated in the Current Population Survey. The other is health care costs in the state relative to other states. In addition, states that exceed their given year's allotment are able to draw on a portion of unspent funds from other states' allotments.[55] The 1998 allotments provided to the 10 study states, shown on Table 14, tended to be larger than the national median. California, Texas, Florida and New York received respectively the four largest amounts in the country, Illinois' allotment was ranked number six, Louisiana 10, New Jersey 12, and North Carolina 15.[56] The two remaining states, Missouri and Colorado, received allotment amounts close to the national median. Between them, the 10 states received 57.5 percent of the federal funds apportioned nationwide in 1998.

Under Title XXI policy, states receive an Enhanced Federal Medical Assistance Percentage for SCHIP—greater, in other words, than the Federal Medical Assistance Percentages provided

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[55]Kenney et al., *Three Years into SCHIP: What States Are and Are Not Spending.* The Urban Institute, September 2000.

[56]Based on FY1998 allotments.

TABLE 14: SCHIP ALLOTMENTS AND EXPENDITURES, IN MILLIONS, 1998-2001

State	FFY	Federal Allotment	Expenditures	Expenditures as % of Allotment for Year	% of Year's Allotment Spent by End of FFY 2000	Redistributed Allocations
California	1998	$854.6	$2.0	0%	30%	---
	1999	$850.6	$67.7	8%	0%	---
	2000	$765.5	$188.0	25%	0%	0
	2001	$704.9	$318.9	45%	--	0
Colorado	1998	$ 41.8	$ 1.0	2%	57%	---
	1999	$ 41.6	$ 9.0	22%	0%	---
	2000	$ 46.9	$13.9	30%	0%	0
	2001	$44.6	$22.8	51%	--	0
Florida	1998	$270.2	$6.4	2%	86%	---
	1999	$268.9	$51.0	19%	0%	---
	2000	$242.0	$125.7	52%	0%	0
	2001	$220.2	$189.3	86%	--	0
Illinois	1998	$122.5	$6.1	5%	44%	---
	1999	$122.0	$14.7	12%	72%	---
	2000	$137.5	$32.7	24%	0%	0
	2001	$159.8	$40.8	26%	--	0
Louisiana	1998	$101.7	---	---	35%	---
	1999	$101.3	$10.4	10%	0%	---
	2000	$91.1	$25.3	28%	0%	0
	2001	$82.0	$37.0	45%	--	0
Missouri	1998	$51.67	---	---	100%	---
	1999	$51.43	$19.7	38%	18%	---
	2000	$57.98	$41.2	71%	0%	$9.24
	2001	$65.5	$62.4	95%	--	$61.8
New Jersey	1998	$88.4	$3.5	4%	79%	---
	1999	$88.0	$19.6	22%	0%	---
	2000	$96.9	$46.9	48%	0%	0
	2001	$98.8	$54.3	55%	--	$107.3
New York	1998	$255.6	$50.1	20%	100%	---
	1999	$254.4	$239.4	94%	100%	---
	2000	$286.8	$401.0	140%	63%	$434.9
	2001	$322.0	$433.3	135%	--	$729.8
North Carolina	1998	$79.5	---	---	100%	---
	1999	$79.1	$34.9	44%	26%	---
	2000	$89.2	$65.5	73%	0%	$20.9
	2001		$88.0	85%	--	$92.1
Texas	1998	$561.3	$1.3	0%	14%	---
	1999	$558.7	$38.5	7%	0%	---
	2000	$502.8	$41.5	8%	0%	0
	2001	$452.5	$271.3	60%	--	0

SOURCE: Centers for Medicare & Medicaid Services (CMS), Memo from Center for Medicaid and State Operations to State, January 25, 2000; *Federal Register* Notices, June 21, 2001 & April 26,2002; Kenney et al., *Three Years into SCHIP: What States Are and Are Not Spending.* The Urban Institute, September 2000; Smith, Vern and David Rousseau. *SCHIP Program Enrollment: December 2002 Update*. Kaiser Commission on Medicaid and the Uninsured. July 2003.

NOTES: The percentages of 1999 and 2000 allotments spent do not take into account redistributed amounts; states have several options as to when they use these funds.

SCHIP=State Children's Health Insurance Program (Title XXI)
FFY=federal fiscal year

under Medicaid. Under this system, the state share of costs was established at 70 percent of what states pay under Medicaid. Thus, SCHIP was a financially attractive program for the states from the start. As shown in Table 15, federal matching rates paid to the 10 study states ranged from 65 percent to 79.21 percent at the time of our study.

To obtain federal funds, states had to contribute matching funds. To match the federal share with state funds, the 10 states use three sources for funding: state appropriations, tobacco settlement funds, and assessments on providers (Table 15). Eight states draw upon general state appropriation monies, and five on tobacco settlement funds. The tobacco settlement in Texas—the largest in the nation—was the only source used for *TexCare*. One state, New York, used provider assessments to obtain the state share of SCHIP costs.

B. IMPLEMENTATION EXPERIENCES

Spending patterns in SCHIP varied across the 10 states we visited. In common with 10 other states nationally, New York, North Carolina and Missouri had spent their full FFY 1998 federal allotment by the time the three-year spending period for the funds had ended (see Table 14). This qualified them for additional redistributed monies from the pool of funds unexpended by the other 37 states and the District of Columbia. New York received the largest redistribution of FFY 1998 funds totaling nearly $435 million, North Carolina received $21 million and Missouri more than $9 million. Of the remaining states, Florida and New Jersey spent a fairly high proportion of their allotments—86 percent and 79 percent, respectively, while Colorado spent 57 percent—the median amount nationwide—and Illinois 44 percent. Spending in Texas, Louisiana, and California was far below the median—Texas spent 14 percent of its allotment.

TABLE 15: FEDERAL MATCHING RATE AND SOURCES OF STATE SHARES

State	Federal Matching Rate for Medicaid (FY 2001)	Enhanced Federal Matching Rate for SCHIP (FY 2001)	Sources of State Matching SCHIP Share
California	51.40%	65.98%	State appropriations
Colorado	50.00%	65.00%	State appropriations
Florida	56.43%	69.50%	Tobacco settlement funds and state appropriations
Illinois	50.00%	65.00%	State appropriations
Louisiana	70.30%	79.21%	Until 1999, foundation grants and school board funds. Since then tobacco settlement funds and state appropriations
Missouri	61.06%	72.74%	State appropriations, and, since 2001, tobacco settlement funds
New Jersey	50.00%	65.00%	Tobacco settlement funds and state appropriations
New York	50.00%	65.00%	Assessments on providers
North Carolina	61.46%	73.02%	State appropriations
Texas	60.17%	72.12%	Tobacco settlement funds

SOURCE: Sources of state match obtained during site visits conducted between May 2001 and January 2002.

Federal Matching Rates available on the web at http://aspe.os.dhhs.gov/health/fmap01

State officials in Missouri and New York attributed their high spending levels to high enrollment rates. Notably, too, both states had programs already in place: a Medicaid program in Missouri and a state-funded children's program in New York. Missouri also cited an overall higher level of per capita costs and large increases in prescription drug costs. In neither case, however, did the high spending lead to a financial crisis and subsequent caps on enrollment. Missouri came closest to a shortfall of state matching spending as a result of a unique constraint known as the "Hancock Amendment," which says that unless taxpayers agree to a tax increase, state revenues cannot increase at a rate that exceeds the growth in personal income. A funding crisis was averted for FFY 2001, however, when the state received approval to use tobacco settlement funds to meet the shortfall. New York, too, was concerned about a shortfall, but in their federal allotment. New York officials complained that they had received an inadequate federal allotment to begin with, considering that "California received three times the amount for twice the number of children." The large amount they received from redistributed allocations helped to alleviate this concern.

The situation in North Carolina was quite different. As already discussed, the state experienced a significant shortfall of funds, resulting in an enrollment freeze in 2001. Informants attributed this problem to inaccuracies in the Current Population Survey data that resulted in an underestimation of eligible children in the state. Though the state's fiscal staff carefully estimated the state share of the budget based on the annual cost per child, the higher than estimated number of eligible children meant that the state budget estimate was too low. Then, in the first fiscal year of the program North Carolina underspent its federal and state allocation because *Health Choice* had not yet begun. The unspent federal funds were carried over into the second fiscal year; but, as a result of state law, the state funds were not. As a result, the budget difficulties arose because of a shortage of state, not federal, funds. Still, informants interviewed

in North Carolina blamed the shortfall on the insufficient federal allocation, because if it had been greater to begin with, the state would have allocated more funds to the program. The financial situation eased in North Carolina when the state received $21 million of redistributed allocations, and in summer 2001 the legislature approved an additional $8 million of state funds for FY 2002 and $12 million for FY 2003.

According to the key informants we interviewed, low spending in the remaining states emerged as a result of four factors:

1. Allotments that exceeded need because the estimation of uninsured children residing in the state included Medicaid eligible but unenrolled children, meaning fewer children were eligible for SCHIP
2. Lower per capita expenditures under SCHIP than anticipated by the federal allotment
3. Income eligibility thresholds that were set below 200 percent of poverty, resulting in fewer children who could qualify for the program
4. A late launch of the program
5. Late implementation of outreach

In California, Florida and New Jersey, state staff believe that the federal estimate of uninsured low-income children was an over-estimate of those who would qualify for SCHIP because it did not account for those that would qualify for Medicaid. This resulted in an allotment that was too much for the states to spend. Officials in California also cited lower per capita expenditures than expected under SCHIP. Slow enrollment was a factor in Florida, where delays resulted from open enrollment periods and waiting lists. New Jersey also experienced slow initial enrollment, in part because of a late launch of its full marketing effort, the same reason given for Illinois. Louisiana attributed its low spending rates to two factors—first, *LaCHIP* was initially implemented with only two small expansions of Medicaid eligibility, first to 133 percent, then to 150 percent of poverty. Second, it was not until the beginning of 2001 that eligibility was raised to 200 percent. A late start was also the cause of the low spending

rates in Texas—that state's separate program component did not begin until April 2001, and the first two years saw negligible spending on behalf of children covered by the limited Medicaid "placeholder" expansion.

State officials and legislators varied in their perception of the fiscal outlook for SCHIP in their respective states, from positive to uncertain. Of note, the last four states visited between November 2001 and January 2002 all expressed the greatest amount of concern. Most of the opinions we heard concerned state financing and tended to be closely connected with legislative and gubernatorial support:

States visited between May and August 2001

- In ***California***, state funding was perceived to be secure—largely because of strong political support. Yet legislative staff reported concern about the outlook for federal financing, owing to the economic slowdown and change of the presidency.

- In ***Colorado***, the outlook for future state funding was uncertain. Although political support for the program appeared strong, a key sponsor of the bills that established the state's Title XXI program was unwilling to speculate about what the state legislature might do if CHP+ enrollment reached the limit established by the state law. (Owing to the state's spending caps, any additional funds for CHP+ must be taken from another program.)

- In ***Louisiana***, legislators in Louisiana appeared broadly supportive of LaCHIP, though the governor was more neutral in his support. All key informants felt that state funding was secure into the future.

- In ***New York,*** informants perceived state funding to be secure into the future, largely because of significant political support from the governor and the state legislature. There were concerns, however, about the adequacy of future federal funding because of the low probability of the continued availability of funds reallocated from other states.

- In ***Texas***, there was strong political support for SCHIP; legislators appeared to be committed to funding the state's share of the program. Yet, owing to the increasingly tight fiscal environment and escalating costs, the governor's office voiced some concerns about the future.

- In ***Missouri***, some state and local officials were concerned that the legislature would want to scale down the program in the future as a result of rising costs and the predicted economic slowdown. Political support for SCHIP was, in fact, the least positive in Missouri of any of the states we visited, with a number of legislators reportedly believing that the eligibility expansion to 300 percent of poverty was too generous.

States visited between November 2001 and January 2002

- In ***Florida*** the state had planned no significant cuts, and a shortfall in 2001 was averted because of an unexpected surplus under *Healthy Kids*. Yet informants indicated that they viewed the programs financial future as vulnerable owing to its link with Medicaid. (Children "spilling over" from SCHIP to Medicaid are increasing budgetary demands at a time of substantial budget shortfalls in the state.) As a result there have been some cuts to the outreach budget at the local level.

- In ***Illinois*** there was a general fear that budget cuts would need to be made in the future. State officials reported that they might have to delay provider payments to balance the budget, a situation that many feared would adversely affect access, as it did in the early 1990s. However retrenchment was seen as unlikely, and there remained strong support for expanding family coverage.

- In ***New Jersey***, state officials were at one point actively considering options for trimming the *FamilyCare* budget. Cutting dental or mental health services, raising premiums for higher-income families and dropping coverage for the GA population were all being contemplated. The Governor also had plans to borrow against future tobacco settlement payments to close the budget gap for 2002, a move which could have ramifications for *FamilyCare* in subsequent years. At the time of this writing, however, program cuts were "off the table" and, according to a key state legislator, "*FamilyCare* is safe for this year."

- In ***North Carolina*** there was a great deal of uncertainty about the future availability of state funds owing to the budgetary difficulties faced by the state. Yet most of the informants felt that, as long as North Carolina was matching federal dollars and not spending state-only money for the program, the future of *Health Choice* was relatively secure due to its widespread political popularity.

XI. COORDINATION OF SCHIP AND MEDICAID IN STATES WITH SEPARATE PROGRAMS

A fundamental feature of Title XXI is that it gave states a choice regarding how they could expand children's health coverage. As discussed earlier in this report, roughly one-third of the states elected to expand through Medicaid, while two-thirds chose to create separate programs, either alone or in combination with smaller Medicaid expansions.[57] For those states expanding Medicaid, coordination between Title XXI and Title XIX was not an issue—the two programs, by definition, were integrated. However, states creating separate programs were required to coordinate SCHIP and Medicaid coverage and operations, and faced numerous challenges in coordinating the two, sometimes very different, programs. Coordination issues arose mostly with regard to three program areas:

- Enrollment and retention
- Outreach and marketing
- Service delivery and access

Ideally, the policies and practices of Medicaid and separate SCHIP programs should be aligned so that children who move between the two programs receive seamless coverage. However, many states adopted separate program expansions under Title XXI specifically in order that the SCHIP program be different from Medicaid and to test new models for enrollment, service delivery, and cost sharing, among other program areas. As a result, rules and policies are often dissimilar, and thus have the potential to confuse families and affect them negatively, as in the cases when enrollment procedures are inefficient and uncoordinated, gaps materialize in

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[57]This trend is seen both nationally, and in our sample of ten states.

coverage and care, and the burden on families related to the need to understand and negotiate two different programs increases.

This section discusses SCHIP and Medicaid coordination, drawing on findings presented in earlier chapters of the report and highlighting both innovative coordination strategies and problems with coordination.

A. ENROLLMENT AND RETENTION

The policy areas of enrollment and retention posed the greatest challenge for coordination in states with separate SCHIP and Medicaid programs. As discussed in Chapter IV, the study states, like those across the nation, have introduced simple eligibility rules and enrollment procedures under SCHIP. Consistently, the study states employ joint SCHIP/Medicaid application forms; permit applications to be submitted by mail; apply no assets test in the SCHIP eligibility process; and typically employ 12 months of continuous eligibility to children; and, to varying extents, require little documentation from parents submitting applications for their children.

However, the study states differed in how much they had done to simplify their Medicaid rules and procedures. As a result, in four states—California, Colorado, New York, and Texas—there were differences in eligibility, enrollment and redetermination procedures between SCHIP and Medicaid. These differences were described as very confusing for families, sometimes resulting in inappropriate interruptions or even losses of coverage, and were observed as presenting the most challenging administrative and coordination problems for states.

In these states, differing enrollment rules sometimes resulted in joint application forms that were longer than necessary for SCHIP, since they had to reflect the rules and requirements for both SCHIP and Medicaid. During the federally required "screen-and-enroll" process, differing rules essentially required families to apply for coverage twice. Reportedly, in states like

California and New York, families were often confused when, after they submitted applications for SCHIP, they were later contacted and told that their children were being considered for Medicaid and that they needed either to submit more information and verification to the state or county, or appear for a face-to-face interview.

One of the more prominent coordination problems concerned information sharing between "single point of entry" vendors (under contract to determine SCHIP eligibility) and county social services departments (which maintain responsibility for Medicaid eligibility determination). In California, Colorado, New York and Texas, we repeatedly heard of problems related to the "deeming" of applications, back and forth, between SCHIP vendors (who had received applications for children who appeared Medicaid-eligible) and county social services agencies (who had screened applicants who appeared SCHIP-eligible), and that the two entities interpreted program eligibility rules differently. Moreover, these entities had problems tracking the status of applications moving between them. Ultimately, these problems had serious implications for families: in one state, applications were described as falling into "a black hole" once they were submitted to the single point of entry; and, in several states, advocates feared that many families were falling through the cracks as their applications "bounced back and forth" between vendors and county agencies.

Coordination problems at redetermination were analogous to those that occurred during initial enrollment. For example, SCHIP and Medicaid programs in California, Colorado, New York and Texas used different forms for redetermining eligibility, and imposed different requirements on families concerning the submission of information and documentation. Families experienced the problems that can arise when two sets of rules apply when screen-and-enroll procedures at renewal time resulted in their applications being referred from SCHIP to Medicaid, or vice-versa. Once again, if a child enrolled in one program was found at redetermination to be

eligible for the other program, it sometimes meant that parents had to complete additional steps, submit additional information, and, sometimes, appear for a face-to-face interview. If parents failed to abide by any of these additional requirements, their child or children might be disenrolled from coverage.

On a more positive note, it appeared that the states were "getting better" at coordinating SCHIP and Medicaid enrollment over time, and that many of the most egregious problems could be attributed to start-up confusion and administrative "glitches." In California, state officials were working with their vendor to design improved tracking mechanisms and, in Texas, the electronic transmission of applications and documentation between the vendor and county social services agencies appeared to smooth screen-and-enroll efforts. In addition, we often heard that community-based application assistors played a key role in alleviating parents' stress and confusion by helping families negotiate the sometimes confusing procedures, and by supporting families when coordination problems arose between vendors and county agencies.

On an even more positive note, four of the states (Florida, Illinois, New Jersey, and North Carolina) reported minimal problems with screen-and-enroll coordination. These states had put into place systems that facilitated the "deeming" of children back and forth and aligned program rules to a greater degree. In North Carolina, for example, the enrollment process between the two programs was reported to be completely seamless. The application process is identical, and children are screened for eligibility for both programs by the same DSS caseworker and automatically enrolled in either program. No single-point-of-entry vendor is involved. No coordination problems were reported. In New Jersey, program requirements are also very well aligned (no face-to-face interview, aligned presumptive eligibility and eligibility periods, and documentation requirements are virtually the same). Though there is a single-point-of-entry vendor that forwards applications to the Department of Social Services, state staff are located at

the vendor which reportedly eases potential problems. The same arrangement exists in Florida. Parents mail forms in to the Florida Healthy Kids Corporation that then sends them on to the KidCare third party administrator. If the child appears to be Medicaid eligible, the third party administrator sends the forms to the DCF Medicaid KidCare Unit. The processing of these Medicaid-eligible applications is greatly facilitated by the co-location of staff at the Medicaid KidCare Unit and the Florida Healthy Kids Corporation. Illinois adopted a streamlined application that is sent to a state-run central processing unit. Problems are eased because if the child is Medicaid eligible they are automatically enrolled at the central processing unit. It is worth noting, however, that key informants reported that parents in Illinois are often unhappy when they find out that their child has been enrolled in Medicaid.

B. OUTREACH AND MARKETING

State outreach efforts also gave rise to coordination challenges. The primary issue was how to balance SCHIP and Medicaid outreach efforts. As discussed in Chapter III, the eight study states with separate programs typically designed marketing campaigns to promote public awareness of SCHIP, while also implementing ambitious community-based initiatives to recruit "hard-to-reach" families with uninsured children at the local level. The programs were given catchy sounding names—*Healthy Families, Kidcare, Family Care, Child Health Plus, TexCare,* etc.—and marketing campaigns presented positive and colorful images of healthy mothers, infants, and children, using upbeat slogans like "Growing Up Healthy," "A Healthier Tomorrow Starts Today" and "Better health for your children, peace of mind for you." Print materials distributed to community-based organizations reproduced these images, logos, and slogans.

Importantly, however, six of the eight study states with separate programs did *not* prominently promote Medicaid in their marketing materials; only California's *Healthy Families/Medi-Cal for Children* campaign and North Carolina's *Health Choice* explicitly placed

Medicaid on an equal footing with SCHIP. In Florida, Illinois and Texas, *KidCare* and *TexCare Partnership* were created as an "umbrella" identity through which SCHIP and Medicaid could be promoted, but the Medicaid identity is not prominently displayed. For years, New York kept the identities of *Child Health Plus* and Medicaid separate, and the same is true for Colorado.

According to key informants interviewed for this study, these arrangements arose for a variety of reasons. For example, the political realities that led some states to develop new programs in the first place also likely influenced the decision not to actively promote the Medicaid entitlement. In addition, some state officials said that Medicaid was not aggressively promoted for fear of "turning off" families who might hold negative opinions of Medicaid, either because of previous negative experiences with the Medicaid enrollment process or, among immigrant Hispanic families, due to fear that Medicaid enrollment may adversely affect their or their child's ability to obtain citizenship. In Colorado and Texas, community-based application assistors defended the marketing emphasis on SCHIP, saying things like, "we can get our foot in the door with SCHIP, and then talk about Medicaid when we have to." Even in California, staff of some (but not all) health plans and community-based organizations said that they tend to market *Healthy Families* and avoid directly discussing *Medi-Cal,* for fear of losing families. Notably, state and local officials in every state with a separate program were quick to point out that they believed their SCHIP campaigns effectively promoted enrollment in both programs, largely because of their use of joint applications. By responding to an advertisement or flyer and calling a program hotline, families can request and receive a joint SCHIP/Medicaid program application and, upon completing it, obtain either SCHIP or Medicaid coverage for their eligible child/children.

Key informants at the state and local level had mixed opinions about the appropriateness of SCHIP-only marketing. Some were pragmatic, believing that the states would attract more

families by promoting a new and "baggage-free" product, while taking comfort in the likelihood that these efforts would also succeed in reaching families with Medicaid-eligible children. Others, however, were philosophically opposed to and offended by this approach because it promoted SCHIP in a very positive light, while effectively maintaining Medicaid in a secondary, perhaps less positive light. Often we heard advocates express fear that such marketing might undermine families' interest in enrolling in Medicaid; these informants consistently believed that the much larger Medicaid program should be promoted equally.

The ultimate impact that these marketing messages have had on families is unclear. We did learn, however, that some parents were confused (and sometimes angry) when they responded to SCHIP advertising, submitted a program application, and then learned that they were being reviewed for Medicaid eligibility.

New York offers an example of how marketing efforts might ideally evolve in the future. There, after maintaining totally separate identities for Child Health Plus and Medicaid for years, the state renamed Medicaid *Child Health Plus "A,"* while the SCHIP program assumed the name *Child Health Plus "B."* As a result, New York officials hoped that Medicaid would accrue all the positive benefits of SCHIP marketing, and that the two programs would begin to be perceived by consumers as one. The desirability of this direction was supported by advocates and other key informants in most of the states we visited; the opinion was commonly expressed that, ultimately, states should promote "health insurance," and not "SCHIP" or "Medicaid."

C. SERVICE DELIVERY AND ACCESS

The third program area where coordination between SCHIP and Medicaid is crucial for children is service delivery. The extent to which SCHIP and Medicaid delivery systems are aligned is a significant aspect of coordination between the two programs, that largely determines whether children who move between the two programs receive seamless and integrated health

care. In cases where SCHIP and Medicaid programs in a given state share the same (or similar) provider networks, children are more likely to receive continuous care from the same provider regardless of which program is paying the bills. If the opposite is true and SCHIP and Medicaid programs use significantly different networks, then children and families may be much more likely to experience disruptions in their relationships with caregivers and their continuity of care. This issue is especially important for "mixed coverage" families (that is, those with children covered by each of the programs), who might face the prospect of having different children enrolled in different health plans, receiving care from different providers.

As discussed in Chapter XII, most of the study states set out to make managed care the foundation of their SCHIP delivery systems.[58] Among the eight states with separate programs, two did not adopt widespread managed care. In these states—Illinois and North Carolina—physicians tended to accept *Health Choice* patients alongside Medicaid and access to care was similar between the two programs in both urban and rural areas.

State officials in the remaining six states explicitly sought to align SCHIP and Medicaid delivery systems to the greatest extent possible, while also expanding the use of managed care arrangements to a larger number of counties, including rural ones. Yet, in only three of these states did these efforts result in closely aligned systems of care for beneficiaries of the two programs. In Colorado, New Jersey, and New York, SCHIP and Medicaid systems were quite well coordinated; most managed care health plans participated in both programs, and delivery arrangements in urban areas, in particular, were quite consistent. In Colorado, the state's authorizing legislation required that plans participating in SCHIP must also participate in Medicaid. In New York, the only difference between the two programs is that one large New

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[58]Louisiana is the only state of the first six we visited whose SCHIP program relies primarily on fee-for-service delivery and payment arrangements.

York City plan participates in SCHIP but not Medicaid. In New Jersey the same five plans participate in *Family Care* and Medicaid. In California, Florida and Texas differences in plan participation across the two programs were more pronounced. In California and Texas, managed care arrangements are found in considerably more counties under SCHIP than Medicaid, and in Texas, only half of the health plans that participate in Medicaid also participate in SCHIP. In Florida, there is some overlap between the 15 plans participating in Healthy Kids and the 13 in Medicaid/MediKids, but most plans participate in one program or the other.

In five of the states, there were more distinct differences between SCHIP and Medicaid service delivery in rural areas. SCHIP programs in California, Colorado, Florida and Texas each operate some form of exclusive provider organization (EPO) with an organized network of participating physicians in their rural regions, while Medicaid programs operate traditional fee-for-service systems.

Despite the remaining differences between SCHIP and Medicaid service delivery networks, it appears that state efforts to achieve SCHIP and Medicaid alignment have fostered relatively coordinated service delivery in most areas of the study states, according to key informants, including state and local officials, providers, and advocates. When the same plans participate in both programs, we heard, families have a much easier time making the transition from one program to the other as family income or circumstances change. We also heard from advocates and local application assistors that families care most about being able to retain their relationships with particular physicians when they switch programs, rather than with particular health plans. On this score, it was reported that close alignment between SCHIP and Medicaid plans, and the provider networks in those plans, had led to consistent access and continued relationships with providers for most families. In Texas, the state with the most distinct SCHIP and Medicaid systems, the fact that SCHIP health plans are dominated by traditional safety net

providers, and that Medicaid enrollment is concentrated in these plans as well, meant that families moving from one program to the other most often have had the same choices of plans and providers.

In the rural areas of the some states, however, more coordination problems related to service delivery were reported. As discussed in Chapter VIII, the SCHIP programs in California, Colorado, and Texas use EPOs in rural areas, which appears to have increased the numbers of physicians available to SCHIP enrollees and, in turn, improved children's access to primary care providers. However, Medicaid's continued reliance on traditional fee-for-service systems in these states, and the often low payment rates used in those systems, has apparently perpetuated inadequate provider availability (due to both shortages of providers and limited numbers of providers who are willing to participate in the program) and, consequently, inadequate access to care. Thus, when families switch programs in these regions, they face a greater likelihood of confronting disruptions in service delivery.

XII. OVERARCHING CONCLUSIONS AND LESSONS LEARNED

The years since the creation of the State Children's Health Insurance Program (SCHIP) have witnessed considerable change in publicly funded health systems for children—all states have implemented Title XXI initiatives (one-third solely through expansions of Medicaid, and two-thirds through the creation of separate programs, either alone or in combination with Medicaid expansions); the average income eligibility threshold for subsidized coverage of children has nearly doubled to 214 percent of the federal poverty level; and, as of December 2002, approximately 3.7 million children were insured by SCHIP.[59] These trends are well reflected among the ten states included in this evaluation—every state we studied except Texas had implemented the major portion of its SCHIP expansion within roughly one year of passage of the law; eight chose to create separate programs, while two expanded coverage of children through Medicaid exclusively; and average income thresholds for children now stand at 227 percent of poverty in the ten study states. Given that our sample includes the three largest SCHIP programs in the nation, enrollment in our study states makes up a large share of the national total—as of December 2001, nearly two million children were covered by SCHIP in the states of California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas.

This study has attempted to document and analyze the experiences of ten states during their early years implementing SCHIP. Based on our interviews with state and local officials, providers, health plans, and advocates, it appears that much has been learned about the

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[59]Vern Smith and David Rousseau. "SCHIP Program Enrollment: December 2002 Update." Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, July 2003.

challenges associated with designing and operating a successful child health insurance program.

Presented below is a synthesis of our overarching conclusions from the case studies.

- ***Environmental factors influenced states' decisions regarding what type of SCHIP expansion to adopt. But both Medicaid expansions and separate programs have succeeded, to varying degrees, in "reinventing" public health insurance systems for children.*** Common factors fueled the rapid adoption of SCHIP in virtually all of our study states, including the availability of enhanced federal matching funds, bipartisan political support for child health insurance expansions, and strong state economies. Beyond this, the states fell into two distinct groups—those that saw Medicaid expansion as both administratively efficient and a means of extending the broadest possible coverage to children and those where considerable political, provider, and/or consumer resistance to Medicaid drove the decision to create new, separate programs. Among those choosing separate programs, policymakers viewed Title XXI as an alternative approach to expand coverage without expanding the entitlement to Medicaid. Moreover, they saw SCHIP as an opportunity to test new models of health insurance, "patterned after private insurance" and characterized by highly visible marketing campaigns, community-based outreach, simplified enrollment, cost-sharing, and provisions to prevent the substitution of public for private coverage and, with the exception of Louisiana, Illinois, and North Carolina, managed care delivery systems. However, the states that expanded Medicaid also viewed Title XXI as a chance to "reinvent" the program and make it more user-friendly; these programs, like the separate ones, adopted unprecedented outreach efforts and greatly simplified and streamlined their enrollment procedures. Using Medicaid Section 1115 waiver authority, Missouri Medicaid officials also incorporated cost-sharing and crowd-out provisions into their SCHIP expansion of Medicaid.

  Generally speaking, key informants interviewed in each of our study states supported the program choices made by state policymakers, recognizing the environmental factors that led them to do so. However, some trade-offs were consistently noted. Most notable, perhaps, was the complexity inherent in the choice to layer a new, separate program upon Medicaid. While separate programs often enjoyed high levels of political and consumer support, they faced significant challenges coordinating their operations with those of Medicaid. As a result, five of the eight states with separate programs faced significant coordination challenges, challenges that appeared to be directly proportional to the degree that the two programs' eligibility rules, administrative structures, and delivery systems differed from one another.

- ***SCHIP outreach is often characterized by a two-pronged strategy—with broad-based marketing designed to raise public awareness, and community-based efforts designed to reach the "hard to reach."*** State and local officials in states with separate programs, in particular, praised the two-tiered strategy they had adopted for SCHIP outreach. These informants described the two components as complementary, with broader marketing succeeding in getting families' attention, sparking initial interest in SCHIP, and building a "brand name" for the program; and community-based efforts, conducted by recognized individuals and organizations at the local

level, providing the opportunity to directly contact parents, discuss the program in detail, answer questions, and clarify misconceptions surrounding either SCHIP or Medicaid. Outreach efforts typically were aided by the adoption of new names (e.g., *LaCHIP, Child Health Plus, TexCare*), the development and distribution of colorful printed promotional materials, and the establishment of toll-free hotlines through which parents could obtain additional information about the programs.

The overall outreach strategy in the two Medicaid expansion programs was notably different. In both Louisiana and Missouri, community-based efforts were extensive and aggressive, but high-visibility marketing and advertising were nearly nonexistent. Key informants explained that less political and financial support had been extended for television and radio advertising, and theorized that this was due to governors' and/or state legislators' long-standing resistance to conducting outreach for this previously "welfare-based" program. Local groups involved with outreach in these states believed their efforts were being undermined by the lack of broader media campaigns; without a well-established identity for SCHIP, outreach workers were required to constantly introduce, describe, and familiarize parents with their newly expanded programs.

- ***Community-based outreach has been given "teeth" by allowing local organizations to provide application assistance.*** In every state we visited, community-based outreach was seen as critically important, often judged as the only way to reach such hard-to-reach families as ethnic minorities, Hispanic families afraid of "public charge," and working families who might have no prior experience with public programs. Importantly, however, traditional community-based outreach has been given a new dimension under SCHIP with the addition of application assistance responsibilities. In seven of the ten study states, community groups have received training in SCHIP and/or Medicaid eligibility rules and procedures and have been certified as "application assistors" charged with helping parents to complete program application forms. These groups have received either up-front funding (in the form of grants or contracts) to carry out this function, and/or retrospective reimbursement (or "finder's fees") for every completed or successful application submitted. Missouri established regional phone centers to provide this type of assistance by specially-trained Medicaid eligibility and enrollment staff. While application assistance efforts have faced various challenges in implementation, they were almost universally praised as an effective strategy for taking outreach beyond an activity that simply informs families of the availability of coverage, to one that produces tangible, measurable results (in the form of enrolled children).

- ***SCHIP programs have simplified enrollment, yet inconsistencies between SCHIP and Medicaid rules in some states with separate programs persist and have created challenges to effective coordination of enrollment efforts.*** Every state we studied adopted a range of policies to simplify the SCHIP application process, including designing joint SCHIP/Medicaid application forms, allowing applications to be submitted by mail, providing community- and/or telephone-based application assistance, dropping assets tests, adopting 12-month continuous eligibility, and reducing verification requirements. Across the board, these simplifications were

praised and often credited as one of the main drivers of states' successful enrollment of children into SCHIP.

But, while most states with separate programs have simplified Medicaid rules and procedures, we observed that they have not always done so to the same extent as they did under SCHIP. In a Medicaid-expansion state, this issue is not as important; in states with separate programs, however, even minor inconsistencies in rules can lead to complications in the conduct of "screen-and-enroll" procedures. In California, New York, and Texas, we heard of numerous cases where families were inconvenienced by the need to submit different information and/or verification to SCHIP and Medicaid programs whose rules were not consistent, of applications that were kicked back and forth between entities responsible for determining SCHIP and Medicaid eligibility due to misinterpretations or misunderstandings of rules, of long delays in establishing eligibility for one or the other program, and of families "falling through the cracks" as states and counties struggled to place children in the program for which they were eligible. Such problems were often cited as fundamental barriers to the creation of more seamless systems of coverage for children. Encouragingly, these problems were apparent to state policymakers, and various efforts had been undertaken (in Texas) or were planned (in New York), to further simplify and bring the rules of the two programs into better alignment.

- ***Eligibility reforms enacted under SCHIP have "spilled over" into Medicaid, resulting in simplified enrollment for both programs.*** Although inconsistencies in SCHIP and Medicaid rules remain, the situation is far better than it might have been had separate SCHIP programs, alone, simplified enrollment. Instead, we observed numerous cases where streamlining strategies that were adopted for SCHIP were extended to Medicaid in the interest of better aligning the programs' operations. In California, New Jersey, North Carolina, and Texas, in particular, strategies that had been resisted by the states for years—including allowing applications to be submitted by mail, reducing verification, and guaranteeing 12 months of eligibility—ultimately were adopted after state officials witnessed their benefits in SCHIP. In a less pronounced or consistent way, SCHIP (and Medicaid) simplification goals appear to be trickling down to the local level and influencing the operations of many county social services agencies. In some localities we visited, county "welfare" offices were undergoing important shifts in their outlook and "culture," viewing their roles anew as facilitating enrollment, rather than preventing it.

- ***Resistance to Medicaid among families with uninsured children reportedly remains high in many states, undermining the states' broader objective of covering all eligible low-income children in either SCHIP or Medicaid.*** Case study respondents in half of the 10 study states—California, Colorado, Illinois, New York, and Texas—reported that perceived consumer resistance to Medicaid was an important factor in their states' decisions to create separate programs under SCHIP. Families' resistance appeared to grow from a number of factors, including negative prior experiences enrolling in Medicaid, the view that Medicaid was a "welfare" program, negative experiences with Medicaid providers and/or their office staff, and immigrant Hispanic families' deeply held fears that enrolling in Medicaid constituted "public charge" and would affect their ability to achieve citizenship for themselves or their children. This

issue was manifest most clearly during screen-and-enroll activities, designed to place children in the correct program. Community-based enrollers in these states consistently described how hard they worked to overcome family resistance to Medicaid and persuade parents to enroll their children. Yet, in sometimes subtle ways, SCHIP appears to retain a "preferred" status in several states—key informants described how politicians consistently praise SCHIP while expressing much less consistent support of Medicaid; marketing campaigns were observed to promote SCHIP, while ignoring Medicaid; and states did not always publicize that Medicaid did not constitute "public charge."

These issues are challenging ones to address. While nearly every state and local official we interviewed acknowledged the strength and benefits of Medicaid vis-à-vis SCHIP, they also were often pragmatic in their desire to promote SCHIP and avoid potentially "turning off" families by directly marketing Medicaid. Advocates pointed out that Medicaid programs "must be doing something right," as empirical evidence clearly shows that the programs are much larger than their SCHIP counterparts, and that rates of participation among eligible children are actually higher in Medicaid than SCHIP. Ultimately, they believed, states needed to de-stigmatize Medicaid and jointly promote the two programs as "health insurance," rather than SCHIP and Medicaid.

- ***Retention is emerging as a concern, and a priority, in many states.*** In at least half of the study states, SCHIP programs have begun to experience rates of disenrollment that were worrisome to key informants. A review of SCHIP and Medicaid renewal policies revealed that states had done less to simplify and streamline their eligibility renewal procedures than they had done for initial enrollment. As a result, Colorado, Louisiana, and New York had witnessed disenrollment rates officials considered problematic—25 to 40 percent. In California, data system weaknesses made the accurate calculation of a retention rate impossible. Significantly, policymakers do not yet know what a reasonable rate of retention should be under SCHIP—the program is simply too new, insufficient research has been focused on the issue, and some children will disenroll appropriately because they are no longer eligible or because they gain access to private health insurance. Yet state officials in nearly every state we visited were already actively reviewing strategies for simplifying renewal, and community-based enrollers were being directed (and sometimes paid) to expand the scope of their efforts to include helping families to reenroll in SCHIP and Medicaid. Whether these result in high rates of retention will need careful monitoring in future years.

- ***Benefit packages adopted for separate SCHIP programs are comprehensive, typically exceeding the coverage available through private insurance options and coming close to that of Medicaid.*** Although benefits under separate SCHIP programs do not offer the same "unlimited" coverage and protection provided by Medicaid, key informants consistently reported that the packages were meeting the needs of enrolled children. We observed that explicit omissions from coverage were few in number—the most significant gap in the states we studied was the lack of preventive dental coverage in Colorado; and even in this case, the state had adopted coverage of this service by the time of this writing. More services are subject to

limits under SCHIP, compared to Medicaid, but key informants were hard-pressed to identify cases where they had heard of children who needed services that were not covered.

- ***Managed care arrangements are the cornerstone of SCHIP programs in nearly three-quarters of the states we examined, and in most of these states, managed care's reach is greater in SCHIP than Medicaid.*** To achieve multiple goals—including cost efficiency, improved access, and modeling the program on private insurance—officials in all but three states in the study have adopted managed care as the primary delivery arrangement for SCHIP enrollees. In most cases, SCHIP programs have contracted with largely the same plans and networks that have been used by Medicaid. For both SCHIP and Medicaid, managed care was viewed as contributing to improvements in access; compared to traditional fee-for-service arrangements, managed care was described as succeeding better in providing children with a primary care medical home. Although some states have not been able to extend managed care to all areas of the state, as originally planned, the majority of SCHIP participants in states with risk-based managed care programs are covered under such arrangements.

- ***Access problems are more a concern in rural areas lacking adequate numbers of providers and/or managed care infrastructure.*** Provider shortages and limited managed care infrastructure, as well as resistance to managed care among physicians, are some of the problems affecting access in rural areas of the states we studied. In California, Colorado, Florida, and Texas, SCHIP programs have developed "exclusive provider organizations" as a strategy for achieving some of the goals of managed care, linking children to a primary care provider and recruiting an identifiable network of providers willing to participate in the program. While access for SCHIP enrollees in rural EPO areas was not judged to be as good as in urban HMO areas, key informants believed that it was better than fee-for-service Medicaid in the same rural areas.

- ***Utilization rates among SCHIP versus Medicaid enrollees are not consistent across the study states.*** In two of the study states—California and New York—children enrolled in SCHIP appear to use significantly fewer services than their Medicaid counterparts. In Texas, however, SCHIP enrollees appeared to be the higher utilizers. Meanwhile, in Louisiana and Missouri, program data revealed similar rates of service use for the two groups, at least for most services. In California and New York, some key informants theorized that SCHIP enrollees' lower utilization was due to the SCHIP population's higher socioeconomic status and potentially better health status, while others feared that access problems explained the difference and that SCHIP families (especially immigrants or those of ethnic and cultural minorities) did not understand managed care and do not know how to avail themselves of care. In Texas, health plan officials saw SCHIP enrollees' higher utilization as a clear sign of pent-up demand among the previously uninsured population, as well as high per capita utilization by children with special health care needs. Generally, key informants agreed that further research and monitoring was needed to quantify and better understand the utilization rates of SCHIP and Medicaid enrollees.

- ***Capitation rates paid to managed care organizations, while difficult to compare directly with Medicaid, appear to be similar.*** SCHIP programs in the study typically have developed capitated payment arrangements that are simpler than those used for Medicaid, with fewer rate cell variations by age and eligibility category. However, while the capitation rates were therefore difficult to compare directly, state SCHIP and local health plan officials typically reported that the two programs' payment levels were very similar, and that SCHIP was not paying plans "better" than Medicaid. State officials explained that, without any better data to work with, they often began with historical Medicaid claims data in developing SCHIP rates. Health plan officials in California and New York reported that, given low utilization rates among SCHIP enrollees, capitation rates were quite adequate. In only one state—Texas—did we hear of plans struggling with capitation payments that did not adequately cover the costs associated with serving program enrollees.

- ***Provider fees under SCHIP, paid either by states through fee-for-service arrangements or by health plans to their network providers, typically are similar to those of Medicaid. This has led to considerable provider backlash in some of the study states.*** In many of the study states, both SCHIP program officials and health plan administrators have chosen to use Medicaid payment structures as a base on which to build SCHIP fees. Fee-for-service rates paid to physicians by SCHIP programs in non-managed care counties, as well as fees paid by health plans to network providers, were reported to be similar to those paid by Medicaid. In every one of our study states—but most notably in California, Louisiana, and Texas—this reportedly was cause for considerable concern in the physician community. Providers often expressed the opinion that Medicaid fees were "the wrong place to start" when setting SCHIP fees, and threatened that they would not be able to participate in the program if doing so meant "losing money on every SCHIP and Medicaid visit." This, too, was an issue that case study informants identified as needing careful attention in the future. Notably, in the states where fees were considered adequate by the medical community, physicians spoke more highly of the program.

- ***Crowd out was not a major concern in the states we visited; state officials suggested that crowd out is being avoided or is occurring at low levels.*** While fear of crowd out was pervasive during the development of SCHIP—leading to the adoption of waiting periods as a strategy for deterring substitution in eight of our ten states—few states now believe that crowd out is occurring to any significant degree. In two of the states, crowd out was deemed a small enough problem that the waiting periods were dropped. In New York, officials report that substitution may be occurring with between four and six percent of enrollees. Several other states reported that they deny between one and 11 percent of applicants for having had insurance within the waiting period. Waiting periods were described by state policymakers and local outreach staff as an apparently successful deterrent, as was the threat in New York that a waiting period would be introduced if many parents dropped their private coverage in order to enroll their children in SCHIP. Outreach and enrollment staff in every state reported that they actively discouraged parents from dropping coverage for their children. Louisiana, which dropped its waiting period as a result of a CMS ruling on such policies under a Medicaid expansion, was the only state in our sample where crowd out was perceived as a problem.

All the states have introduced exceptions to waiting periods to permit families facing hardships to enroll their children into SCHIP. California, Colorado, New Jersey, and Texas each have exception policies that, in varying ways, excuse families who are faced with paying very high rates for existing employer-based insurance. These policies were uniformly viewed as "fair and equitable," and this type of crowd out as "not a bad thing."

- ***Cost-sharing arrangements are viewed positively in most states.*** All eight of the separate programs in our study, and one of the two Medicaid expansions, impose one or more types of cost sharing on enrollees. Generally speaking, the study states set premiums at quite low levels, and require them of children in higher income families. Almost across the board, key informants interviewed for our study, including child advocates, were quite supportive of their states' policies to impose cost sharing upon families with children enrolled in SCHIP. Cost sharing was viewed as a tool for promoting personal responsibility, fostering "pride of ownership," encouraging appropriate utilization, and setting SCHIP apart from Medicaid. In nearly all of the states with cost sharing, key informants of all types believed strongly that premium payments and enrollment fees were not posing a barrier to enrollment, and that copayments, with few exceptions, were not affecting utilization.

  Colorado, however, experienced major problems with its premium component, because premiums were both somewhat higher than in many other states, and were imposed on lower-income families. It was reported that many families resisted enrolling in SCHIP, either because they could not afford program premiums, or because the most populous regions of the state had access to free or low-cost care through the state's well-known Indigent Care Program. Problems with nonpayment of premiums also emerged as the state did not enforce payment requirements and did not disenroll children whose parents were not up-to-date with their premium payments. Eventually, state officials chose to "forgive" all arrears and replaced its premium structure with a simpler, annual enrollment fee. Since then, enrollment in the SCHIP program has increased steadily.

- ***The size of a state's remaining SCHIP allotment is a key factor influencing state interest in pursuing the option to extend coverage to parents under SCHIP.*** While most of the states in the study found the idea of family coverage appealing, New Jersey was the only state that had implemented a SCHIP Section 1115 demonstration program to cover parents at the time of the site visits. California and Louisiana were in the process of pursuing this option. In addition to allowing states to access more federal funds, family coverage is valued in each of these states because, according to key informants, it increases the likelihood that children will enroll and receive appropriate care. Because New York has spent its full 1998 allotment; it could not expand to parents under SCHIP, but is doing so through Medicaid. Missouri had wanted to cover parents under SCHIP, but HCFA was unwilling to approve such a waiver in 1998. So, Missouri also used Medicaid authority to implement parental coverage. Florida and North Carolina had insufficient funds to pursue family coverage.

- ***States' interest in premium assistance programs has been tempered by what are perceived to be restrictive federal rules.*** Prior to federal rules on premium assistance being relaxed, only one state in the study—New Jersey—had implemented a premium assistance program with SCHIP funds, and only one—Texas—was considering adding a premium assistance component. Other states had considered the program but were deterred by the regulations. Illinois has a premium assistance program working within the SCHIP framework, but does not use SCHIP funds. Florida submitted a SCHIP amendment to add a premium assistance component, but was turned down because of its request for a premium cost exemption. Federal regulations also played a large role in Colorado's decision to abandon its plans for a premium assistance program. Thus although the premium assistance option is appealing to states that favor taking advantage of employer contributions "already in the system," state officials expressed concern about the program's feasibility and affordability, given the administrative complexity of operating the program (especially provisions requiring wraparound benefit coverage), and the variation in cost and coverage features across available private insurance packages.

- ***During the site visit data collection period, states had not struggled to finance the state share of SCHIP spending and, where strong political support existed, the fiscal outlook for the program was positive.*** With enhanced federal matching rates available, states were able to finance their share of SCHIP with a combination of general revenue appropriations and tobacco-settlement funds. Spending patterns varied considerably among the study states, with three fully expending their 1998 allotments, two states spending high proportions of their allotments, two states spending at the median national rate, and three spending way below the median. There were no consistent characteristics to explain high rates of spending, although the fact that New York had a large preexisting children's health insurance program, and that Missouri had a demonstration program ready to implement, may help explain why the programs experienced relatively higher rates of enrollment and, therefore, spending. But low spending (relative to allotments) was attributed to a combination of factors, including overestimation of the number of SCHIP eligibles in the state (leading to the allocation of larger-than-needed allotments), low per capita expenditures, low rates of enrollment, and late program starts.

  In the states visited between May and August 2001, future state funding for SCHIP was perceived to be secure in the states where programs enjoyed strong political support (such as in New York, California, Texas, and, to a lesser extent, Louisiana). The future was somewhat cloudier in states where less political commitment was evident, such as Colorado and Missouri. In addition, officials in half the study states were concerned about whether the federal government would continue to support SCHIP at current levels. In the states visited between November 2001 and January 2002 (Florida, Illinois, New Jersey, and North Carolina), shortfalls in state budgets had begun to emerge which led to a much great level of concern among policymakers regarding the availability of future funding. However, in these four states, none of our informants predicted immediate budget cuts, and the programs still enjoyed strong political support.

- ***States with separate programs faced considerable challenges in coordinating the Medicaid and SCHIP programs.*** In many cases outreach, enrollment and service delivery are well-coordinated between the programs. But four states were still facing serious challenges in coordinating their enrollment process, and differences remain between the service delivery systems in most states.

The evidence to date is that SCHIP is a successful program. It is popular among legislators, advocates, and providers. The program is becoming well known among consumers at least in part due to the aggressive mass-media and community-based outreach that states have conducted (though some families are harder to reach than others). Enrolling in the program is simpler than enrolling in Medicaid, as a result of states' extensive simplifications efforts, and Medicaid enrollment may also be getting easier as SCHIP policies are "imported" to Medicaid. Families' access to primary medical care, once they are enrolled, is thought by key informants to be good (though access to dental care and specialty services in not very good). To date, providers appear more willing to participate in SCHIP than they are in Medicaid, although lower payment rates than they would like may result in lower participation in the future. Although worsening economic and budget conditions in the states may have negative consequences for SCHIP, it appears that, at least for the short term, the future of the program is secure.

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APPENDIX A

OVERVIEW OF THE EVALUATION’S CASE STUDY METHODS

The case studies comprised a series of site visits for the purpose of interviewing key informants involved with the SCHIP program. Protocols were developed to collect information about the structure of and changes in the program. The core protocol, used for interviewing state SCHIP and Medicaid program administrators, contained questions about outreach, enrollment, crowd-out, benefits, service delivery, cost-sharing, family coverage and premium assistance programs and financing. Five shorter protocols were developed for interviewing governors and state legislative staff, child and family advocates, state and local outreach and enrollment staff, health plan officials, health care providers, and Medicaid eligibility staff. The protocols were reviewed and revised following completion of two "pilot" site visits to New York and Louisiana.

By October 2001, 6 of the 10 site visits had been carried out. Teams of two individuals visited each of the states—California, Colorado, Louisiana, Missouri, New York, Texas—for five days, accompanied by a federal official from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) (see Table 16).[60] The site visits occurred between late May and late August of 2001, and resulted in detailed state site visit reports based on the information gathered. The remaining visits—to Florida, Illinois, New Jersey, and North Carolina—took place between November 2001 and January 2002.

Between 15 and 21 interviews were carried out in each state, with between 40 and 50 state and local officials. Each site visit started in the state capital with a large meeting of state SCHIP and Medicaid administrators. Included in the meeting, generally, were the SCHIP and/or Medicaid director(s) and program staff responsible for outreach, eligibility and enrollment,

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[60]The case studies, under the leadership of The Urban Institute, drew their teams from both the Institute and Mathematica. To ensure that the two organizations followed consistent procedures, a researcher from Mathematica accompanied the Urban Institute on the initial pilot site visit to New York; likewise, the lead researcher from The Urban Institute joined Mathematica during its pilot visit to Louisiana.

benefit package design, service delivery systems and managed care, and data collection and monitoring.

TABLE 16: STUDY STATES AND DATES OF SITE VISITS

State	*Dates of site visit*
California	8/16/01 - 8/22/01
Colorado	7/23/01 - 7/27/01
Missouri	6/25/01 - 6/29/01
Louisiana	6/11/01 - 6/15/01
New York	5/29/01 - 6/4/01
Texas	6/25/01 - 6/29/01
Florida	11/26/01 – 11/30/01
Illinois	11/5/01 - 11/9/01
New Jersey	January 2002
North Carolina	12/3/01 - 12/7/01

The following afternoon and subsequent day were spent in the capital, interviewing informants with state-level concerns, responsibilities, and perspectives, including state legislators and their staff; the governor's staff; state public health officials; provider associations; health plan associations; and private sector vendors under contract with the state to perform various administrative functions.

After spending two days in each state's capital, we spent three days in two to three local communities. During this time, we interviewed key informants representing the following groups: providers, child and family advocates, health plans, local Medicaid eligibility offices, outreach workers, and community-based application assistance staff.

Each local area that we visited is described in Table 17. The selection of each local area took into account a series of factors, including: urban/suburban/rural status, rates of SCHIP enrollment, ethnic and immigrant populations, and the degree of success of SCHIP implementation.

TABLE 17: CHARACTERISTICS OF LOCAL AREAS VISITED

State	Local Area	General Description	% State Population	% SCHIP Enrollees	Ethnicity/Race
California	Los Angeles City	Largest city in the state with the highest concentration of eligible uninsured and enrolled children	11%	30.5%	Multicultural 46% Hispanic Also high Southeast Asian population
	San Bernardino County	One of the most populous and fastest-growing regions in the state, east of Los Angeles, comprising several large cities and low-income suburban and desert communities	5%	6.7%	39% Hispanic
	Kern County	A rural region in the San Joaquin Valley which includes the city of Bakersfield	1.95%	12.5%	38% Hispanic, including migrant farmworkers
Colorado	Denver	State's capital and largest city	13%	18%	
	Six-county San Luis Valley	Rural south-central Colorado; Poverty rate 2-3 times the state average		5%	~ 50% Hispanic
Florida	Broward County	Second most populous county in Florida, which contains Ft. Lauderdale, the state's fourth largest metropolitan area.	10%	13%	18% Black, 16% Hispanic
	Okeechobee County	Rural area	0.2%	0.4%	82% White, 16% Hispanic
Illinois	Cook County, City of Chicago	Largest city in the state, high concentration of KidCare enrollees, 10% of children are uninsured	43%	48%	Multicultural, large Hispanic and African-American neighborhoods
	DuPage County	Very large, wealthy suburban county, outside of Chicago. Only 5.6% of children are below poverty, but there is a growing immigrant population.	7%	3%	Growing immigrant and Hispanic populations,
	Macon County	Rural county with high poverty rates, manufacturing is the dominant industry. Unemployment is high, 5.3% in 2001, and increasing.	1%	1%	Nearly 25% African American.
Louisiana	New Orleans	Major urban area	11%	12%	Multicultural 67% Black; 3.1% Hispanic 2.6% Asian
	3 towns in Thibodaux region: Houma Thibodaux Franklin	Primarily rural area comprised of seven bayou parishes. Population 30,000 Population 14,000 Population 9000, poorest area	9%	9%	>30% Cajun

TABLE 17 *(continued)*

State	Local Area	General Description	% State Population	% SCHIP Enrollees	Ethnicity/Race
Missouri	St. Louis City	Major urban center	6%	7.4%	51% White 48% Black
	St. Louis County		18%	18%	84% White 14% Black
	Cape Girardeau County	Rural area	1.23%	1.3%	94% White 5% Black
New Jersey	Hudson County	12 contiguous municipalities in the northeast corner of the state	7%	12%	14% African American, 40% Hispanic
	Cumberland and Gloucester Counties	Agricultural area in the southwest corner of the state	5%	6%	Cumberland: 20% African American, 19% Hispanic Gloucester: 9% African American, 3% Hispanic
New York	New York City	City with highest concentration of uninsured children and program enrollees in the state	42.20%	58.70%	27% Hispanic
	Syracuse	Medium sized city in Onondaga County in central New York	2.42%	1.71%	2.4% Hispanic
	Cortland County	Rural area in the south-central upstate region	0.26%	0.23%	1.16% Hispanic
North Carolina	Durham County	Urban area including the town of Durham	3%	2%	40% African American
	Henderson County	Rural county; retirement community with service economy	1%	1.4%	4% minority, mainly Hispanic
	Duplin County	Very rural county; agriculture is main industry	1%	1%	32% minority, growing Hispanic pop.
	Guilford County	Urban area including the cities of Greensboro and High Point	5%	4%	Diverse mix of immigrant groups, only 4% Hispanic.
Texas	Dallas	Large city in north-central Texas	5.7%		35% Hispanic
	Waco	Mid-sized city of around 114,000	0.5%		24% Hispanic
	San Antonio	Large city in south-central Texas	5.7%		58% Hispanic, plus undocumented immigrants