New Federalism
Issues and Options for States
An Urban Institute Program to Assess Changing Social Policies
THE URBAN INSTITUTE
Series A, No. A-65, June 2004

SCHIP
State Children's Health Insurance Program Evaluation

Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis

Ian Hill, Holly Stockdale, and Brigette Courtot

In the aftermath of the FY 2004 budget cycle, SCHIP's glass is either half full or half empty, depending on one's perspective.

At the beginning of 2003, nearly every state in the nation was facing its third straight fiscal year budget deficit. According to the National Conference of State Legislatures, states confronted a combined budget deficit of $78.4 billion in fiscal year 2004 (NCSL 2004). Early in the economic downturn, states closed gaps using reserves, special "rainy day" funds, budget and accounting maneuvers, and tobacco settlement funds. But increasingly, states have had to make real program cuts to address budget shortfalls. During fiscal year (FY) 2003, 40 states—the most in recorded history—made either across-the-board or selective program cuts totaling $11.8 billion (NGA and NASBO 2003). Few state programs were immune to cuts; even such high-priority programs as Medicaid, K–12 education, higher education, and public safety were reduced in most states.

But how has the State Children's Health Insurance Program (SCHIP)[1] fared during these difficult times? To answer this question two years ago, we interviewed SCHIP administrators and other state officials in 13 states as part of our multiyear SCHIP evaluation conducted under the *Assessing the New Federalism* (ANF) project.[2] We found that SCHIP had largely "dodged the first budget ax" in FY 2002: only one state had reduced eligibility thresholds under the program (for parents, not children); no states had cut benefits (while four states actually expanded coverage of such critical services as dental care); only two states had raised cost sharing; and only one state had cut provider reimbursement. The one program area where a significant number of states had reduced spending—roughly half of the 13 states we studied—was outreach (Howell, Hill, and Kapustka 2002).

State officials explained why SCHIP seemed largely immune to significant cuts, citing its strong popularity among consumers, providers, and politicians; the fact that it was small and inexpensive (relative to Medicaid) and not an entitlement (making it a program that policymakers felt they could "control"); its high federal matching rate (making it a less attractive target for cuts); and its success at its critical objective—insuring low-income children. But these same officials hinted that continued fiscal pressures could result in future cuts to SCHIP.

Given states' ongoing budget difficulties, it was important to repeat our survey last year and update our understanding of how SCHIP programs were affected. Telephone interviews with state SCHIP officials conducted during September and October 2003 found that the program was indeed suffering more severe cutbacks than during 2002. Highlights (or lowlights) include the following:

Resource Id # 5669
Squeezing SCHIP: States Use Flexibility To Respond To The Ongoing Budget Crisis

TABLE 1. Characteristics of SCHIP Programs and Financing in Assessing the New Federalism States

State	Program type	Children enrolled June 2002	Children enrolled June 2003	Change (%)	Financing sources
Alabama	S	53,135	60,383	14	General revenue and tobacco settlement funds
California	C	606,546	720,044	19	General revenue and tobacco settlement funds
Colorado	S	43,679	53,118	22	Designated fund; funded by general revenue and tobacco settlement funds
Florida	C	246,432	330,866	34	General revenue and tobacco settlement funds
Massachusetts	C	50,094	56,261	12	Designated fund; funded by general revenue and cigarette taxes
Michigan	C	44,477	51,424	16	General revenue
Minnesota	M	23	19[a]	–17	Provider taxes
Mississippi	S	52,456	56,690	8	General revenue and tobacco settlement funds
New Jersey	C	95,468	92,170	–3	General revenue and tobacco settlement funds
New York	C	526,204	403,935	–23	Provider taxes
Texas	S	529,980	512,986	–3	General revenue and tobacco settlement funds
Washington	S	6,869	7,305	6	Designated fund; funded by provider, liquor, and tobacco taxes as well as tobacco settlement funds
Wisconsin	M	31,861	35,785	12	General revenue and tobacco settlement funds
Total	C: 6 M: 2 S: 5	2,287,224	2,380,967	4[b]	General revenue: 10 Tobacco settlement funds: 9 Other sources: 4

Source: Kaiser Commission on Medicaid and the Uninsured (2003) ("Program type"); Smith and Rousseau (2003) ("Children enrolled" 2002 and 2003 and "Change"); Campaign for Tobacco-Free Kids (2002) ("Financing sources").
C = combination; M = Medicaid; S = separate
a. Minnesota covered children up to 275 percent of the federal poverty level under its MinnesotaCare program when SCHIP legislation was passed, so few children are covered by SCHIP. Minnesota received an SCHIP waiver in 2001 that allows use of SCHIP funds to cover parents of children in MinnesotaCare.
b. National change was 7 percent.

actual cutbacks, especially in eligibility or benefits. In interviews, officials relayed policymakers' reluctance to cut this popular program and emphasized that the need for SCHIP (and Medicaid) was heightened during an economic downturn. But last year a distinctly different picture emerged. During 2003, every state in our sample except New York enacted at least one program cut, indicating that severe budget distress is taking its toll on SCHIP. Cuts were made most often in eligibility, enrollment simplification, cost sharing, and provider reimbursement. Additionally, the majority of officials reported that most, if not all, state money for outreach had been eliminated. On a more positive note, most states continue to work on simplifying their enrollment procedures, and the majority of states have either preserved, or even expanded, their benefit packages.

Table 2 summarizes policy changes in the ANF states in 2003. In

real step backward. Fiscal pressures in one-third of our study states were apparently severe enough in 2003 to persuade policymakers to take those backward steps. Specifically,

- Three states—Minnesota, Texas, and Washington—reduced continuous eligibility guarantees from 12 months to six;
- Washington discontinued its policy of allowing families to "self declare" their earnings, and has reverted to requiring parents to submit income verification as part of the application process;
- Texas added an assets test to the eligibility determination process for children in families with incomes over 150 percent of FPL, and Minnesota established a new, uniform assets limit for children stricter than the previous SCHIP limit, but more generous than the Medicaid limit; and
- Massachusetts reduced the amount of time that enrollees have to submit their renewal applications from 60 days to 30.

Despite these setbacks, two-thirds of the study sample actually simplified their enrollment processes. For example,

- Florida, New Jersey, and New York redesigned their SCHIP applications to make them easier, more readable, and more user-friendly;
- Alabama, Michigan, and Washington started preprinting their renewal applications for SCHIP enrollees; and
- Five states continue to develop electronic applications for the coming year (Florida, Massachusetts, Michigan, New Jersey, and Texas).

Of particular note, New York took a number of steps to further simplify the renewal process for children enrolled in Child Health Plus and Medicaid. First, the state simplified its renewal application form. Second, it eliminated the face-to-face interview requirement for renewals under Medicaid. Finally, in an unprecedented move, New York implemented "presumptive eligibility" for SCHIP renewals. Under this policy, if a family submits an incomplete renewal package but appears otherwise eligible, the state will continue to cover the child (presuming he or she is still eligible) until a complete package is submitted for review.

California, despite eliminating all funding for outreach over the past two years, began phasing in two new initiatives that promise to significantly streamline entry into the state's Medi-Cal and Healthy Families programs. The first, "express lane eligibility," will use information gathered on the federal Free and Reduced Lunch Program application to complete children's Medi-Cal applications. The second, "CHDP Gateway," will allow uninsured children who receive check-ups through the state's Child Health and Disability Prevention (CHDP) program to be "pre-enrolled" into two months of temporary Medi-Cal/Healthy Families coverage while CHDP providers complete and submit a formal application on their behalf.

Outreach

By our second survey, most ANF states had virtually eliminated outreach funding. In 2002, a majority of states had begun reducing outreach spending, and Massachusetts, Washington, and Wisconsin had "zeroed out" their outreach budgets. Last year, officials in seven states described additional cuts in outreach during 2003 (Alabama, California, Colorado, Florida, Michigan, Mississippi, and Texas).

While Alabama, Mississippi, and Texas eliminated support for their mass media campaigns, the other states discontinued funding for community-based outreach that often involved assisting families with completing their SCHIP/Medicaid applications. In California, large cuts in 2002 saw the elimination of every outreach effort except its Certified Application Assistor (CAA) program. However, midway through 2003, the CAA program was de-funded as well. Colorado and Michigan eliminated similar application assistance fees. These cuts are likely to reduce enrollment significantly, as application assistance programs have been regarded as one of the more effective strategies for enrolling and retaining children in coverage (Cohen Ross and Hill 2003; Wooldridge et al. 2003).

Although outreach funding at the state level has been significantly curtailed, officials described several examples of ongoing outreach at the local level, without formal state funding. In Alabama, regional staff continues to encourage potential recipients to sign up for SCHIP and get on the state's new waiting list. In Colorado, outreach workers are conducting training sessions with hospitals and schools and providing some application assistance, albeit without receiving a fee. Mississippi officials describe working with local grantees of the Robert Wood Johnson Foundation–funded "Covering Kids and Families" program to promote SCHIP and Medicaid enrollment. Michigan is using its limited outreach funds to train local health departments on using the state's new electronic application. And Texas continues to provide grants to community-based organizations to support outreach for Medicaid and SCHIP.

Two states—Minnesota and New Jersey—escaped cuts to their outreach

TABLE 3. Modifications of Cost Sharing Requirements during FY 2003

State	Eligibility level affected	Premiums	Copayments
Alabama	133–150% of FPL	New annual fee—$50 per child/$150 family maximum	New copayments imposed on families ($0–$10 for pharmacy and medical services)
	151–200% of FPL	Increased annual fee from $50 per child/ $150 family maximum to $100 per child/ $300 family maximum	Increased copayments to families ($1–$20 for pharmacy and medical services)
Florida	133–200% of FPL	Increased monthly premiums for all families from $15 to $20 per family	Increased copayments for all families (from $3 to $5 for pharmacy and medical services)
Massachusetts	150–200% of FPL	Increased monthly premiums for all families from $10 per child/$30 family maximum to $12 per child/$36 family maximum	No changes
New Jersey	151–200% of FPL	Increased monthly premiums from $15 to $16.50 per family	No changes
	201–250% of FPL	Increased monthly premiums from $30 to $33 per family	
	251–300% of FPL	Increased monthly premiums from $60 to $66 per family	
	301–350% of FPL	Increased monthly premiums from $100 to $110 per family	
Texas	101–150% of FPL	New monthly premiums of $15 per family (previously annual premium of $15 per family)	Increased copayments for all families with incomes at 100% of FPL or above: office visit copay increases of $2 or $3, as well as increases to emergency room and pharmacy copays (increases vary by eligibility band, 100–150% of FPL band had no copays before this change)
	151–185% of FPL	Increased monthly premiums from $15 to $20 per family	
	186–200% of FPL	Increased monthly premiums from $18 to $25 per family	
Wisconsin	150–185% of FPL	Increased annual premiums from 3% of the family's net income to 5%	Increased pharmacy copayments for fee-for-service population (accounts for about 30% of Badgercare) from $1 ($5 maximum) to $3 ($12 maximum)

Source: Urban Institute telephone interviews with state SCHIP administrators.
Note: Native Americans are exempt from all cost sharing measures.

enrollees (earning between 133 and 200 percent of FPL). Texas, like Alabama, imposed new copayments on its poorest enrollees (earning below 150 percent of FPL), and increased copayments for all other families. Wisconsin increased pharmacy copayments from $1 to $3 for children in families with income between 150 and 185 percent of FPL enrolled in fee-for-service arrangements.

To reduce the number of families that disenroll owing to nonpayment of premiums, two states expanded payment options for families. In addition to the customary check or money order, Florida now accepts credit card

2003);[9] one more reduced its upper income eligibility threshold (Alaska, from 200 percent of FPL to 175 percent); four (Arizona, Connecticut, Indiana, and Nebraska) reduced continuous eligibility for children from 12 months to six (Ku and Nimalendran 2003); and seven instituted or increased premiums for children (Georgia, Kentucky, Maryland, Nevada, New Hampshire, Vermont, and Wyoming). While states were generally more likely to target adults than children, children will still be significantly affected by 2003's cuts to Medicaid, SCHIP, and other state health insurance programs. One group estimated that almost half of all persons losing coverage—490,000 to 650,000—would be children.[10]

On the other hand, some states continued to enhance their SCHIP programs in 2003, even in the face of severe fiscal pressures. Several states added coverage of pregnant women. The two states with the largest programs implemented or expanded innovative initiatives to streamline children's access to coverage. Two-thirds of states in our study took steps to further simplify enrollment. And as many states added benefits to their SCHIP packages as eliminated them.

So many states increasing cost sharing is clearly worrisome, given the potential for premiums and copayments to create barriers to enrollment and service use. Yet almost without exception, state officials said that they were confident that cost sharing increases would not cause serious problems for families. Why? First, the increases were quite small. (Indeed, most premiums increased by $5 or less per month, and most copayments were raised by just a dollar or two. Two exceptions were Texas and Wisconsin.) Second, the increases were, in many cases, the first imposed in the history of the program. This relative stability contrasts sharply with the private insurance sector, where premiums have increased at double-digit rates for several years running (Strunk and Ginsburg 2003). Finally, during the budget development process, proposed increases in cost sharing were described as the *least* controversial of the cuts being considered in children's health programs. Officials took comfort in this, seeing it as a reflection of stakeholders' (including child advocates') view that SCHIP cost sharing was still relatively affordable.

It is also important to consider how SCHIP fared relative to other state programs. Here too one might find at least a modicum of optimism. Recent studies have found that, during 2003, states most often targeted cuts at higher education, state workforce compensation, and aid to localities, among other programs (Holahan et al. 2004). These studies also documented states' increased willingness to aggressively cut Medicaid by reducing provider reimbursement, eliminating optional benefits, and reducing eligibility standards (Smith and Rousseau 2003). But Medicaid coverage for adults was the most common target, as the program was described as "a key component of [states'] efforts to balance their budgets" in fiscal year 2004.

Compared with other state budget cuts, SCHIP cuts were universally described by state officials as among the smallest, and last, cuts to be adopted. Indeed, these officials said that the program retained much of its political support and popularity, and used phrases such as "very painful" and "last resort" to describe how legislators felt about the SCHIP cuts. In 2002, we reported that one reason why SCHIP is so politically popular in states with separate programs is that, since it is not an entitlement, policymakers and state legislators have greater flexibility to control costs through the use of such strategies as enrollment caps, benefit cuts, and cost sharing increases (Howell et al. 2002). Clearly, more state officials felt compelled to make use of this flexibility in 2003. By the same token, policymakers may feel free to reverse some of these cuts when fiscal conditions improve.

Conclusions and Outlook

That SCHIP experienced serious cuts in the past year is indisputable. Equally indisputable is that the federal and state capacity to insure poor and near poor children remains strong, and certainly much stronger than it was in 1997 before SCHIP was created. All 50 states (and the District of Columbia) maintain SCHIP programs with upper income eligibility thresholds that average over 200 percent of FPL. Every state's application process can still fairly be characterized as simplified, using shortened forms that can be submitted by mail, requiring minimal verification, and guaranteeing coverage for at least six months. Nearly every state provides coverage of a comprehensive array of benefits, beyond minimum requirements of the Title XXI statute. And while cost sharing in separate programs is widespread, premiums and copayments in all states but one are set at levels well below the maximum permitted by federal law.

SCHIP's early success has been well documented. It has insured nearly 4 million children (Smith and Rousseau 2003) and, combined with Medicaid, helped reduce the rate of uninsurance among low-income children from roughly 23 percent to just over 17 percent (Dubay et al. 2002). Yet the program is certainly in transition, and fiscal pressures have led states to implement cuts that threaten to reverse these positive gains.

Hill, Ian. 2000. "Charting New Courses for Children's Health Insurance." *Policy & Practice* 58(4): 30–38.

Hill, Ian, Mary Harrington, and Corinna Hawkes. 2002. "Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Interim Findings from Six State Site Visits." Submitted to the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Princeton, NJ, and Washington, DC: Mathematica Policy Research and the Urban Institute.

Hill, Ian, Holly Stockdale, and Heidi Kapustka. Forthcoming. "State Cost Sharing under SCHIP." Washington, DC: The Urban Institute. *Assessing the New Federalism* policy brief.

Holahan, John, Randall R. Bovbjerg, Terri Coughlin, Ian Hill, Barbara A. Ormond, and Stephen Zuckerman. 2004. *State Responses to Budget Crisis in 2004: An Overview of Ten States.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Howell, Embry, Ian Hill, and Heidi Kapustka. 2002. "SCHIP Dodges the First Budget Ax." Washington, DC: The Urban Institute. *Assessing the New Federalism* Policy Brief A-56.

Kaiser Commission on Medicaid and the Uninsured. 2003. "State Health Facts." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Kenney, Genevieve, Jennifer Haley, and Alexandra Tebay. 2003. "Children's Insurance Coverage and Insurance Rates Improve." *Snapshots of America's Families III*, No. 1. Washington, DC: The Urban Institute.

Ku, Leighton, and Sashi Nimalendran. 2003. "Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP, and Other State Health Insurance Programs." Washington, DC: Center on Budget and Policy Priorities.

Westpfahl Lutzky, Amy, and Ian Hill. 2003. *Premium Assistance Programs under SCHIP: Not for the Faint of Heart?* Washington, DC: The Urban Institute. *Assessing the New Federalism* Occasional Paper No. 65.

The National Conference of State Legislators (NCSL). 2004. *State Budget Update: February 2004.* Denver: NCSL.

National Governors Association (NGA) and National Association of State Budget Officers (NASBO). 2003. *The Fiscal Survey of States.* Washington, DC: NGA and NASBO.

Pernice, Cynthia, and David Bergman. 2004. "State Experience with Enrollment Caps in Separate SCHIP Programs." Portland, ME: National Academy for State Health Policy.

Smith, Vernon K., and David M. Rousseau. 2003."SCHIP Program Enrollment: June 2003 Update." Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Strunk, Bradley C., and Paul Ginsburg. 2003. "Tracking Health Care Costs: Trends Stabilize but Remain High in 2002." *Health Affairs* Web Exclusive. http://www.content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.266v1.

Wooldridge, Judith, Ian Hill, Mary Harrington, Genevieve Kenney, Corinna Hawkes, and Jennifer Haley. 2003. "Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program." Washington, DC: The Urban Institute.

About the Authors

Ian Hill is a senior research associate with the Urban Institute's Health Policy Center, where he directs the qualitative component of the Institute's SCHIP evaluation and has developed a series of cross-cutting papers on states' implementation experiences under SCHIP.

Holly Stockdale is a research associate with the Urban Institute's Health Policy Center.

Brigette Courtot is a research assistant with the Urban Institute's Health Policy Center.