



**SCHIP**  
State Children's  
Health Insurance  
Program Evaluation

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

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

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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)<sup>1</sup> 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.<sup>2</sup> 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 chil-

dren); 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:

- While none of our study states actually reduced its upper income eligibility threshold, one state—Texas—did change its methodology for counting family income, effectively reducing its upper limit;
- Three states implemented enrollment freezes, placing thousands of children who would have previously been eligible for coverage onto waiting lists;
- Nearly one-third of states enacted changes in enrollment policies, which will make it more difficult for families to apply for SCHIP;
- Half the states raised cost sharing amounts for enrollees and/or imposed new cost sharing on families that didn't previously have to pay;
- Nearly half the states either froze or reduced reimbursement rates to providers serving SCHIP enrollees; and
- Most states discontinued support for outreach activities.

But not all the news was bad. Only two of the 13 study states reduced benefits for children; two-thirds of the study states reported new efforts to simplify enrollment and renewal procedures; and large states such as California and New York implemented innovative initiatives to enroll more children or dramatically expanded outreach spending. Perhaps most important, every state participating in the survey reported that SCHIP programs retained strong political support and fared quite well, relative to other state programs.

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

## SCHIP Programs in the ANF States

In its brief six-year history, the SCHIP program has dramatically affected uninsurance rates in the United States. Nearly 4 million low-income children were enrolled in the program as of June 2003, and rates of uninsurance among low-income children dropped from 12.6 percent to 10.1 percent between 1999 and 2001 (Smith and Rousseau 2003; Kenney, Haley, and Tebay 2003). Clearly, however, these important gains reflect the fact that SCHIP was implemented during a dramatic economic expansion; the early years of the program witnessed very rapid implementation by the states, as well as unprecedented investment in both outreach and enrollment simplification (Dubay, Hill, and Kenney 2002; Hill, Harrington, and Hawkes 2002). States generally implemented comprehensive benefit packages and imposed relatively low levels of cost sharing (Hill 2000).

These trends are certainly well represented by the 13 ANF states, which include the four SCHIP programs with the largest enrollment (California's, Florida's, New York's, and Texas's) and together account for nearly two-thirds of total SCHIP enrollment (CMS 2004). However, the study states differ from states generally in a number of important ways. First, more ANF states have "separate" SCHIP programs than is the case nationally (11 out of 13 versus two-thirds), meaning a larger proportion of ANF states are able to impose enrollment caps, benefit reductions, and cost sharing hikes. Second, the ANF states have higher than average eligibility thresholds: in 2003, while the national average upper income threshold for SCHIP was 212 percent of FPL, the ANF state average was 227 percent of

FPL.<sup>3</sup> Very few states cover parents of SCHIP enrollees, but three ANF states do (New Jersey, Minnesota, and Wisconsin). Finally, the ANF sample includes two of the three states whose programs were "grandfathered" into SCHIP because of their history as state-funded child health programs (Florida and New York). These last three characteristics may be significant, because they indicate that ANF states have historically had more generous coverage, and may have had a longer history of extending child health coverage to children ineligible for Medicaid, than states generally. As a result, ANF states may have faced even greater pressures on their state budgets in 2003, because of increased enrollment and expenditures. On the other hand, they may also be more resilient in the face of budget pressures, given their long-standing commitment to this vulnerable population.

Table 1 provides additional characteristics of SCHIP programs in the 13 ANF states, including recent enrollment figures and state and federal funding information.

## How Did SCHIP Programs Change during 2003?

In our interviews with SCHIP officials, we asked directors to describe the budget environments in their states and highlight any policy changes made in the areas of eligibility, enrollment, outreach, benefits, cost sharing, provider reimbursement, and crowd out. We concluded our discussions by focusing on whether SCHIP programs continued to enjoy high levels of political support (as had been the case in 2002) and how much that support may have protected the program from cutbacks.

In 2002, SCHIP administrators in the ANF states reported very few

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 <sup>a</sup>	-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 <sup>b</sup>	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 sam-

ple 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 out-

reach 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

TABLE 2. Changes Enacted or under Consideration in SCHIP

State	Eligibility/ Enrollment cap	Enrollment process	Outreach	Benefits	Cost sharing	Reimbursement rates	Crowd out
Alabama	-	+	-	+	-, +		+
California		+	-			-	
Colorado	-		-				
Florida	-	+	-	-	-, +		
Massachusetts	*	-, +			-	-	
Michigan	*	+	-				
Minnesota	*	-		+			
Mississippi			-				
New Jersey		+			-		
New York		+	+				
Texas	-	-, +	-	-	-	-	
Washington	*	-, +				-	
Wisconsin					-	-	-

Source: Urban Institute telephone interviews with state SCHIP administrators.

Key: - = Restrictions enacted

+ = Expansions enacted

\* = Expanded eligibility for pregnant women

the sections that follow, we discuss these changes in more detail.

### Eligibility

The most obvious way for states to reduce enrollment or control enrollment growth in a children's health insurance program is to cut eligibility. Even Medicaid programs have this flexibility, although once an upper income threshold for Medicaid is established, all children in families with incomes below that level are *entitled* to coverage. Separate SCHIP programs, however, are explicitly not entitlement programs. Like Medicaid, their eligibility thresholds are flexible, but SCHIP enrollment can also be capped if policymakers decide the budget can no longer sustain the program. While only one study state cut eligibility under SCHIP in 2002 (New Jersey, and for parents, not children), four states took such action in 2003. Texas enacted a de facto reduction in income thresholds. Three other states instituted enrollment caps. Specifically,

- Texas changed its income test from a "net" to a "gross" basis, eliminating all deductions from income and effectively reducing its upper income limit from 240 percent of FPL to 200 percent;
- Texas also imposed a 90-day waiting period before program benefits become effective for new enrollees;<sup>4</sup>
- Alabama capped enrollment in the AllKids program in October 2003 and by March 2004, approximately 11,500 children had been on the waiting list (Pernice and Bergman 2004);<sup>5</sup>
- Florida imposed an enrollment cap when Healthy Kids enrollment reached just over 271,000 children and had amassed a waiting list of over 100,000 children by January 2004, roughly 25,000 of whom were noncitizen children eligible for the state-only funded component of the KidCare program;<sup>6</sup>
- Colorado instituted its enrollment cap when enrollment reached

approximately 53,000 children; the state does not keep a waiting list.

While these cuts clearly signal a different, and negative, trend, it is worth emphasizing that the vast majority of states chose not to impose such drastic reductions. An equal number of study states (four) actually expanded eligibility under SCHIP during 2003, albeit not to children. Both Michigan and Washington extended eligibility to pregnant women with incomes up to 185 percent of FPL, Massachusetts expanded coverage to this population up to 200 percent, and Minnesota up to 275 percent.<sup>7</sup>

### Enrollment Procedures

In 2002, no ANF states were interested in making their enrollment procedures more difficult. Rather, state officials repeatedly told us that they were proud of their progress in simplifying SCHIP (and Medicaid for children) enrollment, and said that reversing this progress would be a

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

budgets. New York was the only state in our sample to actually increase funding for outreach. New York doubled funding of its “Facilitated Enrollment” program, which puts monies out to a large network of community-based organizations to support staff that help families enroll in Child Health Plus and Medicaid.

### Benefits

With two notable exceptions, states largely protected their SCHIP benefit packages in 2003. As in 2002, some states actually expanded their coverage. Alabama increased the maximum number of days it covers for substance abuse services, and liberalized its dental benefit (the state will no longer count the cost of preventive dental care against a child’s \$1,000 annual cap). Minnesota enhanced mental health benefits for at-risk children.

Two states reduced benefits for children, one more severely than the other. Florida imposed a new annual cap on its dental benefit; children will now be covered only for the first \$750 of dental care they receive, an amount that state officials reported would meet the needs of the vast majority of enrollees. Texas cut numerous benefits from its package, including dental, vision, chiropractic, home health, and hospice services, as well as benefits for eyeglasses and hearing aids. The state also tried to scale back its behavioral health coverage, but federal CMS officials judged that such a move would reduce Texas’s level of coverage below minimum benchmark standards. A modified behavioral health package was restored in February 2004 and the state is paying claims for services received back to September 2003.

New Jersey is the only other state in our sample that curtailed benefits, but did so for parents (not children) by shifting them into the state’s Plan D coverage, which is the most limited

package offered under Title XXI and places restrictions on dental, chiropractic, long-term care, and certain behavioral health services.

### Cost Sharing

SCHIP rules grant states with separate programs considerable latitude in designing cost sharing policies, and permit states to charge premiums, copayments, and coinsurance totaling no more than 5 percent of a family’s income. Until now, while states have made significant use of this cost sharing authority, they have rarely imposed cost sharing at levels anywhere near the federal upper limit. Most charge premiums, annual enrollment fees, and copayments at approximately 1 percent of family income (Dubay et al. 2002; Hill, Stockdale, and Kapustka forthcoming).

This pattern is apparently reversing. A majority of states in our sample increased their fees during the past year, and one imposed new cost sharing on the poorest families, which did not have to pay such fees previously. Specific changes are detailed below, and in table 3.

- Representing perhaps the largest increase, Wisconsin raised its monthly premium from 3 percent of family income (already the highest SCHIP premium in the nation) to 5 percent (the maximum allowed by law) for families with incomes between 150 and 185 percent of FPL.
- Alabama imposed a new annual fee of \$50 per child (\$150 per family maximum) on families with incomes between 133 and 150 percent of FPL. The state also raised its existing annual premium for families with incomes between 151 and 200 percent of FPL from \$50 per child (\$150 family maximum) to \$100 per child (\$300 family maximum).

- Florida raised its monthly premium by \$5, from \$15 to \$20 per family, for those earning between 133 and 200 percent of FPL.
- Massachusetts raised its premiums from \$10 per child per month/\$30 family maximum, to \$12 per child per month/\$36 family maximum, for families with income between 150 and 200 percent of FPL.
- New Jersey implemented a 10 percent across-the-board premium increase, raising its monthly premiums from \$15 to \$16.50 per family for those earning between 151 and 200 percent of FPL, from \$30 to \$33 per family for those earning between 201 and 250 percent of FPL, from \$60 to \$66 per family for those earning between 251 and 300 percent of FPL, and from \$100 to \$110 per family for those earning between 301 and 350 percent of FPL.
- Texas also dramatically raised fees for some of its lowest income enrollees. For families with earnings between 101 and 150 percent of FPL, the state switched from a \$15 per family *annual* fee, to a new \$15 per family *monthly* premium. The state also increased monthly premiums from \$15 to \$20 per family for those earning between 151 and 185 percent of FPL, and from \$18 to \$25 per family for those earning between 186 and 200 percent of FPL.<sup>8</sup>

States that raised premiums also tended to ratchet up copayments. Alabama imposed new copayments on the poorest enrollees (children in families earning between 133 and 150 percent of FPL) and raised existing copayments for families earning between 151 and 200 percent of FPL. Florida’s copayments for pharmacy and medical office visits increased from \$3 to \$5 for all Healthy Kids

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

payments over the Internet and via phone, 24 hours a day. Alabama plans to begin accepting credit card payments over the phone in 2004.

### *Provider Reimbursement*

Typically, provider reimbursement is one of the first places states turn when they need to reduce health program costs. But SCHIP has rarely seen reimbursement rate cuts. Our 2002 survey found that only one of the 13 ANF states reduced provider reimbursement in response to growing fiscal pressures.

Last year, however, nearly half the states in our sample reported either a rate freeze or rate cut to SCHIP providers. California and Wisconsin froze rates to participating health plans, Texas reduced its rates by 2.5 percent, and Massachusetts reduced its rates by 3 percent. Washington brought SCHIP capitation rates down to Medicaid levels by eliminating its \$8.00 “CHIP Kicker,” a payment adjustment that had been added to Medicaid capitation rates to compensate health plans for the expected higher cost of serving SCHIP enrollees.

### *Crowd Out*

Crowd out (substituting public health insurance coverage for private) was one of the most hotly debated issues during the development of SCHIP legislation. Concerns that SCHIP would crowd out children’s existing coverage led many states to include policies that discouraged families from dropping their private insurance. The most common policy was waiting periods, during which children must be uninsured before being allowed to enroll in SCHIP. Worries about substitution have apparently diminished among many state policymakers. An increasing number of states have either reduced or eliminated waiting periods, or added var-

ious exemptions to waiting periods for families paying high amounts for existing coverage (Wooldridge et al. 2003; Dubay et al. 2002).

States have rarely turned to their crowd out prevention policies to reduce program costs. This year, however, Wisconsin implemented a new policy requiring parents with employment to provide written documentation that they do not have an offer of health insurance at their place of employment. For those families that do have an offer, state officials will investigate whether it is more cost-effective to subsidize employer-sponsored insurance or enroll the family into direct coverage under BadgerCare. To date, enrollment in Wisconsin’s “premium assistance” program has been very low, as few families’ employer-sponsored coverage has met the cost-effectiveness test (Lutzky and Hill 2003). Therefore, it is hard to predict how much this policy will affect the make-up of the SCHIP program.

Notably, Alabama actually liberalized its crowd out policies in 2003. The state added an exception to its 90-day waiting period for children whose existing insurance is an individual policy or was obtained under COBRA arrangements, because of the typically high costs of such coverage.

### *Administrative Cuts*

We asked SCHIP officials if they have made cuts to their administrative budgets. Most said “yes,” but described these cuts as relatively insignificant and as not affecting SCHIP program operations. Only one ANF state (California) reported having to lay off staff, but many officials described how early retirement offers and hiring freezes that have left vacancies unfilled contributed to shrinking staffing levels. Officials from two states reported that attrition among senior staff and the resulting

loss of “institutional memory” were significant setbacks.

### **Is the Glass Half Full, or Half Empty?**

*On one hand*, it would be easy to review the findings from this survey and conclude that SCHIP is in trouble. Without question, cuts to SCHIP programs are more widespread than in 2002. In response to ongoing budget shortfalls, a third of the states in our study either reduced eligibility or capped enrollment, closing thousands of children out of coverage, at least for the time being. Most states have discontinued their outreach efforts, which means fewer families will be made aware of programs that can provide their children with health insurance. One-third of states reinstated application procedures that will make it harder for parents to enroll their children into SCHIP and Medicaid, likely suppressing enrollment even among eligible children. Two large states ratcheted back on benefits coverage, so some children will have to do without dental care and other services. Out-of-pocket expenses will increase for many families, as half the study states imposed new or increased cost sharing onto parents of enrolled children. Higher premiums may also result in more uninsurance among eligible children. And five states either reduced provider reimbursement or froze it at last year’s level (effectively cutting rates that didn’t keep up with inflation), which may undermine access to care depending on how providers react to the cuts.

Consistent with these findings, SCHIP programs beyond the ANF sample also scaled back their programs in the past year. Three more states froze enrollment under SCHIP by November 2003 (Maryland, Montana, and Utah) (Cohen Ross and Cox

2003);<sup>9</sup> 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.<sup>10</sup>

*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.

What the future will hold for SCHIP is uncertain. Bolstered by generous federal matching funds, the program appears to retain much of its political support, which continues to protect it relative to other state programs. State revenue projections are generally improving, creating hope that the worst of SCHIP's cuts are behind it. Yet federal Medicaid fiscal relief, which states acknowledge played a critical role in helping them avert deeper cuts, is due to expire in June 2004, and uncertainty over the adequacy of federal funding for SCHIP remains (Ku and Nimalendran 2003). More generally, it appears that the residual effects of three years of economic downturn, and state actions to cope with it (including the exhaustion of budget reserves and "rainy day" funds, the redirections of tobacco settlement dollars, and deep cuts to the state workforce and local aid) may last for a considerable time and weaken states' ability to recover quickly (Holahan et al. 2004).

Six years ago, federal policymakers made a critical commitment to promoting the health of children with the creation of SCHIP, and states followed suit by implementing generous programs quickly and aggressively. Time will tell whether governments will continue to maintain this commitment to our most vulnerable population.

## Notes

1. In August 1997, Congress enacted SCHIP as Title XXI of the Social Security Act, providing states with \$40 billion over 10 years to support expansions of health insurance to children ineligible for Medicaid.
2. The ANF states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.
3. UI analysis of state income threshold information, February 2004.
4. Some exceptions apply.
5. Nearly half of these 11,500 children had been removed from the waiting list and enrolled in coverage, as slots opened, by March 2004.

6. In March 2004, the Florida legislature approved \$25 million in new funding to allow KidCare to begin enrolling children from the waiting list. An estimated 90,000 children on the waiting list will receive coverage by April 2004. However, new rules will prohibit any new enrollees who are noncitizens into the state-only component, and will make ineligible any children whose parents have access to employer-sponsored insurance, unless the cost of dependent coverage exceeds 5 percent of family income. The new legislation will also limit future enrollment to two semi-annual open enrollment periods each year.
7. Technically, under Title XXI rules, expansions for pregnant women are for coverage of the "unborn child." Colorado implemented its SCHIP expansion for pregnant women in spring 2003—a policy approved by its legislature and federal officials in 2002—but chose to cancel its coverage in November 2003, when the enrollment cap for children was instituted.
8. Families at or below 100 percent of FPL (in Texas's SCHIP program as a result of immigration status or failing the state's Medicaid asset test) are not charged enrollment fees or monthly premiums.
9. Montana reopened enrollment in January 2004. Tennessee has also frozen enrollment for some children under TennCare, its Medicaid Section 1115 waiver program. In January 2004, California's governor announced that he would seek to impose an enrollment cap on the state's Healthy Families program during 2004.
10. Urban Institute internal data collection, December 2003.

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