

**“SCHIP Dodges the First Budget Ax”**  
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#### Overview of Findings

The five-year-old State Children’s Health Insurance Program (SCHIP), which currently benefits 3.8 million low-income children, faces its first real fiscal challenge as states contend with deficits surpassing \$36 billion in fiscal 2002.

What are the prospects for retrenchment of this joint federal-state endeavor? To answer that question, Urban Institute health policy researchers interviewed SCHIP administrators and other officials in 13 states during the summer of 2002. The study, part of the Urban Institute’s multiyear SCHIP evaluation being conducted by its *Assessing the New Federalism* (ANF) project, looked at how SCHIP is faring in Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.

The SCHIP budgets in almost all of these states, which together account for 64 percent of SCHIP enrollment, are under exceptional pressure because of deteriorating state circumstances, swift growth in SCHIP enrollment, or the lack of SCHIP funds carried over from earlier years.

SCHIP directors reported very few cutbacks, especially in eligibility or benefits, during the program’s first year under the budget ax. Only New Jersey, with a rapidly increasing enrollment and a large forecasted deficit, restricted eligibility—but the limitations applied to parents and not to children.

No state cut its benefit package in fiscal 2002. Colorado, Florida, Mississippi, and New York continued plans made prior to the budget squeeze to enhance their benefits, primarily for dental care.

On the other hand, many ANF states have reduced their outreach efforts, but this contraction reflects a perception in many states that there is less need to advertise a mature program.

New Jersey began raising its premiums in 2002 and Texas imposed additional co-payments on some services. Only one state, Minnesota, has cut, by 0.5 percent, reimbursement rates to health plans. Looking to the future, more states report they are considering cuts to SCHIP than are considering expansions.

SCHIP was found to be largely immune from significant cuts because:

- SCHIP is widely viewed as successfully addressing a vital need, bringing health coverage to uninsured children;
- SCHIP is not seen as overly costly, especially compared to Medicaid;
- Governors and legislators like programs they feel they can control, and the fact that SCHIP is generally not an entitlement reinforces this attribute;
- High federal match rates make it extremely difficult to justify major program cuts;
- No governor or legislator wants to cut a program that explicitly serves children, especially during an election year;

All this could change if state budget difficulties persist, enrollments continue upward, and congressional funding falters. For states that offer parental coverage, policymakers will likely look first at trimming coverage for adults. Reductions in SCHIP's services to children are likely to be minor initially, in the hope that the gains made by low-income children will not be reversed.

## **Background**

The State Children's Health Insurance Program is a relatively new program to provide health insurance coverage to low-income previously uninsured children and—in some states with waivers—their parents. The program was authorized as Title XXI of the Social Security Act in 1997 with joint federal and state funding. The federal financial contribution to the program is substantial, ranging from 65 to 84 percent of total program dollars depending on the state (Federal Register 2002). States have rapidly taken advantage of this new source of funding for health insurance. All states have implemented SCHIP, and, during the first quarter of calendar year 2002, about 3.8 million children were enrolled in the program (Centers for Medicare and Medicaid Services 2002).

Because SCHIP programs were initiated at a time of unprecedented economic expansion, with most states enjoying strong fiscal situations, states were able to invest in rapid expansion of their SCHIP programs. In addition, Title XXI afforded states considerable flexibility in designing their SCHIP programs, another factor that fueled its rapid adoption. States were given flexibility to set income eligibility limits up to 200 percent of the federal poverty level or higher, and to increase coverage either through the expansion of Medicaid or the creation of separate programs. States opting for separate programs were given additional flexibility to adopt more limited benefit packages than required for Medicaid; impose cost sharing at significantly higher levels than allowed by Medicaid; cap enrollment; and adopt various options to prevent SCHIP from crowding out existing private health insurance. Making extensive use of this flexibility, states have typically invested unprecedented resources in outreach and enrollment simplification; adopted benefit packages that are quite comprehensive; imposed relatively low levels of cost sharing; and used waiting periods (of six months or less) during which previously insured children must be uninsured before they are permitted to enroll in SCHIP.<sup>1</sup>

For the first time in the life of SCHIP, states are now facing severe economic difficulties. Forty-six states confronted budget deficits in fiscal year (FY) 2002, leading to a combined deficit of \$36.1 billion across all the states. State fiscal situations are expected to deteriorate even further in FY 2003 with combined deficits predicted to increase to \$57.9 billion (National Conference of State Legislatures 2002). In order to close these budget gaps states have been forced to use special “rainy day” funds, spend tobacco settlement funds in unplanned ways, raise taxes, or make cuts in programs.

During 2002 state budgets were particularly stressed due to the continued growth in Medicaid spending, which comprises more than 20 percent of all state budgets. According to the National Association of State Budget Officers (2002), Medicaid spending increased by 13.3 percent in FY 2002 and 10.6 percent in FY 2001. This compares to only 5 percent total state revenue growth between FY 2000 and FY 2002.

SCHIP is a much smaller program than Medicaid. At the federal level, total SCHIP expenditures were only \$2.7 billion in FY 2001, while federal expenditures for Medicaid were \$130.4 billion (Congressional Budget Office 2002). However, SCHIP spending continues to grow rapidly due to continued increases in enrollment. SCHIP expenditures increased by 45.7 percent from FY 2000 to FY 2001 (Kaiser Commission on Medicaid and the Uninsured 2002) and are forecast to grow by 74 percent from FY 2001 to FY 2005, a rate of growth that is substantially above the Medicaid forecast of 38 percent (Congressional Budget Office 2002). Consequently, although small in scale relative to some other state programs, growth in SCHIP also puts increasing pressure on state budgets.

### **SCHIP Programs in the ANF States**

As SCHIP passes its fifth birthday, we evaluated how the first economic recession since SCHIP implementation has affected political and financial support in 13 states. The study was

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<sup>1</sup> For a more detailed discussion of states’ use of program flexibility, see: Dubay, Lisa; Ian Hill; and Genevieve Kenney. 2002. *Five Things Everyone Should Know about SCHIP*. Washington, DC: The Urban Institute *Assessing the New Federalism* Policy Brief A-55.

conducted as part of *Assessing the New Federalism* (ANF), a multiyear Urban Institute project analyzing state social programs for low-income populations and how they have changed. During this larger project, which began in 1996, the health care programs of 13 states (listed in table 1) have been studied in depth. Among these 13 ANF states are the four largest states in terms of SCHIP enrollment—California, Florida, New York, and Texas—which together encompass over half of the nation’s SCHIP population. The 13 states account for 64 percent of total SCHIP enrollment.

SCHIP programs in the 13 ANF states differ in several distinct ways from other states. While roughly two-thirds of all states created separate programs (either alone or in combination with Medicaid expansions), 11 of the 13 ANF states have such programs. Second, the ANF states are more generous than the average state in terms of eligibility thresholds. While in 2002 the average income threshold for SCHIP nationally is 213 percent of the federal poverty level, it is 227 percent of poverty in the ANF states.<sup>2</sup> Very few states cover parents under SCHIP, but three ANF states do (New Jersey, Minnesota, and Wisconsin). In addition, two of the three programs in the nation that were “grandfathered” into SCHIP by virtue of their history as state-funded child health programs are included in the ANF sample (Florida and New York). In most other ways, however, the ANF states offer a representative cross-section of the nation’s SCHIP programs. Each has, similar to other states across the nation, aggressively conducted outreach, simplified enrollment, adopted generous benefits coverage, imposed cost sharing, and implemented various policies to prevent crowd out.

Almost all of the ANF states face pressure on their SCHIP budgets, either through severe pressure on their state budgets, rapid enrollment growth, or a lack of carry-over SCHIP funds from previous years (see table 1). Examining the ANF states’ experiences with SCHIP during calendar year 2002—just as FY 2002 has drawn to a close and the budget for FY 2003 has been finalized—will give a good indication of how SCHIP programs are faring nationally during a period of budgetary stringency.

Some characteristics of the 13 SCHIP programs in the ANF states are critical to understanding how state officials view their SCHIP budget situations (see table 1):

- Eleven of the ANF states have separate programs.<sup>3</sup> This is important from the point of view of state budgeting, since a separate program can be “capped” (for example, applicants can be put on a waiting list), while a Medicaid SCHIP program cannot be.
- Most ANF states have sources of funding for the state match that are outside the state general funding process. For example, 9 of the 13 states use tobacco settlement funds for some portion of the state match, and 5 use some other source, other than general revenue. Three states protect their SCHIP funds by placing them in special accounts. These

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<sup>2</sup> Data current as of September 2002. A state’s average income eligibility threshold for children was calculated by determining the income eligibility thresholds for children of each age up to age 19, summing the thresholds, then dividing by 19.

<sup>3</sup> In nine of the ANF states, the separate program is combined with a Medicaid expansion, although the Medicaid expansion portion of the combined programs is declining in size in most of the states.

additional sources of financing provide some protection from the competition for general revenue funds.

- All but three ANF states have experienced growth in SCHIP enrollment between FY 2001 and 2002, often very substantial growth.<sup>4</sup> The inclusion of parent coverage puts additional pressure on some of the programs.
- Four of the ANF states (Massachusetts, New Jersey, New York and Wisconsin) met or exceeded expected enrollment growth early in the program and spent their full federal allocation. (As a result, they received reallocated federal matching funds from other states.) With growth continuing in three of these four states, they do not have the cushion provided by rollover funds from previous unused federal SCHIP money that other ANF states have.

We explored whether the ANF states have adopted any cost-cutting strategies for their SCHIP programs to address their budget difficulties. To do so, during the summer of 2002 we conducted interviews with SCHIP administrators in each state, interviewing both the directors of SCHIP programs and others that they chose to include. The interviews took about 45 minutes and covered the following topics:

- The state's overall budget situation at the time of the interview (in most cases the FY 2003 budget was final or close to final);
- Changes to SCHIP in response to the budget situation that have either been enacted in 2002 or are under discussion;
- (Briefly) changes in other health programs, particularly Medicaid;
- Their assessment of how SCHIP is faring relative to other programs in the state and why.

Since we did not interview the Medicaid director (unless they also direct the SCHIP program), we could not get a complete or detailed picture of proposed and enacted Medicaid changes.<sup>5</sup>

### **How Have State SCHIP Programs Changed During 2002?**

As states struggle to address budget shortfalls and consider ways to reduce health spending, a number of policy strategies are available for modifying the SCHIP program. Such approaches have been used for many years to manage Medicaid spending, although each can have serious consequences for access to health care. For example, states can:

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<sup>4</sup> From FY 2001 to 2002 older children in combination programs began to be covered by Medicaid rather than SCHIP, due to the phasing in of mandatory Medicaid eligibility levels, explaining a leveling off or decrease in SCHIP enrollment in some states.

<sup>5</sup> This topic is being studied further in an Urban Institute study in 7 of the 13 ANF states.

- Restrict eligibility requirements, thereby making fewer children (or parents) eligible for a program, or cap enrollment at current levels.
- Institute more complex enrollment or re-enrollment procedures that result in fewer families successfully completing the enrollment process.
- Reduce the amount or intensity of outreach they perform, calling less attention to the program and, thereby, reducing rates of enrollment.
- Cut back on the benefits that a program covers or impose tighter limits on services.
- Adjust cost-sharing rules in an attempt to either reduce enrollment (by raising monthly premiums) or utilization (by imposing higher copayments).
- Reduce reimbursement rates to health plans and providers.

Another possible outcome of pressure on states to control spending is that policymakers may decide to forego planned expansions of coverage or services. California serves as a case in point. In January 2001, California received a waiver to cover some of the parents of SCHIP enrollees. However, despite widespread support for the initiative, Governor Gray Davis vetoed the portion of the state's budget that would have extended funding for parental coverage in September 2002, citing the need to reduce overall state spending.<sup>6</sup>

During their first year facing severe budget stringency, SCHIP administrators reported very few actual cutbacks, especially in eligibility or benefits. In our discussions, officials voiced a reluctance to cut this popular program and emphasized that the need for SCHIP (and Medicaid) was heightened in the aftermath of September 11 and the economic downturn. Only New Jersey—a state with rapidly increasing enrollment and a large forecasted deficit (table 1)—restricted eligibility, although only for new parents and not children. While states report that they are continuing to simplify their enrollment processes, many of them have reduced spending on outreach for the program; these reductions in part reflect their perception that there is less need to advertise a mature program.

No state cut its SCHIP benefit package. In fact, counter to what one might expect during a period of tight budgets, some states report a recent increase in program benefits. However, these enhanced benefits (primarily for dental care) reflect policy changes from prior years that were being implemented this year. Looking to the future, more states are considering cuts to SCHIP than are considering expansions.

Table 2 shows the major changes that have been enacted by SCHIP programs in 2002, as reported by program staff in the 13 ANF states. The table categorizes the changes according to whether they concerned:

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<sup>6</sup> During site visits to California in the summer of 2001, conducted as part of a national evaluation of SCHIP, virtually all of those interviewed were excited by the prospect of adding parental coverage and believed it would be passed by the legislature and signed by the governor (Hill and Hawkes, forthcoming).

- **Eligibility** (the rules that govern who is eligible for the program);
- **The enrollment process** (the procedures for enrolling in it);
- **Outreach** (programs that advertise the program or provide assistance in enrolling in it);
- **Benefits** (what services are covered);
- **Cost sharing** (whether the beneficiary pays a portion of the cost); and
- **Reimbursement rates** (rates paid to providers or health plans).

**Eligibility.** One aspect of SCHIP that some state policymakers welcomed from the onset of the program is that SCHIP is not an entitlement. In a separate SCHIP program, in contrast to Medicaid, a state has the flexibility to control program growth through a limit on the number of people enrolled. When states began facing budget hardships, some advocates for the program were concerned that states might restrict SCHIP eligibility as a means of controlling their SCHIP budget.

The only ANF state that has restricted SCHIP eligibility this year is New Jersey, which capped enrollment for parents. The restriction applies only to parents who are new applicants, and does not affect eligibility for parents who are already enrolled. None of the ANF states enacted such restrictive measures for children. Two states—Alabama and Washington—are discussing the possibility of enrollment caps for children, but no firm proposals are as yet in place. For example, Washington has considered capping enrollment at its budgeted level of 7000 children and forming a waiting list for new applicants. Two states have actually expanded or plan to expand in small ways the number of parents and children who are eligible for SCHIP. Colorado is waiting for approval for its waiver to cover pregnant women between 133 and 185 percent of the poverty level, and Wisconsin has expanded its premium assistance program.

**Enrollment Process.** We also found that states are not interested in making their enrollment processes more difficult, and some continue to simplify them. These changes could lead to increased enrollment. Officials feel that they have made great progress in simplifying enrollment, and that to reverse course is a mistake that could undermine the good will the program has built.

In several states, enrollment processes are actually being further simplified. For example, California officials will allow uninsured children who are screened by the state’s Child Health and Disability Program to be “pre-enrolled” in SCHIP while a formal application is submitted. In New York, several similar measures are being considered, including eliminating the requirement for a face-to-face interview at enrollment renewal; adding a grace period for renewal application submission; and a simpler joint application form. Colorado plans to implement presumptive eligibility for the pregnant women it will cover. Florida has recently taken an array of steps to

streamline the enrollment process, such as adding an on-line application. None of the states we interviewed is considering changing its waiting period for enrollment. Only one state has modified its enrollment process in a way that could possibly deter enrollment; Massachusetts no longer sends a reminder notice at renewal.

**Outreach.** While the ANF states have not yet restricted their SCHIP program eligibility or enrollment policies in large ways, we did find that a majority of them are reducing, or considering reducing, outreach spending. States reported several types of reduced SCHIP outreach efforts. For example, California has eliminated funding for mass media campaigns and its outreach grants to community organizations. (Funding was retained, however, for the state's toll-free hotline and the Certified Application Assistance program, under which community organizations are paid a \$50 fee for every child they help to successfully enroll in the program.) In Florida, Minnesota, Mississippi, New Jersey, Texas, and Washington, outreach efforts are also being curtailed to varying degrees. Examples of these include reductions in the budgets for mass media (New Jersey), printing of brochures and other materials (Minnesota), and community outreach grants (Washington). State officials in Alabama and Massachusetts anticipate reductions in outreach spending in the near future. At the same time, New York has increased outreach spending this year in anticipation of its new (non-SCHIP) family coverage expansion.

Some states—such as Florida, Alabama and Texas—have reduced or plan to reduce outreach. They do not view this as a budget strategy, saying instead that intensive outreach for a mature program is no longer necessary. For example, one official in Florida stated: “We’ve achieved an 85 percent name recognition with Healthy Kids, so widespread outreach is less necessary.” The long-term plan in Texas has always been to reduce state-funded outreach and emphasize community-funded outreach, once the state reached its enrollment target of 485,000 children (which occurred in 2001).

**Benefits.** In the case of SCHIP benefits, we found that none of the 13 states have eliminated benefits, and four states expanded program benefits during 2002. Colorado and Florida substantially enhanced their SCHIP programs by adding dental benefits, and Mississippi improved its existing dental coverage. New York added emergency transportation and hospice benefits. Separate SCHIP programs may or may not offer such benefits, because these services are often not in the benchmark plans the states must mirror in setting their benefit policies. States that do offer dental benefits find that they are extremely popular due to the heavy unmet need for this service among low-income children. It is important to note that the movement toward covering dental care began in these states some time ago, so implementing the benefits this year was the result of a longer process initiated before the states’ budget difficulties began. For example, Colorado and Florida were the only states not offering dental coverage in an earlier 18 state study of SCHIP dental benefits, and Mississippi’s benefits were more restrictive than most states (Almeida, Hill, and Kenny 2001).

Two states (Wisconsin and New Jersey) reported that they might consider reducing SCHIP benefits. Wisconsin may do so if the state’s budget situation continues to deteriorate; however, there are no specific proposals under consideration. New Jersey has proposed to change the benefit package for parents to a package with more limited benefits, similar to private coverage.

**Cost Sharing.** Cost sharing under SCHIP can come in the form of annual enrollment fees, premiums, or copayments at the time of service delivery. Five states are either considering or have imposed increased cost sharing, which can affect program costs either through deterred enrollment (in the case of enrollment fees or premiums) or reduced use of services (in the case of copayments). In March 2002, Texas began imposing additional co-payments on some services. The impetus for these changes did not come from a desire to raise additional revenues, but rather from a stated desire to reduce unnecessary services. For example, the lowest-income families (below the poverty level) are now charged \$3 for each emergency room visit and \$3 for each brand name drug prescription. Copayments rise by income level to the point where the highest income families (186-200 percent of poverty) now pay \$50 per emergency room visit and \$20 per brand name drug prescription, in contrast to previous levels of \$35 per emergency room visit and \$10 per brand name drug. New Jersey has proposed raising premiums annually according to the growth in inflation. Program staff said that this decision was made with the view that SCHIP is based on a private-sector model where premiums rise annually. The 10 percent increase this year is viewed as a “catch-up” process, since premiums had not been raised before; growth in them will likely be less in future years.

Three states—Alabama, Massachusetts, and Washington—are considering increasing cost sharing as a cost containment strategy. For example, Massachusetts proposes to increase premiums for families between 150 and 200 percent of poverty, although the level of the increase has not been determined. Washington is proposing to impose a premium for all families above 100 percent of the poverty level. The premium for families above 200 percent of the poverty level would increase from \$10 to \$20 per child per month. Washington would also increase drug copayments and add an emergency room copayment.<sup>7</sup>

**Reimbursement Rates.** The final cost containment strategy we investigated is reduced provider rates. The states with which we spoke are resisting this method of cost containment for SCHIP at the present time. Only one state has cut reimbursement rates for SCHIP; Minnesota reported that it has cut reimbursements to health plans by 0.5 percent. Since each year states must consider whether to increase or reduce provider fees, if rates are not raised for inflation or kept on par with private sector rates, there is a risk that access to care will deteriorate. It is too early to tell whether the more subtle cost containment strategy of a slow erosion in provider fees will be characteristic of SCHIP programs, as it has been for many Medicaid programs over the years.

### **Why Is SCHIP Resilient?**

During the first year of severe budgetary stringency since the program began, SCHIP has been, to a large degree, protected from the budget ax. The major program reductions that were most consistently reported were in the area of outreach, and some of these changes were reported to be due to program maturity rather than budgetary considerations.

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<sup>7</sup> The state has also applied for a waiver to impose the same copayments for Medicaid in order to retain consistency between the two programs.

At the same time, several important program expansions were reported during 2002. While it is surprising that states would expand programs in a year of budget difficulty, it is important to note that most of these expansions were in the works prior to the onset of the recession. Still, the popularity of SCHIP made legislators and program staff reluctant to derail important planned expansions.

The lack of major cuts in SCHIP stands in sharp contrast to the situation faced by other state agencies (health and nonhealth), many of which have taken large cuts both in direct program costs and administrative costs. For example, Mississippi's Department of Human Services (which administers welfare programs) announced a possible 25 percent cut in administrative staff for FY 2003. Medicaid is also being targeted for program savings in most states, although the state officials with whom we spoke said that proposed Medicaid cuts usually will affect adults, rather than children.

Among our 13 states, SCHIP programs were found to be spared from significant cuts despite the fact that these states were generally facing the toughest economic conditions and largest budget deficits they had seen in over a decade. The reasons given for this resilience were numerous and consistent among the various state officials, for instance:

- SCHIP is widely viewed as addressing a vital need and, as the number of uninsured children falls in many states, it is perceived as working well to achieve its primary goal.
- SCHIP programs in most states are small in relation to Medicaid. Therefore, they are not seen as overly costly.
- Governors and state legislators like programs that they feel they can control, and the fact that SCHIP is not an entitlement (in states with separate programs) reinforces this attribute. This leads to a more positive program image but not, to date, to significant use of capped program enrollment.
- A high federal match rate makes it extremely difficult to justify significant program cuts, especially as the increased cost of caring for uninsured children is likely to lead to increased state-only expenditures.
- No governor or legislator has wanted to cut a program that explicitly serves children, especially during an election year.

We also found that many of the points outlined above apply to the Medicaid programs in the ANF states, at least with regard to their coverage of children. However, because of the large size of Medicaid, it cannot be ignored in the budget process to the degree that SCHIP has been to date.

## **Conclusion**

As states enter fiscal year 2003, the budgetary stringency that they faced in FY 2002 continues and deficits are predicted to increase. The ANF states did not use cuts in their SCHIP

programs during the most recent fiscal year to save money in any substantial way. This continues a pattern reported earlier by Fox, Reichman, and McManus (2002) for previous years in a larger group of states. It is important to emphasize that the ANF experience may not be entirely representative of the national pattern, and indeed several smaller non-ANF states have taken more stringent approaches (Ornstein 2002).

If state budget difficulties continue into another fiscal year, SCHIP (and its parallel program, Medicaid, which covers more poor children) could become subject to the budget ax in more ANF states. Indeed, at this point more states are considering program restrictions than are considering expansions. This is due to several factors including continued program enrollment growth and an uncertain picture regarding future federal funding. (See Dubay, Hill, and Kenney, 2002, regarding the impact of the “SCHIP Dip” on available federal funds.) Observing patterns in some of the more mature and generous programs—such as those in New Jersey and Washington which have begun cutting their programs in several ways—suggests that states with parental coverage will first examine their coverage of adults and cut those benefits before cutting benefits for children. States that do modify their SCHIP programs for children are likely to make minor modifications first, in the hope that recent gains in access to care for low-income children will not be reversed.

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**Table 1**  
**Characteristics of SCHIP Programs and Financing in Study States**

State	Type of SCHIP Program <sup>1</sup>	Number of Children Enrolled FY 2002 (Q2) <sup>2</sup>	Percent Increase in Enrollment FY 2001 to 2002 <sup>2</sup>	Sources of SCHIP Financing <sup>3</sup>	Received Reallocated SCHIP Funds <sup>4</sup>	Forecast of FY 2003 State Budget Gap as Percent of General Fund Budget <sup>5</sup>
Alabama	Combination	47,779	43	General revenue and tobacco settlement funds	No	0.4
California	Combination	616,370	33	General revenue and tobacco settlement funds	No	28.0
Colorado	Separate	43,609	43	Designated fund; funded by general revenue and tobacco settlement funds	No	7.0
Florida	Combination	273,952	28	General revenue, tobacco settlement funds, and local matching funds	No	0.0
Massachusetts	Combination	69,978	-4	Designated fund; funded by general revenue, and cigarette taxes	Yes	15.0
Michigan	Combination	47,240	-2	General revenue	No	4.1
Minnesota	Medicaid	23 <sup>6</sup>	109	Provider taxes	No	11.5
Mississippi	Combination	53,547	44	General revenue and tobacco settlement funds	No	0.0
New Jersey	Combination	100,629	22	General revenue and tobacco settlement funds	Yes	25.6
New York	Combination	594,521	0	Provider taxes	Yes	13.0
Texas	Combination	560,588	95	General revenue and tobacco settlement funds	No	0.0
Washington	Separate	7,621	68	Designated fund; funded by provider, liquor and tobacco taxes, as well as tobacco settlement funds	No	8.0
Wisconsin	Medicaid	36,671	10	General revenue and tobacco settlement funds	Yes	5.0
<b>Total</b>	Combination: 9 Medicaid: 2 Separate: 2	2,452,528	22 <sup>7</sup>	General revenue: 10 Tobacco settlement funds: 9 Other sources: 5	Yes: 4 No: 9	Not available

1. Source: Centers for Medicare and Medicaid Services (<http://www.cms.gov/schip/chip-map.asp>, accessed September 4, 2002)

2. Source: Centers for Medicare and Medicaid Services (<http://www.cms.gov/schip/fy02sger.pdf>, accessed September 4, 2002) Data represent children ever enrolled in the second quarter of FY 2002.

3. Source: Personal communication with state officials and Campaign for Tobacco Free Kids, et al., 2002.

4. Source: Federal Register, 67(81): April 26, 2002.

5. Source: "Preliminary State Budget and Tax Actions Report," National Conference of State Legislatures, [www.ncsl.org/programs/fiscal/presbta.02.htm](http://www.ncsl.org/programs/fiscal/presbta.02.htm), accessed September 4, 2002.

6. Minnesota covered children up to 275% FPL under its Minnesota Care program at the time SCHIP legislation was passed. Minnesota received an SCHIP waiver in June 2001 that allows use of SCHIP funds to cover parents of children on Minnesota Care.

7. Total for Percent Increase in Enrollment represents nationwide totals.

**Table 2**  
**Major Changes Enacted or Under Consideration in SCHIP Programs in ANF States**

State	Eligibility	Enrollment Process	Outreach	Benefits	Cost Sharing	Reimbursement Rates
Alabama	(-)		(-)		(-)	
California		+	-			
Colorado	(+)	(+)		+		
Florida		+	-	+		
Massachusetts		-	(-)		(-)	
Michigan						
Minnesota			-			-
Mississippi			-	+		
New Jersey	-		-	(-)	(-)	
New York		+	+	+		
Texas			-		-	
Washington	(-)		-		(-)	
Wisconsin	+			(-)		
<b>Total</b>	- 1 State (-) 2 States + 1 State (+) 1 State	- 1 State (-) 0 States + 3 States (+) 1 State	- 7 States (-) 2 States + 1 State (+) 0 States	- 0 States (-) 2 States + 4 States (+) 0 States	- 1 State (-) 4 States + 0 States (+) 0 States	- 1 State (-) 0 States + 0 States (+) 0 States

**Key:** - = Restrictions enacted      + = Expansions enacted  
 (-) = Restrictions considered      (+) = Expansions considered