The passage of the Balanced Budget Act (BBA) of 1997 and the creation of the State Children's Health Insurance Program (SCHIP) as Title XXI of the Social Security Act launched a wave of speculation over how and whether states would use the flexibility they had been seeking to design new approaches for insuring low-income children. With $24 billion in federal funds set aside for the program's first five years, and enhanced federal matching rates serving to provide the right incentives, the law gave states three options for expanding coverage—through Medicaid, the creation of a new or expansion of an existing separate state program, or through a combination of the two.

CHARTING New Courses for Children's Health Insurance

By Ian Hill

At the time, several analysts and organizations studied the law and reviewed the apparent advantages and disadvantages of these alternatives (Center for Health Policy Research, 1997; House Committee on Commerce, 1997; Mann, 1997; Weil, 1997). These analyses generally concluded that:

- Using SCHIP authority to expand Medicaid would permit states to efficiently build upon an existing infrastructure of rules, administrative agencies and processes, provider networks, enrollment procedures, and claims payment and other systems. These advantages might allow a state to more quickly start a SCHIP initiative and, over time, provide more seamless coverage to families covered under the expanded Medicaid initiative. Medicaid expansion would also extend the entitlement feature of Medicaid to SCHIP—the law stated that federal matching dollars would continue to be made available (at regular Medicaid rates) to Medicaid/SCHIP expansions even if a state exhausted its SCHIP allocation. On the other hand, going with Medicaid would require conformance with a federal construct that many states consider inflexible while also, depending on the state, potentially burdening the expansion with any negative reputation that Medicaid had acquired among providers, consumers, and politicians during its history.
- Creating or expanding a separate state program under Title XXI would provide states the opportunity to, within certain federal parameters, design new benefit packages and service delivery arrangements, impose cost sharing, adopt simpler eligibility rules and processes, and generally create a new image for a program separate from Medicaid (and any welfare connotations it might engender). More important, this route would also permit states to avoid the entitlement obligation of Medicaid and create enrollment and budget caps if they desired. On the other hand, creating a separate program would subject a state to considerably more administrative start-up effort as well as ongoing coordination challenges between the new program and the existing Medicaid program.

Today, roughly three years after enacting Title XXI, we are able to not only observe the outcome of states' decision-making but also analyze their early implementation experiences with alternative program designs. As part of the Urban Institute's *Assessing the New Federalism* project and, more specifically, its SCHIP evaluation,[1] the institute examined why states chose the models they did and how these choices are playing out as states move into their third year of implementation. The analysis is based on information collected from a broad range of state and local officials during site visits and telephone interviews in 18 states.[2]

1 The paper was primarily funded by the Robert Wood Johnson Foundation and the David and Lucille Packard Foundation as part of the institute's Assessing the New Federalism project.

2 The 18 study states were selected for their diversity in size, population characteristics, geographic location, and SCHIP model. Four- or five-day site visits were conducted in 15 states—Alabama, California, Colorado, Connecticut, Florida, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Wisconsin—while multiple telephone interviews were conducted in three additional states—Minnesota, Texas, and Washington.

Getting Behind the Numbers: Why Did States Make the Choices They Made?

It is first important to note the enthusiasm with which states pursued Title XXI's optional authority. Within six months of the BBA's passage, 18 states had submitted SCHIP plans to the Health Care Financing Administration (HCFA) and four had been approved; by the first anniversary of the law, 48 states had submitted plans and 41 had received approval; and by the fall of 1999, every state and the District of Columbia had plans in place and only three were pending federal approval (Bruen & Ullman, 1998; National Governors' Association, 1999; Ullman, Hill & Almeida, 1999). According to key respondents in the 18 states interviewed for this study, a common set of factors was cited as fueling this rapid state response, including the availability of enhanced federal matching funds, bipartisan support for children's insurance expansions, and strong economies in the states.

At first glance, it appears that the states were evenly divided in their choices of Medicaid versus separate programs—18 states adopted Medicaid expansions, 15 states implemented separate programs, and 18 states chose a combination approach (Health Care Financing Administration, 2000). A closer examination of the 18 "combination" states, however, reveals that in most the Medicaid portion of the Title XXI initiative represented a relatively small component of the overall effort, while separate programs received the lion's share of attention during both the policy design and implementation phases. For example, many of the combination states in our sample—Alabama, California, Florida, Mississippi, New York, Texas—and across the nation more generally, simply accelerated poverty-level coverage for all children up to age 18 as the Medicaid portion of their SCHIP initiative because federal law would have eventually required the change anyway. In Alabama, policymakers described the move as "a logical first step" and a "no brainer" extension of the entitlement. Like many other states nationally, the phase one expansions in Alabama, Mississippi, and Texas also served as "placeholders" that locked in states' access to fiscal year 1998 federal allotments while policymakers designed separate programs for children in families with higher incomes. Viewed from this perspective, therefore, the national picture looks significantly different: a large majority of states—two-thirds—has chosen to focus their SCHIP initiatives on new programs, either separately or in combination with Medicaid expansions.[3]

Among the states included in this study, a consistent set of factors was identified as leading the majority of states to decide that SCHIP offered an important opportunity to test alternatives to Medicaid. Interviews with state Medicaid and SCHIP directors, governors' staff and state legislators, providers, and child advocates revealed several common reasons why states opted for the non-Medicaid route, including:

- Political resistance to expanding a federal entitlement program;
- Legislative objection to fueling further growth in the Medicaid program or bequeathing further power to the executive branch's Medicaid agency;
- The perception that access to care problems has plagued, and would continue to plague, Medicaid recipients;
- Fear that children's issues and priorities would fade as Title XXI was subsumed within the larger Medicaid bureaucracy; and
- Concern that the inertia of that bureaucracy would cause it to be slow to change and innovate.

Even more prevalent was policymakers' expressed desire to create programs that are "more like private insurance" and, closely correlated with this, to build new insurance systems free of the welfare-related stigma that was perceived as pervasive among both consumers and providers of care. In Colorado, Florida, New York, and Pennsylvania, preexisting children's health insurance programs taught officials and advocates just how popular child health programs could be among working families when they are designed after more mainstream private products. In California and Michigan, officials were all too familiar with the widespread dissatisfaction of providers with Medicaid, as well as the strong negative attitudes that many families held toward the program. Officials in these states pointed to their very large numbers of eligible, but not enrolled, children as evidence of families' resistance. They, therefore, set out to create new models, viewing SCHIP as a natural bridge between Medicaid and private insurance and believing that "building on a flawed system" simply would not work.

In contrast, it is also interesting to note the factors that persuaded other states to continue their Medicaid programs. In each of the three

3 The 18 states in our sample included 10 combination programs (Alabama, California, Connecticut, Florida, Massachusetts, Michigan, Mississippi, New Jersey, New York, and Texas), four separate programs (Colorado, North Carolina, Pennsylvania, and Washington), and four Medicaid-only expansions (Missouri, Minnesota, Ohio, Wisconsin). More important, each of the Medicaid-only states we studied possesses a Section 1115 waiver, which permitted them greater flexibility to implement policies under SCHIP than normally afforded a Title XIX program without a waiver. Therefore, to some extent, the findings of this study may not generalize to all Medicaid-only SCHIP expansions.

Medicaid-only states included in this study—Missouri, Ohio, and Wisconsin—key respondents described how Medicaid was a well-respected program among state legislators, that Medicaid administrators were viewed as smart and capable managers, and that the program was efficient in terms of administrative costs. Each state, as well, had successfully implemented managed care initiatives under Medicaid, and so was enjoying improved relations with insurers and providers in the state. In the months prior to the passage of the BBA, these states had also completed intensive plans to expand eligibility for children and families under their Section 1115 waivers, so it was logical to fold these plans into Title XXI to obtain enhanced match. Finally, it was generally expressed that the Medicaid programs in at least two of these three states—Missouri and Wisconsin—tended to have less stigma attached to them; that is, consumer advocates described a state environment in which families were less likely to equate Medicaid with the cash assistance programs to which they were formerly linked. In Missouri, this separation of identities was attributed to the popular MC+ managed care program, in place since 1995. In Wisconsin, the state's long history of implementing welfare reform appeared to have succeeded in delinking Medicaid from cash assistance in the minds of state residents.

What Have Been the Trade-Offs Between Medicaid and Separate Programs?

With roughly two years of implementation experience to draw on, state and local officials in the 18 study states were asked to comment on the early successes and failures of their SCHIP initiatives. More specifically, they were queried at length regarding the strengths and weaknesses of their Medicaid or separate program expansions and asked to reflect on the results of having chosen one route over another.

Enrollment

One of the leading arguments for adopting a Medicaid expansion under SCHIP was the potential it afforded states to efficiently build on existing eligibility rules and infrastructures; in contrast, a new separate program would likely require the development of a whole new enrollment system. Indeed, it is safe to say that developing and implementing SCHIP enrollment systems has brought the largest challenges to new programs. New programs have worked hard to develop new eligibility systems, often resulting in new agencies or vendors becoming involved in application processing—Alabama's State Employee Insurance Board, California's Managed Risk Medical Insurance Board, Colorado's Child Health Advocates, Florida's Healthy Kids Corporation, Michigan's contract with Maximus—and, in turn, creating significant administrative confusion and complexity surrounding role definition, referrals, and coordination of effort. In their zeal to simplify eligibility rules, new programs have instituted myriad policies and practices but changes have frequently been inconsistent with existing rules under Medicaid. For example, new programs may

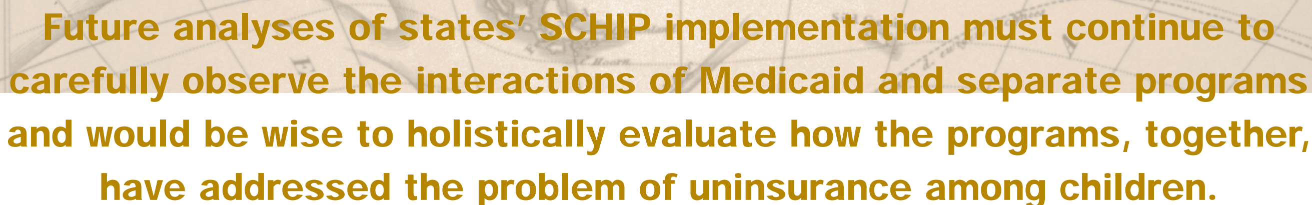
- permit applications to be mailed in while Medicaid requires a face-to-face interview (Alabama and New York);
- drop assets tests while Medicaid programs retain them (Colorado);
- eliminate or reduce verification requirements while Medicaid does not (Alabama); and
- count income differently from Medicaid, reviewing families' *gross* income as opposed to income *net* of work and child care disregards (Alabama, New York, and Pennsylvania).

In some states, new programs may even use different forms from Medicaid (New York initially, and Pennsylvania) but even in states with joint forms, inconsistent rules and policies have sometimes led to the design of onerous and overly complex applications designed to "cover the bases" for both programs (the best example being California's first attempt at a combined Healthy Families/Medicaid form which totaled 28 pages).

Together, the numerous disconnects between Medicaid and separate programs, aside from creating confusion, also pose severe challenges to the statutorily required "screen and enroll" process.[4] Many states reported that, especially in the early months of their programs, agencies' consideration of applications for both programs often entailed two significantly different reviews and calculations, resulting in long delays in establishing children's eligibility for one program or the other.

Finally, states with new programs acknowledged the difficulties and confusion that can occur when children in the same family are split among SCHIP and Medicaid programs. Only three states in our sample—Connecticut, Michigan, and New Jersey—and five states nationally used Title XXI as an opportunity to level out their

4 States using Title XXI authority to implement new programs are required by the law to screen all applicants for Medicaid eligibility before reviewing them for separate program eligibility. This so-called "screen and enroll" requirement is intended to ensure that Medicaid-eligible children are enrolled in that program, thereby granting them the entitlement protection they are entitled to under Title XIX. In addition, this requirement ensures that enhanced federal matching funds are directed to support only those children eligible under Title XXI rules.



Future analyses of states' SCHIP implementation must continue to carefully observe the interactions of Medicaid and separate programs and would be wise to holistically evaluate how the programs, together, have addressed the problem of uninsurance among children.

Medicaid upper-income thresholds for children of all ages. Thus, most states with new programs have the potential for creating "split" families where one or more child is enrolled in SCHIP while others are enrolled in Medicaid. California officials estimate that between 8 percent and 12 percent of Healthy Families enrollees have siblings that are also in Medi-Cal. In contrast, virtually every Medicaid-only SCHIP program has equalized upper-income thresholds for children of all ages.

Despite these challenges, however, state and local officials in states with new programs almost universally believe the effort has been worth it. Key respondents from diverse perspectives agreed that new SCHIP approaches were succeeding in "de-stigmatizing" the eligibility process by permitting alternative means for applying for coverage—through health plans in New York and Pennsylvania, in community-based agencies in California and Colorado, and by mail in every separate program. In doing so, these officials believe that SCHIP is eliminating one of the main sources of stigma often attributed to Medicaid—that which grows from the process of sitting down, face to face, with an eligibility worker in a county "welfare" office and completing a long application that delves deeply into families' personal and financial circumstances (Perry et al., 2000; Southern Institute on Children and Families, 2000; Stuber et al., 2000). The fact that these states consistently reported that families who applied for SCHIP but were found eligible for Medicaid often vigorously resisted that referral and sometimes even refused to continue the application process, bolstered officials' opinions that the changes they were making were important and appropriate.[5] Furthermore, several states reported that they have worked through many of the "bugs" between their separate and Medicaid programs and have made strides in improving coordination. Both California and Florida have simplified their applications, aligned eligibility rules, and used a single point of entry for reviewing and triaging applications between the two programs, and New York has recently begun implementing its ambitious "facilitated enrollment" system that is designed to better coordinate the eligibility process.

Of note, a review of the eligibility processes in the three Medicaid-only states included in this study illustrates that the rate of innovation has, in fact, been slower and that these programs tend to rely on more traditional approaches to eligibility determination. While Missouri instituted a new short form, expanded eligibility to 12 continuous months, and permitted applications to be submitted by mail, the state also continues to require considerable verification of income, net worth, and access to other forms of health insurance. The state legislature, concerned over the potential for "welfare fraud," actually reversed its decision to permit applicants to self-declare personal income and state law now requires the collection of income verification. Wisconsin, which shortened its application form and began outstationing eligibility workers at 80 sites across 20 counties, still bases its entire eligibility system through county social services offices and requires face-to-face interviews (either with outstationed workers or in county offices in the 52 remaining counties without such workers). Ohio described a county-based eligibility process that requires the submission of considerable documentation—Social Security card, income verification, and separate items for proving identity, age, citizenship, and residence—and which varies considerably in degree of enforcement by social services agencies county to county.[6] The entire Ohio system was also described as being hampered by the outdated CRIS-E information sys-

5 Officials in several states in our study expressed frustration that they could not offer families more choice between Medicaid and separate state programs (due to "screen and enroll" requirements). California officials even discussed an interest in proposing to HCFA that Healthy Families be permitted to enroll Medicaid-eligible children into their program, if requested by parents, and receive regular Medicaid matching rates on behalf of these children. While not included in this study, Arkansas has been embroiled in a heated dispute with HCFA over a similar issue-state officials would like to permit families to choose between their regular Medicaid program and ARKids First, a slightly less generous program designed under the state's Medicaid 1115 waiver. To date, federal officials have denied this request.

6 Recognizing these problems, the state planned to implement simplified verification requirements beginning July 2000.

Medicaid expansions appear to permit states to efficiently build upon an existing program infrastructure, but at the potential cost of being burdened by the very legacy that those existing infrastructures possess, often manifested as consumer and provider resistance and political mistrust and disdain. Separate programs, on the other hand, take on hugely complex and challenging administrative burdens related to both start-up and ongoing coordination with Medicaid, but with the potential of creating a product that is more attractive to consumers and providers by virtue of its distinctness from Medicaid and that program's welfare legacy.

tem, which continues to improperly terminate many Healthy Start cases in which parents are also receiving food stamps and fail to show up for their three-month food stamp interview, in spite of the fact that the SCHIP program has a six-month eligibility period. This system problem was identified in the fall of 1998 yet had not been fixed as of spring 2000, the time of our site visit (Schwalberg, Hill & Mathis, 1999).

Outreach

A close corollary to enrollment strategies, outreach efforts publicize the availability of a new program, the importance of health insurance for children, and the means by which families can apply for coverage. Medicaid programs, over the years, have rarely engaged in outreach; the historical welfare attachment of the program has succeeded in stifling support, either politically or financially, for such efforts. Title XXI, on the other hand, was created for the explicit purpose of insuring uninsured children and thus embodied a clearer, at least implied, mandate for conducting outreach. Still, believing that the majority of program funds should be devoted to providing care, SCHIP's congressional drafters required that states spend no more than 10 percent of their allocation on administrative activities, including outreach.

An analysis of the outreach efforts of both separate and Medicaid Title XXI expansions yields mixed results. Among new and separate programs, one generally sees an encouraging level of effort. Without solid research on effective practices, most states have employed "shotgun" or multipronged strategies that combine statewide media campaigns with more "grass roots" regional or local efforts. Various strategies that garnered attention for their creativity include Alabama's sending application packets—roughly 800,000 in all—home with every school-age child at the start of the 1998 school year; New York's and Pennsylvania's permitting managed care plans to market SCHIP to potential eligibles; Massachusetts' provision of "mini grants" to community-based agencies to support the conduct of local initiatives; and North Carolina's creation of HealthChoice Outreach Coalitions in each of the state's 100 counties to spearhead targeted community efforts. Still, faced with the 10 percent "admin cap" and uncertain continuance of Section 1931 Medicaid outreach dollars,[7] many states characterized their outreach as insufficient and inconsistent. No state included in this study, with the possible exception of Colorado, invested significant resources in market research to determine the most effective ways of publicizing its programs to their target populations.

On the Medicaid side, similar mixed results were noted. Encouragingly, the three Medicaid-only states in this study did report planning and conducting outreach at levels never before witnessed, and two of the three made concerted efforts to create and market new program images under SCHIP—MC+ for Kids in Missouri and BadgerCare in Wisconsin.[8] Yet efforts in both

7 As part of federal welfare reform legislation, $500 million in federal funds was made available to states to support outreach aimed at ensuring that families making the transition off welfare did not lose their Medicaid benefits. These monies, whose availability was scheduled to expire in October 1999 but were subsequently extended, could also be used to support SCHIP-related outreach as long as it publicized Medicaid as well.

8 In Ohio, officials both within and outside of government acknowledged that the state had not done a good job of building an identity for the SCHIP program. While officially called Healthy Start, the state gave counties virtually limitless autonomy to design and conduct their outreach efforts. Unfortunately, this resulted in many counties creating their own name and logo for SCHIP. Depending on which county you visit, SCHIP in Ohio can be called Healthy Start, CHIP, or Healthy Start Plus, among others.

Missouri and Ohio were focused at the county and local levels and primarily funded by federal dollars, at least in part because officials were reluctant to conduct "high visibility" marketing for SCHIP. Furthermore, few or no state dollars were earmarked for outreach in these states due to legislative resistance to overtly conducting "outreach for a welfare program." Finally, in five of the 10 combination program states included in this study, little or no distinct outreach was conducted for the Medicaid portion of the SCHIP expansion. In Alabama, Michigan, Mississippi, New York, and Texas, the lion's share of outreach efforts and funding has been devoted to the separate components of their SCHIP programs, perhaps also reflecting the long-standing political resistance to or bureaucratic culture unfamiliar with outreach.

Benefits

One of the most persuasive arguments made in support of adopting Medicaid expansions under Title XXI was that Medicaid extends to children the broadest possible benefits coverage and virtually open-ended protection under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of the statute.[9] Conversely, Title XXI permits states adopting separate programs to cover a more limited scope of benefits.

A careful review of the coverage policies of new programs under SCHIP reveals, however, that states have typically adopted rich benefits packages that, while not the equal of EPSDT, are quite broad and "better than most private plans," according to key respondents ranging from SCHIP officials to pediatricians to private insurers to child advocates. In most states in this study, coverage has been provided for services beyond the minimum established in federal law, critical children's services such as hearing, vision, and dental care have been added, and guidelines for well-child visits established by the American Academy of Pediatrics have even been incorporated into policy. Explicit gaps in coverage appear to be few—most often non-emergency transportation, case management, and enabling services are not covered—and service limits are less severe than many advocates feared they would be. The services most frequently subject to limits include mental health and substance abuse services and rehabilitative therapies. While these exclusions and limits certainly hold implications for certain subgroups of children, specifically adolescents and children with chronic illnesses and disabilities, several states have designed special wraparound benefits or other provisions to augment benefits coverage for special populations—eg, Alabama's ALLKids Plus, California's CCS "carve out," Connecticut's HUSKY Plus, Florida's Children's Medicaid Services system, among others (Schwalberg, Hill & Mathis, 2000). In those states without supplemental coverage, virtually all key respondents reported that they had heard of no cases where children were experiencing problems with coverage, suggesting that the breadth of SCHIP separate program packages appeared to be meeting the needs of the vast majority of enrolled children.

Service Delivery Arrangements and Access

A cited advantage of pursuing a Medicaid expansion under SCHIP was that the program already had in place a service delivery network and that no new recruitment efforts, rules, contracts, or network development would need to occur. Furthermore, an expanded Medicaid program, it was argued, would possess that much more purchasing power and thus be able to negotiate favorable rates with managed care plans and provider groups. Finally, it was often stated that Medicaid expansions would provide more stable, continuous coverage for families as their income and eligibility status changed. Medicaid families, whether financed as Title XIX or Title XXI recipients, could receive care from the same network of providers.

Many others argued, however, that a fundamental weakness of many state Medicaid programs was, in fact, poor access. Chronic problems with low provider participation, fueled by low reimbursement rates, cumbersome and slow payment processes, and high rates of "no shows" among Medicaid recipients are well chronicled characteristics of the Medicaid program. Furthermore, Medicaid managed care systems in many states have experienced considerable instability in recent years (Felt-Lisk, 1999; Hurley & McCue, 2000). As a result, the promise of unlimited coverage afforded by EPSDT has in many states been undermined by access problems (HCFA, 1999).

In certain states, therefore, the passage of SCHIP was viewed as an ideal opportunity to move away from the traditional Medicaid delivery system and work to improve children's access to care. Among our study states, the most striking examples of this can be seen in Alabama, Michigan, Mississippi, and Pennsylvania, where separate SCHIP program officials took advantage of the large presence in their states of Blue Cross/Blue Shield organizations to develop new, and sometimes exclusive, contractual arrangements, thereby opening up to enrollees access to the largest networks of providers in the states. In Alabama, for example, Blue Cross insures roughly 80 percent of covered lives in the state; therefore the ALLKids

9 Under OBRA-89, the EPSDT portion of the Medicaid statute was amended to require states to cover any service needed by a child to treat a condition identified during an EPSDT screen, even if that service was not covered by the state plan.

contract with Blue Cross affords these children the potential of truly mainstream access to care. Similarly, in Mississippi, the separate program's Blue Cross network includes 90 percent of all physicians in the state and all of its acute care hospitals; enrollees in SCHIP, who carry the same insurance card as all other Blue Cross enrollees, are perceived as enjoying markedly better access to care than their Medicaid counterparts.

Michigan has even taken this approach and applied it to dental care—an area in which most Medicaid programs have been plagued by poor access. Under MIChild, Michigan has developed arrangements with capitated dental organizations—primarily Delta Dental and Blue Cross—whereby dentists participating in these plans that are accepting any new patients must also accept MIChild patients. Through these contracts, MIChild has gained access to roughly 90 percent of dentists in the state and, to date, this access appears to be translating into robust utilization—an estimated 75 percent of enrollees in the two largest MIChild dental plans have received at least one preventive dental exam (Almeida, Hill & Kenney, 2000). In each of these states, providers interviewed for this study expressed very favorable attitudes toward SCHIP and much higher levels of willingness to participate in the program relative to Medicaid.

To be sure, not all states have felt it necessary to radically depart from established Medicaid networks; the separate SCHIP programs in California, Colorado, Connecticut, Massachusetts, New Jersey, and New York use managed care networks that are quite similar, if not exactly, like those used by Medicaid. Though even in these states, managed care organizations and providers often preferred their experiences participating in SCHIP vis a vis Medicaid for a variety of reasons, including improved payment rates, simpler administrative rules, and less onerous contracting requirements. Among Medicaid-only states, however, it should be noted that the very strength of managed care initiatives undertaken in recent years was a primary reason that state officials in Missouri, Ohio, and Wisconsin opted to pursue Medicaid expansions.

Cost Sharing

Fearing that the imposition of cost sharing would create barriers to both enrollment and use, proponents of Medicaid expansions cited that program's prohibition against most types of cost sharing as a clear advantage of the option. But proponents of separate programs viewed Title XXI's flexibility to institute premiums, enrollment fees, and copayments as an opportunity to create programs that more closely resemble private insurance and to eliminate, or at least reduce, the perception that SCHIP is a "government hand-out," thereby making it more attractive to working families.

In fact, cost-sharing arrangements under SCHIP are not a feature that set new and separate programs significantly apart for Medicaid expansions, at least among the states included in this study.[10] Separate programs typically begin imposing premiums of between $6.00 and $18.00 per child per month on families earning incomes between 150 and 200 percent of poverty, with higher amounts charged to families with higher incomes,[11] and copayments of $5.00 and $10.00 on such services as physician visits and prescription drugs[12] (Ullman & Hill, 2000). Even in the Medicaid states in our sample, however, policymakers have opted to impose cost sharing on higher-income families. Using Section 1115 waiver authority, these states decided that it was appropriate, as they raised income eligibility thresholds, to begin imposing premiums or enrollment fees. Politically, the inclusion of cost sharing was necessary if program expansions were to take place. In Missouri, dropping premiums from the SCHIP plan would have been a "deal breaker" for many state legislators.

While it is too early to assess the consequences of cost sharing on consumer behavior under SCHIP, qualitative information gathered by this study is encouraging. So far, in virtually every state we studied, reports from diverse key respondents, including child and family advocates, suggest that cost-sharing amounts appear to be affordable for families with children enrolled in SCHIP and do not appear to be creating barriers to enrollment (in the case of premiums and enrollment fees) or use (in the case of copayments).[13]

Implications for the Future

It is far too early to judge whether separate programs or Medicaid expansions will more successfully achieve SCHIP's goals of reducing the numbers of uninsured children

10 All of the Medicaid-only states in our sample possess Section 1115 waivers and use that authority to impose cost sharing on enrollees. Without such waivers, Medicaid programs face more restrictive rules regarding the types and amounts of cost sharing that can be imposed on recipients.

11 Three states in our study—California, Colorado, and Florida—impose lower premium amounts on families with incomes between 100 and 150 percent of poverty.

12 Copayments as high as $25 are charged for inappropriate emergency room visits in a limited number of states.

13 A notable exception to this finding was in Colorado, where higher levels of premiums were charged to families at lower incomes, and where a statewide indigent care program continues to offer free or low-cost/sliding scale care to individuals who need it. In that state, many instances were cited where families chose to continue receiving care through the indigent care program rather than sign up for SCHIP. Recognizing this, Colorado officials were considering proposals to reduce or eliminate premiums under SCHIP at the time of this writing.

in our nation and affording them improved access to care. Ultimately, it may be futile to try to answer this question, as historical and environmental contexts vary considerably across the states—circumstances in one state may make it entirely appropriate to expand Medicaid, while circumstances in another may dictate that a new model be pursued.

Still, some general themes have emerged from this study that may help inform future policy. Based on the experiences of the states included in this study, Medicaid expansions appear to permit states to efficiently build upon an existing program infrastructure, but at the potential cost of being burdened by the very legacy that those existing infrastructures possess, often manifested as consumer and provider resistance and political mistrust and disdain. Separate programs, on the other hand, take on hugely complex and challenging administrative burdens related to both start-up and ongoing coordination with Medicaid, but with the potential of creating a product that is more attractive to consumers and providers by virtue of its distinctness from Medicaid and that program's welfare legacy.

This study also revealed that the relationships between Medicaid and SCHIP are not static, but quite dynamic. On one hand, there is growing evidence that, rather than "leaving Medicaid behind," the development of separate programs in many states has allowed for the testing of new policy strategies and, upon seeing their effects, the application of these strategies to Medicaid. With regard to eligibility policies, in particular, many states reported that innovations designed for their separate programs—shorter forms, 12-month continuous eligibility, reduced verification, mail-in applications—have "spilled over" to Medicaid.

With outreach, sometimes by design and sometimes by accident, SCHIP campaigns are commonly credited with finding as many Medicaid-eligible children as SCHIP eligibles. In Connecticut, Massachusetts, and New Jersey, separate programs have stimulated state officials to reinvent and merge the images of all their publicly sponsored health insurance programs—HUSKY, MassHealth, and KidCare, respectively—so that a single program can be marketed and so that enrollees are, essentially, blind to whether they are Title XXI or Title XIX recipients. The extent of spill-over of service delivery innovations to Medicaid is less clear. In at least one example, the Michigan state legislature recently appropriated monies to support a new Medicaid dental pilot project in 28 counties that will be patterned after that of the MIChild program due to its apparent early success.

On the other hand, remaining concerned that SCHIP may contribute to the creation of two tiers of care for low-income families in states with separate programs is not completely unwarranted. Typically, separate programs, targeted to higher-income children, have enjoyed greater political support, as well as that of policymakers, providers, and consumers, than their Medicaid counterparts. At least in part, this broad-based support grows from the simple, single-population focus of SCHIP relative to its vastly larger, more complex and costly sibling. New SCHIP initiatives have often seen this support translate into simpler eligibility rules and more generous provider reimbursement. Yet preliminary data from the Urban Institute SCHIP evaluation remind us that the significant majority of uninsured children—nearly 60 percent—are eligible for Medicaid, not SCHIP (Dubay & Haley, in press). Therefore, future analyses of states' SCHIP implementation must continue to carefully observe the interactions of Medicaid and separate programs and would be wise to holistically evaluate how the programs, together, have addressed the problem of uninsurance among children.

Looking forward, many important questions merit consideration. Where is the SCHIP headed, as various proposals suggest the program be expanded to cover parents of child enrollees? Will SCHIP's current popularity and states' considerable "pride of ownership" last or, as the program matures and federal oversight grows, will it develop its own bureaucratic inertia and acquire the negative trappings of other government programs? Will more Medicaid programs acquire the political will or bureaucratic creativity to push the limits of Title XIX and innovate as separate programs have?[14] Will the interests of children ultimately be better served under Title XXI where kids are the sole priority, or does the entitlement nature of Title XIX better protect children even though the population has typically not received priority attention within the much broader Medicaid program? Is it reasonable for states and the federal government to support two major programs for low-income children and families? Or, as the programs interact and influence one another, should a merger be considered? If so, how might that look?

Today, the answers to these questions are not predictable. What does seem clear, however, is that SCHIP has permitted states to develop new models for publicly sponsored health insurance from which many valuable lessons can be learned regarding how to make programs more easily accessible and publicly acceptable. ●

14 Indiana, not included in this study, is a good example of a state that has reinvented its Medicaid program-now called Hoosier Healthwise-within the broad flexibility already afforded by Title XIX.

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