

Highlights from The Urban Institute's SCHIP Evaluation



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The State Children's Health Insurance Program (SCHIP), enacted in August, 1997, provided new incentives for states to extend public health insurance coverage to low-income uninsured children. The federal government offered states a higher federal match and greater flexibility to design their programs than they enjoyed under Medicaid.

States took advantage of this new opportunity. All states and the District of Columbia expanded coverage under SCHIP. Many states took advantage of the option to develop separate non-Medicaid programs. This allowed states to alter the benefit package, impose premiums and co-payments, and implement waiting periods to prevent people from replacing private coverage with public coverage (crowd-out).

This research is part of a comprehensive evaluation of the State Children's Health Insurance Program primarily funded by the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation as part of the Urban Institute's *Assessing the New Federalism* project. Additional financial support came from The Annie E. Casey Foundation, the W. K. Kellogg Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, The McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, The Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.

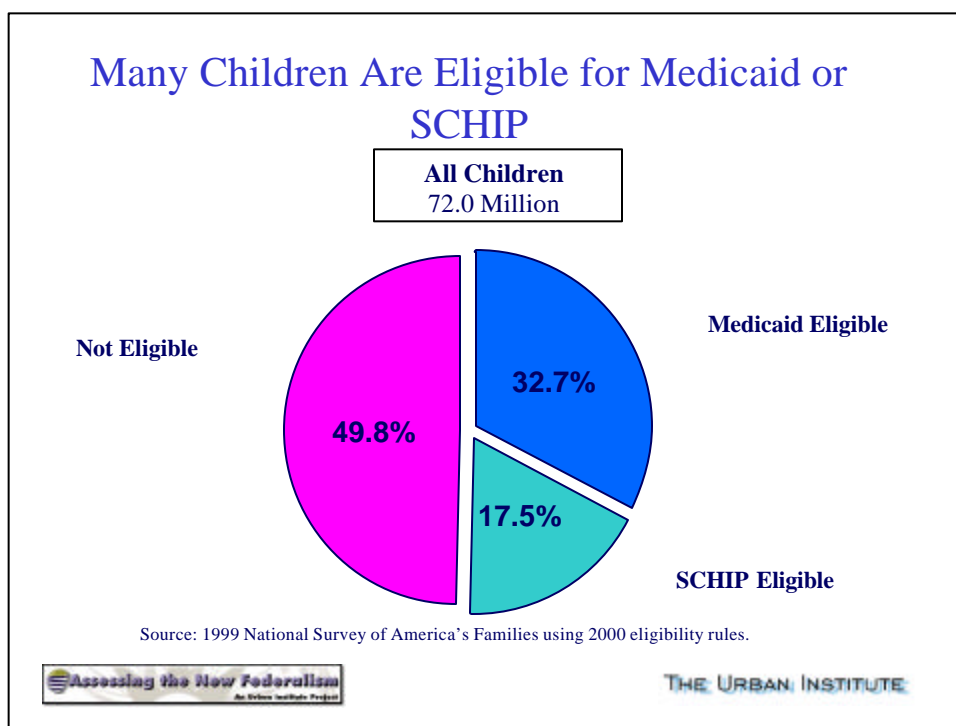
Part 1: Quantitative Findings

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September 2002



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This summary of key quantitative findings from the Urban Institute's SCHIP evaluation relies on data from the 1999 National Survey of America's Families (NSAF). NSAF is nationally representative and has large samples in 13 states (AL, CA, CO, FL, MA, MI, MN, MS, NJ, NY, TX, WA, and WI). The first section analyzes eligibility and participation in Medicaid and SCHIP, reviews what we know about why parents enroll their children, and identifies some promising mechanisms for increasing participation.



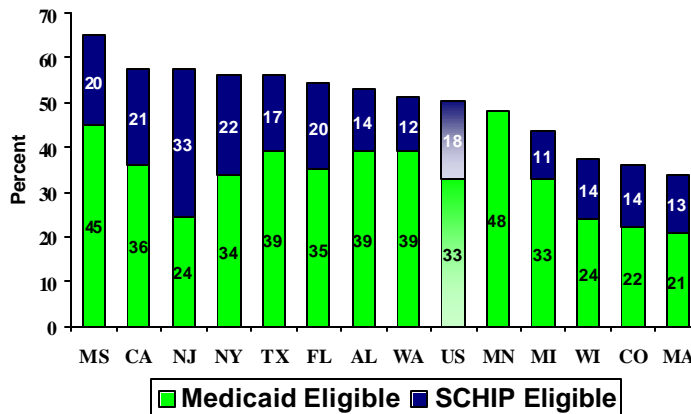
Together, the Medicaid and SCHIP programs provide a broad safety net that can protect as many as half of all children in the event of an economic downturn or a significant erosion of private coverage.

This graph shows the share of children who were eligible for Medicaid and SCHIP based on the rules in place in July of 2000.* It shows that 33 percent of all children age 17 and under are eligible for Medicaid and that 17 percent are eligible for SCHIP.

Importantly, about 71 percent of all SCHIP eligible children have private coverage. These children will only be eligible for SCHIP if they become uninsured and meet the state-specific criteria designed to prevent crowd-out or the substitution of public for private coverage.

*To examine questions on eligibility and participation in Medicaid and SCHIP, *Assessing the New Federalism* researchers developed a detailed Medicaid and SCHIP eligibility model. Information on the model is available in ANF Policy Briefs, B-40, *Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era* and B-41, *Children's Eligibility for Medicaid and SCHIP: A View from 2000*.

Potential Eligibility for Public Coverage Varies Across States



Source: 1999 National Survey of America's Families using July 2000 eligibility rules.



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Eligibility for public coverage varies dramatically across states as NSAF data for the 13 ANF study states shows.

Less than 38 percent of children in WI, CO, and MA are eligible for Medicaid or SCHIP compared with 65 percent of all children in MS.

Two factors explain this variation. First, states have different eligibility thresholds. While CO has the lowest income eligibility threshold (185 percent of poverty), NJ has the highest (350 percent of poverty).

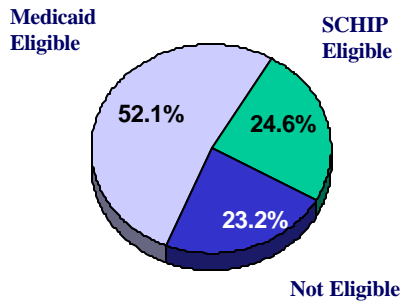
Second, eligibility for public coverage varies because of differences in the income distribution across the states. For example, both MA and MS have comparable eligibility thresholds yet 34 percent of all children in MA are eligible while 65 percent are eligible in MS. A smaller proportion of children in MA are eligible because average income in MA is higher than in MS.

Similarly, MN and WA — two states heralded for their expansive coverage of children prior to SCHIP — were covering about the same share of children as Mississippi, which, with the exception of infants, set eligibility at the mandated minimum levels.

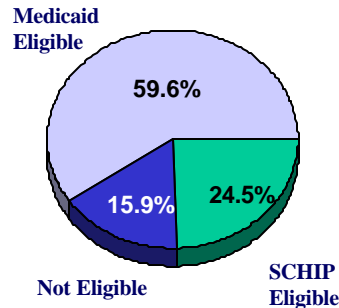
Expansion of eligibility thresholds placed different financial burdens on states depending on how wealthy the state was. This likely had a considerable effect on how states designed their SCHIP programs.

Most Uninsured Children are Eligible for Public Insurance Coverage

Uninsured Children



Low-Income Uninsured Children



Source: 1999 National Survey of America's Families using July 2000 eligibility rules.



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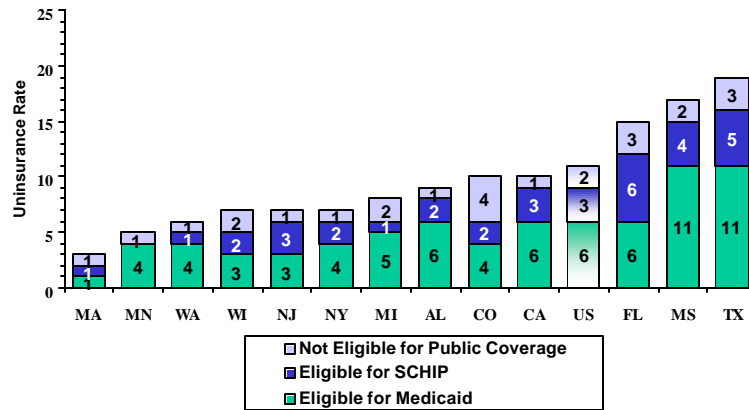
This chart shows that the key to solving the problem of uninsured children is increasing participation among children who are eligible, particularly focusing on those eligible for Medicaid.

All but 23 percent of uninsured children and 16 percent of low-income uninsured children are eligible for Medicaid or SCHIP. While 23 percent seems high, it means that at most 4 percent of all children are uninsured but not eligible for public coverage.

About half of the low-income uninsured children who are not eligible for Medicaid or SCHIP are non-citizens who meet the income requirements but are ineligible due to their immigration status. This group will be expanding over time as new immigrants enter the country who cannot be covered by simply increasing eligibility thresholds under Medicaid and SCHIP.

While much of the focus is on enrolling SCHIP-eligible children, it is critical to note that the vast majority of eligible but uninsured children are eligible for Medicaid, not SCHIP.

Increasing Participation is Critical to Equalizing Uninsurance Across States Among Citizen Children



Source: 1999 National Survey of America's Families, using 2000 SCHIP eligibility rules.

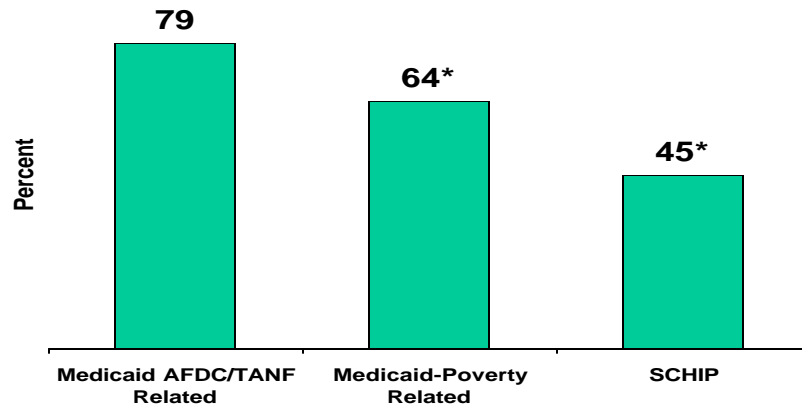


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This graph shows the uninsurance rate for children in each of the ANF states. It details the share of the uninsured in each state that is eligible for Medicaid or SCHIP or ineligible for public coverage.

While the uninsurance rate for children varies greatly across states, there is little variation across the states in the share of children who are uninsured and ineligible for Medicaid or SCHIP. This means that by increasing participation among children eligible for Medicaid and SCHIP, states could eliminate most of the state variation in uninsurance among children.

Participation Varied By Eligibility Group in 1999 Among Citizen Children (excluding children with private coverage)



Source: 1999 National Survey of America's Families.

*Statistically different than participation rate for Medicaid/AFDC/TANF related at 5% significance level.



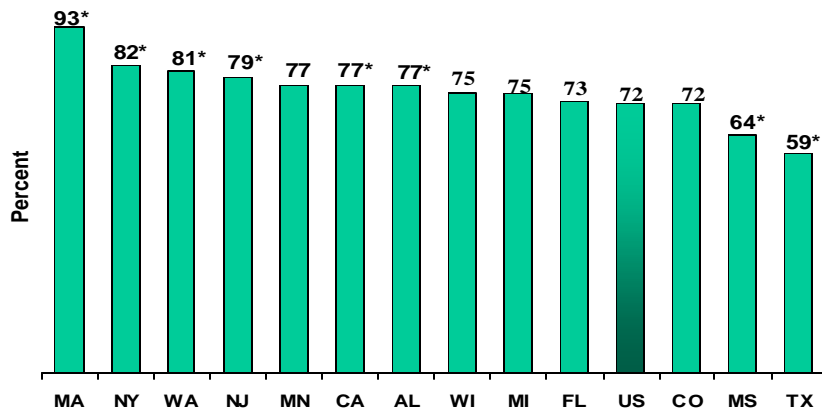
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This chart presents participation rates among eligible children when children with private coverage are excluded.

Consistent with historic patterns, children eligible for Medicaid due to welfare related rules participate at higher rates than children eligible for Medicaid due to the poverty related expansions — 79 percent compared to 64 percent. In other words, low-income children associated with the welfare system are more likely to receive Medicaid than low-income children in families not receiving cash assistance.

In 1999, very early in SCHIP's history, 45 percent of all SCHIP-eligible children participated. This is likely a good news story. Given the newness of the program in 1999, a relatively low level of participation was to be expected. The picture is probably quite different now given the dramatic increases in SCHIP enrollment and declines in uninsurance for low-income children occurring since 1999.

Medicaid Participation Varied By State in 1999 Among Citizen Children (excluding children with private coverage)



Source: 1999 National Survey of America's Families.

* Statistically different from the rest of the nation at the 10% confidence level.

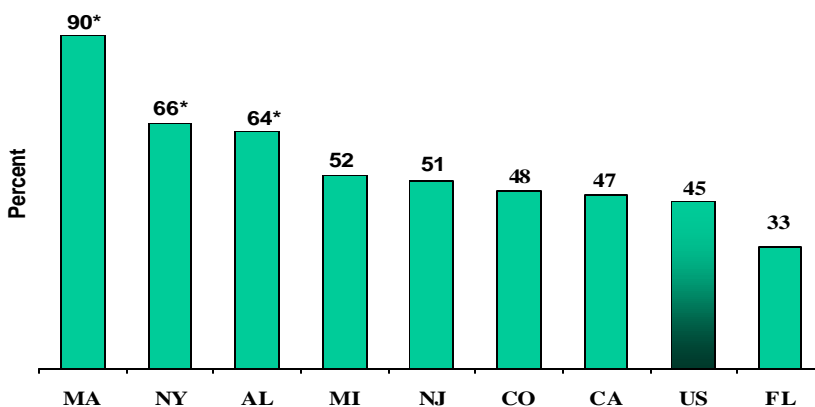


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Not surprisingly, Medicaid participation among citizen children without private coverage varies considerably across states. MA is clearly an outlier, enrolling 93 percent of eligible uninsured children.

In comparison, MS and TX have participation rates of 64 and 59 percent respectively. Medicaid participation rates in MS and TX may have improved since 1999. Both states were late in implementing their SCHIP programs and it is likely that outreach efforts conducted around SCHIP and more recent improvements in Medicaid enrollment systems increased participation in Medicaid as well.

SCHIP Participation Varied By State in 1999 Among Citizen Children (excluding children with private coverage)



Source: 1999 National Survey of America's Families.

* Statistically significantly different from the rest of the nation at the 10% confidence level



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SCHIP participation among children without private coverage also varies across states.

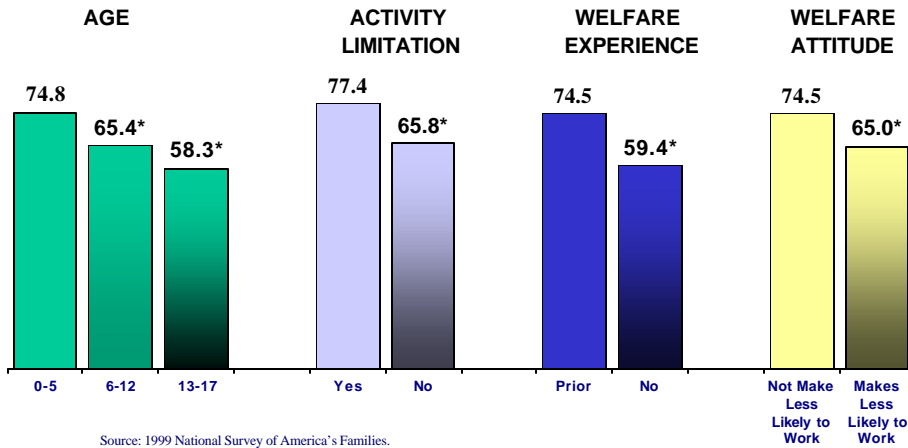
The three states with the highest participation rates — MA, NY, and AL — were all early implementers of SCHIP that early on launched strong outreach programs. That they have the highest participation rate suggests that other states may catch up over time. It also demonstrates the potential for increasing participation among SCHIP eligible children.

MA is again an outlier — enrolling 90 percent of SCHIP eligible children.

In contrast, Florida enrolled only about 35 percent of SCHIP eligible children. In 1999, some FL counties maintained waiting lists because county matching funds were not available. This may account in part for the lower participation rate. This problem has since been resolved and participation may have increased since 1999.

TX, MS, WI were left off this chart because of their late implementation of SCHIP.

Participation in Medicaid/SCHIP Varies Among Citizen Children 0-17 (excluding children with private coverage)



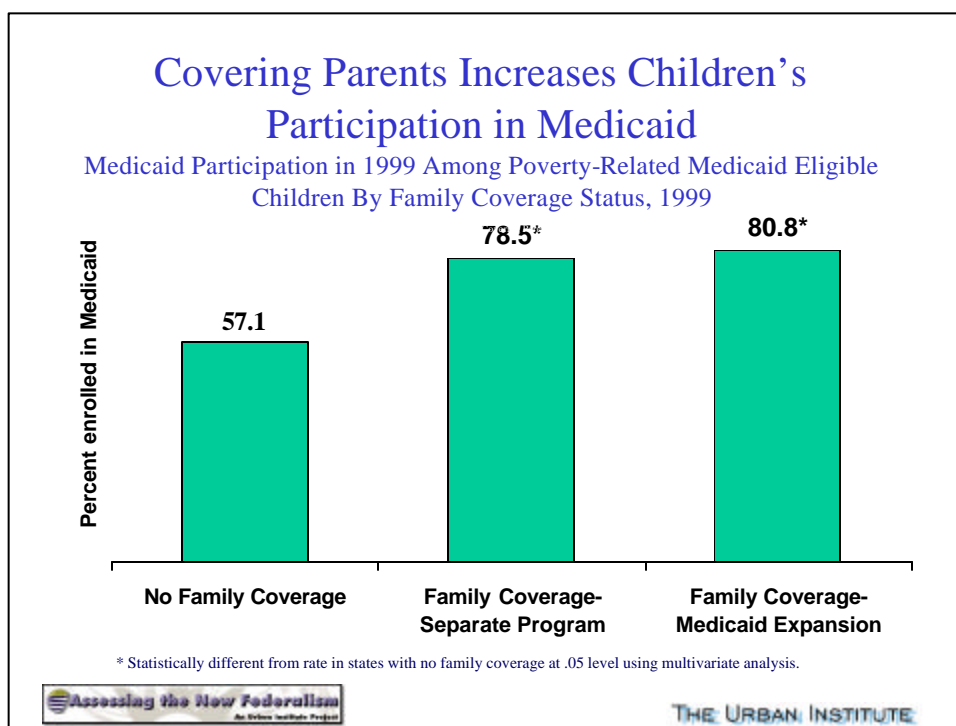
Assessing the New Federalism
An Urban Institute Program

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In addition to cross-state variation, participation in public health insurance programs (excluding those with private coverage) also varies by age, whether the child has a functional limitation, recent welfare experience, and parental opinions about welfare.

- Participation in Medicaid and SCHIP declines as children get older. Pre-school children are most likely to participate in public health insurance programs, and teenagers are least likely to participate.
- Children with a health condition that limits activity are more likely to have public coverage.
- Children with no recent welfare experience participate in Medicaid and SCHIP at lower levels than those with recent welfare experience. This means that as welfare caseloads fall, public health insurance programs may face greater difficulty reaching children.
- Parents with more negative opinions towards welfare are less likely to enroll their children in Medicaid and SCHIP.

While these results are combined for those eligible for Medicaid and SCHIP, the patterns hold for both programs separately.

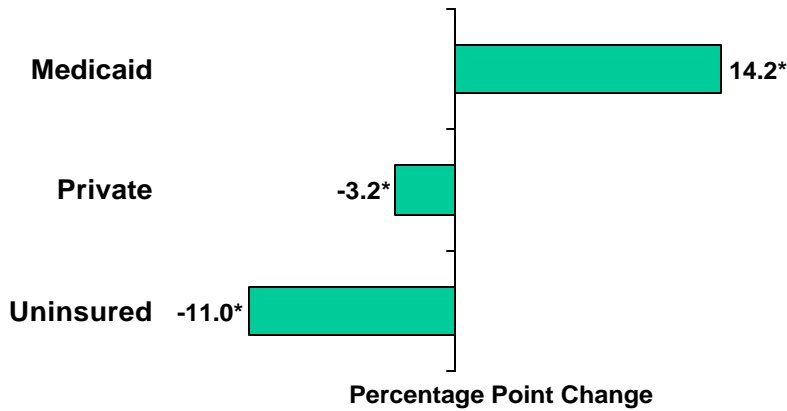


Extending public health coverage to parents may be a promising option for increasing participation among children.

The federal government has created several new opportunities for states to extend Medicaid and SCHIP benefits to parents with federal financing, and a number of states have taken advantage of these new opportunities to expand coverage. In addition, a handful of other states had previously created separate state-funded programs extending health insurance benefits to parents.

1999 NSAF data show that states that have expanded coverage to parents of poverty-related eligible children have significantly higher participation rates. In 1999, Medicaid participation rates among children who are eligible under the poverty-related provisions are 20 percentage points higher in states that also cover parents than in states that do not have family coverage.

Impact of Expansion in Coverage for Parents on Children in Massachusetts



Source: 1997 and 1999 National Survey of America's Families.

* Difference between Massachusetts and the rest of the nation is significant at .05 level using multivariate analyses.

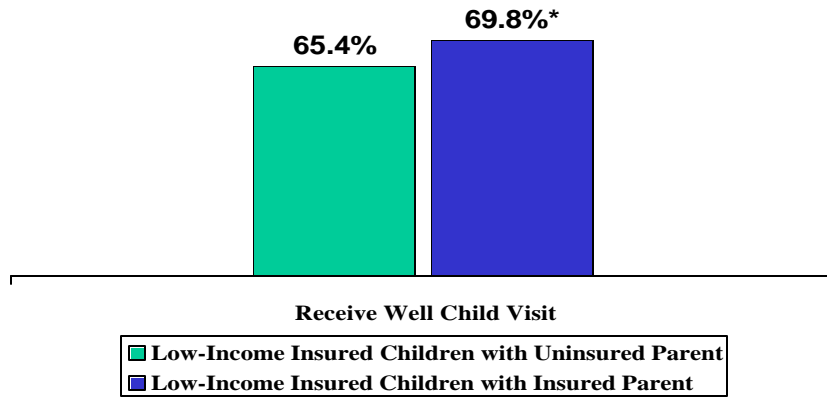


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The MA experience provides additional support for the notion that expansion in coverage to parents can improve the participation of children in Medicaid and SCHIP.

Relative to children in other states, Massachusetts experienced a large increase in Medicaid participation between 1997 and 1999 when the state extended health insurance coverage to parents. The vast majority of children enrolling in public programs were previously uninsured. Crowd-out, identified as the decline in private coverage, was modest. The result was an 11 percent decline in the uninsurance rate.

Covering Parents Leads to Small Increases in Access Among Insured Children



Source: 1999 National Survey of America's Families

* Different from low-income insured children with uninsured parent at .05 level using multivariate analysis.



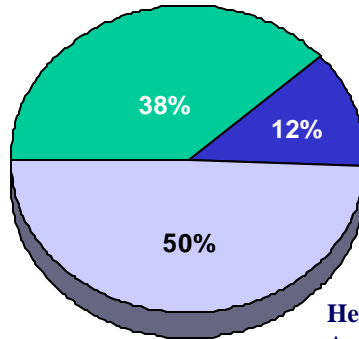
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Extending public health insurance coverage to parents not only reduces uninsurance among children, it may also lead to increases in access to health care among insured children.

1999 NSAF data suggest that low-income insured children with an uninsured parent are about four percentage points less likely to have received well-child care compared to low-income insured children with insured parents. The results for physician visits are similar. This suggests that insured parents may be more effective than uninsured parents at managing the health care needs of their children.

Many Low-Income Parents with Uninsured Children Are Confused About Medicaid/SCHIP Programs

**Heard of Programs
and Aware Child
Can Participate
Without Receiving
Welfare**



**Haven't Heard of
Medicaid or SCHIP**

**Heard of Programs but Not
Aware Child Can
Participate Without
Receiving Welfare**

Source: 1999 National Survey of America's Families



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Many low-income parents with uninsured children have not heard about Medicaid or SCHIP or are confused about who qualifies for coverage.

The good news is that in 1999 just 12% of uninsured children had parents who hadn't heard of Medicaid or SCHIP.

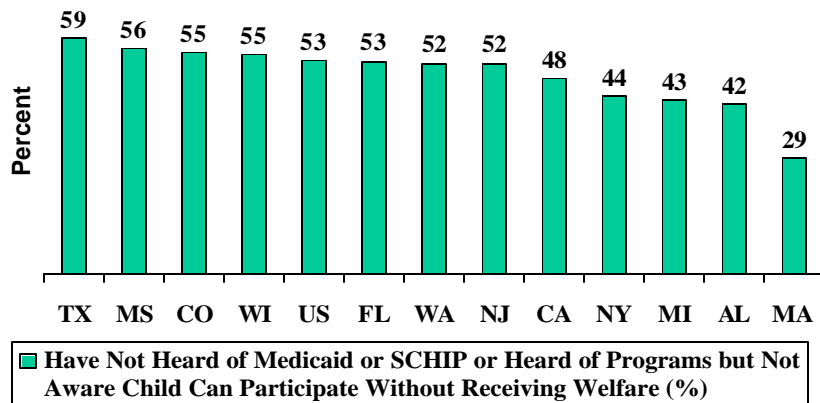
The problem is that while welfare reform de-linked Medicaid and TANF, many parents appear not to know that families who are not on welfare can qualify for coverage for their children. Half of the parents of uninsured children had heard of Medicaid and/or SCHIP, but did not understand that welfare receipt was NOT necessary for enrolling in Medicaid or SCHIP.

Only 38% of parents had both heard of the programs and understood that welfare participation was not necessary to be eligible.

In conclusion, the majority of low-income families with uninsured children face knowledge barriers, with a substantial share confused about the connection between welfare and Medicaid.

A more complete discussion of this issue can be found in Policy Brief B-34, *How Familiar Are Low-Income Parents with Medicaid and SCHIP?*

Confusion About Medicaid/SCHIP Programs Varies Across States (low-income children)



Source: 1999 National Survey of America's Families



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Confusion about the rules governing Medicaid and SCHIP varies across states.

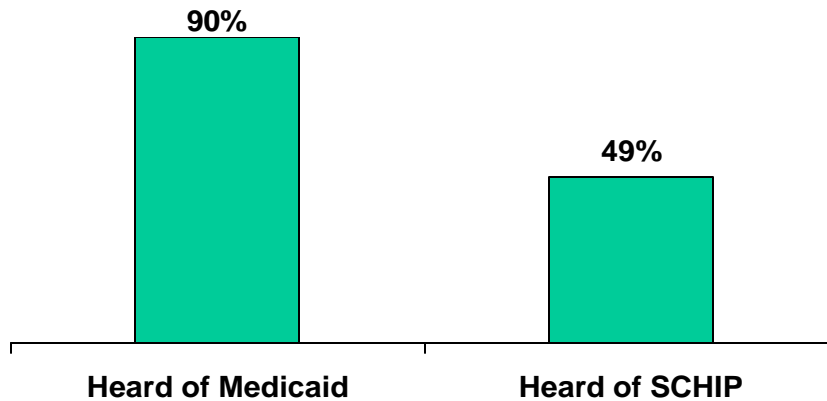
This chart provides a state-by-state breakdown of the percentage of all low-income families with children (not just those with uninsured children) who were not familiar with Medicaid and/or SCHIP **or** were confused about eligibility. A higher number indicates more knowledge problems.

Nationally, 53% were either unfamiliar with one of the programs (9 percent) or had heard of Medicaid and/or SCHIP but were confused about eligibility (44 percent).

In the 13 ANF study states, lack of familiarity with the programs and knowledge about eligibility ranged from 29% in MA to nearly 60% in TX.

State variation may relate to the time states started their SCHIP programs. For example, confusion about Medicaid and SCHIP tended to be higher in states, like MS and TX, which began their programs later. Low-income families were more knowledgeable about Medicaid and SCHIP in states like MA and AL that started their programs much earlier.

Awareness of Separate SCHIP Programs Lags Behind Awareness of Medicaid (low-income children)



Source: 1999 National Survey of America's Families



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Not surprisingly, awareness of separate SCHIP programs lags behind awareness of Medicaid. For low-income children who lived in states with separate SCHIP programs, 90% had parents who had heard of Medicaid but only 49% had parents who had heard of SCHIP.

This is to be expected considering how new most SCHIP programs were in 1999, but it demonstrates that new SCHIP programs have a long way to go to reach the level of awareness that Medicaid enjoys.

Reasons Low-Income Uninsured Were Not Enrolled in Medicaid or SCHIP Programs Are Complex

Reason Child Not Insured	Percent
Knowledge gaps	32%
Administrative hassles	10
Enrolled in past year but not at present	18
Applied for coverage but not enrolled	11
Not needing or wanting program	22
Other main reason given	7
Total	100%

Source: 1999 National Survey of America's Families



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Knowledge barriers are not the only barriers that keep low-income children from being covered. Parents also cited administrative hassles, perceived lack of need for health insurance coverage, and other reasons their children were not enrolled. In addition, a sizeable group of uninsured children had either been covered at some point in the previous year or had applied for coverage but were not yet enrolled.

Of all low-income uninsured children, a third (32%) had parents who identified a **knowledge barrier**. This includes the children of parents who hadn't heard of Medicaid/SCHIP, didn't think their child was eligible, or didn't know how to get more information about the programs. Investment in outreach and education can help resolve this problem.

The parents of 10% of uninsured children cited **administrative hassles** as a barrier to insurance. They couldn't obtain the necessary documents or faced transportation or language barriers. Even though states have made applying for these programs easier, much remains to be done.

18% had been enrolled in Medicaid or SCHIP at some point in the past year but were uninsured by the time they were interviewed. Did their parents not value the program or was the redetermination process too burdensome?

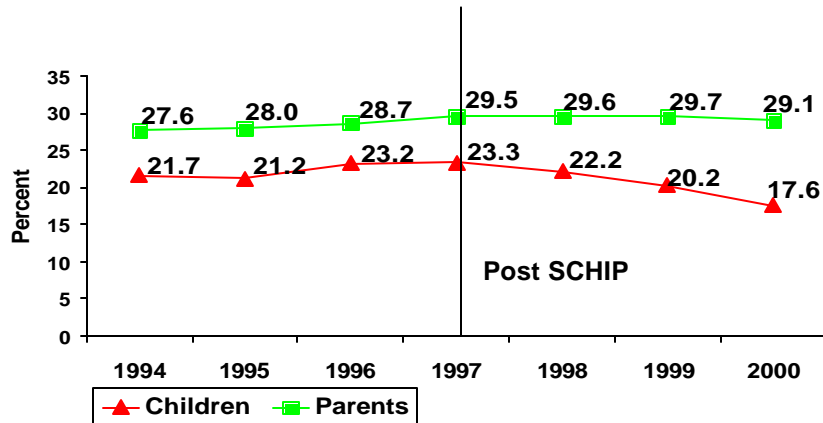
The 11% of children whose parents had applied for coverage but were not yet enrolled may simply reflect a normal proportion of applications awaiting an eligibility determination. Even in a perfect system, there may be a group of this size waiting for a determination.

22% of low-income uninsured children had parents who said they **didn't need or want public health insurance coverage** because their children didn't need health insurance or they didn't want help from the government. While these children are healthier than other low-income uninsured children and have fewer reported unmet needs, most did not receive preventive care, so their parents may need to be made more aware that ongoing monitoring of children's health is important and beneficial even to healthy children.

Finally, **7%** gave some other main reason for not inquiring or applying that couldn't be classified in any of the other categories.

A more complete discussion of this issue can be found in Policy Brief B-35, *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?*

Uninsurance Dropping for Near Poor Children But Not for Near Poor Parents



Source: 1995-2001 Current Population Survey



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Ultimately, SCHIP will be judged primarily by the extent to which it reduces uninsurance since that may be key to improving children's health status. Evidence from the Current Population Studies suggests that SCHIP is having an important impact on the uninsurance rate for children with incomes between 100 and 200 percent of poverty. This is the group most likely to benefit by SCHIP and possible spillover effects on Medicaid. Uninsurance among children dropped 5.7 percentage points between 1997 and 2000. This is in contrast to their parents who saw virtually no change in their uninsurance rate. The fact that the uninsurance rate is declining for children relative to their parents suggests that the reduction in uninsurance among children may be due to the SCHIP expansions.

Part 2: Qualitative Findings

Ian Hill
The Urban Institute
August 2002



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The State Children's Health Insurance Program (SCHIP), enacted in August, 1997, provided new incentives for states to extend public health insurance coverage to low-income uninsured children. The federal government offered states a higher federal match and greater flexibility to design their programs than they enjoyed under Medicaid.

States took advantage of this new opportunity. All states and the District of Columbia expanded coverage under SCHIP. Many states took advantage of the option to develop separate non-Medicaid programs. This allowed states to alter the benefit package, impose premiums and co-payments, and implement waiting periods to prevent people from replacing private coverage with public coverage (crowd-out).

This summary of key qualitative findings from the Urban Institute's SCHIP evaluation are quite consistent with information collected under a Congressionally mandated study also conducted by the Urban Institute.

This research is part of a comprehensive evaluation of the State Children's Health Insurance Program primarily funded by the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation as part of the Urban Institute's *Assessing the New Federalism* project. Additional financial support came from The Annie E. Casey Foundation, the W. K. Kellogg Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, The McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, The Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.

Research Design

Case studies (Summer '99 - Spring '00)

Week-long site visits to 15 states; telephone interviews with 3 others

Broad range of key informants interviewed to discuss experiences of alternative models

Detailed examination of wide range of implementation challenges and strategies

Cross-cutting papers describing challenges, innovative strategies, and lessons learned



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SCHIP provided state policymakers great flexibility to tailor the program to meet the specific needs of each state. To study the choices states made, ANF initiated a series of case studies.

Researchers spent a week in each of the 13 ANF focal states as well as MO and OH — two days in the state capitol speaking with administrators and legislators and three days in communities interviewing health care providers, community organizations involved with outreach, managed care organizations, advocates, and front-line program administrators.

The structured interviews covered a variety of topics including: program design and policy history; outreach; benefit package; service delivery and payment arrangements; cost sharing; crowd out; special populations such as children with special health care needs, and financing.

In addition to the site visits to the 13 ANF focal states, MO, and OH, telephone interviews were conducted with key stakeholders in NC, PA, and CT.

Policy and Program Design

Enhanced federal match, strong economy, and bi-partisan support fueled rapid state response

Strong interest in alternatives to Medicaid:

Fear of entitlement

Belief in many states that Medicaid was either “broken” or too burdened by political/provider/consumer resistance

Opportunity to test new models



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SCHIP gave states an enhanced federal match compared with Medicaid. Combined with a strong economy and state budget surpluses, all states established programs. Within 12 months of Congressional passage, 48 states submitted plans and the federal government approved 41. By the second anniversary, all 50 state programs were approved.

Two-thirds of the states took advantage of the opportunity to establish SCHIP as a separate program. They chose a separate program because they wanted to avoid expanding an entitlement program; believed that Medicaid was either “broken” or too burdened by political, provider, and consumer resistance; or were eager to test new approaches.

Outreach

Significant marketing/outreach challenge: At least three distinct target populations

Working poor (w/ no prior experience with public programs)

Ethnic minorities (mainly Hispanics with fear of public charge)

Former welfare recipients (whom states had recently “turned away”)

Despite challenges, states undertook unprecedented outreach



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As states launched programs, amid great fanfare and high expectations for success, outreach and enrollment became top priorities. Administrators in many states had little prior experience with outreach and soon learned that they faced many challenges in reaching the target population of low-income children.

It soon became clear that different outreach strategies were required to reach the various distinct sub-populations of children who might be eligible for SCHIP, including children of working poor parents who had no prior experience with public programs; children of ethnic minority parents who might not be aware of the program or might fear that involvement with government programs could adversely affect applications for citizenship; and children of former welfare recipients who had recently been turned away from government benefits.

Outreach (cont.)

Two complementary components emerged and worked well together

Mass media, to raise awareness and build “brand recognition”

Community-based efforts, to persuade “hard to reach” families to enroll

While both types of programs have been very active in outreach, Separate Programs appeared to enjoy more explicit mandate/permission to market than Medicaid expansions



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To overcome these challenges, states invested heavily in outreach.

Most states we studied implemented two complementary approaches:

- A mass media campaign (involving radio and television public service announcements, print materials, etc.), designed to raise public awareness of the availability of new coverage and stress the importance of insurance for children;
- Community-based efforts, designed to persuade “hard to reach” families to enroll. States have increasingly funded a wide variety of community organizations, including schools, churches, ethnic organizations, and other well-established, “trusted” groups to perform outreach and to assist families in applying for coverage.

Interestingly, separate SCHIP programs have appeared to enjoy more explicit political and financial support to market themselves than have Medicaid expansions.

Enrollment and Retention

Outreach efforts complemented by massive effort to simplify/streamline enrollment:

Short forms/mail-in applications; reduced/eliminated verification; community-based application assistance; MCO-based enrollment; Internet enrollment

Efforts to simplify eligibility redetermination slower to emerge

Significant “spill over” as *most* reforms have been adopted by Medicaid



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Efforts to reach out to families with eligible children were complemented by significant efforts to simplify and streamline their enrollment. Consistent with their belief that SCHIP should be more like private insurance, policymakers set out to make it as easy to apply for the program as possible. Simplification strategies that have become the “norm” across states include: using short and simple application forms to jointly determine SCHIP or Medicaid eligibility; reducing or even eliminating documentation that must be submitted with applications; dropping asset tests from the process; permitting applications to be submitted by mail (thereby eliminating the need for a face-to-face interview in a public welfare office); and paying community-based organizations to provide “application assistance” to families. Some states have even explored using managed care organizations as enrollment entities and designed Internet-based enrollment systems.

Simplification of the SCHIP enrollment process has had a direct and positive impact on Medicaid. Most, if not all, of the strategies used by SCHIP programs have been adopted by Medicaid thereby facilitating access to both programs.

Unfortunately, while initial enrollment procedures have been vastly simplified, the same can not be said of rules and procedures followed to renew children’s coverage.

Enrollment and Retention (cont.)

Medicaid still lags behind Separate programs in enrollment/renewal simplification

Eligibility disconnects seriously complicate “screen and enroll” efforts, seamlessness

Medicaid’s continued reliance on county “welfare” infrastructure undermines reality of delinking

Family resistance to Medicaid still strong in many states

Retention rates of 50% or less not uncommon



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Despite this significant progress, there is still room for improvement of eligibility and retention processes. For example:

Medicaid programs still lag behind their separate program counterparts in enrollment simplification. Differences in rules regarding assets tests, the need for face-to-face interviews with eligibility workers, and verification can complicate the federally required “screen and enroll” process and contribute to confusion among parents.

Many states still use county “welfare” departments to determine Medicaid eligibility, and this practice can cause resistance to the program among some families.

Finally, many states have begun to experience disenrollment rates of approximately 50 percent as children come up for renewal. Thus, the need to simplify eligibility redetermination procedures is clear.

Benefit Package Design

Benefits in Separate Programs approach breadth of Medicaid/Broader than most private insurance

Cover preventive services w/ AAP guidelines

Cover dental, hearing, vision (usually)

No deductibles or coinsurance

Coverage gaps and service limits less significant than many feared

Even advocates cite few problems with benefits



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While Medicaid expansions were required to adopt that program's rich benefits coverage, states creating separate programs had the flexibility to establish a more limited set of benefits, as long as packages met certain minimum benchmarks.

The benefits package adopted by study states with separate programs, however, were found to approach the breadth of Medicaid coverage and were consistently described as "much broader than private insurance."

These programs generally cover a broad range of preventive, primary, and acute care services. The vast majority of states were found to go beyond minimum benchmark coverage to add services known to be critical for children, such as dental, hearing, and vision care. In addition, both coverage gaps and service limits were less significant than permitted by the law.

Key informants interviewed for the study, including child advocates, could cite almost no cases where they heard of children that needed services that were not covered.

Service Delivery and Payment Arrangements

Use of managed care almost universal; largely credited with resulting in “good” access to care

SCHIP networks not always same as Medicaid; mixed implications for access

SCHIP payments often based on Medicaid’s; to extent these rates viewed as unfairly low, SCHIP access problems emerge/increase

**When SCHIP rates higher, equity issues arise
Promising models for dental care and access**



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In studying service delivery and payment arrangements under SCHIP, we found that:

Most states set out to build models that relied exclusively, or primarily, on managed care arrangements.

Most states initially built SCHIP networks upon those in place for Medicaid, but complete alignment was seldom achieved. Where differences persisted, it was usually separate programs that used managed care arrangements more extensively than Medicaid programs.

In a small number of states where Medicaid service delivery had historically been problematic, SCHIP followed a different path, contracting with mainstream provider networks like Blue Cross/Blue Shield for payments more comparable to commercial rates.

Access to care was generally described as good under SCHIP and, in some states, as better than access under Medicaid.

Most often, SCHIP payments (both managed care capitations and fee-for-service rates) were based on those of Medicaid. To the extent that these rates were viewed by providers as unfairly low, access problems appeared to emerge.

States have also used SCHIP to develop managed care models for the delivery of dental care which have shown promising early results.

Cost Sharing

**Cost sharing policies vary considerably:
premiums, enrollment fees, copays**

**No state's cost sharing appears to approach the
law's 5% of income ceiling**

**Even family advocates describe cost sharing as
nominal, not a barrier to enrollment or use, and
may even enhance program image (except in
CO!)**

**Premium collection/logistics are more
problematic, often affecting retention**



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While federal law virtually prohibits states from imposing co-payments, premiums or other forms of cost sharing on Medicaid beneficiaries without a waiver, states have considerable flexibility under SCHIP to implement cost sharing, as long as enrollees' total out-of-pocket costs don't exceed five percent of family income in a given year.

Indeed, the vast majority of separate SCHIP programs have established monthly premiums, annual enrollment fees, and/or copayments. Policymakers in these states argued that cost sharing would help SCHIP mirror private insurance, build personal responsibility, and distance SCHIP from welfare.

Encouragingly, in almost every state we studied, cost sharing was described by key informants as "nominal" and "affordable." The imposition of cost sharing generally begins with families that earn incomes over 150 percent of poverty; annual fees are typically \$25 to \$50 per child; and monthly premiums often fell in the \$5 to \$15 per child range.

Key informants, including advocates, most often stated the belief that cost sharing did not seem to be imposing barriers to either enrollment or utilization.

Hoping to promote family responsibility and avoid the stigma of welfare, Colorado adopted some of the highest premiums found in any SCHIP program in the country. As many families fell behind in their payments and enrollment lagged state targets, Colorado officials looked to other states and determined that their policies were outside the national mainstream. State officials ultimately forgave all delinquent payments, dropped the monthly premium, and adopted a simpler, less expensive annual enrollment fee.

Crowd Out

Crowd out prominent issue during design phase

Strategies to prevent include waiting periods, cost sharing, employer subsidy programs, monitoring

Qualitative evidence, while limited in validity, suggests crowd out not occurring much

Concern over crowd out has faded considerably

Some reducing/removing crowd out “firewalls,” and conducting outreach to employers

Growing use of exceptions related to cost/limited nature of private insurance



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Upon the passage of SCHIP, federal and state policymakers expressed great concern that low-income parents would drop existing private insurance coverage in order to enroll in SCHIP. As a result, states were required to demonstrate to the federal government how they intended to discourage so-called “crowd out,” and state legislatures eagerly adopted a number of strategies to do so.

Most often, states imposed waiting periods, lasting 3, 6, or even 12 months, during which a previously insured child had to be *uninsured* before being permitted to enroll in SCHIP. Other strategies states described as preventing crowd out were cost sharing, employer subsidy programs, and monitoring.

Interviews with key informants revealed that there was little perceived crowd out occurring. Supporting this, we found that local outreach/enrollment staff actively discouraged parents from dropping their private insurance, and state data indicated that few children applying for coverage reported already having private insurance.

As a result, state policymakers’ concern about crowd out appears to be fading. NJ and MS reduced or eliminated their waiting periods, and a large number of states permit exceptions to waiting periods for families whose private insurance is deemed too expensive.

Coverage of Parents

Several states interested in extending coverage to parents of SCHIP children through premium assistance and family coverage waivers

Premium assistance: Federal rules considered too rigid/inflexible, especially 60% employer contribution/cost effectiveness requirements

Massachusetts—very challenging to administer employer subsidy

Family coverage: Wisconsin—parental coverage a boon to enrollment



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Based on the notion that parents are more likely to cover their children if they can receive coverage at the same time, several states have begun to extend SCHIP coverage to parents.

States have two mechanisms for extending this coverage. States can apply for a waiver from the federal government or they can establish premium assistance programs to encourage employers to offer insurance coverage to their workers.

Among our study states, we observed one state with a small, but successful (in the opinion of state administrators) premium assistance program, and learned that other states had been discouraged from pursuing this strategy due to federal rules that were viewed as overly rigid and inflexible.

We also observed a parental coverage program in WI which did, indeed, seem to spur very rapid enrollment among eligible children.

Children with Special Health Care Needs

Most states not focused on CSHCN during design

Exceptions include: “wrap around” models (CT and NC), special managed care systems (FL and MI), and service carve-outs (CA)

Even child advocates cite few examples of problems with coverage or access

Surprising early findings regarding the numbers/types of CSHCN being served through special models



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We found that most states were not focused on children with chronic illnesses and disabilities during the design phase of SCHIP and implemented few specific policies to address their special needs.

However, several of our study states did enact special benefit or service delivery arrangements designed to ensure that this vulnerable population was well covered. In states like CT and NC, special “wrap around” benefits were identified for this population that were not extended to the entire SCHIP population. And in CA, FL, and MI, special service delivery arrangements, relying on Title V systems and Children’s Hospitals, were extended from Medicaid and applied to SCHIP.

Encouragingly, providers, child advocates, and others believed that children with special health care needs were being well served under SCHIP and cited few examples of problems with coverage or access.

States which did develop special programs for this population had experienced low enrollment, suggesting that children with disabilities may already be enrolled in Medicaid or have private insurance and are, therefore, prohibited from signing up for SCHIP.

Overarching Conclusions

SCHIP is small compared to Medicaid, yet its influence has already been far reaching

SCHIP stimulated vast reforms, making delinking of health/welfare a reality (...whether through Separate Programs or Medicaid expansions)

States quite satisfied with enrollment progress

Clear trade-offs b/w Medicaid/Separate paths:

Medicaid more administratively efficient, but required “reinvention” of program

Separates face serious start-up/coordination challenges, but may provide more attractive “product” to consumers and providers



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While SCHIP is only a fraction of the size of Medicaid, it has served as a catalyst for major reforms in public health insurance programs. The early years of SCHIP implementation have witnessed innovations in the areas of outreach, enrollment simplification, benefits and access, and the general delinking of health insurance systems from welfare.

Despite a slow start, the rate of enrollment has steadily increased.

Some of the system trade-offs that can result from the adoption of alternative models—Medicaid expansions vs. separate programs—have also become clearer:

Medicaid expansions have been efficient, building upon existing infrastructures. At the same time, they also came with considerable “baggage” from their welfare legacy. This required policymakers to “reinvent” the programs, particularly in terms of enrollment policies.

Separate programs faced serious start-up challenges, as new programs were created from scratch. But flexibility in the law permitted states great latitude to design the programs they wanted in a manner that could appeal to consumers and providers. Separate programs have, however, faced ongoing coordination challenges with Medicaid.

Overarching Conclusions, (cont.)

Future Outlook — Is the sky falling?

SCHIP's popularity is enormous (among politicians, consumers, and most providers)

Whether economic downturn will severely erode this popularity remains to be seen

Retrenchment likely in form of less outreach, enrollment caps (in some states), benefit limits and cost sharing hikes (at margin), reduced fees

But political fallout and benefits of enhanced match likely to protect SCHIP from severe cuts



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During its short history, SCHIP has benefited from strong federal and state economies. With the recent downturn and the return of tight state budgets, however, many worry about the future and speculate that states may cut or cap eligibility. At this time, it is difficult to predict whether SCHIP's enormous popularity will wane and whether the poor economy will erode the program.

From these case studies, and research since, it seems likely that SCHIP and Medicaid expansions will survive largely intact. Policymakers have expressed the strong sentiment that the programs are too popular to dramatically cut and that the political fall-out from doing so would be too great. Rather than eligibility cuts, then, it seems more likely that retrenchment may take the form of reduced outreach and enrollment caps similar to those being enacted in a small number of states.