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ABSTRACT

Under the Balanced Budget Act of 1997, Congress established the State Children's Health Insurance Program (SCHIP) to expand health insurance coverage to uninsured low-income children. This report summarizes the major findings of the first year of a national evaluation of SCHIP. Following a summary of major findings, the report examines state variations in eligibility for SCHIP, trends in SCHIP and Medicaid enrollment, trends in the number of uninsured children before and after implementation of SCHIP, successes and challenges in enrolling and retaining children in SCHIP, and state recommendations for improving Title XXI, authorization for SCHIP. Major findings noted include the following: (1) all 50 states and the District of Columbia have implemented SCHIP programs, which are tailored to each state's need, context, and capacity; (2) states vary in the extent to which they have expanded health insurance coverage for low-income children under SCHIP; (3) enrollment is continuing to increase at an impressive rate; (4) findings on the trend in the uninsured rate by poverty level are at least suggestive of an early influence of SCHIP, though the time series must be extended before valid inferences may be drawn about the direction and magnitude of change; (5) almost all states have made a deliberate attempt to streamline and simplify their application and redetermination policies and forms, and the majority have eliminated assets testing, and many have also reduced verification requirements; and (6) states recommended a variety of changes to coverage, financing, administration, and program orientation, with the constraints of the 10 percent administrative cap being mentioned most frequently. Overall, findings indicate that SCHIP is exhibiting growing momentum. The report's three appendices include a summary of amendments to Title XXI state plans, simulated program eligibility for a hypothetical family at various percentages of poverty, and number of children ever enrolled in SCHIP, by state. (Contains 12 references.) (HTH)

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Implementation of the State Children's Health Insurance Program: Momentum Is Increasing After a Modest Start

First Annual Report

January 2001

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CHAPTER I

INTRODUCTION AND SUMMARY OF MAJOR FINDINGS

Under the Balanced Budget Act of 1997, Congress established the State Children's Health Insurance Program (SCHIP) to expand health insurance coverage to uninsured low-income children. States were given the option of developing separate child health programs, expanding Medicaid, or using a combination of the two approaches. States also were given flexibility to initiate employer buy-in or premium assistance programs, to develop family coverage components, or to develop public health initiatives for low-income children.

The SCHIP program has been more challenging to implement than might have been expected. States are gaining momentum, however, as their programs mature and gain public awareness. Enrollment continues to grow at a steady pace; the number of children ever enrolled during the first three months of 2000 was higher than the number ever enrolled during federal fiscal year (FFY) 1999. In this report, we review how SCHIP programs have evolved over time and how they are likely to evolve as states examine the strengths and weaknesses of their programs. We also present state perspectives on how the rules and regulations surrounding the implementation of SCHIP have affected their progress.

This report summarizes the major findings of the first year of a national evaluation of SCHIP, sponsored by the Health Care Financing Administration (HCFA) and conducted by Mathematica Policy Research, Inc. (MPR). The report addresses the following key questions:

- What is the extent of coverage expansion offered under SCHIP, and how much does SCHIP expand eligibility beyond Medicaid?
- How many children enrolled in SCHIP, and how has enrollment grown over time?

- What effect has SCHIP had on the uninsured rate for low-income children?
- How do states assess their successes and challenges in enrolling and retaining children in SCHIP?
- What recommendations do states have for improving Title XXI?

Our analysis is based on several sources, including the state SCHIP evaluations mandated under Title XXI (submitted to HCFA in spring 2000), quarterly enrollment data submitted by states to HCFA, and national data on trends in the number of uninsured children. We begin with an overview of the current status of SCHIP, then review our major findings before presenting our detailed findings in later chapters.

THE CURRENT STATUS OF SCHIP

All 50 states and the District of Columbia have implemented SCHIP programs, which are tailored to each state's need, context, and capacity.[1] As of March 31, 2000, 19 states operated Medicaid expansion programs (which we call M-SCHIP programs), 15 states operated separate SCHIP programs (known as S-SCHIP programs), and 17 states used both approaches to expand coverage. The implementation of SCHIP has been gradual. Although Title XXI authorized enrollment as of October 1, 1997, only eight states began covering children under SCHIP during 1997 (Table 1). The majority of states began enrollment in 1998 (33 states in all), while eight states began enrollment in 1999. Two states began enrolling children in 2000.

The SCHIP program continues to grow and is still evolving; state approaches are being modified and expanded as states gain experience and knowledge. As of August 1, 2000, 31 states have received approval for 52 program amendments, and 11 states have amendments pending. Since their initial implementation, 21 states have amended their state plans to expand eligibility, either by raising eligibility thresholds within existing SCHIP programs (13 states) or by establishing new S-SCHIP programs (8 states). Appendix A summarizes amendments approved as of August 1, 2000.

As the program approached its three-year anniversary, states and the Congress raised concerns about the significant portion of the FFY 1998 SCHIP allotment that remained unspent. Only 45 percent of the FFY 1998 allotment had been spent as of June 30, 2000. This could potentially leave $1.9 billion of the FFY 1998 allotments to be reallocated to states that have been able to spend their full FFY 1998 allotment.

[1]In addition, the five territories utilize Title XXI funds to extend their Medicaid programs. The territories' SCHIP programs are not discussed in this report and will be evaluated separately.

TABLE 1

PROGRAMS FUNDED THROUGH TITLE XXI, AS OF MARCH 31, 2000

State	Type of SCHIP Program	Program Name[a]	Date Enrollment Began	
			M-SCHIP	S-SCHIP
Alabama	COMBO	Medicaid Expansion/ALL Kids	February 1998	October 1998
Alaska	M-SCHIP	Denali KidCare	March 1999	-
Arizona	S-SCHIP	KidsCare	-	Novermber 1998
Arkansas	M-SCHIP	Arkansas Medicaid Program	October 1998	-
California	COMBO	Medi-Cal for Children/Healthy Families Program	March 1998	July 1998
Colorado	S-SCHIP	Child Health Plan Plus (CHP+)	-	April 1998
Connecticut	COMBO	Husky	October 1997	July 1998
Delaware	S-SCHIP	Delaware Healthy Children Program	-	February 1999
District of Columbia	M-SCHIP	DC Healthy Families	October 1998	-
Florida[b]	COMBO	Medicaid for Teens/Healthy Kids	April 1998	April 1998
Georgia	S-SCHIP	PeachCare for Kids	-	January 1999
Hawaii	M-SCHIP	Hawaii Title XXI Program	July 2000	-
Idaho	M-SCHIP	Idaho Children's Health Insurance Program	October 1997	-
Illinois	COMBO	KidCare Assist Expansion/KidCare Share/KidCare Premium	January 1998	October 1998
Indiana	COMBO	Hoosier Healthwise	June 1997	January 2000
Iowa	COMBO	Medicaid/HAWK-I	July 1998	January 1999
Kansas	S-SCHIP	HealthWave	-	January 1999
Kentucky	COMBO	KCHIP	July 1998	November 1999
Louisiana	M-SCHIP	LaCHIP	November 1998	-
Maine	COMBO	Medicaid Expansion/Cub Care	July 1998	August 1998
Maryland[c]	M-SCHIP	Maryland's Children's Health Program	July 1998	-
Massachusetts[d]	COMBO	MassHealth/Family Assistance	October 1997	August 1998
Michigan	COMBO	Healthy Kids/MIChild	April 1998	May 1998
Minnesota	M-SCHIP	Minnesota Medical Assistance Program	September 1998	-
Mississippi	COMBO	Mississippi Health Benefits Program	July 1998	January 2000
Missouri	M-SCHIP	MC+ for Kids	July 1998	-
Montana	S-SCHIP	Children's Health Insurance Plan	-	January 1999
Nebraska	M-SCHIP	Kids Connection	July 1998	-
Nevada	S-SCHIP	Nevada Check-Up	-	October 1998
New Hampshire	COMBO	Healthy Kids	May 1998	January 1999
New Jersey	COMBO	NJ KidCare	February 1998	March 1998
New Mexico	M-SCHIP	State Children's Health Insurance Program	March 1999	-
New York	COMBO	Medicaid/Child Health Plus (CHPlus)	January 1999	April 1998
North Carolina	S-SCHIP	NC Health Choice for Children	-	October 1998
North Dakota	COMBO	Healthy Steps	October 1998	October 1999
Ohio	M-SCHIP	Healthy Start	January 1998	-
Oklahoma	M-SCHIP	SoonerCare	December 1997	-
Oregon	S-SCHIP	CHIP	-	July 1998
Pennsylvania	S-SCHIP	CHIP	-	May 1998
Rhode Island	M-SCHIP	RIte Care	October 1997	-

TABLE 1 *(continued)*

State	Type of SCHIP Program	Program Name[a]	Date Enrollment Began M-SCHIP	Date Enrollment Began S-SCHIP
South Carolina	M-SCHIP	Partners for Healthy Children	August 1997	-
South Dakota	M-SCHIP	South Dakota's Health Insurance Program	July 1998	-
Tennessee	M-SCHIP	TennCare for Children	October 1997	-
Texas[e]	M-SCHIP	Medicaid	July 1998	-
Utah	S-SCHIP	Utah CHIP	-	August 1998
Vermont	S-SCHIP	Dr. Dynasaur	-	October 1998
Virginia	S-SCHIP	Virginia's Children's Medical Insurance Plan	-	October 1998
Washington	S-SCHIP	Washington State CHIP	-	February 2000
West Virginia[f]	COMBO	WV SCHIP	July 1998	April 1999
Wisconsin	M-SCHIP	BadgerCare	April 1999	-
Wyoming	S-SCHIP	Wyoming Kid Care	-	December 1999

SOURCE: Title XXI State Evaluations, Section 2.1 of State Evaluation Framework.

M-SCHIP = State operates Medicaid expansion program
S-SCHIP = State operates separate SCHIP program
COMBO = State operates both an M-SCHIP and S-SCHIP program

[a] When more than one name is noted, the first is that of the M-SCHIP program, and the rest are the names of S-SCHIP programs.

[b] Florida also uses Title XXI funds for its MediKids, CMS (Children's Medical Services), and BHSCN (Behavioral Network) programs. These programs cover children under age five, those with special bealth care needs, and those with serious behavioral health care needs, respectively. Enrollment for these programs began on October 1, 1998.

[c] On November 7, 2000, Maryland received approval for an S-SCHIP program; enrollment will begin July 1, 2001.

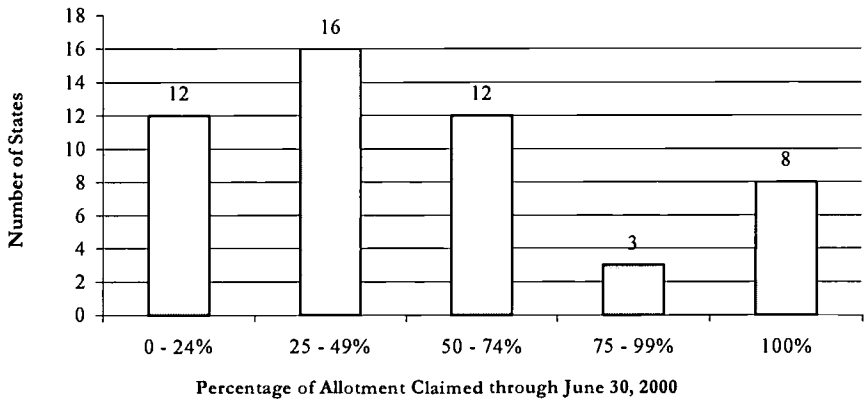
[d] Massachusetts also uses Title XXI funds for its Common Health program. This program covers disabled children. Enrollment began on October 1, 1997.

[e] On November 8, 1999, Texas received approval for an S-SCHIP program; enrollment began April 3, 2000.

[f] As of October 13, 2000, West Virginia's SCHIP program was amended to incorporate the M-SCHIP component into the S-SCHIP compone nt effectively eliminating the M-SCHIP program.

As shown in Figure 1, 8 states spent all their FFY 1998 allotment as of June 30, 2000 (Alaska, Indiana, Kentucky, Maryland, Massachusetts, New York, North Carolina, and South Carolina); at the other end of the continuum, 12 states spent less than a fourth of their allotment. The level of SCHIP spending depends on a variety of factors, including the time it takes to design and implement a new program, when enrollment actually begins, and limitations within the Title XXI statute that have prevented some states with pre-existing child health programs from qualifying for SCHIP. The level of federal SCHIP expenditures is clearly a function of how early a state implemented its SCHIP program (Table 2). The states that implemented SCHIP programs in 1997 spent 76 percent of their FFY 1998 allotment, declining to 43 percent for those implementing in 1998, and 31 percent for those implementing in 1999.

Figure 1: Percentage of the FFY 1998 SCHIP Allotment Claimed by States, As Of June 30, 2000



SOURCE: Mathematica Policy Research analysis of Federal expenditures as reported by states on HCFA form 21-C through June 30, 2000.

Table 2: Summary of SCHIP Federal Allotments and Federal Expenditures (As of June 30, 2000)

Date Enrollment Began	FFY 1998 Federal Allotment (in millions)	Federal Expenditures (in millions)	Percent of FFY 1998 Allotment Spent
1997 (8 states)	$ 390.3	$ 295.2	75.6
1998 (33 states)	3,485.1	1,509.4	43.3
1999 (8 states)	293.3	91.0	31.0
2000 (2 states)	55.6	0.1	0.3

SUMMARY OF MAJOR FINDINGS

State Variations in Eligibility for SCHIP

States vary in the extent to which they have expanded health insurance coverage for low-income children under SCHIP. Title XXI authorized states to expand coverage to children in families with income up to the higher of 200 percent of poverty or 50 percentage points above the Medicaid eligibility level in effect on March 31, 1997.

- As of March 31, 2000, 18 states had implemented SCHIP eligibility at 200 percent of poverty, and another 10 states set eligibility thresholds above 200 percent of poverty. Twenty-three states chose a threshold lower than 200 percent of poverty.

- States implementing M-SCHIP only programs tend to have more modest income eligibility thresholds; as of March 31, 2000, 12 of the 19 states with M-SCHIP only programs set eligibility below 200 percent of poverty, whereas 5 of the 15 S-SCHIP only programs and 6 of the 17 states with combination programs had an income threshold below 200 percent of poverty. States with combination programs typically have implemented a modest expansion through Medicaid and a broader expansion through their S-SCHIP programs.

- States with Section 1115 demonstration programs or other Medicaid expansions prior to SCHIP typically have implemented narrower SCHIP programs because they had established relatively high Medicaid income thresholds pre-SCHIP. Thus, it is important to view SCHIP expansions in the context of prior Medicaid expansions. These states typically have used SCHIP to fill the gaps for specific age or income groups (such as adolescents).

- Simulations of eligibility for a hypothetical family of six with an infant and children ages 5, 10, and 17 demonstrate state variation in eligibility for traditional Medicaid, M-SCHIP, and S-SCHIP programs. Of the 27 states included in the simulation, 18 covered all four children in families where gross income was 200 percent of poverty and one state covered only the infant.

Age of Child	Number of States Covering Children in Families With Gross Income of 200 Percent of Poverty Through: Traditional Medicaid	M-SCHIP	S-SCHIP	Child Not Eligible
Infant	8	3	8	8
Age 5	4	3	11	9
Age 10	3	4	11	9
Age 17	3	4	11	9

- Of the 27 states included in the simulation, 16 had implemented an S-SCHIP program, either alone or in combination with an M-SCHIP program. At 133 percent of poverty, in 9 of the 16 states, the two older children would be eligible for S-SCHIP and the two younger children would be eligible for Medicaid.

Families with children enrolled in both Medicaid and S-SCHIP programs may face complexities resulting from differences across programs such as eligibility rules, benefit packages, and provider networks. States with S-SCHIP programs and age-based eligibility standards in Medicaid have the additional challenge of developing a system that is seamless from the family's perspective and that provides for smooth transitions as children age out of the Medicaid program and into SCHIP.

Trends in SCHIP and Medicaid Enrollment

SCHIP enrollment is continuing to increase at an impressive pace. Only about 1 million children were enrolled in SCHIP in FFY 1998, while in FFY 1999, close to 2 million children were enrolled in SCHIP at some point during the year. Growth appears to be continuing at a steady pace into the first half of FFY 2000.

- SCHIP enrollment grew 29 percent from the fourth quarter of FFY 1999 through the second quarter of FFY 2000, among the 37 states that have submitted enrollment data for the second quarter of FFY 2000.

- Ten of the 37 states reported growth rates exceeding 50 percent during the first six months of FFY 2000.

- Between the second quarter of FFY 1999 and the second quarter of FFY 2000, enrollment grew by 90 percent in the 35 states reporting data in both quarters. Enrollment more than doubled in 17 states.

SCHIP enrollment is heavily concentrated in states that implemented their programs in the first year following passage of the SCHIP legislation.

- Altogether, the 19 states implementing SCHIP programs before July 1, 1998 accounted for over three-fourths of SCHIP enrollment during FFY 1999. The three states with preexisting comprehensive child health programs--Florida, New York, and Pennsylvania--accounted for close to 40 percent of total SCHIP enrollment in FFY 1999.

Information on the extent of turnover in SCHIP is not yet available. We estimated that about 18 percent of children who were ever enrolled in SCHIP in FFY 1999 were not enrolled in the last quarter of that year. In other words, about 350,000 children were enrolled at some time during the year but had disenrolled by the last quarter. States have indicated that many of the children who disenrolled from SCHIP did so because they were eligible for Medicaid coverage or because they aged out of SCHIP. A more thorough analysis is needed before any definitive conclusions can be reached about SCHIP turnover. For example, many states had not yet faced annual redeterminations for their SCHIP programs by the end of FFY 1999. Further research is required to analyze the extent of transfers between Medicaid and SCHIP, versus disenrollment in which children leave public insurance coverage altogether.

One measure of the effect of SCHIP is the extent to which public insurance coverage for children has expanded beyond the traditional Medicaid program. In FFY 1999, SCHIP has increased the number of children with public insurance coverage by 10 percent or more in 17 states. The greatest gain was in Oklahoma, where the number of children with public insurance coverage increased by 66 percent.

SCHIP also may have been instrumental in stemming declines in child Medicaid enrollment, due both to its expansion of Medicaid coverage through M-SCHIP programs and the spillover effect of state outreach efforts for SCHIP. HCFA 2082 data for FFY 1995, 1996, and 1997 showed child Medicaid enrollment (under age 21) of 21.6, 21.2, and 21.0 million, respectively (data are not yet available for FFY 1998). We estimate that overall child Medicaid enrollment, including the 700,000 children enrolled in M-SCHIP, reached 21.0 million in FFY 1999.

Trends in the Number Of Uninsured Children Before and After SCHIP

SCHIP was implemented at a time when uninsured rates were rising, especially among the lowest-income children, many of whom were eligible for Medicaid but were not enrolled. During the five years preceding SCHIP (1993 to 1997), uninsured rates rose an average of three-tenths of a percentage point per year (from 14.1 to 15.3 percent). The increase was largest among children in families below 50 percent of poverty, where the proportion uninsured rose from 18.8 percent in 1993 to 26.1 percent in 1997. Throughout this period, however, the highest proportion uninsured was found among children in families between

100 and 150 percent of poverty, 27.8 percent of whom were uninsured in 1997. That SCHIP will extend coverage to many children in this group raises expectations that the uninsured rates will be reduced in the near future.

Only limited data are available to measure the short-term effect of SCHIP on uninsured rates. We compared uninsured rates in 1997 (pre-SCHIP) and 1998 (post-SCHIP) based on the 1998 and 1999 Current Population Survey (CPS).

- There were no statistically significant changes in the uninsured rates between 1997 and 1998, whether for all children or for subgroups by poverty level. The rise of 0.3 percentage point in the overall child uninsured rate between 1997 and 1998 appears to be a continuation of the pre-SCHIP trend, but the lack of statistical significance requires a more cautious interpretation.

These findings should not be surprising, given that most states were just beginning to implement their programs in 1998. In addition, about 250,000 children were transferred into SCHIP from preexisting state programs. Although none of the differences within poverty group were significant, the following trends may signal the early effects of SCHIP on reducing the rate of uninsured low-income children.

- Among children between 100 and 150 percent of poverty, the group with the highest proportion uninsured in every year from 1993 through 1997, there appears to be a reversal of the recent pre-SCHIP trend. The proportion uninsured dropped from 1997 to 1998 and while the reduction was not statistically significant, it suggests a divergence from the pattern found in earlier years among children in the two lower income groups. Given where the early eligibility expansions were most far-reaching, if SCHIP had any effect in 1998, it is in this group that we would expect the effect to be most pronounced.

- In the next higher income group, children between 150 and 200 percent of poverty, a gradual year-to-year rise in the uninsured rate between 1993 and 1996 flattens out and stays relatively flat through 1998.

In sum, our findings on the trend in the uninsured rate by poverty level are at least suggestive of an early influence of SCHIP, but the time series must be extended before we can draw valid inferences about the direction and magnitude of change.

Successes and Challenges in Enrolling and Retaining Children in SCHIP

In their SCHIP evaluation reports to HCFA, states highlighted many changes they have made to their enrollment and re-enrollment procedures to facilitate access to insurance coverage. Almost all states have made a deliberate attempt to streamline and simplify their SCHIP application and redetermination policies and forms. The vast majority of states have eliminated assets testing, and many have also reduced verification requirements. In addition, the majority have moved to mail-in applications for SCHIP and are not requiring face-to-face interviews.

Many states have made similar changes to their Medicaid programs as well. States also discussed broader enrollment issues they are trying to address, such as reducing stigma, improving retention rates, implementing cost-sharing, training staff, modifying automated systems to accommodate SCHIP, and centralizing eligibility determination.

Many examples of state strategies to improve enrollment and retention were included in the evaluation reports. For example:

- Oklahoma reduced its application form from 16 pages to 1 page, eliminated the assets test and began to accept a self-declaration of income. In FFY 1999, the state's M-SCHIP program increased enrollment in Medicaid by more than 60 percent.

- Illinois reported that its approval rate for KidCare applications improved to about 80 percent after the state ended face-to-face interviews, dropped the asset test, reduced and simplified verification requirements, streamlined the application, developed a centralized intake unit and began to reimburse KidCare Application Agents who assist families with paperwork.

- Florida uses what it calls a passive re-enrollment process in its S-SCHIP program. At the point of redetermination, families receive a letter with information from their initial application and are asked to make corrections as necessary. If there is no response, Florida assumes that there have been no changes and coverage continues. The premiums provide assurance that families are active participants.

States reported that they face ongoing enrollment challenges as well.

- In particular, states with S-SCHIP programs often face coordination issues with Medicaid. Navigating and understanding coverage can be a problem when the same family has children covered by two different programs. The redetermination process can be confusing when the Medicaid and SCHIP programs are not using the same redetermination forms. States also

recognize the need for system changes to seamlessly transfer children between Medicaid and S-SCHIP programs when eligibility changes.

- Other problem areas include processing applications for SCHIP when a family is also receiving food stamps and determining eligibility when families do not pay the required premiums or enrollment fees (at least one state identified nonpayment as the leading cause of denied applications).

There is no single approach to structuring SCHIP enrollment and redetermination processes; states must assess the positives and negatives of each approach to find the practices best suited to their program. Additional research on best practices will also be useful in informing state efforts.

State Recommendations for Improving Title XXI

Congress mandated that the Title XXI state evaluations identify ways that SCHIP could be improved. To assist them in meeting their objectives under Title XXI, states recommended various changes in coverage, financing, administration, and program orientation. The following recommendations were mentioned most frequently:

- The most common concern among states is that the 10 percent administrative cap significantly constrains state efforts to conduct outreach, particularly among states with S-SCHIP programs that cannot obtain regular Medicaid matching funds for excess expenditures. States offered a number of suggestions ranging from changes in the way the cap is calculated to removal of outreach costs from the cap to raising the level of the cap.

- States perceive a shift in the direction of the Title XXI program at the federal level, signaling less flexibility, particularly for S-SCHIP programs. This concern is motivated by the perception that the proposed SCHIP regulations reflect a Medicaid orientation that could add to the costs and limit creativity among SCHIP programs.

- States reported that they face significant barriers in coordinating with employer-sponsored insurance, an important vehicle for expanding insurance coverage among low-income children and for avoiding crowd-out of private insurance coverage. Some barriers mentioned by states are the requirements for employer contributions, waiting periods without health insurance coverage, and requirements for health plans (such as benefits and cost-sharing limits).

- States also suggest that they cannot succeed in reducing the number of uninsured low-income children until coverage is expanded to certain omitted

groups, such as children of public employees, immigrant children, and uninsured parents. Some states believe that a sizable proportion of uninsured children will not gain coverage until their parents are covered as well. In addition, some states suggest extending SCHIP to children with catastrophic coverage only (the "underinsured"), who may lack insurance coverage for routine and preventive care.

CONCLUDING REMARKS

The SCHIP program is exhibiting growing momentum. The number of enrollees is rising each quarter, and states are considering new approaches to reach those who are potentially eligible but who remain uninsured. States also are turning increasing attention toward retention, to ensure continuity of coverage among those who are enrolled. Recent evidence also suggests that SCHIP outreach and enrollment simplification may have had spillover effects onto Medicaid enrollment.

As new data become available, further research will be conducted to document SCHIP enrollment and disenrollment trends and to measure the extent of transfers between SCHIP and Medicaid. In addition, we will continue to track national trends in the number and proportion of children who remain uninsured. We also will continue to highlight "best practices" in state performance, as reflected in the state evaluations and annual reports.

The federal and state governments have gained considerable experience over the past three years since the SCHIP program was implemented. They are continually striving to improve the SCHIP program to meet the goal of reducing the number of uninsured low-income children.

CHAPTER II

STATE VARIATIONS IN ELIGIBILITY FOR SCHIP

To understand how states have expanded publicly-financed health insurance coverage for low-income children, it is first necessary to understand the extent of eligibility expansions under SCHIP relative to each state's traditional Medicaid program.[1] Prior Medicaid expansions set a "floor" for SCHIP eligibility; where traditional Medicaid eligibility ends, SCHIP coverage begins. Medicaid income thresholds typically vary by age and states have considerable flexibility in the design of Medicaid and SCHIP eligibility policies, such as how they conduct income tests, how they define income and family size, whether they perform asset tests, and whether they impose residency requirements. State variation in eligibility policies results in considerable differences across states in the extent of the SCHIP expansion and, ultimately, in who is eligible for SCHIP.

This chapter begins with an overview of the extent of eligibility expansions under SCHIP, and then presents a simulation of Medicaid and SCHIP eligibility for a hypothetical family with four children to illustrate the level of state variation in SCHIP eligibility. State policies regarding income definitions, thresholds, and disregards were abstracted from each

[1] Title XXI authorized states to expand coverage to children in families with income up to the higher of 200 percent of poverty or 50 percentage points above the Medicaid level in effect on March 31, 1997. Some groups of children cannot be covered under SCHIP, such as children residing in a public institution or institution for mental diseases; children who are eligible for coverage through a state employee health benefits plan; or certain types of immigrants.

state's evaluation of its Title XXI program.[2] In an addendum to the state evaluation framework, states were asked to describe their eligibility policies as of September 30, 1999, for the Medicaid poverty expansion program and each component of SCHIP.

VARIATIONS IN MEDICAID AND SCHIP INCOME THRESHOLDS

The "floor" for SCHIP eligibility was set by the mandatory and voluntary Medicaid expansions for children in the late 1980s and early 1990s.[3] As of March 31, 1997, ten states had implemented the Medicaid expansions as mandated, while the remaining states opted to provide more generous coverage for children (see Table 3). Thirty-five states covered infants at levels above 133 percent of poverty and 9 states covered children ages 1 through 16 above the mandated levels.[4] Seventeen states covered children born on or before September 30, 1983, at 100 percent of poverty, and 7 states used even more generous thresholds for this group of children. The other 27 states, however, covered these children at the much lower levels set by state welfare and medically needy programs.

With the introduction of SCHIP, more children are eligible for publicly-financed health insurance. As of March 31, 2000, 18 states had established SCHIP eligibility at 200 percent of poverty and another 10 states have established even more generous thresholds. Twenty-three states set more modest thresholds below 200 percent of poverty. States implementing M-SCHIP only programs tend to have more modest income thresholds; as of March 31, 2000, 12 of the 19 states with M-SCHIP only programs set eligibility below 200 percent of poverty, whereas only 5 of the 15 states with S-SCHIP only programs and 6 of the 17 states with combination programs had an income threshold below 200 percent of poverty. Of the 10 states that established income thresholds above 200 percent of poverty, 4 implemented M-SCHIP only programs, 2 implemented S-SCHIP only programs, and 4 implemented combination programs. States with combination programs typically have implemented a modest expansion through Medicaid (often targeted to a particular age group) and a broader expansion through their S-SCHIP programs.

[2] Information was abstracted from Sections 3.1.1 through 3.1.4 and the addendum to Table 3.1.1 of the state evaluation framework.

[3] State Medicaid programs are mandated to cover children through age five under 133 percent of poverty, and children six years and older (born after September 30, 1983) under 100 percent of poverty. Medicaid programs also have had the option of covering children born on or before September 30, 1983 up to 100 percent of poverty.

[4] Two states (Rhode Island and Wisconsin) cover children ages 1 through 5 above the mandated level, but cover children ages 6 through 16 at the mandated level. Massachusetts and Maine cover children ages 6 through 16 above the mandated level, but cover children ages 1 through 5 at the mandated level.

TABLE 3

MEDICAID AND SCHIP INCOME THRESHOLDS BY PROGRAM TYPE AND BY STATE

State	Medicaid thresholds as of March 31, 1997				SCHIP thresholds as of March 31, 2000	
	Infants	Ages 1 through 5	Ages 6 through 16	Ages 17 through 18	M-SCHIP	S-SCHIP
M-SCHIP Only (N = 19)						
			Percent of FPL			
Alaska	133	133	100	71	200	-
Arkansas[a]	133	133	100	18	100	-
District of Columbia	185	133	100	50	200	-
Hawaii[b]	185	133	100	100	185	-
Idaho	133	133	100	100	150	-
Louisiana	133	133	100	10	150	-
Maryland[c]	185	185	185	40	200	-
Minnesota[d]	275	275	275	275	280	-
Missouri	185	133	100	100	300	-
Nebraska	150	133	100	33	185	-
New Mexico	185	185	185	185	235	-
Ohio[e]	133	133	100	33	150	-
Oklahoma[f]	150	133	100	48	185	-
Rhode Island[g]	250	250	100	100	250	-
South Carolina	185	133	100	48	150	-
South Dakota	133	133	100	100	140	-
Tennessee[h]	No limit	No limit	No limit	No limit	100	-
Texas[i]	185	133	100	17	100	-
Wisconsin	185	185	100	45	185	-
S-SCHIP Only (N = 15)						
Arizona	140	133	100	30	-	200
Colorado	133	133	100	37	-	185
Delaware	185	133	100	100	-	200
Georgia	185	133	100	100	-	200
Kansas	150	133	100	100	-	200
Montana	133	133	100	41	-	150
Nevada	133	133	100	31	-	200
North Carolina	185	133	100	100	-	200
Oregon	133	133	100	100	-	170
Pennsylvania	185	133	100	41	-	200
Utah	133	133	100	100	-	200
Vermont	225	225	225	225	-	300
Virginia	133	133	100	100	-	185
Washington	200	200	200	200	-	250
Wyoming[j]	133	133	100	55	-	133

TABLE 3 *(continued)*

State	Medicaid standards as of March 31, 1997				SCHIP standards as of March 31, 2000	
	Infants	Ages 1 through 5	Ages 6 through 16	Ages 17 through 18	M-SCHIP	S-SCHIP
Combination Programs (N = 17)						
Alabama	133	133	100	15	100	200
California	200	133	100	82	100	250
Connecticut	185	185	185	100	185	300
Florida	185	133	100	28	100	200
Illinois	133	133	100	46	133	185
Indiana	150	133	100	100	150	200
Iowa	185	133	100	37	133	185
Kentucky	185	133	100	33	150	200
Maine	185	133	125	125	150	185
Massachusetts	185	133	114	86	150	200
Michigan	185	150	150	100	150	200
Mississippi	185	133	100	34	100	200
New Hampshire[k]	185	185	185	185	300	300
New Jersey	185	133	100	41	133	350
New York[l]	185	133	100	51	100	192
North Dakota[m]	133	133	100	100	100	140
West Virginia[n]	150	133	100	100	150	150

SOURCES: SCHIP standards based on Mathematica Policy Research analysis of Title XXI State Evaluations, Table 3.1.1; Medicaid standards based on HCFA web site and Table 2 from HCFA's State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 - September 20, 1999.

NOTE: Title XXI stipulates that a child's family income must exceed the Medicaid income level that was in effect on March 31, 1997 in order for that child to be eligible for SCHIP-funded coverage.

[a]Only children born after 9/1/82 but before 10/1/83 are eligible for M-SCHIP. Arkansas increased Medicaid eligibility to 200 percent of FPL, effective September 1997, through Section 1115 demonstration authority.

[b]Children ages 1 through 5 are eligible for M-SCHIP. An amendment to increase the SCHIP threshold to 200 percent and the age criterion to all children under age 19 was approved September 22, 2000 and took effect July 1, 2000.

[c]Effective July 1, 2001, Maryland will implement an S-SCHIP program that extends coverage to children in families with income above 200 percent of poverty but at or below 300 percent of poverty.

[d]Only children ages 0 through 2 are eligible for M-SCHIP.

[e]Ohio was approved to extend coverage to 200 percent of poverty as of July 2000.

[f]M-SCHIP covers children through age 17.

[g]The Rhode Island Medicaid program covers children ages 0 through 7 to 250 percent of FPL, and children 8 and older to 100 percent of FPL. An amendment to increase the M-SCHIP income threshold to 300 percent of poverty has been approved, but not implemented.

TABLE 3 *(continued)*

[h]Under its Section 1115 demonstration, Tennessee has no upper eligibility level. The currently approved Title XXI plan covers children born before 10/1/83 in the expansion group and who enrolled in TennCare on or after April 1, 1997. TennCare recipients with income above the poverty level are charged a monthly premium based on a sliding scale. Premium subsidies end when income reaches 400 percent of poverty.

[i]On April 3, 2000, Texas implemented an S-SCHIP program with an income threshold of 200 percent of poverty.

[j]S-SCHIP covers children ages 6 through 18.

[k]Infants are covered through M-SCHIP, and children ages 1 through 18 are covered through S-SCHIP.

[l]New York's S-SCHIP program covers children up to 192 percent of the non-farm poverty threshold, which effectively covers children in families with gross income up to 222 percent of poverty.

[m]M-SCHIP only covers 18-year-olds.

[n]As of March 31, 2000, children ages 1 through 5 were covered through M-SCHIP, all others through S-SCHIP. Beginning October 2000, West Virginia was approved as an S-SCHIP only program to cover children through 200 percent of poverty. Their program is no longer a combination plan.

TAXONOMY OF SCHIP EXPANSIONS

The level of coverage expansion brought about by Title XXI is a function not only of the upper income eligibility threshold established under SCHIP, but also the "floor" where Medicaid coverage stops and SCHIP coverage begins. To better understand the extent of eligibility expansions under SCHIP, we developed a taxonomy that arrays each state along two dimensions: the absolute level of its SCHIP income threshold as of March 31, 2000, and the level of the expansion relative to eligibility thresholds under the Medicaid program in place as of March 31, 1997. Both dimensions are important in understanding the generosity of SCHIP coverage expansions within each state.

Table 4 classifies states according to the two dimensions. The columns reflect the absolute level of each state's SCHIP income threshold as of March 31, 2000: at or below 150 percent of poverty (12 states); between 150 and 200 percent of poverty (11 states); at 200 percent of poverty (18 states); or above 200 percent of poverty (10 states). The rows reflect the extent to which SCHIP has extended eligibility for publicly-financed health insurance coverage beyond the thresholds set by Medicaid as of March 31, 1997. Narrow expansions reflect increases of less than 50 percentage points in all age categories, or at least a 50 percentage point increase in one age category only (9 states); intermediate expansions reflect increases of at least 50 percentage points in two age categories (8 states); and broad expansions reflect increases of at least 50 percentage points in three or four age categories (34 states).[5]

Many states with narrow expansions had previously expanded Medicaid through Section 1115 demonstration programs (such as Arkansas, Maryland, Minnesota, and Tennessee). In such cases, SCHIP fills the gaps for specific age or income groups. Of the 9 states with narrow SCHIP programs, 7 implemented M-SCHIP only programs. Relatively few children will be eligible for SCHIP coverage in these states and consequently, these programs can be expected to enroll a small number of children.

- Maryland's Medicaid program covers children born after September 31, 1983 up to 185 percent of poverty. The M-SCHIP program covers children with family income below 200 percent of poverty. As a result, the Maryland SCHIP program provides coverage to children of all ages, but within a narrowly defined income group.

- Minnesota's M-SCHIP program extends coverage to children two years old and younger who live in families with incomes between 275 and 280 percent of poverty.

[5] The four age categories are: less than age 1, 1 through 5, 6 through 16, and 17 through 18.

TABLE 4

ABSOLUTE AND RELATIVE LEVELS OF INCOME THRESHOLDS UNDER
THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM
AS OF MARCH 31, 2000

Level of SCHIP Income Thresholds Relative to Medicaid	Absolute Level of SCHIP Income Thresholds			
	At or below 150 percent of poverty (N = 12)	151 to 200 percent of poverty (N = 11)	At 200 percent of poverty (N = 18)	Over 200 percent of poverty (N = 10)
Narrow (N=9)	Arkansas[a] North Dakota South Dakota Tennessee[a] Texas[b] Wyoming	Hawaii[b]	Maryland[a,b]	Minnesota[a]
Intermediate (N = 8)	Idaho Louisiana Montana Ohio[b] South Carolina West Virginia[b]	Oregon Wisconsin		
Broad (N = 34)		Colorado Illinois Iowa Maine Nebraska New York Oklahoma Virginia	Alabama Alaska Arizona Delaware District of Columbia Florida Georgia Indiana Kansas Kentucky Massachusetts Michigan Mississippi Nevada North Carolina Pennsylvania Utah	California Connecticut Missouri New Hampshire New Jersey New Mexico Rhode Island[b] Vermont Washington

SOURCE: Mathematica Policy Research analysis of Title XXI State Evaluations.

NOTE: The relative level of SCHIP income reflects the magnitude of the expansion relative to traditional Medicaid across four age categories: less than 1 year, 1 through 6, 5 through 16, and 17 through 18.

Narrow = Increased coverage by less than 50 percentage points or increased coverage by at least 50 percent points for one age c ategory

Intermediate = Increased coverage by at least 50 percentage points for two age categories

Broad = Increased coverage by at least 50 percentage points for three or four age categories

[a]Coverage of children through Medicaid was generous in these states prior to SCHIP. As a result, SCHIP programs in these states are small. The Section 1115 Medicaid waiver program in Arkansas provides coverage through 200 percent of FPL, and the Tennessee Medicaid waiver program does not base eligibility on income. The Medicaid program in Maryland covers children born after September 30, 1983 up to 185 percent of poverty while Minnesota's Medicaid program covers all children under age 19 up to 275 percent of poverty.

[b]These states expanded SCHIP eligibility after March 31, 2000. See Table 3 for details.

Of the 34 states that implemented broad expansions through SCHIP, 26 target families with incomes of 200 percent of poverty or higher.[6] Among states with broad expansions, all but eight had established S-SCHIP programs (either alone or in combination with M-SCHIP programs). States with broad expansions can be expected to extend publicly-financed insurance coverage to a larger proportions of children than states with narrower expansions.

SCHIP is a dynamic program, with new programs being established and income thresholds of existing programs being raised. We can expect states to shift within the taxonomy as they increase their SCHIP thresholds and the size of their expansions relative to Medicaid. Since initial implementation, 21 states have raised their SCHIP eligibility thresholds, 13 within an existing SCHIP program (Arizona, California, Florida, Hawaii, Kentucky, Louisiana, Mississippi, Nebraska, New York, Pennsylvania, Rhode Island, South Dakota, and Wisconsin), and another 8 by phasing in an S-SCHIP program after initially implementing an M-SCHIP program (Alabama, Illinois, Indiana, Iowa, Mississippi, North Dakota, Texas, and West Virginia).[7] Idaho is the only state where eligibility decreased, from 160 percent to 150 percent of poverty.

SIMULATION OF MEDICAID AND SCHIP ELIGIBILITY

Whether a child is eligible for Medicaid or SCHIP in a given state is not always readily apparent because Medicaid and SCHIP programs vary not only in the income thresholds that are used, but also in other eligibility criteria that are applied. For example, program eligibility may vary depending on the type of income test that is used (income tests can be based on gross or net income or a combination of both), how income is counted, and the disregards that are used. To demonstrate the effects of varying eligibility policies, we simulated Medicaid and SCHIP eligibility for a hypothetical family of four children. The simulation is based on detailed information on Medicaid and SCHIP eligibility rules from 27 states.[8]

Our simulation is based on a hypothetical two-parent family with four children--an infant and three children ages 5, 10, and 17. In each program and state, we assumed the

[6]As of July 1, 2000, Hawaii increased its threshold to 200 percent of poverty and changed the age criterion from covering only children ages 1 through 5 to covering all children under age 19. These changes move Hawaii into the group of states with broad expansions and a SCHIP income threshold at 200 percent of poverty. Similarly, the implementation of Texas' S-SCHIP program on April 3, 2000, covering children up to 200 percent of poverty, shifts Texas from a narrow to a broad expansion. Beginning October 2000, the SCHIP threshold in West Virginia was increased to 200 percent of poverty which moves West Virginia into the broad expansion group.

[7]The legislature in South Dakota has approved an increase in the M-SCHIP threshold from 140 to 200 percent of poverty Rhode Island has approval to increase coverage to 300 percent of poverty, but has not implemented this change as of this report.

[8]In an addendum to Table 3.1.1 of the state evaluation framework, states reported Medicaid and SCHIP income eligibility criteria by age, income counting rules, and disregard policies. As of this report, 31 states had submitted the addendum and 27 states provided sufficient information for the simulation. One addendum was not submitted in time for inclusion in this report.

family qualifies for any earnings and child care disregards used by the program. Monthly child-care expenses were assumed to be $329.[9] Program eligibility was determined at six levels of gross income: 100, 133, 150, 185, 200, and 250 percent of poverty.[10] The simulations take into account whether programs use gross or net income tests, the income thresholds for each program, and the types and amounts of earnings and child care disregards that are allowed.

Results

Figure 2 summarizes the results of the simulation. (Refer to Appendix B for results for each state.) Each bar in Figure 2 represents the number of states where an individual child is eligible for public coverage at each level of gross income. Results are grouped by income level. Prior to SCHIP, there was considerable variation across ages and income levels in the number of states offering coverage under Medicaid. Older children were less likely to have been eligible for coverage at all levels of income relative to younger children. With the implementation of SCHIP, income eligibility for publicly-financed coverage has become more uniform across the different age groups. At each level of income, either all children in the family typically are eligible for coverage, or they are not. In general, younger children are more likely to obtain coverage through traditional Medicaid, while adolescents often obtain coverage through SCHIP. As a result, SCHIP has become vitally important for adolescents given the high level of uninsured within this population.[11]

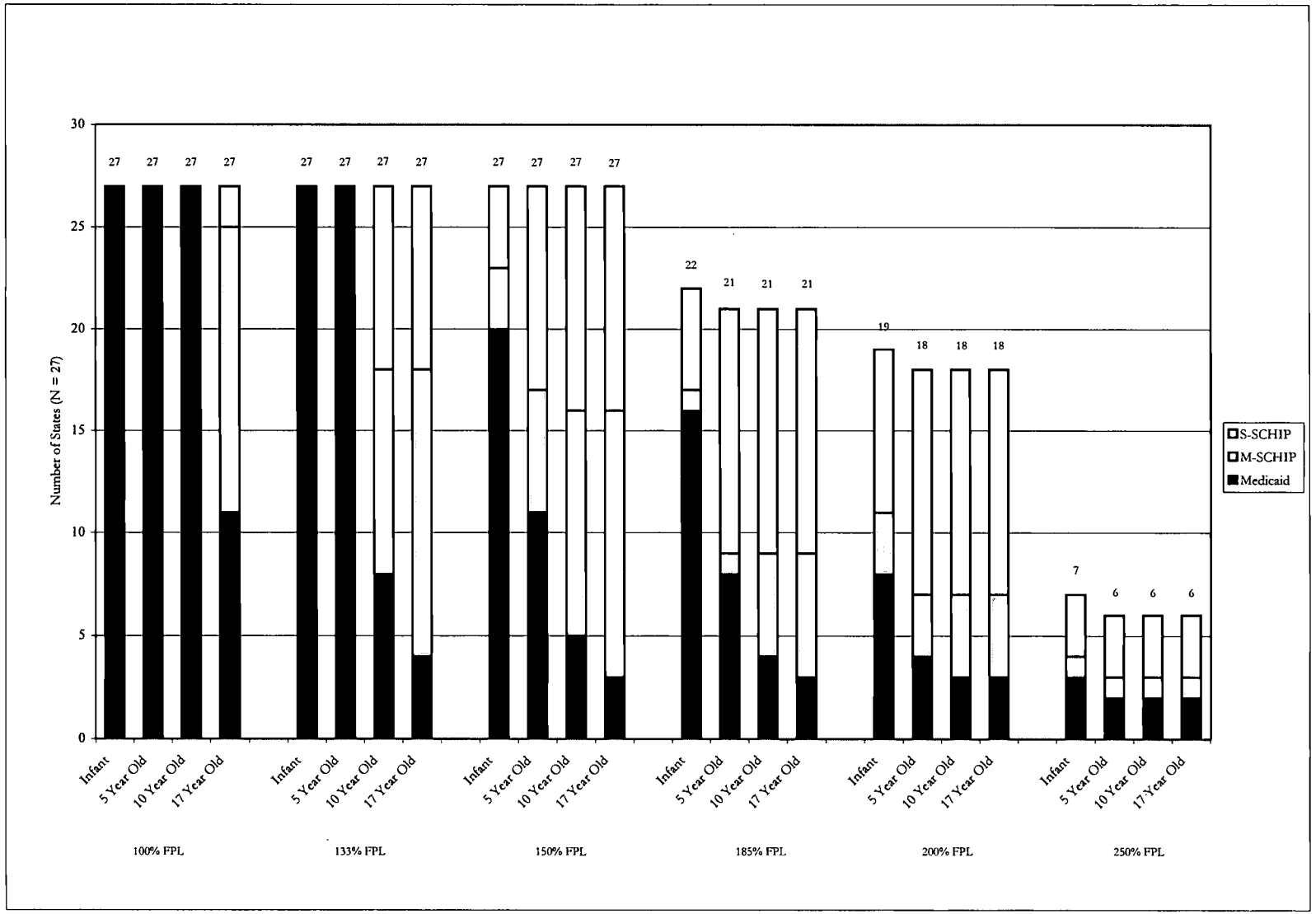
[9]The most recent research available estimates that the average weekly child care expenditure for preschoolers in families with income above poverty was $76.03 in 1993 (Casper 1995). When this is annualized to 52 weekly payments and converted to a monthly rate, the amount is $329 per month.

[10]In 1999, for a family of six, these levels translate to gross annual income of $22,340 (100 percent of poverty), $29,712 (133 percent of poverty), $33,510 (150 percent of poverty), $41,329 (185 percent of poverty), $44,680 (200 percent of poverty), and $55,850(250 percent of poverty) (*Federal Register 1999*).

[11]Adolescents had the highest uninsured rates prior to SCHIP; 16.1 percent of children ages 12 to 17 were uninsured in 1996, compared to 14.8 percent of all children (U.S. Census Bureau 1998). M-SCHIP programs in 10 states are designed to extend coverage to adolescents. Most of these states (9 of the 10) accelerated coverage of children born on or before September 30, 1983, with family income at or below 100 percent of poverty, a group of children states must cover through age 18 by September 30, 2001. Unless these states amend their SCHIP programs to cover additional groups of children, M-SCHIP enrollment will drop over time as these children age into traditional Medicaid and become ineligible for SCHIP.

FIGURE 2

SIMULATED MEDICAID AND SCHIP ELIGIBILITY OF FOUR CHILDREN
BY FAMILY INCOME AS A PERCENT OF THE 1999 FEDERAL POVERTY LEVEL (BASED ON A SIMULATION FOR 27 STATES)



SOURCE: Mathematica Policy Research analysis of Title XXI State Evaluations, Addendum to Table 3.1.1.

NOTE: Based on 27 states that submitted a complete addendum (11 M-SCHIP only programs, 6 S-SCHIP only programs, and 10 combination programs).

Up through 150 percent of poverty, all children in this hypothetical family are eligible for coverage in all 27 states, although the source of coverage may vary by age and income level. At 100 percent of poverty, for example, the three younger children are covered through the Medicaid programs, while the 17-year-old is covered by Medicaid in 11 of the 27 states, M-SCHIP in 13 states and, S-SCHIP in the remaining 2 states. At 133 percent of poverty (the mandatory level for Medicaid coverage for all children through age 5), the infant and 5-year-old are always eligible through traditional Medicaid, while the 10-year-old is covered by the SCHIP program in 19 states, and the 17-year-old is covered by SCHIP in 23 states.

At 250 percent of poverty, only 6 of the 27 states cover all four children, including 2 states through traditional Medicaid (Tennessee and Minnesota), 1 state through its M-SCHIP program (Nebraska), and 3 states through their S-SCHIP programs (California, New Jersey, and Washington).[12] Tennessee and Minnesota have established generous Medicaid thresholds through Section 1115 demonstration programs, while the SCHIP programs use generous disregards to raise the effective income eligibility level for SCHIP. Nebraska disregards 20 percent of earnings and all child care expenses; based on our simulation, a family of six with gross family income of 250 percent of poverty would have a net income of 182 percent of poverty, qualifying the children for coverage under M-SCHIP. These results illustrate the impact of disregards and demonstrate that income thresholds alone do not always fully indicate who is eligible for program benefits.

Families living in states that have implemented an S-SCHIP program may face additional complexities if younger children are covered through Medicaid and older children through the state's S-SCHIP program. Of the 27 states represented in our simulation, 16 had implemented an S-SCHIP (either alone or in combination with an M-SCHIP program). In our simulations, this family would have at least one child in Medicaid and another in S-SCHIP in at least a few states at all but the highest (250 percent of poverty) levels of income. For example, at 133 percent of poverty, in 9 of the 16 states the two older children would be eligible for S-SCHIP and the two younger children would be eligible for Medicaid. At levels above 133 percent of poverty, the infant is likely to be covered by Medicaid, while the older children are covered by S-SCHIP.

For families negotiating Medicaid and S-SCHIP programs at the same time, they may face complexities that result from differences across programs in such areas as eligibility rules (including the timing of redeterminations), benefits packages, and provider networks. States with S-SCHIP programs have the additional challenge of developing a well coordinated system that is seamless from the family's perspective and that provides for smooth transitions as children age out of the Medicaid program and into SCHIP.

[12] In Iowa, only the infant is eligible for coverage through the Medicaid program at this level of income, due the use of a 20 percent earnings disregard.

Caveats

In practice, results are likely to differ somewhat from these simulations. Earnings and child-care disregards may not apply to all families, and some families may benefit from other disregards such as those for child support. Asset tests were not modeled because few states use such tests in their SCHIP programs; but in those few states, low-income children may be determined ineligible for Medicaid or SCHIP due to assets in excess of program limits, despite meeting income requirements. The simulations also do not adequately account for the impact of the reporting process. Programs that conduct extensive review and verification of income may calculate income differently than programs relying on self-declaration. For example, Medicaid programs may require more extensive income reporting and verification than SCHIP programs, which are trying to simplify the eligibility determination process (although in many states efforts to simplify the application process are spilling over to Medicaid).

Implications

This analysis demonstrates how SCHIP interacts with and builds on Medicaid for children of different ages and income levels. In general, SCHIP has established income thresholds that are uniform across different age groups and therefore plays an important role in extending coverage to adolescents. Prior to SCHIP, older adolescents (ages 17 and 18) living below poverty were not eligible for Medicaid coverage in nearly half the states. Future analyses will focus on enrollment patterns and uninsured rates within the adolescent population to determine whether SCHIP has made a difference within this group of children.

The simulation graphically depicts state variation in the role of Medicaid, M-SCHIP, and S-SCHIP in providing public insurance coverage for low-income children. This variation is evident in the different income thresholds used by the programs and the Medicaid thresholds that vary by age group in most states. It also illustrates how some families must negotiate two programs. For example, in 9 of the 16 states with S-SCHIP programs that were included in the simulation, a family with income at 133 percent of poverty would have the two older children in Medicaid and the two younger children in S-SCHIP. This interaction between programs increases the challenge that states face in explaining the options available to families and in coordinating coverage between programs when family circumstances change or when children age out of one program and into another.

The simulation also demonstrates that most of the expansions at the higher levels of income are through S-SCHIP programs, although in some states, traditional Medicaid continues to play an important role. In general, when states have opted to expand eligibility at or above 200 percent of poverty, it has been through separate programs, rather than through Medicaid expansions. This is reflected in the enrollment patterns, which we turn to next.

II. State Variations in Eligibility for SCHIP

CHAPTER III

TRENDS IN SCHIP AND MEDICAID ENROLLMENT

Considerable attention has focused on state progress in enrolling children in SCHIP. State data show that the SCHIP program is gaining momentum; enrollment figures for the most recent quarter suggest that as many children were ever enrolled in the second quarter of federal fiscal year (FFY) 2000 as were ever enrolled in all of FFY 1999. This section discusses annual and quarterly trends in SCHIP enrollment and quantifies the extent to which coverage has expanded beyond traditional Medicaid. This analysis is based on the Statistical Information Management System (SIMS), a quarterly reporting system for SCHIP (Title XXI) and Medicaid (Title XIX) enrollment maintained by HCFA. MPR worked closely with states to validate their data and reconcile inconsistencies as necessary.

ANNUAL SCHIP ENROLLMENT TRENDS

SCHIP enrollment is continuing to increase at an impressive pace. Only about 1 million children were enrolled in SCHIP in FFY 1998, and a sizeable proportion of these (over one quarter) transferred to SCHIP from preexisting child health programs.[1] In FFY 1999, close

[1]Florida, New York, and Pennsylvania had preexisting comprehensive child health programs that were permitted to convert to SCHIP by Title XXI. Estimated enrollment in these pre-SCHIP programs totaled 275,000, with 50,000, 170,000, and 55,000 children, respectively, by state.

to 2 million children were enrolled in SCHIP at some point during the year (Table 5).[2] Thus, program enrollment almost doubled in a one-year period as new programs were implemented and existing programs gained greater public awareness.

The size of individual state SCHIP programs in FFY 1999 varied considerably, ranging from less than 100 children enrolled in Minnesota's M-SCHIP program to over 500,000 children enrolled in New York's S-SCHIP program.[3] Several factors can influence program size, including the relative generosity of the financial criteria used for eligibility, the size of the potentially eligible population, and program maturity. In Minnesota, for example, the state's income threshold for Medicaid children was already at 275 percent of poverty prior to SCHIP. Minnesota's M-SCHIP program extended eligibility to a narrow eligibility group (children ages 0 through 2 with family income from 275 to 280 percent of poverty). In contrast, New York's program, which existed before the SCHIP legislation was passed, had pre-SCHIP enrollment of about 170,000 children, who were subsequently rolled over to SCHIP. New York's program uses an income threshold ranging from 100 to 192 percent of poverty (plus disregards) for children age 6 and older. These factors, coupled with the state's large potentially eligible population, have caused New York's S-SCHIP enrollment to far surpass other states.

During FFY 1999, SCHIP enrollment was heavily concentrated in the 19 states that implemented their programs before July 1, 1998. Altogether, the 19 early implementation states accounted for more than three-fourths of FFY 1999 SCHIP enrollment (1.5 million). The three states with pre-SCHIP programs (Florida, New York, and Pennsylvania) and thus the longest period of implementation, accounted for close to forty percent of total SCHIP enrollment in FFY 1999 (750,000 children). Indeed, the grandfathered programs in Florida and New York have come close to tripling their enrollments under SCHIP, suggesting that substantial enrollment growth may occur in other states, as their SCHIP programs mature.

[2]In states with combination programs, it is possible that children could be double counted in the total if they were enrolled in the M-SCHIP program for part of the year and the S-SCHIP program for another part of the year. In future analyses, MPR will access how often this occurs.

[3]As this report was being completed, an article by Jennifer Steinhauer in *The New York Times* (September 30, 2000) suggested that half of New York's S-SCHIP children were eligible for Medicaid, although some of these children may have qualified for the state's M-SCHIP program. This could reduce overall SCHIP enrollment in FFY1999 by as many as 250,000 children, but increase Medicaid enrollment by the same amount. However, in the absence of definitive information, we have not changed any of the SCHIP enrollment data reported by New York to HCFA.

TABLE 5

NUMBER OF CHILDREN EVER ENROLLED IN SCHIP, BY STATE AND BY PROGRAM
FOR FEDERAL FISCAL YEAR (FFY) 1999

State	Type of SCHIP Program[a]	Date SCHIP Enrollment Began[b]	Number Ever Enrolled FFY 1999		
			S-SCHIP	M-SCHIP	Total[c]
Total			**1,288,932**	**669,230**	**1,958,162**
Number of states reporting					**48**
Alabama	COMBO	2/2/1998	26,213	13,242	39,455
Alaska	M-SCHIP	3/1/1999	-	8,033	8,033
Arizona	S-SCHIP	11/1/1998	26,807	-	26,807
Arkansas	M-SCHIP	10/1/1998	-	913	913
California	COMBO	3/1/1998	187,854	34,497	222,351
Colorado	S-SCHIP	4/22/1998	24,116	-	24,116
Connecticut	COMBO	10/1/1997	5,277	4,635	9,912
Delaware	S-SCHIP	2/1/1999	2,433	-	2,433
District of Columbia	M-SCHIP	10/1/1998	-	2,180	2,180
Florida	COMBO	4/1/1998	116,123	38,471	154,594
Georgia[d]	S-SCHIP	1/1/1999	47,584	-	47,584
Hawaii	M-SCHIP	7/1/2000	-	NI	NI
Idaho	M-SCHIP	10/1/1997	-	8,482	8,482
Illinois	COMBO	1/5/1998	7,567	35,132	42,699
Indiana	COMBO	6/1/1997	NI	31,246	31,246
Iowa	COMBO	7/1/1998	2,890	10,398	13,288
Kansas	S-SCHIP	1/1/1999	14,443	-	14,443
Kentucky	COMBO	7/1/1998	NI	830	830
Louisiana	M-SCHIP	11/1/1998	-	21,580	21,580
Maine	COMBO	7/1/1998	3,786	9,871	13,657
Maryland[e]	M-SCHIP	7/1/1998	-	18,072	18,072
Massachusetts	COMBO	10/1/1997	24,408	43,444	67,852
Michigan	COMBO	4/1/1998	14,825	11,827	26,652
Minnesota	M-SCHIP	9/30/1998	-	19	19
Mississippi[f]	COMBO	7/1/1998	NR	13,218	13,218
Missouri	M-SCHIP	7/1/1998	-	49,529	49,529
Montana	S-SCHIP	1/1/1999	1,019	-	1,019
Nebraska	M-SCHIP	7/1/1998	-	9,713	9,713
Nevada	S-SCHIP	10/1/1998	7,573	-	7,573
New Hampshire	COMBO	5/1/1998	3,700	854	4,554
New Jersey	COMBO	2/1/1998	43,824	31,828	75,652
New Mexico[d]	M-SCHIP	3/1/1999	-	1,908	1,908
New York[d]	COMBO	4/15/1998	519,401	3,000	522,401
North Carolina[d]	S-SCHIP	10/1/1998	59,542	-	59,542
North Dakota	COMBO	10/1/1998	NI	266	266

TABLE 5 *(continued)*

State	Type of SCHIP Program[a]	Date SCHIP Enrollment Began[b]	Number Ever Enrolled FFY 1999 S-SCHIP	M-SCHIP	Total[c]
Ohio	M-SCHIP	1/1/1998	-	83,688	83,688
Oklahoma	M-SCHIP	12/1/1997	-	40,196	40,196
Oregon	S-SCHIP	7/1/1998	27,285	-	27,285
Pennsylvania	S-SCHIP	5/28/1998	81,758	-	81,758
Rhode Island	M-SCHIP	10/1/1997	-	7,288	7,288
South Carolina	M-SCHIP	8/1/1997	-	56,819	56,819
South Dakota	M-SCHIP	7/1/1998	-	3,191	3,191
Tennessee	M-SCHIP	10/1/1997	-	9,732	9,732
Texas	M-SCHIP	7/1/1998	-	50,878	50,878
Utah	S-SCHIP	8/3/1998	14,898	-	14,898
Vermont	S-SCHIP	10/1/1998	2,055	-	2,055
Virginia	S-SCHIP	10/26/1998	16,895	-	16,895
Washington	S-SCHIP	2/1/2000	NI	-	NI
West Virginia	COMBO	7/1/1998	6,656	1,301	7,957
Wisconsin	M-SCHIP	4/1/1999	-	12,949	12,949
Wyoming	S-SCHIP	12/1/1999	NI	-	NI

SOURCE: Mathematica Policy Research analysis of HCFA's Statistical Information Management System (SIMS) as of June 27, 2000.

NI = State's SCHIP program was not implemented in FFY 1999. Hawaii, Washington and Wyoming did not implement their SCHIP programs until FFY 2000. Indiana, Kentucky, and North Dakota had active M-SCHIP programs in FFY 1999, but did not implement their S-SCHIP programs until FFY 2000.

NR = State has not yet reported SCHIP enrollment to HCFA.

[a]The type of SCHIP program is as of March 31, 2000.

[b]The date enrollment began is taken from the state evaluations submitted by states to HCFA in spring 2000.

[c]In states with combination programs, it is possible that children could be double counted in the total if they were enrolled in the M-SCHIP program for part of the year and in the S-SCHIP program for another part of the year.

[d]The enrollment data are from HCFA's SIMS system as of June 27, 2000, with a few exceptions. The data for Georgia, New Mexico, and North Carolina came from the state evaluations submitted to HCFA in spring 2000. In addition, New York's M-SCHIP data were provided directly by the state.

[e] In July 2000, Maryland was authorized to claim enhanced match retroactively for children covered under the state's Section 111 5 demonstration program. The revised SCHIP enrollment count for the number ever enrolled in FFY 1999 is 69,452.

[f]Mississippi has not yet reported on its S-SCHIP program.

QUARTERLY SCHIP ENROLLMENT PATTERNS FOR FFY 1999

HCFA's SCHIP reporting system also captures information on the number of children ever enrolled in SCHIP for each quarter. Appendix C includes quarterly enrollment data by state from the first quarter of FFY 1998, through the second quarter of FFY 2000. As a result of program turnover, the number ever enrolled in any single quarter during a year is always expected to be less than the number ever enrolled at any point during that year.

The number of children ever enrolled in the fourth quarter of FFY 1999 was about 1.6 million (Table 6), compared to 2.0 million children ever enrolled during the year (Table 5). This suggests a turnover rate of about 18 percent for the year (if we calculate program turnover by dividing the number of children ever enrolled in the fourth quarter by the number of children ever enrolled for the year). Stated another way, about 350,000 children were enrolled in SCHIP at some point during the first three quarters of FFY 1999 who were not enrolled during the fourth quarter. However, numerous states mentioned that the most common reason for children disenrolling from SCHIP was that family circumstances had changed, making children eligible for traditional Medicaid instead of SCHIP. Thus, many children who disenrolled from SCHIP may not have lost their public insurance status—they may have simply transferred from SCHIP to Medicaid. Some children may also have gained private insurance coverage. States also mentioned that some level of program turnover is explained by older children who "aged out" of the SCHIP program. In addition, turnover can occur when family income exceeds SCHIP income thresholds, or families fail to meet other redetermination requirements. In states that charge premiums, families that are not up-to-date in their premium payments may lose eligibility.

Several states reported in their evaluations that their SCHIP turnover rates were lower than they experience with children in their traditional Medicaid programs. For example, South Carolina reported a disenrollment rate of 8.6 percent for its SCHIP program in FFY 1999, compared to an 11.1 percent rate for Medicaid. South Carolina attributed its low turnover in part to the state's guarantee of continuous eligibility for a 12 month period—a policy adopted by SCHIP programs in 25 states. However, states were not always clear about how they were calculating disenrollment in their evaluation reports, so a more thorough analysis is needed before any definitive conclusions can be reached about SCHIP turnover. In addition, many states had not yet faced annual redeterminations for their SCHIP programs.

As part of our evaluation activities in the coming year, MPR staff will be applying a uniform methodology for determining turnover rates across states for both their SCHIP and traditional Medicaid programs, using person-based data from HCFA's Medicaid Statistical Information System (MSIS). This will enable us to differentiate the extent of disenrollment or turnover caused by transfers between SCHIP and Medicaid, versus disenrollment in which children leave publicly insured coverage altogether.

TABLE 6

NUMBER OF CHILDREN EVER ENROLLED IN SCHIP BY STATE FROM SECOND QUARTER OF FFY1999 THROUGH SECOND QUARTER OF FFY 2000

State	Type of SCHIP Program[a]	Date SCHIP Enrollment Began[b]	Number Ever Enrolled[c]			Percent Change Between	
			Second Quarter FFY 1999	Fourth Quarter FFY 1999	Second Quarter FFY 2000	Second Quarter FFY 1999 and Second Quarter FFY 2000	Fourth Quarter FFY 1999 and Second Quarter FFY 2000
Total			**1,129,606**	**1,608,383**	**1,809,005**	**89.6%**	**29.1%**
Number of states reporting			**44**	**46**	**38**	**35**	**37**
Alabama	COMBO	2/2/1998	17,532	26,213	26,866	53.2%	2.5%
Alaska	M-SCHIP	3/1/1999	2,274	7,936	NR	-	-
Arizona	S-SCHIP	11/1/1998	11,445	19,924	34,958	205.4%	75.5%
Arkansas[d]	M-SCHIP	10/1/1998	NR	913	1,140	-	24.9%
California[e]	COMBO	3/1/1998	87,587	178,791	265,402	203.0%	48.4%
Colorado	S-SCHIP	4/22/1998	15,135	20,932	33,114	118.8%	58.2%
Connecticut[e]	COMBO	10/1/1997	2,860	4,478	5,264	84.1%	17.6%
Delaware	S-SCHIP	2/1/1999	816	2,565	6,552	702.9%	155.4%
District of Columbia	M-SCHIP	10/1/1998	1,317	1,964	1,914	45.3%	-2.5%
Florida	COMBO	4/1/1998	78,827	128,432	155,969	97.9%	21.4%
Georgia[e]	S-SCHIP	1/1/1999	17,433	45,789	74,337	326.4%	62.3%
Hawaii	M-SCHIP	7/1/2000	NI	NI	NI	-	-
Idaho	M-SCHIP	10/1/1997	4,672	5,285	7,450	59.5%	41.0%
Illinois	COMBO	1/5/1998	28,750	39,099	50,189	74.6%	28.4%
Indiana[e]	COMBO	6/1/1997	27,063	30,647	NR	-	-
Iowa	COMBO	7/1/1998	6,926	9,896	11,877	71.5%	20.0%
Kansas	S-SCHIP	1/1/1999	7,955	13,882	18,345	130.6%	32.1%
Kentucky	COMBO	7/1/1998	6,753	27,766	73,595	989.8%	165.1%
Louisiana[g]	M-SCHIP	11/1/1998	12,503	20,504	29,400	135.1%	43.4%
Maine	COMBO	7/1/1998	8,247	10,180	12,594	52.7%	23.7%
Maryland[h]	M-SCHIP	7/1/1998	12,889	16,657	16,554	28.4%	-0.6%
Massachusetts	COMBO	10/1/1997	41,380	55,028	67,087	62.1%	21.9%
Michigan[g]	COMBO	4/1/1998	14,484	21,052	NR	-	-
Minnesota	M-SCHIP	9/30/1998	15	6	NR	-	-
Mississippi[e]	COMBO	7/1/1998	9,719	10,872	NR	-	-
Missouri	M-SCHIP	7/1/1998	34,104	44,190	55,529	62.8%	25.7%
Montana	S-SCHIP	1/1/1999	948	924	3,949	316.6%	327.4%
Nebraska[g]	M-SCHIP	7/1/1998	5,164	6,925	7,382	43.0%	6.6%
Nevada	S-SCHIP	10/1/1998	4,436	7,190	9,016	103.2%	25.4%
New Hampshire	COMBO	5/1/1998	1,219	2,053	2,953	142.2%	43.8%

TABLE 6 *(continued)*

State	Type of SCHIP Program[a]	Date SCHIP Enrollment Began[b]	Number Ever Enrolled[c]			Percent Change Between	
			Second Quarter FFY 1999	Fourth Quarter FFY 1999	Second Quarter FFY 2000	Second Quarter FFY 1999 and Second Quarter FFY 2000	Fourth Quarter FFY 1999 and Second Quarter FFY 2000
New Jersey[g]	COMBO	2/1/1998	31,645	46,653	65,896	108.2%	41.2%
New Mexico	M-SCHIP	3/1/1999	NI	1,736	3,705	-	113.4%
New York[d, g]	COMBO	4/15/1998	330,741	438,421	511,787	54.7%	16.7%
North Carolina	S-SCHIP	10/1/1998	33,835	57,420	69,996	106.9%	21.9%
North Dakota[e]	COMBO	10/1/1998	135	134	1,491	1004.4%	1012.7%
Ohio	M-SCHIP	1/1/1998	51,637	60,985	NR	-	-
Oklahoma	M-SCHIP	12/1/1997	22,651	NR	NR	-	-
Oregon	S-SCHIP	7/1/1998	15,803	17,472	21,266	34.6%	21.7%
Pennsylvania[e]	S-SCHIP	5/28/1998	74,046	82,893	89,610	21.0%	8.1%
Rhode Island	M-SCHIP	10/1/1997	4,055	5,752	7,278	79.5%	26.5%
South Carolina	M-SCHIP	8/1/1997	42,813	49,469	NR	-	-
South Dakota	M-SCHIP	7/1/1998	1,827	2,696	3,391	85.6%	25.8%
Tennessee[c]	M-SCHIP	10/1/1997	NR	NR	NR	-	-
Texas[f]	M-SCHIP	7/1/1998	40,358	34,980	30,353	-24.8%	-13.2%
Utah	S-SCHIP	8/3/1998	8,117	13,697	17,028	109.8%	24.3%
Vermont	S-SCHIP	10/1/1998	907	1,483	2,218	144.5%	49.6%
Virginia	S-SCHIP	10/26/1998	8,145	14,580	NR	-	-
Washington	S-SCHIP	2/1/2000	NI	NI	NI	-	-
West Virginia	COMBO	7/1/1998	438	7,569	12,280	2703.7%	62.2%
Wisconsin	M-SCHIP	4/1/1999	NI	12,350	NR	-	-
Wyoming	S-SCHIP	12/1/1999	NI	NI	1,270	-	-

SOURCE: Mathematica Policy Research analysis of HCFA's Statistical Information Management System (SIMS) as of June 27, 2000.

NI = State's SCHIP program was not implemented in FFY 1999. Hawaii, Washington, and Wyoming did not implement their SCHIP programs until FFY 2000. Indiana, Kentucky, and North Dakota had active M-SCHIP programs in FFY 1999, but did not implement their S-SCHIP programs until FFY 2000.

NR = State has not yet reported SCHIP enrollment to HCFA, or, if noted, the reported data have not been included due to inconsistencies.

[a]The type of SCHIP program is as of March 31, 2000.

[b]The date enrollment began is taken from the state evaluations submitted by states to HCFA in spring 2000.

[c]Data for the following state programs are not reported, since the quarterly data the states have provided to HCFA are not complete or appear to have inconsistencies: California M-SCHIP, Connecticut M- SCHIP, Mississippi M-SCHIP, and Tennessee M-SCHIP.

[d] Because Arkansas and New York did not report any quarterly M-SCHIP enrollment for the fourth quarter of FFY 1999, data shown here are the ever enrolled in FFY 1999. However, the number ever enrolled for the year is usually higher than the number ever enrolled for the quarter. MPR did not include Arkansas M-SCHIP data for Q1 1999 through Q3 1999 due to data inconsistencies.

[e]Data for the first quarter of FFY2000 were imputed averaging data from the fourth quarter of FFY1999 and the second quarter of FFY 2000 for the following states: Georgia S-SCHIP, North Dakota M-SCHIP, and Pennsylvania S-SCHIP. MPR also imputed Pennsylvania's data for Q2 1999 by averaging data from Q1 1999 and Q3 1999.

[f] Enrollment in the Texas M-SCHIP program declined because children aged out of M-SCHIP and onto traditional Medicaid. The S-SCHIP program in Texas began in the third quarter of FFY 2000; however, no enrollment data have been reported to HCFA. Beginning in the third quarter of FFY 2000, the type of program for Texas will change to COMBO.

[g]The enrollment data are taken from HCFA's SIMS system as of June 27, 2000, for all states except Louisiana, Michigan, Nebraska, New Jersey, and New York. For these states, MPR received the following data directly: Louisiana Q2 1999 and Q2 2000 M-SCHIP; Michigan Q1 2000 S-SCHIP; Nebraska Q1 2000 M-SCHIP; New Jersey Q2 1999 through Q2 2000 all SCHIP data; and New York Q1 2000 and Q2 2000 M-SCHIP.

[h]In July 2000, Maryland was authorized to claim enhanced match retroactively for children covered under the state's Section 1115 demonstration program. Revised SCHIP enrollment counts are as follows: 29,054 (second quarter, FFY 1999); 63,016 (fourth quarter, FFY 1999); and 74,437 (second quarter, FFY 2000).

QUARTERLY SCHIP ENROLLMENT PATTERNS FOR FFY 2000

Preliminary data for the first two quarters of FFY 2000, also shown in Table 6, indicate that the number of children covered by SCHIP programs is still increasing at a substantial rate and that program enrollment has not yet reached a plateau. As of June 27, 2000, 37 states had submitted enrollment data for both the fourth quarter of FFY 1999 and the second quarter of FFY 2000. Overall enrollment for these 37 states increased by 29 percent from the fourth quarter of FFY 1999 to the second quarter of FFY 2000.

Several states are reporting extraordinary rates of growth from the last quarter of FFY 1999 through the second quarter of FFY 2000. During this six-month period, SCHIP enrollment grew by 50 percent or more in 10 states (Arizona, Colorado, Delaware, Georgia, Kentucky, Montana, New Mexico, North Dakota, Vermont, and West Virginia). About 11 states have not yet reported their second quarter data for FFY 2000, so this assessment is based on partial data. If we compare enrollment in the second quarter of FFY 2000 to that in the second quarter of FFY 1999, or one year back, an even larger group of states experienced high growth rates. Over this one year period, SCHIP enrollment more than doubled in 17 states. Variation in growth rates across states may be a function of recent eligibility expansions, outreach initiatives or simplification efforts, or other features of program implementation.

After making some conservative assumptions about the enrollment levels for states not yet reporting, we estimate that total SCHIP enrollment for the quarter ending March 31, 2000 reached at least 2.1 million children, an increase of at least 27 percent from the fourth quarter of FFY 1999 (Figure 3).[4] S-SCHIP programs continue to expand at a faster rate than M-SCHIP programs. These projections suggest S-SCHIP enrollment in the second quarter of FFY 2000 had increased by at least 31 percent from the fourth quarter of FFY 1999, while overall M-SCHIP enrollment increased by at least 17 percent over this six-month period.

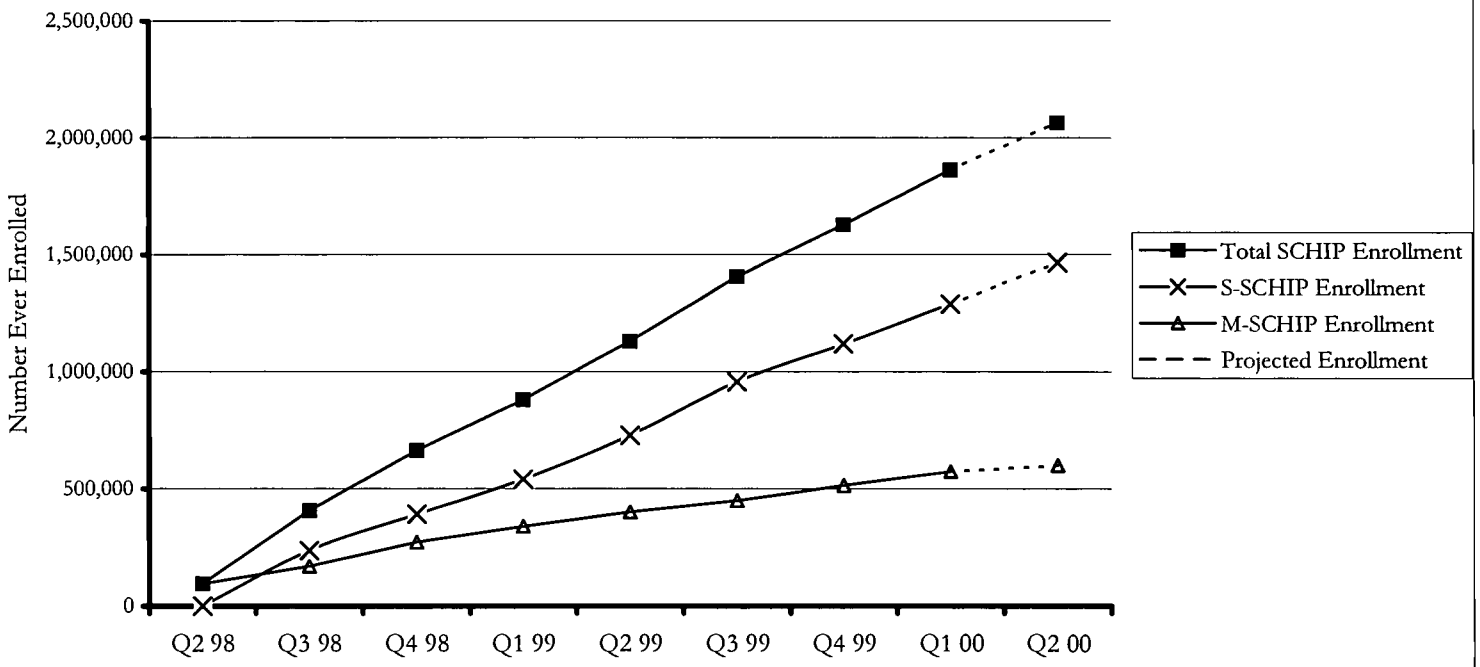
ANNUAL MEDICAID ENROLLMENT PATTERNS FOR CHILDREN

SCHIP programs are prohibited from enrolling children who qualify under traditional Medicaid eligibility rules. Title XXI requires states to screen SCHIP applicants to see if they qualify for coverage under the traditional Medicaid program and enroll eligible children in Medicaid. As a result, SCHIP outreach and recruitment were expected to have a spillover

[4]This estimate is based on actual enrollment data for the states reporting complete information and, in the states not yet reporting, we assumed no additional SCHIP enrollment growth beyond the fourth quarter of FFY 1999. In addition, quarterly M-SCHIP data were not available for California, Connecticut, Hawaii and Tennessee, and quarterly S-SCHIP data were not available for Mississippi or Washington. Thus, this is a very conservative estimate.

FIGURE 3

TOTAL SCHIP, M-SCHIP, AND S-SCHIP ENROLLMENT
FROM QUARTER 2, FFY1998 THROUGH QUARTER 2, FFY 2000



SOURCE: Mathematica Policy Research analysis of HCFA's Statistical Information Management System.

NOTE: For states not yet reporting enrollment in the first and second quarters of FFY 2000, enrollment was projected using data from the most recent quarter. Neither actual nor projected data are included for M-SCHIP programs in California, Connecticut, Hawaii, and Tennessee, nor for S-SCHIP programs in Mississippi and Washington.

effect that might help stem annual declines in Medicaid child enrollment that began to occur in many states around 1995 and 1996 (Ellwood and Ku 1998).

As part of their SCHIP reporting through SIMS, states are required to provide data on child enrollment in traditional Medicaid to HCFA, including the number ever enrolled by year and the number ever enrolled by quarter.[5] The counts of Medicaid children ever enrolled during the year reported into the SIMS system differ somewhat from the counts of children ever enrolled in Medicaid during the year under the HCFA-2082 report. SIMS data are supposed to be limited to Medicaid children under age 19, while HCFA-2082 data for states can include children through age 20 (states have the option of covering children under Medicaid through age 20). Thus, SIMS counts of Medicaid children may understate the number of children ever enrolled in Medicaid for a year, compared to the HCFA-2082 report.

In FFY 1999, about 19.7 million children under age 19 were ever enrolled in the traditional Medicaid program according to the SIMS data, with five states not reporting (Table 7).[6] In FFY 1997, the five states not yet reporting enrolled just under 0.8 million children, according to HCFA-2082 data. If these states have been able to maintain three-fourths of their FFY 1997 child enrollment levels for Medicaid (0.6 million children), we estimate that traditional Medicaid enrollment for children under age 19 reached 20.3 million in FFY 1999. If we add the 0.7 million children enrolled in M-SCHIP, 21 million children under age 19 were enrolled in Medicaid in FFY 1999.[7]

HCFA-2082 data for FFY 1995, 1996 and 1997 showed Medicaid enrollment for children to be 21.6, 21.2 and 21.0 million, respectively (Ku and Bruen 1999).[8] We estimate Medicaid child enrollment in FFY 1999 using SIMS data reached 21 million (including M-SCHIP children). Based on the SIMS data, it appears that the FFY 1999 enrollment levels for Medicaid children (when they are eventually published in an edited form from the HCFA-2082 report) will equal and may exceed the FFY 1997 level. If Medicaid child enrollment does finally stabilize in FFY 1999, it is important to note that the 0.7 million children enrolled in Medicaid as a result of M-SCHIP may have made a critical difference. In addition, anecdotal reports from states indicate that SCHIP outreach and coordination efforts have been important to maintaining or even increasing enrollment in the traditional Medicaid groups, since the SCHIP screening process determines that many children are eligible for traditional Medicaid when they apply for SCHIP.

[5]This reporting is in addition to the routine HCFA-2082 reporting for Medicaid.

[6]States not reporting child Medicaid enrollment data for FFY 1999 into SIMS include Hawaii, Idaho, New Hampshire, Washington, and Wyoming.

[7]HCFA instructions indicate that M-SCHIP children are not supposed to be included in the Medicaid counts.

[8]HCFA-2082 data for FFY 1998 are not yet available in the edited time-series on enrollment produced by the Urban Institute.

TABLE 7

NUMBER OF CHILDREN EVER ENROLLED IN MEDICAID AND SCHIP, BY STATE FOR FEDERAL FISCAL YEAR (FFY) 1999

State	Type of SCHIP Program[a]	Date SCHIP Enrollment Began[b]	Number Ever Enrolled FFY 1999		SCHIP Ever Enrolled as a Percent of Medicaid Ever Enrolled
			Medicaid	SCHIP	
Total			**19,668,711**	**1,958,162**	**9.9%**
Number of states reporting			**46**	**48**	**46**
Alabama	COMBO	2/2/1998	242,732	39,455	16.3%
Alaska	M-SCHIP	3/1/1999	53,421	8,033	15.0%
Arizona	S-SCHIP	11/1/1998	387,213	26,807	6.9%
Arkansas	M-SCHIP	10/1/1998	155,504	913	0.6%
California	COMBO	3/1/1998	3,263,848	222,351	6.8%
Colorado	S-SCHIP	4/22/1998	195,217	24,116	12.4%
Connecticut	COMBO	10/1/1997	167,892	9,912	5.9%
Delaware	S-SCHIP	2/1/1999	52,617	2,433	4.6%
District of Columbia	M-SCHIP	10/1/1998	74,522	2,180	2.9%
Florida	COMBO	4/1/1998	1,067,409	154,594	14.5%
Georgia[c]	S-SCHIP	1/1/1999	986,566	47,584	4.8%
Hawaii	M-SCHIP	7/1/2000	NR	NI	-
Idaho	M-SCHIP	10/1/1997	NR	8,482	-
Illinois	COMBO	1/5/1998	896,115	42,699	4.8%
Indiana	COMBO	6/1/1997	342,666	31,246	9.1%
Iowa	COMBO	7/1/1998	147,496	13,288	9.0%
Kansas	S-SCHIP	1/1/1999	144,415	14,443	10.0%
Kentucky	COMBO	7/1/1998	312,171	830	0.3%
Louisiana	M-SCHIP	11/1/1998	425,592	21,580	5.1%
Maine	COMBO	7/1/1998	90,000	13,657	15.2%
Maryland[d]	M-SCHIP	7/1/1998	325,983	18,072	5.5%
Massachusetts	COMBO	10/1/1997	448,403	67,852	15.1%
Michigan	COMBO	4/1/1998	749,683	26,652	3.6%
Minnesota	M-SCHIP	9/30/1998	301,987	19	0.0%
Mississippi[e]	COMBO	7/1/1998	339,861	13,218	3.9%
Missouri	M-SCHIP	7/1/1998	404,817	49,529	12.2%
Montana	S-SCHIP	1/1/1999	69,313	1,019	1.5%
Nebraska	M-SCHIP	7/1/1998	124,194	9,713	7.8%
Nevada	S-SCHIP	10/1/1998	84,960	7,573	8.9%
New Hampshire	COMBO	5/1/1998	NR	4,554	-
New Jersey	COMBO	2/1/1998	413,756	75,652	18.3%
New Mexico[c]	M-SCHIP	3/1/1999	248,181	1,908	0.8%
New York[c]	COMBO	4/15/1998	972,188	522,401	53.7%
North Carolina[c]	S-SCHIP	10/1/1998	642,500	59,542	9.3%
North Dakota	COMBO	10/1/1998	29,517	266	0.9%

TABLE 7 *(continued)*

State	Type of SCHIP Program[a]	Date SCHIP Enrollment Began[b]	Number Ever Enrolled FFY 1999		SCHIP Ever Enrolled as a Percent of Medicaid Ever Enrolled
			Medicaid	SCHIP	
Ohio	M-SCHIP	1/1/1998	610,851	83,688	13.7%
Oklahoma	M-SCHIP	12/1/1997	60,772	40,196	66.1%
Oregon	S-SCHIP	7/1/1998	238,339	27,285	11.4%
Pennsylvania	S-SCHIP	5/28/1998	813,407	81,758	10.1%
Rhode Island	M-SCHIP	10/1/1997	67,706	7,288	10.8%
South Carolina	M-SCHIP	8/1/1997	353,245	56,819	16.1%
South Dakota	M-SCHIP	7/1/1998	28,463	3,191	11.2%
Tennessee	M-SCHIP	10/1/1997	637,141	9,732	1.5%
Texas	M-SCHIP	7/1/1998	1,585,918	50,878	3.2%
Utah	S-SCHIP	8/3/1998	206,255	14,898	7.2%
Vermont	S-SCHIP	10/1/1998	60,286	2,055	3.4%
Virginia	S-SCHIP	10/26/1998	370,163	16,895	4.6%
Washington	S-SCHIP	2/1/2000	NR	NI	-
West Virginia	COMBO	7/1/1998	193,264	7,957	4.1%
Wisconsin	M-SCHIP	4/1/1999	282,162	12,949	4.6%
Wyoming	S-SCHIP	12/1/1999	NR	NI	-

SOURCE: Mathematica Policy Research analysis of HCFA's Statistical Information Management System (SIMS) as of June 27, 2000.

NI = State's SCHIP program was not implemented in FFY 1999. Hawaii, Washington, and Wyoming did not implement their SCHIP programs until FFY 2000. Indiana, Kentucky, and North Dakota had active M-SCHIP programs in FFY 1999, but did not implement their S-SCHIP programs until FFY 2000.

NR = State has not yet reported any Medicaid or SCHIP enrollment to HCFA. Hawaii, Idaho, New Hampshire, Washington, and Wyoming have not reported child Medicaid enrollment for FFY1999.

[a]The type of SCHIP program is as of March 31, 2000.

[b]The date enrollment began is taken from the state evaluations submitted by states to HCFA in spring 2000.

[c]The enrollment data are from HCFA's SIMS system as of June 27, 2000, with a few exceptions. The data for Georgia, New Mexico and North Carolina came from the state evaluations submitted to HCFA in spring 2000. In addition, New York's M-SCHIP data were provided directly by the state.

[d]In July 2000, Maryland was authorized to claim enhanced match retroactively for children enrolled in the state's Section 1115 demonstration program. Revised enrollment counts for the number ever enrolled in Medicaid and SCHIP are 279,284 and 69,452, respectively.

[e]Mississippi has not yet reported on its S-SCHIP program.

State Highlight: Measuring the Effect of SCHIP on Traditional Medicaid Enrollment

New Jersey estimates that, as of September 30, 1999, more than 22,000 children were enrolled in Medicaid as a result of the NJ KidCare program publicity and outreach. The state constructed a monthly Medicaid eligibility database of new enrollments from January 1993 through July 1998 and found that, during the five years prior to SCHIP, April enrollment was 7 to 8 percent greater than the level during the same month in the previous year. In April 1998, after SCHIP began, enrollment was 28 percent greater than the previous April. This difference was trended forward to September 1999. Adding the 22,133 new Medicaid enrollees to the 42,100 SCHIP enrollees raises the total new enrollment attributable to SCHIP by more than 50 percent, to 64,233.

EXTENT OF SCHIP EXPANSION BEYOND MEDICAID

One measure of the effect of the SCHIP program is the extent to which the number of children who are publicly insured in each state has grown beyond those covered by the traditional Medicaid program. We calculate this measure by dividing the number of children enrolled in SCHIP by the number of children enrolled in the traditional Medicaid program for a state. This approach no doubt underestimates the effect of SCHIP, since outreach efforts for SCHIP may have boosted Medicaid enrollment (the denominator). Nevertheless, this measure is useful in assessing SCHIP impacts.

Table 7 shows that, in FFY 1999, SCHIP extended federally financed child health insurance coverage beyond traditional Medicaid by 10 percent nationally.[9] In FFY 1999, just over 20 million children under age 19 were enrolled in traditional Medicaid, while the SCHIP programs accounted for another 2 million children. Several states reported extraordinary extensions of coverage through SCHIP. The most dramatic example is Oklahoma, where 60,772 children were covered under its traditional Medicaid program in FFY 1999, and an additional 40,196 children were covered as a result of its M-SCHIP program. Thus, in Oklahoma, 66 percent more children were covered as a result of SCHIP than would have been covered by traditional Medicaid alone. Other states with major expansions beyond

[9]If we adjusted for the children who were publicly insured in Florida, New York and Pennsylvania prior to the implementation of SCHIP, the extent of public coverage beyond traditional Medicaid at the national level would be 8.5 percent, instead of 9.9 percent in FFY 1999.

Medicaid include New York (53.7 percent increase in coverage), New Jersey (18.3 percent), Alabama (16.3 percent), South Carolina (16.1 percent), Maine (15.2 percent), Massachusetts (15.1 percent), and Alaska (15.0 percent). Six of these eight states were in the group that implemented their programs before July 1, 1998. Five of these eight states had both M-SCHIP and S-SCHIP programs, while three had only M-SCHIP programs.

At the other end of the spectrum, SCHIP enrollment in eight states appears to have had a negligible effect on total enrollment at least through FFY 1999, with enrollment expanding by less than 3 percent relative to Medicaid. These states include Minnesota (0.0 percent beyond Medicaid), Kentucky (0.3 percent), Arkansas (0.6 percent), New Mexico (0.8 percent), North Dakota (0.9 percent), Montana (1.5 percent), Tennessee (1.5 percent), and the District of Columbia (2.9 percent). However, these data have to be interpreted with caution, since several of these states had already undertaken major expansions to their traditional Medicaid programs prior to SCHIP (through Section 1115 demonstrations or Section 1931 changes), including Arkansas, Minnesota, and Tennessee. Additionally, SCHIP enrollment from the fourth quarter of FFY 1999 through the second quarter of FFY 2000 increased substantially in four of these states--Kentucky (165.1 percent), Montana (327.4 percent), New Mexico (113.4 percent), and North Dakota (1,012.7 percent). The dramatic growth in Kentucky and North Dakota occurred in part because they began to implement S-SCHIP programs, in addition to their M-SCHIP programs.

CONCLUSION

The SCHIP program is beginning to hit its stride now that all 50 states and the District of Columbia have begun enrolling children in SCHIP, and several have expanded eligibility to reach a larger segment of the uninsured population. We will continue to track enrollment in SCHIP and Medicaid on a quarterly basis, to document aggregate trends. Future reports also will provide a more in-depth assessment of enrollment in SCHIP and Medicaid based on MSIS. Analyses will focus on the dynamics of eligibility across states and programs, including continuity of coverage and turnover. As mentioned earlier, we also will examine the extent of transfers between programs and, where possible, examine the extent to which transfers occur between Medicaid programs (either traditional Medicaid or M-SCHIP) and S-SCHIP programs. In addition, we will track patterns of new enrollment and disenrollment across states and programs.

CHAPTER IV

TRENDS IN THE NUMBER OF UNINSURED CHILDREN BEFORE AND AFTER SCHIP

As we have just seen, SCHIP enrollment continues to grow at a steady pace. One issue of great interest to policymakers is whether the growth in SCHIP enrollment is producing a measurable reduction in the number of uninsured children or whether the enrollment growth is being offset by losses in coverage elsewhere, including a substitution of public for private coverage. The possibility of a substitution effect is a particular concern in the states with broad expansions that target families with incomes above 200 percent of poverty (as seen, for example, in Table 4). A fundamental measure of the effectiveness of SCHIP is the extent to which SCHIP has reduced the proportion of low-income children without health insurance. A related measure is the distribution of health insurance coverage among low-income children, to ensure that children eligible for Medicaid are enrolled and that children who are covered by employer-sponsored insurance (ESI) maintain that coverage, rather than substituting SCHIP for other coverage.

Change in health insurance status is difficult to measure. Not only are there widespread concerns about the accuracy of self-reports on the presence and type of coverage, but, because aggregate coverage tends to change slowly, several years of data may be required to ascertain the direction and magnitude of any trends. Moreover, very large sample sizes are required to produce reliable estimates of effects within the target population, even at the national level. At the State level, existing sample sizes are generally inadequate to support precise estimates of coverage even for all children. Due to lag times in data collection and dissemination, only limited evidence is available at this time to shed light on the early effects of SCHIP on health insurance coverage among low-income children.

This chapter focuses on three questions:

1. What national trends, if any, were evident in the percentage of children who were without health insurance prior to the implementation of SCHIP?

2. Is there any evidence that these trends have been altered or interrupted during early implementation of SCHIP?

3. How has the source of health insurance coverage changed during the early implementation of SCHIP?

DATA AND METHODS

This analysis is based on the Current Population Survey (CPS), a monthly survey whose primary purpose is to measure labor force participation at the national and state levels. The March supplement gathers information on health insurance coverage of the general population.[1] Because the March CPS provides annual measures of the health insurance coverage of the population, and because the data are released within six months of their collection, the CPS has become the most widely cited source of estimates of the size and characteristics of the uninsured population.

The time series for this analysis is from 1993 through 1998, as measured in the March CPS of the subsequent year.[2] This analysis uses 1997 data (based on the March 1998 CPS) as the baseline year for determining the effect of SCHIP. Although SCHIP went into effect during late 1997, most states began enrolling children in mid-1998 or later. Currently, we have only one year of post-SCHIP data (corresponding to the 1998 reference year).

[1]The March supplement also is the source of the federal government's official annual estimates of the incidence of poverty in the United States.

[2]We start our series at 1993 because the March 1994 CPS, the source of the 1993 estimates, was the first to use population weights based on the 1990 census, and the introduction of the new census data has been shown to affect estimates of the uninsured (Fronstin 1997). The CPS health insurance questions changed with the March 1996 data release, but the major impact of these changes is seen in the distribution of coverage between employer-sponsored insurance and a residual "other insurance" category. The effect of the new questions on estimates of the uninsured has been shown to be negligible (Fronstin 1997).

Classification of Insurance Coverage

Taking into account the Census Bureau's edits, all insurance coverage reported in the March CPS is assigned to one or more of the following sources: (1) coverage by a current or former employer or union, which may be paying all, part, or none of the cost of premiums; (2) coverage purchased directly by the insured; (3) CHAMPUS, CHAMPVA, or military coverage; (4) Medicare; (5) Medicaid, including "other government coverage"; or (6) coverage obtained from someone living in another household and which cannot be assigned to any of the previous sources.

Because the CPS asks the respondent to report every source of coverage during the previous calendar year, a respondent or child may be recorded as having several different sources of coverage. To simplify our description of the sources of coverage, we created a hierarchical classification that, with one exception, assigns coverage to only one source. The classification includes the following:

- Medicaid without employer-sponsored insurance (ESI)
- ESI without Medicaid
- Medicaid and ESI
- Privately purchased coverage
- CHAMPUS, CHAMPVA, or military coverage
- Medicare
- Source unknown (coverage provided by someone outside the household)

Children were assigned to the first category for which they qualified. Children who could not be assigned to any of the sources of coverage were classified as uninsured.[3]

Caveats About Measurement of the Uninsured

The CPS is widely used for estimates and analysis of health insurance coverage despite certain well-known limitations in the data (Lewis et al. 1998). The three main concerns are, first, that the uninsured are measured only indirectly; second, that there is uncertainty about the reference period of the uninsured episode; and third, that the CPS undercounts by as

[3]Beginning with the March 1998 CPS, the Census Bureau has removed the Indian Health Service from the sources of coverage that identify persons as insured. A person with only Indian Health Service coverage is now classified as uninsured. We have maintained that convention.

much as a third the number of children enrolled in Medicaid. The annual estimates of insurance coverage, collected in March of each year, are intended to refer to the previous calendar year. Respondents are asked to indicate whether they were *ever* covered by specific types of health insurance during that period. Those who do not report that they had any type of insurance coverage during the year are counted as uninsured, but they are never asked if they were indeed uninsured. Those who report that they had no insurance coverage were, in theory, uninsured for the entire year. Yet the magnitude of the estimated number of uninsured children lies close to alternative survey estimates of the number who are uninsured at a point in time, or roughly twice the number estimated to be uninsured for an entire year.[4] As a result, the estimates of uninsured children from the CPS are commonly interpreted as describing the number who are uninsured at a point in time.

The Medicaid undercount in the CPS has always been a problem but it is getting worse. Although there have been widespread reports of declining Medicaid enrollment (Ellwood and Ku 1998), the CPS counts of Medicaid coverage are declining much more significantly than the HCFA counts. As a percentage of the HCFA estimate, the CPS estimate fell from 83 percent in 1993 to 68 percent in 1998, and the gap between the estimates grew by nearly 3 million children. If a third of Medicaid children are not counted under Medicaid, where *are* they counted? Unfortunately, the answer to this question is unknown, making it difficult to assess how the continuing growth in the undercount may affect observed trends in the uninsured population.

The indirect measurement of the uninsured, the uncertainty about the reference period, and the size of the Medicaid undercount pose obstacles for analyses of the effects of SCHIP, especially those concerning changes in the number and characteristics of uninsured children.[5]

TRENDS AMONG THE UNINSURED

Table 8 reports the trend from 1993 to 1998, in the number and percentage of children under age 19 without health insurance.[6] Because SCHIP expands coverage differentially

[4]These estimates were derived from the Survey of Income and Program Participation (SIPP), a longitudinal survey much better suited than the CPS to measuring the incidence and duration of spells without insurance.

[5]In future work under this project we hope to document both the strengths and limitations of the CPS estimates of insurance coverage by conducting comparative analysis with the National Health Interview Survey (NHIS), an annual survey which measures insurance coverage as of the survey date.

[6]The universe is the civilian, noninstitutionalized population under the age of 19 (at the time of the survey, the following March).

TABLE 8

NUMBER AND PERCENTAGE OF CHILDREN WITHOUT HEALTH INSURANCE, BY POVERTY LEVEL, 1993 THROUGH 1998

Poverty Level (Percent of FPL)	Reference Year of Survey					
	1993	1994	1995	1996	1997	1998
	Number of Children Uninsured (Thousands)					
Total	10,293	10,678	10,503	11,300	11,586	11,871
Less than 50%	1,472	1,643	1,594	1,784	1,900	1,886
50% to < 100%	2,099	2,115	1,993	2,061	2,006	2,111
100% to < 150%	2,066	2,084	2,066	2,200	2,210	2,065
150% to < 200%	1,496	1,594	1,707	1,818	1,691	1,726
200% to < 250%	1,030	1,067	969	1,066	1,116	1,274
250% to < 300%	622	670	709	739	743	614
300% to < 350%	417	414	368	524	494	576
350% or more	1,091	1,091	1,098	1,108	1,425	1,618
	Percent of Children Uninsured					
Total	14.1	14.4	14.0	15.1	15.3	15.6
Less than 50%	18.8	21.4	23.3	24.8	26.1	27.9
50% to < 100%	23.1	24.0	22.0	24.3	24.8	26.3
100% to < 150%	25.2	25.4	24.6	26.2	27.8	26.1
150% to < 200%	19.0	20.1	20.8	21.7	21.2	21.7
200% to < 250%	13.7	14.8	13.0	14.1	15.0	17.2
250% to < 300%	9.6	10.0	10.3	10.9	10.8	9.4
300% to < 350%	7.6	7.1	6.3	8.8	8.3	10.1
350% or more	5.3	5.1	5.0	5.0	5.9	6.3

SOURCE: Mathematica Policy Research analysis of Current Population Survey, March 1994 through March 1999.

within the low-income population, trends in the uninsured are disaggregated by poverty level.[7]

Pre-SCHIP Trends

SCHIP was implemented at a time when uninsured rates were rising, especially among the lowest-income children who presumably were eligible for Medicaid but were not enrolled (Selden et al. 1998). During the pre-SCHIP period, the percentage of children without health insurance rose 1.2 percentage points, from 14.1 percent in 1993 to 15.3 percent in 1997, or an average of 0.3 percentage points per year. The increase was largest among children in families below 50 percent of poverty, where the proportion uninsured rose an average of nearly 2 percentage points a year, from 18.8 percent in 1993 to 26.1 percent in 1997. The uninsured rates in other poverty groups showed a generally upward trend--but much more modest than what we found among children below 50 percent of poverty.

As shown in Table 8, 27.8 percent of children in families between 100 and 150 percent of the federal poverty level (FPL) were uninsured in 1997. These children often were not eligible for Medicaid, and their families either were not offered or could not afford other types of insurance coverage. SCHIP extended coverage to many of these children as well as other low-income children.

Preliminary Evidence of the Short-term Effects of SCHIP

According to the CPS, there were no statistically significant changes in the uninsured rates between 1997 and 1998, whether for all children or for subgroups by poverty level.[8] The rise of 0.3 percentage points in the overall child uninsured rate between 1997 and 1998 is not statistically significant, but it appears to be a continuation of the pre-SCHIP trend.[9]

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[7]Poverty is measured relative to the Census Bureau's poverty thresholds, which are the basis for the official estimates of poverty in the United States. Medicaid and SCHIP programs generally use the alternative "poverty guidelines" prepared by the Department of Health and Human Services (DHHS). The two are comparable in level, but the poverty guidelines are simpler, having uniform increments by family size, although they also recognize higher living costs in Alaska and Hawaii than the rest of the states, which the poverty thresholds do not do (Fisher 1992).

[8]Over the range of observed rates the standard error for an annual estimate for the entire population of children is about 0.18 percent, implying a 95 percent confidence interval of plus or minus .36 percent for each of the estimates. Taking into account the sample overlap between consecutive March surveys, a 0.45 percentage point change in the entire population of children between consecutive years would be defined as statistically significant at the 0.05 level. The Census Bureau favors a .1 percent level of significance in its published reports on the CPS; but, even with this more liberal standard, the change in the percentage of children uninsured between 1997 and 1998 is not statistically significant (Campbell 1999). This is true as well of the much larger percentage point change in the proportion uninsured among children in poverty; that is, this change is not significant either.

[9]A confidence interval of plus or minus 0.45 percentage points around the estimated change of 0.3 percentage point covers a rather broad range of possibilities that only additional years of data can help to *(footnote continued)*

Thus, it would appear that implementation of SCHIP had not yet had a measurable effect on the modest year-to-year growth in the percentage of children without health insurance. Moreover, the estimate of change in the uninsured rate is simply not precise enough for us to draw conclusions about whether the earlier upward trend has abated since SCHIP was introduced. These findings should not be surprising given the early enrollment patterns in SCHIP and the start-up time needed to implement these programs. As we saw in the previous chapter, enrollment doubled from FFY 1998 to 1999 and continued to grow at the rate of one million per year through early 2000.

Although none of the differences within poverty group were significant, two trends may signal the early effects of SCHIP on reducing the rate of uninsured low-income children. The first trend is that among children between 100 and 150 percent of poverty, who had the highest proportion uninsured in every year from 1993 through 1997, there appears to be a reversal of the recent pre-SCHIP trend. The proportion uninsured drops between 1997 and 1998; although not statistically significant, these data suggest an apparent reversal of the pre-SCHIP trend and a divergence from the pattern found among children in the two lower-income groups. Children between 100 and 150 percent of poverty were more likely to gain coverage under SCHIP than those at lower poverty levels, many of whom were already eligible for Medicaid. If SCHIP has had any effect on the uninsured as yet, it is in this group that we would expect the effect to be most pronounced. The second encouraging trend is that in the next higher income group, children between 150 and 200 percent of poverty, a gradual year-to-year rise in the uninsured rate between 1993 and 1996 flattens out and stays relatively flat through 1998.

In sum, our findings on the trend in the uninsured rate by poverty level are at least suggestive of an early influence of SCHIP, but the time series must be extended before we can draw valid inferences about the direction and magnitude of change. However, it is clear from the findings presented in this section that, as additional data become available, it will be important to look within poverty level for evidence of an effect of SCHIP on the uninsured rate.

resolve. The March 2000 CPS, to be released at the end of September 2000, will provide important data on the number of uninsured children during 1999.

CHANGES IN THE SOURCE OF COVERAGE

Information on changes in the source of insurance coverage for children over time is of interest, for two reasons. First, it can help explain trends in the proportion of children who are uninsured; second, it can demonstrate the extent to which shifts in coverage coincided with the implementation of SCHIP.

Changes in Coverage from 1997 to 1998

Table 9 reports the distribution of children by source of coverage in 1997 and 1998 (as recorded in the March 1998 and 1999 CPS supplements, respectively). Among all children, the proportion who were covered by ESI during the preceding year (including those who also had Medicaid coverage during the year) rose by 0.8 percentage points, while the proportion covered by Medicaid declined by 0.6 percentage points. Both changes, while relatively modest, are statistically significant.

None of the changes in coverage within the poverty level are statistically significant, although certain patterns are suggestive of changes that may become more evident with one or more additional years of data. Among children below 100 percent of poverty--those most likely to have been eligible for Medicaid for much of the year--the proportion with Medicaid coverage for any part of the year declined by a few percentage points, while the proportion with ESI coverage rose by almost the same amount.[10] That low-income children might be replacing Medicaid with ESI could be interpreted as a favorable outcome of welfare reform or the strong economy if the result were confirmed with additional data, but the magnitude of this change in coverage is small.

Among children in families with incomes between 100 percent and 250 percent of poverty--the group most likely to be eligible for coverage under SCHIP--we see the opposite movement. Medicaid coverage rose by about two percentage points, while ESI held steady (100 to 150 percent of poverty) or declined by 2 to 3 percentage points (150 to 250 percent of poverty). The Census Bureau includes SCHIP coverage under Medicaid if it was reported as some form of government insurance, so the rise in Medicaid coverage--again, if supported by additional data--could be due to coverage obtained under SCHIP.

The offsetting reduction in ESI among those with higher income levels (above 150 percent of poverty), though not statistically significant, could be explained by a number of factors such as: involuntary loss of ESI due to job loss or job transition; voluntary discontinuation of coverage by employers or employees due to cost; substitution of public

[10]Poverty level is based on income for the entire calendar year. A child might have been income-eligible for Medicaid for only part of the year, and thus we see children with reported Medicaid coverage even among those whose families had annual incomes well above poverty.

TABLE 9

DISTRIBUTION OF SOURCES OF COVERAGE BY POVERTY LEVEL, 1997 AND 1998: CHILDREN UNDER 19

Source of Coverage in Previous Year	All Children	Poverty Level (Percent of FPL) < 50%	50% to < 100%	100% to < 150%	150% to < 200%	200% to < 250%	250% to < 300%	300% to < 350%	350% or Greater
				1997 Reference Year (March 1998 CPS)					
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicaid without ESI	17.1	59.2	51.9	26.6	11.8	6.6	3.9	2.9	1.6
ESI without Medicaid	56.6	6.5	11.7	30.7	52.1	64.6	73.5	79.2	84.1
ESI and Medicaid	2.9	1.4	4.7	5.5	5.2	3.4	2.2	1.6	1.6
Privately purchased coverage	3.4	1.5	2.0	3.3	4.1	4.0	3.9	3.6	3.8
CHAMPUS, CHAMPVA	1.5	1.0	0.8	2.0	1.7	2.7	2.1	1.3	1.1
Medicare	0.1	0.3	0.4	0.3	0.1	0.1	0.0	0.0	0.0
Source unknown	3.0	3.9	3.6	3.7	3.7	3.6	3.4	3.1	1.8
Uninsured	15.3	26.1	24.8	27.8	21.2	15.0	10.8	8.3	5.9
				1998 Reference Year (March 1999 CPS)					
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicaid without ESI	16.3 *	56.6	47.9	28.9	13.7	8.4	4.0	2.7	1.3
ESI without Medicaid	57.2 *	7.3	14.6	30.8	50.4	61.5	73.4	75.6	84.3
ESI and Medicaid	3.1	1.7	5.0	5.2	4.0	3.7	3.5	2.3	1.8
Privately purchased coverage	3.0	1.9	2.0	2.8	3.8	3.6	3.2	3.4	3.2
CHAMPUS, CHAMPVA	1.3	0.5	0.5	1.5	1.9	1.9	2.1	1.7	1.1
Medicare	0.2	0.5	0.4	0.6	0.0	0.1	0.0	0.0	0.0
Source unknown	3.3	3.7	3.2	4.2	4.5	3.8	4.3	4.2	2.0
Uninsured	15.6	27.9	26.3	26.1	21.7	17.2	9.4	10.1	6.3

SOURCE: Mathematica Policy Research analysis of the Current Population Survey, March 1998 and March 1999.

*Significantly different from the previous year at the .05 level.

coverage for private coverage; or simply "noise" in the data. This is similar to findings by Cunningham and Park (2000) in their analysis of the first two rounds of the Community Tracking Study (CTS) household survey.[11] Accounting for these patterns, however, requires much better data than either the CPS or CTS can provide at present.

Longitudinal Analysis of Change in Coverage

While the overall distribution by source of coverage changed little from 1997 to 1998, it would be incorrect to infer that changes in coverage among children were rare. Rather, the relative stability of the aggregate distribution over the two years masks considerable movement among different sources of coverage. To estimate the amount of movement between sources of coverage, we exploited a feature of the CPS sample design that provides a sizable subsample of respondents for whom data are collected in two consecutive March surveys. When the respondents' records are matched between surveys, they can be analyzed longitudinally.[12]

Altogether, we estimate that 28 percent of children changed their source of insurance coverage, gained coverage, or lost coverage between 1997 and 1998 (data not shown). Changes were more common among lower-income children than higher income children; 37 percent of those *below* 200 percent of poverty, but only 21 percent of those *above* 200 percent of poverty changed their coverage between 1997 and 1998. This percentage is broadly consistent with estimates based on longitudinal data from earlier in the decade.[13]

Table 10 focuses on transitions among uninsured children. Of those uninsured in 1997, 45 percent were still uninsured in 1998; another 30 percent gained ESI coverage and 16 percent obtained Medicaid. Children just above poverty were most likely to remain

[11]Comparing sources of coverage between 1996-97 and 1998-99, Cunningham and Park (2000) found that a rise in public coverage was offset by a decline in private coverage among children below 200 percent of poverty, with most of the change occurring between 100 and 200 percent of poverty. Below the poverty level public coverage did not change while private insurance declined.

[12]There are some caveats that should be mentioned regarding the longitudinal analysis of matched CPS records. First, to maintain the representativeness of the sample over time, the Census Bureau returns to the same addresses rather than following their original occupants to new addresses. Respondents who move are not reinterviewed; rather, the new occupants—if any—are interviewed in their place. As a result, when records are matched at the person level, the resulting sample excludes persons who moved between the two years. Since moving may be associated with changes in employment and other characteristics, the exclusion of movers probably understates the amount of change in health insurance coverage. Second, response error and imputation for nonresponse to individual questions may have the opposite effect; that is, they may result in the amount of year-to-year change being overstated. Third, the CPS public use file does not contain unique person-level identifiers that can be matched over time. While the matches that users can construct are highly accurate, they are not perfect. Matching errors will tend to overstate year-to-year change as well.

[13]Czajka and Olsen (2000), using data from the 1992 panel of the SIPP, found that the number of transitions reported between July 1993 and June 1994 amounted to nearly one change for every three children. While the types of changes they examined were somewhat less inclusive than those represented here, it was quite common for children to record *two* transitions during the period. The actual number of children with one or more changes in coverage was probably closer to one in five.

uninsured in 1998. Of those who obtained coverage, it was fairly evenly divided between Medicaid and ESI. Not surprisingly, uninsured children in the lowest-income group (less than 50 percent of poverty) were the most likely to obtain Medicaid (30 percent), while higher-income children were more likely to gain ESI coverage.

CONCLUSION

States are pursuing a variety of initiatives under the SCHIP "umbrella" that could have an effect on uninsured rates in the future, including coverage expansions, outreach initiatives, enrollment simplification, and increased coordination with ESI. Future analyses will track not only aggregate trends in uninsured rates, but also transitions between uninsured and insured status, and trends within individual states.[14]

It should not be surprising that we observed no significant reductions in uninsured rates, given the enrollment patterns in 1998 and the large fraction of initial enrollment attributed to grandfathered programs. A longer time series will be required to observe the effects of SCHIP on uninsured rates. Additional data from both the March CPS and other

[14]Congress has appropriated $10 million annually for the Census Bureau to increase the sample size of the March supplement to the Current Population Survey, which provides the most widely used annual estimates of the health insurance coverage of the U.S. population. The funding will support a near-doubling of the March CPS sample size beginning in March 2001, with most of the increase being allocated to improve the precision of state estimates.

TABLE 10

CHILDREN UNINSURED IN 1997: SOURCE OF COVERAGE IN 1998 BY POVERTY LEVEL IN 1997, ESTIMATES BASED ON MATCHED CPS SAMPLES

Poverty Level in 1997 (Percent of FPL)	Source of Coverage in 1998								
	Total	Still Uninsured	Medicaid without ESI	ESI without Medicaid	ESI and Medicaid	Private Coverage	CHAMPUS, CHAMPVA	Medicare	Source Unknown
Total	100.0%	44.8	16.2	29.7	1.4	3.7	0.5	0.1	3.6
Less than 50%	100.0%	42.2	30.1	19.1	0.5	3.3	0.3	0.0	4.5
50% to < 100%	100.0%	53.3	16.2	21.8	1.6	2.0	0.6	0.0	4.5
100% to < 150%	100.0%	55.5	17.5	16.2	1.1	4.6	1.2	0.4	3.6
150% to < 200%	100.0%	47.9	16.8	26.0	4.6	3.9	0.0	0.0	0.8
200% to < 250%	100.0%	40.3	13.6	35.9	1.2	7.4	0.0	0.0	1.3
250% to < 300%	100.0%	34.8	8.7	51.6	0.6	1.9	1.2	0.0	1.2
300% to < 350%	100.0%	42.4	10.3	43.1	0.0	1.4	0.0	0.0	2.8
350% or more	100.0%	24.8	2.8	61.1	0.4	3.7	0.2	0.1	6.8

SOURCE: Mathematica Policy Research analysis of matched records in the March 1998 and March 1999 Current Population Survey samples.

ESI = employer sponsored insurance.

sources will be released over the next several months.[15] Further analysis also is required of the dynamics of insurance coverage. This analysis underscores the dynamic nature of health insurance coverage among children. There is considerable movement between insured and uninsured status over a two-year period. One goal of SCHIP is to provide seamless health insurance coverage for low-income children, helping them transition between Medicaid and ESI as their circumstances change. Through longitudinal analyses, we can assess whether fewer children are continuously uninsured and whether more children remain continuously insured by transitioning between sources of public and private coverage.

[15]Data from the March 2000 CPS will be released at the end of September 2000. Data from the 1998 NHIS will be released in November 2000, providing an alternative annual time series to the March CPS. Data from the second round of the National Survey of America's Families (NSAF) will be released in the fall as well, providing estimates that parallel the CTS in their reference period. Longitudinal data from the SIPP and the Medical Expenditure Panel Survey (MEPS) lag behind these cross-sectional surveys. Ultimately, they will support analyses of the dynamics of insurance coverage pre- and post-SCHIP, and their data may prove to be essential to investigating the existence of crowd-out; based on projected release dates, however, it will be at least another year before either survey will be available for the evaluation of SCHIP.

CHAPTER V

SUCCESSES AND CHALLENGES IN ENROLLING AND RETAINING CHILDREN IN SCHIP

We turn now to a synthesis of states' reflections on the strengths and weaknesses of their SCHIP eligibility determination and redetermination processes, as reported in their SCHIP evaluations to HCFA. States recognize that families may encounter barriers that can prevent or impede their successful enrollment and retention in SCHIP. Therefore, states are attempting to identify, address, and overcome these barriers to enroll more children in SCHIP. The chapter begins with state perspectives on key aspects of the eligibility determination process for SCHIP, including application and redetermination forms, the mail-in option, coordination of eligibility among programs, verification of personal information, and the timeliness of eligibility determinations. Then, several broader enrollment issues are addressed: reducing stigma, improving retention rates, implementing cost-sharing, training staff, modifying automated systems to accommodate SCHIP, and centralizing eligibility determination.

This chapter is based on information reported in Sections 3.1.7, 3.1.8, 4.2.2, 5.1.1, and 5.2 of the state evaluations. It is important to note that individual states highlighted particular themes in their discussion of enrollment and retention. Undoubtedly, many of the successes and challenges described in this section are shared by several states, although not all states discussed them.

KEY ASPECTS OF THE SCHIP ELIGIBILITY DETERMINATION PROCESS

Application and Redetermination Forms

Recognizing that Medicaid applications are confusing and lengthy, almost all the states have made a deliberate effort to streamline and simplify their SCHIP application and redetermination forms. In the evaluation reports, close to 40 states indicated that they had simplified their application forms. The vast majority of states have eliminated assets testing for SCHIP and many have also reduced verification requirements. Not all states reported on the length of their SCHIP application forms, but over 20 states indicated that their forms are four pages or less, including Arizona, Arkansas, the District of Columbia, Florida, Georgia, Indiana, Iowa, Kentucky, Maine, Maryland, Michigan, Minnesota, Nebraska, Nevada, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, and Virginia.

In Oklahoma, where the M-SCHIP program in FFY 1999 increased the number of publicly insured children by over 60 percent beyond traditional Medicaid, the state reduced its application form for all children applying for Medicaid from 16 pages to 1 page. The state also eliminated the assets test and moved to accept a self-declaration of income—steps that enabled the state to simplify the application process considerably.

State Highlight: Developing Shorter Forms

Initially, California developed a 28-page SCHIP/Medicaid application form. Focus group testing and stakeholder review pointed to the length and complexity of the application as barriers to enrollment. Although the form was a good training tool for Community-Based Organizations and Certified Application Assistants, it was not effective as an application. Subsequently, the state produced a four-page user-friendly application, as well as a two-page redetermination form. California also provided application materials and toll-free information lines in eleven languages.

Thirteen states mentioned areas in which their application or redetermination forms could still use improvement (Connecticut, Delaware, Iowa M-SCHIP, Maine, Nebraska, New Hampshire, North Dakota, Oregon, Pennsylvania, Tennessee, Vermont, Virginia, and West Virginia). For example, Vermont plans to develop SCHIP application forms in languages other than English. North Dakota is revising its application form to make it shorter. Several states are focusing additional attention on improving the redetermination process:

- During redetermination, enrollees in Connecticut, Delaware, and Maine must provide information already collected at the initial application, such as birth date or social security numbers. All three states hope to include pre-filled information so that enrollees do not have to provide duplicate information at renewal.

- New Hampshire reported that currently there is no difference in the state's SCHIP application and redetermination process and that streamlining the redetermination form and procedures would enhance operations.

The Mail-in Option

To decrease the burden on new applicants or re-enrollees, close to 40 states reported in their evaluations that they have eliminated the requirement for face-to-face interviews and moved to mail-in applications. This approach is more convenient because it assists working families who find it difficult to visit an eligibility office during the day and helps those who have transportation issues.

- Several states, including Alaska, California, Delaware, Kansas, Louisiana, and Massachusetts, mentioned that they also provide postage paid return envelopes.

- Michigan has a "no wrong door" policy. Maximus (the state's administrative contractor), local TANF offices, and local health departments all accept applications via mail or in-person.

State Highlight: The Benefits of a Simplified, Mail-in Application

Illinois believes that its mail-in application has increased enrollment. It allows families to interact with KidCare by phone and through the mail, as they would interact with a private insurer. Ending face-to-face interviews encourages working families to apply. Other steps to improve the mail-in process include: dropping the assets test; removing the verification requirements regarding where and with whom children live; simplifying the income verification requirements; eliminating all non-essential questions; and developing a centralized intake unit at the state level that can accurately and consistently process a large volume of applications. Illinois also reimburses KidCare Application Agents who assist families with needed paperwork. Illinois indicated that their approval rate for submitted applications has improved significantly to about 8 out of 10.

Some states, however, mentioned that the use of mail-in applications can have unintended consequences. For example, this process does not allow intake workers to educate applicants about eligibility requirements, benefits, or the redetermination process. The mail-in approach also limits the amount of assistance a state may provide in completing the application. Nine states noted limitations with the mail-in application process: Delaware, Kansas, Kentucky, Louisiana, Maine, Mississippi, Missouri, Oregon and Virginia.

- Louisiana and Missouri reported that some applicants would benefit from face-to-face assistance because illiteracy may be a barrier to filling out the mail-in application. To address this problem, Missouri and many other states offer a toll-free assistance line.

- Delaware, Kansas, and Kentucky reported that the mail-in process increases the likelihood that applications will be incomplete, thereby lengthening the eligibility determination process. As a result, Kentucky provides reminders on the application envelope that list the "must do's" for the application.

Coordination of Eligibility Among Programs

Most states are striving to achieve a seamless relationship between their SCHIP and Medicaid programs, so that children move easily between programs as their life circumstances change. Because S-SCHIP and Medicaid programs can differ in eligibility rules and benefits, coordination between programs can be complicated. Of importance in

addressing this problem, the state evaluations revealed that 30 of the 32 states with S-SCHIP programs (as of March 2000) are using a combined application form for S-SCHIP and Medicaid. States have also designed with other strategies for improving coordination.

- Oregon designed its S-SCHIP program to build on its 1115 Medicaid demonstration experience. A single application and joint eligibility determination process allow members of mixed-eligibility families to be enrolled in the same health plan.

- Arizona locates eligibility staff for Kids Care (its S-SCHIP program) and Medicaid in the same office.

State Highlight: Coordinating with Medicaid

Georgia's SCHIP application includes a check-off box for parents to request that their children's applications be referred to Medicaid if they are identified as potentially eligible for Medicaid. Parents can then apply for Medicaid without having to file a separate application and without any further intervention. For families that do not check the box, a representative from Right from the Start Medicaid (RSM) calls the family and provides information and counseling about the benefits of the Medicaid program. To date, no one has ultimately refused Medicaid after speaking with an RSM worker. The state considers this component "a tremendous strength to the program as families receive the information necessary for them to make an informed choice and correct any misperceptions they may have about the Medicaid program."

In the evaluation reports, several states pointed to ongoing challenges in making sure their systems are seamless, particularly when S-SCHIP programs are involved.

- Alabama has difficulty during the redetermination process because its M-SCHIP and S-SCHIP programs do not use the same redetermination forms, making referrals between the two programs more challenging.

- Connecticut is still working to make the referral process between Husky A (M-SCHIP) and Husky B (S-SCHIP) seamless. The state has developed an automated tracking and referral process and conducted training to assist staff in transferring cases between the two programs more easily.

- Kansas and Wyoming reported that families are confused by the relationship between their S-SCHIP programs and Medicaid and the different eligibility criteria for the two programs. Kansas is working to create a "seamless single program (from the public perspective)." Until that is done, however, the state seeks to improve communication with S-SCHIP families.

- Families in Florida do not always understand that S-SCHIP and Medicaid are separate programs, and that they can get either program even if they are denied welfare. The state has also found that families in which children are enrolled in two different programs may not understand the need to reapply for one child if they just reapplied for another child.

Verification of Personal Information

To determine eligibility, SCHIP programs generally verify applicant age, income, and citizenship. Thirteen states cited documentation requirements as a barrier to enrollment and retention (Alabama M-SCHIP, Arkansas, District of Columbia, Iowa M-SCHIP, Louisiana, Minnesota, New Hampshire, New Jersey, North Carolina, North Dakota, Oregon, Pennsylvania, and Virginia). As a result of the burden caused by verification, states are using a variety of methods to assist enrollees:

- Louisiana uses on-line birth records to verify age to reduce the burden on applicants.

- Pennsylvania is working to reduce the amount of income verification required. Currently, the state requires documentation of a full month's work; however, the state is considering allowing one pay stub (for a shorter time period) to serve as sufficient verification of income.

- New Jersey is evaluating the use of alternate verification sources, such as data from the Department of Health and Social Services vital statistics records.

- Georgia, Idaho, and Maryland have chosen to allow self-declaration of income, to decrease the burden on applicants. HCFA reports that at least seven states are now using this approach.

- Illinois and Ohio recognize that income verification is a barrier; they believe, however, that it is essential to maintaining program integrity and have chosen to reduce other documentation requirements but not the requirement for income verification.

- West Virginia has decided not to require income verification as part of the redetermination process, in order to reduce the number of children disenrolling from SCHIP.

- Minnesota has a delayed verification process. An applicant has 30 days after enrollment to submit necessary verification.

State Highlight: Simplifying Documentation Requirements for Cash Income

New Jersey is working to make income-verification requirements easier for those "paid under the table." New Jersey will accept a letter from an employer on the its letterhead stating the monthly amount an employee receives. If the employer refuses to submit such a letter due to legal concerns, New Jersey offers a solution: the agency obtains verbal confirmation from the employer as to the applicant's income. The agency, on its letterhead, attests to communication with the employer and the stated income of the employee.

The Timeliness of Eligibility Determinations

In discussing the strengths of their SCHIP programs, several states highlighted their ability to quickly process SCHIP applications. Timely processing of applications allows eligible applicants rapid access to the services offered by the SCHIP program. Alaska reported that it is able to process applications within two working days. Georgia's third party administrator must process applications within 10 days to meet contract performance specifications.

Other states expressed some concern with delays in applications processing (Alabama, Delaware, District of Columbia, Kansas, Indiana, Maryland, Nebraska, New Jersey, Virginia, and West Virginia).

- Delaware and the District of Columbia are finding that a lack of staff leads to delays in processing applications. In Delaware, processing times exceed the optimum level of 10 days, but are within the mandated 45 days. Delaware is attempting to hire more staff to address its shortage.

- Maryland reported that 68 percent of M-SCHIP applications are processed by local health departments in 10 days or less. However, the state determined that M-SCHIP applications with an associated food stamp case were a weakness in the system because those cases must be transferred to the local department of social services for processing. To correct this delay, the

state worked with advocates to develop a plan to expedite processing of all applications, including those with food stamps; the goal is to process all applications within 10 days.

- Kansas expressed concern that its simplified renewal process is not designed to handle the significant changes in personal information that may occur within the 12 months of guaranteed eligibility, such as changes in family composition, address, and income. Kansas is working to improve the renewal process to accommodate this issue, and is not considering changing its 12 months guaranteed eligibility policy.

BROADER ISSUES RELATED TO ENROLLMENT AND RETENTION

Now, we turn from the eligibility determination (or redetermination) process to focus on state comments about broader issues related to SCHIP enrollment and retention.

Reducing Stigma

Families' perceptions of SCHIP can affect enrollment and retention. Because SCHIP is a public program, many states have found that some applicants attach a certain stigma to the program, often linking it with welfare or Medicaid. State officials believe this stigma discourages some eligible families from applying for health coverage through SCHIP (Arizona, Georgia, Iowa, Kansas, Kentucky, Michigan, North Dakota, Ohio, Oregon, and Rhode Island). For example, Arizona, Kansas, Michigan and Ohio mentioned in their evaluation reports that some families who applied for SCHIP coverage, but were determined to be eligible for Medicaid, decided to defer coverage because of the stigma attached to Medicaid.

To reduce the stigma associated with SCHIP and Medicaid, states are using a variety of approaches.

- Arkansas decided to name its M-SCHIP program ARKids Plus to take advantage of the outreach efforts and positive name recognition associated with its ARKids First 1115 demonstration.

- In Vermont and several other states, families that apply only for health care benefits mail their applications to a centralized processing unit, which has no overt connection to the state's welfare department.

State Highlight: Reducing Stigma At Little or No Cost

Indiana has taken a number of steps to reduce the stigma associated with its M-SCHIP program. The old Indiana Medicaid card was replaced with a Hoosier Health Card that resembles a commercial insurance card. Hoosier Healthwise is referred to as health insurance rather than public assistance. Children enrolled in the program are "members" not "recipients."

Improving Retention Rates

States also are finding that continuity of enrollment is affected by the structure of the re-enrollment process. Thus, many states are now shifting their focus so that they not only enroll, but "keep" eligible children in SCHIP and Medicaid. Some report that the process of re-enrolling has its own barriers, such as duplicative verification requirements, the need to complete a new application form, or a face-to-face interview. As shown in Table 11, states are undertaking or planning several initiatives to improve retention rates:

- Simplifying redetermination forms and the re-enrollment process (35 states)
- Using caseworkers or outreach programs to follow up with SCHIP recipients who do not respond to redetermination notices (31 states)
- Providing easy-to-use renewal form (30 states)
- Allowing mail-in of renewal application (23 states)
- Conducting surveys to learn more about why people disenroll (9 states)
- Mailing specific notices to recipients at risk of disenrolling, such as those with incomes on the border of eligibility limits (6 states)
- Using media campaigns to increase awareness about SCHIP and redetermination procedures (4 states)

States provided many examples of steps they are taking to improve the renewal process.

- In Alabama, children enrolled in the state's S-SCHIP program receive an ALL Kids insurance card with a "good through" date printed on the card. Parents and providers then know when coverage ends and when to expect the annual renewal. Alabama's M-SCHIP program allows a family to set up one review date, even if family members have multiple entry dates into Medicaid.

TABLE 11

STATE APPROACHES FOR IMPROVING SCHIP RETENTION RATES FOR ELIGIBLE CHILDREN

State	Simplify Re-enrollment Processes and/or Policies[a]	Follow-Up through Caseworkers and Outreach Programs[b]	Provide Easy-to-Use Renewal Form	Allow Mail-In of Renewal Application	Send out Reminder Notices	Conduct Special Surveys	Send Targeted Mailings	Conduct Information Campaigns
Total (N = 51)	**35**	**31**	**30**	**23**	**22**	**9**	**6**	**4**
M-SCHIP Only (N = 19)	**13**	**12**	**8**	**8**	**7**	**1**	**4**	**3**
Alaska	✓	✓		✓	✓			
Arkansas			✓	✓	✓			
District of Columbia	✓		✓	✓	✓			✓
Hawaii								
Idaho	✓					✓		✓
Louisiana		✓	✓	✓				
Maryland	✓	✓	✓					
Minnesota	✓	✓	✓				✓	
Missouri				✓			✓	
Nebraska	✓	✓	✓	✓	✓		✓	
New Mexico								
Ohio	✓	✓		✓				
Oklahoma	✓	✓						
Rhode Island	✓	✓	✓					
South Carolina	✓	✓			✓		✓	
South Dakota	✓	✓	✓		✓			
Tennessee	✓	✓			✓			✓
Texas		✓						
Wisconsin	✓			✓				
S-SCHIP Only (N = 15)	**7**	**6**	**8**	**7**	**8**	**4**	**1**	**0**
Arizona	✓	✓	✓	✓				
Colorado					✓			
Delaware	✓		✓			✓		
Georgia	✓		✓	✓	✓	✓		
Kansas	✓	✓	✓		✓			
Montana		✓		✓		✓		
Nevada	✓		✓	✓	✓			
North Carolina			✓	✓				
Oregon					✓			
Pennsylvania	✓	✓	✓		✓	✓		

TABLE 11 *(continued)*

State	Simplify Re-enrollment Processes and/or Policies[a]	Follow-Up through Caseworkers and Outreach Programs[b]	Provide Easy-to-Use Renewal Form	Allow Mail-In of Renewal Application	Send out Reminder Notices	Conduct Special Surveys	Send Targeted Mailings	Conduct Information Campaigns
Utah	✓	✓						
Vermont			✓	✓	✓			
Virginia		✓		✓	✓		✓	
Washington								
Wyoming								
Combination Programs[c] (N = 17)	15	13	14	8	7	4	1	1
Alabama	✓	✓	✓	✓	✓			
California	✓	✓	✓		✓			
Connecticut	✓	✓	✓				✓	
Florida	✓	✓	✓	✓		✓		
Illinois	✓	✓	✓					
Indiana	✓	✓			✓			
Iowa	✓							
Kentucky	✓	✓	✓		✓			
Maine	✓	✓	✓	✓		✓		
Massachusetts		✓	✓	✓	✓			
Michigan	✓	✓	✓	✓	✓			✓
Mississippi	✓		✓	✓				
New Hampshire	✓			✓		✓		
New Jersey	✓		✓			✓		
New York	✓	✓	✓	✓	✓			
North Dakota		✓	✓					
West Virginia	✓	✓	✓					

SOURCE: Mathematica Policy Research analysis of Title XXI State Evaluations, Sections 3.1.8 and 4.2.4 of State Evaluation Framework. It is important to note that individual states highlighted particular themes in their discussion of retention. The approaches shown in this table may be used by other states, although they may not have mentioned them in their evaluation.

[a]Simplifying processes and policies may include: reducing verification requirements, offering 12 months continuous enrollment, and convening workgroups to review and modify re-enrollment policies.

[b]States reported a variety of approaches to follow-up, including phone calls, caseworker visits, and community-based outreach programs.

[c]Combination states did not report separately on their re-enrollment efforts for S-SCHIP and M-SCHIP programs.

- Pennsylvania conducted focus groups to determine why many parents were not returning redetermination information. The state found that the reasons given for failure to renew mostly related to "lifestyle." Many parents said that they meant to do it, but got too busy, or forgot to send it in by the deadline. To improve retention, Pennsylvania is altering the appearance of renewal notices, conducting follow up telephone calls, and reducing income verification requirements.

State Highlight: Making Renewal Easier

Florida uses what it calls a passive re-enrollment process to maintain enrollment in its S-SCHIP and M-SCHIP programs (Healthy Kids, MediKids, and the Children's Medical Services Network). Families whose children are up for renewal receive a letter including demographic information they submitted with the initial application and are asked to make corrections as necessary. If there is no response, Florida assumes that there have been no changes and coverage extends for six more months. The use of premiums in the S-SCHIP program also provides assurance to the state that families are active participants.

State Highlight: A Multi-Faceted Approach to Improve Retention

Massachusetts is engaged in a number of activities to improve retention in its M-SCHIP and S-SCHIP programs. First, the state is hoping to increase the response from families at re-certification time by sending up to four reminder letters including a self-addressed return envelope and making follow-up phone calls. In addition, the state is looking into a computer-generated form that prints out current information about the family and requires that they correct any information that has changed, sign the form, and return it to the state.

Finally, the state has a number of targeted initiatives to learn more about the children who disenroll from SCHIP such as (1) developing a profile of the characteristics of people who drop out of the program; (2) assessing whether premiums are a barrier to participation in the program; and (3) awarding small grants to provide community-based support for outreach in an effort to identify those who may be eligible and help them enroll as well as help those who are enrolled maintain eligibility.

Implementing Cost-sharing

A few states have found that their cost-sharing policies have resulted in barriers to enrollment either due to an applicant's failure to pay the enrollment fee or premium or the state's lack of experience in collecting fees. This is an area, however, where more empirical research is required in order to understand better the extent to which cost-sharing serves as a barrier.

- North Carolina found that failure to pay an enrollment fee--$50 per child with a $100 family maximum--was the leading cause of denied applications.
- New Jersey requires that families mail a monthly premium check, but the process has proven to be time-consuming and costly for both the state and families. To address concerns with financial barriers, New Jersey is considering implementing features that would make it easier for families to pay premiums, such as an automatic debit or credit card payments.
- In March 2000, California established a "sponsorship" process to allow third parties to pay premiums on behalf of SCHIP applicants. The state reported

that this drew local charitable organizations into the outreach process and helped uninsured families learn about insurance coverage.

Training SCHIP Staff

SCHIP has imposed new expectations on state eligibility staff. In the past, many eligibility workers focused on moving people off welfare and Medicaid, and relatively little attention was focused on whether families were staying on Medicaid at the point of redetermination. Now, the orientation in most state SCHIP programs is that staff should encourage and assist eligible families during both the application and redetermination processes.

- North Carolina likens the changes with SCHIP to a paradigm shift saying that "there is a need to retool the thinking of eligibility workers into a form of insurance agent."

- Ohio found that its caseworkers were not perceived as being helpful in the application process, so the state began a series of technical assistance sessions for front line eligibility staff. These sessions focused on Medicaid eligibility rules, but they also promoted consistency and a consumer-friendly philosophy.

State Highlight: Internal Marketing to Field Staff

Louisiana trained eligibility field staff about the importance of health insurance and the consequences of being uninsured. They also explained why families may incorrectly assume children are not eligible and discussed other barriers to enrollment. They then challenged field staff to find solutions in assisting children to obtain coverage in LaCHIP or Medicaid. The state found that staff buy-in reduced procedural rejections. They also reported that staff were more creative and proactive in obtaining essential verifications.

Modifying Automated Systems for SCHIP

To determine eligibility, either initially or upon renewal, most states rely on automated eligibility systems. Ideally, these systems should be able to accommodate any special SCHIP eligibility rules, such as 12-month continuous eligibility. Quite often, however, it is difficult

to incorporate SCHIP rules when the systems are primarily designed for welfare and food stamps eligibility. A number of states felt that their systems served as a barrier to enrollment and reenrollment (Alabama S-SCHIP, Delaware, Kansas, Minnesota, New Hampshire, New Jersey, Ohio, Rhode Island, and West Virginia).

- Ohio's system does not fully support different programs' eligibility determination and application processes; for example, it does not allow for verification requirements related to Medicaid and M-SCHIP that differ from those used by the food stamp and cash assistance programs. Ohio is working to enhance its system so that traditional Medicaid or M-SCHIP eligibility will continue when other eligibility, such as food stamps, is terminated due to unrelated requirements.

- The West Virginia SCHIP program guarantees eligibility for 12 months unless a child ages out or applies and is found eligible for Medicaid. The system in West Virginia, however, automatically and erroneously transfers children from SCHIP to Medicaid if something changes in the child's case, such as initiating services from another program.

State Highlight: An Interactive System for SCHIP and Medicaid Eligibility

Wisconsin designed its BadgerCare program to use an automated eligibility determination system called Client Assistance for Reemployment and Economic Support (CARES). The CARES system leads an eligibility worker through an interactive process to determine eligibility in four programs: Medicaid, food stamps, child care, and Temporary Assistance for Needy Families (TANF). This minimizes costs and integrates program delivery to families who have family members eligible for traditional Medicaid and others eligible under the BadgerCare expansion.

Centralizing Eligibility Determination

Many states process initial applications and reapplications at a central location, to facilitate consistency in applying SCHIP eligibility rules and to increase efficiency compared to processing applications at multiple local sites. States, however, note a variety of pros and cons to centralization (Alabama S-SCHIP, Alaska, Kansas, Nebraska, Ohio, and Virginia).

- Alaska uses a single, statewide office to process SCHIP applications. As a result, clients needing assistance must rely on the state's outreach partners or take the initiative and seek support from the statewide office. Alaska's concern is that applicants may not find the support they need to apply.

- Kansas processes S-SCHIP applications at a central location, unless the applicant is involved in other programs, such as food stamps. In that situation, the application is sent to a local office, where it is maintained. As family circumstances change, a case may move between the central location and local agencies. This may be confusing to a family enrolled in SCHIP who is notified of the transfer, but does not understand the reason for it.

- In Virginia, because eligibility determination is performed at the local level, there are inconsistencies in the length of the eligibility determination process.

- Ohio conducts eligibility determination at local county offices and believes that this inhibits consistency. For example, county agencies sometimes impose additional documentation and verification requirements. Ohio is training its staff to ensure consistent application of eligibility rules and procedures.

CONCLUSION

It is interesting to note that some program features were viewed as barriers to enrollment in some states and beneficial to enrollment in other states. For example, Alaska thought centralization of the application process was a barrier, while Virginia believed that the lack of centralization was a barrier. Furthermore, some of the practices designed to overcome barriers were found to have inherent trades-offs. Mail-in redetermination applications are designed to reduce the burden on recipients; however, they also impede direct communication between SCHIP staff and SCHIP recipients. It is apparent that there is no clear solution to structuring enrollment and redetermination processes; rather each state must assess the positives and negatives of each approach to find the practices best suited to their state. Additional research on "best practices" will also be useful in informing state efforts.

CHAPTER VI

STATE RECOMMENDATIONS FOR IMPROVING TITLE XXI

Congress mandated that the state evaluations include recommendations for improving the State Children's Health Insurance Program, and virtually all states suggested ways in which the program could be improved to help them achieve the goal of expanding health insurance coverage for previously uninsured low-income children. States offered a wide range of recommendations, and their responses ranged in length from a single sentence to several pages. Because the question was open-ended, some states focused on a single priority, while others specified multiple priorities. It should be noted, however, that priorities mentioned by one state could be important to other states even though the issues were not raised in their state evaluations.

This chapter synthesizes the states' comments, reported in Section 5.3 of the state evaluations. The recommendations reflect several basic themes:

- Improve coverage of uninsured low-income children by extending coverage to certain excluded populations (such as children of public employees), by covering uninsured parents, and by increasing options for buying into employer-sponsored insurance (ESI)

- Improve the financing and administration of the program by eliminating or modifying the 10 percent administrative cap, by allowing a longer time frame for spending the Title XXI allotment, and by improving technical assistance and coordination among federal programs (for example, by facilitating outreach through other public assistance programs or conducting national media campaigns)

- Maintain flexibility for separate SCHIP programs, rather than imposing Medicaid-like rules and regulations

RECOMMENDATIONS TO IMPROVE COVERAGE

Expand Coverage for Children of Public Employees

One of the most common recommendations made by states was to extend SCHIP coverage to children of public employees (Alabama, Arizona, Arkansas, Florida, Georgia, Iowa, Kansas, Louisiana, Maine, and Ohio). The Title XXI statute explicitly excludes coverage of "a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family members employment with a public agency in the State" (Section 2110(b)(2) (B)). States view this exclusion as inequitable to children in families where one of the parents is employed by the state.

State Perspectives on Coverage of Children of Public Employees

Alabama: "We have many state employees whose income is well within the ALL Kids guidelines and they are not able to afford the $164 per month premiums for family coverage."

Louisiana: "If a Medicaid expansion program is the chosen option, then these children would be eligible.... (We) recommend that this exclusion be removed so that this population would qualify for both options."

Maine: "The state recognizes the importance of preventing crowd-out. However, we are concerned that children of public employees are treated differently than other children in this regard. We recommend that state crowd-out strategies, such as waiting periods, apply to all children who are applying regardless of the families' source of employment."

Allow Coverage of Uninsured Parents

Title XXI allows states to purchase family coverage through group health plans if such coverage is cost-effective relative to coverage of children only. States are concerned that this poses a barrier to covering parents and, therefore, recommended that Title XXI be amended to allow uninsured parents to qualify and enroll in SCHIP. Several states (California, Illinois,

Kentucky, Nevada, Rhode Island, and Wisconsin) noted that expanding coverage to uninsured parents is necessary if SCHIP programs are to meet their goals of reaching uninsured children.

- Wisconsin officials noted that they view such coverage "as a matter of good public policy and for practical purposes: more eligible children are enrolled when a public health program is offered to the entire family, rather than children alone." The state was required to utilize a Section 1115 waiver under Title XIX to cover uninsured adults through BadgerCare, rather than through the SCHIP program.

- Rhode Island also "wants to cover adults under its CHIP program. The State believes firmly that comprehensive quality care cannot be accomplished to meet identified needs of targeted, low-income children until this is accomplished."

Allow Coverage of Other Populations

Several states commented that specific populations are excluded from coverage under SCHIP, and recommended modifying treatment of these groups. For example:

- Florida and Minnesota both suggested allowing coverage of noncitizen children who do not currently qualify for SCHIP. As Minnesota wrote, "states cannot effectively cover all children as long as the citizenship barriers are in place" in both the Medicaid and SCHIP programs.

- Montana requested that children residing in Institutions for Mental Diseases (IMD) at the time of eligibility redetermination be allowed to remain on SCHIP.

Remove Barriers to Coordinating with Employer-Sponsored Insurance

To more effectively expand coverage and avoid crowd-out, states felt the need for increased flexibility to coordinate with employer-sponsored insurance coverage (Arizona, California, Florida, Iowa, Kansas, Kentucky, Minnesota, Ohio, Oregon, and Washington). To date, three states have developed premium assistance initiatives (see box); others are interested in following their lead but expressed concerns about the requirements imposed either under statute or as a matter of federal policy. The requirements are not viewed as "employer- or insurer-friendly" (Florida), and they are considered more restrictive than the employer buy-in requirements under Title XIX (Kansas). States cited a variety of barriers to coordination with ESI coverage, including requirements for benefits, premiums, cost-sharing, and waiting periods.

- Florida, Maryland, and Wisconsin reported that the requirement that employers share at least 60 percent of the premium cost is too stringent. Maryland conducted a survey of employers and found that the average employer contribution was less than 60 percent. Maryland's premium assistance program, signed into law in April 2000 (but not yet implemented), requires a minimum employer contribution of 50 percent. Wisconsin recommended that the primary criterion be cost effectiveness relative to other SCHIP coverage, without specifying a minimum percentage contribution.

- Utah and Washington recommend that children be made eligible for premium assistance without having to be uninsured for six months. This can introduce an inequity for families who have been struggling to pay the premium.

- Arizona noted that unique SCHIP protections mandated in the Title XXI statute (such as no cost-sharing for preventive care and a five percent cap on total cost-sharing) make coordination with employer-sponsored insurance challenging and impose additional administrative costs on the state and on providers.

State Highlights: Coordination with Employer-sponsored Insurance (ESI) Coverage

Several states are in the forefront of developing initiatives to assist families in obtaining ESI coverage for children and, in some cases, their parents. These programs are funded through a variety of sources, including Title XXI (SCHIP), Title XIX (Medicaid), and state-only funds.

Illinois offers the KidCare Rebate program through state-only funds to provide support to low-income families (between 133 and 185 percent of poverty) who have "acted prudently" and purchased coverage for their children. Families receive $75 per month per child toward the purchase of private insurance. The program offers families a choice of health plans that are not government operated. According to the state, "Some families with uninsured children who would otherwise be eligible for KidCare Share or Premium choose to enroll their kids in private insurance with the assistance of KidCare Rebate." As of April 1, 2000, about 3,200 children were enrolled in this state-only program.

Massachusetts offers a Premium Assistance option to families that have access to ESI coverage through an employer. The employer must contribute at least 50 percent of the cost and must meet the benchmark benefit level to qualify for coverage under Title XXI. Family premiums generally do not exceed $10 per child or $30 per family per month. The state pays the cost-sharing for well-child visits and for out-of-pocket expenses exceeding 5 percent of income.

Wisconsin has developed the BadgerCare Health Insurance Premium Payment (HIPP) program to help families purchase ESI coverage, provided they have not had employer-sponsored group coverage in the previous six months and that the employer pays at least 60 percent but less than 80 percent of the premium share. Employer verification of insurance coverage and determination of the cost-effectiveness of subsidizing ESI coverage through BadgerCare are routine components of the Medicaid/SCHIP eligibility determination process. If cost effectiveness of family coverage can be demonstrated, parents and children are covered under the Title XXI enhanced match. Otherwise, adults are covered under a Medicaid (Title XIX) waiver rather than through SCHIP (Title XXI).

Ease Provisions Related to Crowd-Out

Six states (Connecticut, New Hampshire, South Carolina, Utah, Washington, and Wisconsin) reported that anti-crowd-out provisions are counterproductive to the goal of providing seamless coverage for low-income children. Connecticut, for example, is opposed to the proposed minimum six-month waiting period for ESI premium assistance, and suggested reducing the waiting period or designing other strategies to avoid crowd-out. South Carolina also is opposed to anti-crowd-out requirements because they may discriminate against low-income families (especially those below 150 percent FPL) who have struggled to provide health insurance coverage to their children. They are concerned that families may drop coverage to be eligible for SCHIP, and then third-party resources are lost. South Carolina recommends requiring that families retain such coverage and that SCHIP coverage be coordinated with other third parties.

RECOMMENDATIONS TO IMPROVE FINANCING AND ADMINISTRATION

Eliminate or Modify the 10 Percent Administrative Cap

Twenty-one states commented that the 10 percent administrative cap posed significant limitations on program design, implementation, and expansion (Arizona, California, Colorado, Connecticut, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Montana, New Hampshire, New Jersey, New York, North Carolina, Vermont, and Washington). States recognize that Congress intended to devote Title XXI funds to purchase child health insurance and to minimize administrative expenses; North Carolina noted that this was a "laudable goal," but "unrealistic."

Some states indicated that the cap has limited their ability to conduct outreach and enrollment--activities essential to make families aware of SCHIP, help them apply, determine their eligibility, and, ultimately, get them services. Moreover, Arizona and Connecticut suggested that the 10 percent administrative cap limits evaluation. The limits are particularly difficult for small states, like Vermont, that have only a limited administrative claim under Title XXI.[1]

Several comments focused on the inequities faced by S-SCHIP programs because, unlike M-SCHIP programs, they cannot obtain matching funds for SCHIP administrative expenses under Title XIX. They recommended expanding the cap to minimize disincentives to states that prefer to develop S-SCHIP programs. Several states (such as Idaho, Indiana, and Nebraska) had been interested in designing an S-SCHIP program but did not pursue that option because they thought it would not be possible to design and operate such a program within the 10 percent cap.

State recommendations ranged from outright elimination of the cap to more targeted modifications.

- New Hampshire recommended lifting the 10 percent cap to allow states to staff SCHIP programs adequately and make system improvements with the goal of "having the 'old' Medicaid program look more like the 'new' CHIP program."
- New York suggested redefining the expenditures that are subject to the 10 percent cap, requesting that the cost of premiums be excluded for children who are presumptively eligible but who are later found to be ineligible.

[1]Some states, in contrast, reported that the 10 percent cap had no effect on program design or else they relied on other funding sources to supplement the administrative funds allowed under Title XXI. Many states used state funds to support outreach efforts under SCHIP. Other states subsidized labor costs, systems development, supplies, printing, and mailing, among other expenses.

- Nevada offered several suggestions for relieving the financial pressure on states, including raising the cap from 10 to 15 percent, removing outreach and marketing expenses and the costs of external quality review from the cap, and allowing states to draw up to 10 percent of the unused portion of the allotment for administrative expenses.

- Indiana, Iowa, and Michigan suggested removing outreach activities from the cap. According to Michigan, the cap "is a structural barrier to an effective CHIP outreach program... A solution would be legislation that distinguishes outreach activity from activities that administer the program."

States also recommended that special allowances be made to help states during the start-up period of new SCHIP programs or new components:

- Maryland expressed concern that the 10 percent cap would impose financial constraints in setting up a unit to administer its new premium assistance program. Texas also expressed concern about the effect of the cap on the design and implementation of its new S-SCHIP program.

- California and Colorado recommended that expenditures be permitted to exceed the 10 percent cap during program start-up (such as the first three years of the program), while Washington recommended that all up-front administrative costs be funded through federal matching dollars.

- Kansas suggested that the 10 percent cap be based on the state allocation or some other amount to allow for start-up expenses before premiums are paid on behalf of eligible children.

Extend the Deadline for Spending the SCHIP Allotment

At the time states submitted their evaluations in March 200, the deadline for spending their FFY 1998 SCHIP allotment was approaching. Some states recommended that they be allowed to keep their unspent SCHIP allotments for more than three years. Maryland and New Jersey, for example, suggested that the reallocation take place after five years rather than three years, to allow states to cover more uninsured individuals (including uninsured parents).

Oklahoma recommended that states be allowed to spend their allotment to cover uninsured children who are newly enrolled in Medicaid. Children who are eligible for Medicaid must be enrolled in Medicaid and are ineligible for SCHIP. According to Oklahoma, "states with high numbers of prior Medicaid eligible uninsured children (like Oklahoma) will never be able to access all of their federal allotment in order to enroll this traditionally hard to reach population; at the same time SCHIP holds states accountable for

enrolling them." Oklahoma concluded that states would have an incentive to adopt more effective outreach programs if the SCHIP allotment could be applied to covering uninsured children who are found eligible for traditional Medicaid.

Several states that had exhausted their FFY 1998 allotment were seeking opportunities to increase their funding to continue serving uninsured children. New York, for example, recommended that unspent allotments be redirected to states in need of additional funding. "Therefore, we recommend that those states that exceed their approved allotments be given the necessary funding to sustain their successful programs." Indiana suggested that states with S-SCHIP programs be allowed to access federal Medicaid funds once their SCHIP allocation has been exhausted (similar to M-SCHIP programs).

Improve Technical Assistance and Coordination Among Federal Programs

One area frequently cited by states is the need for additional coordination at the federal level to assist states with outreach and enrollment. States offered several examples where federal leadership would be helpful in resolving issues:

- Colorado cited the importance of resolving the confidentiality issues in working with the National School Lunch Program (NSLP). In fact, considerable progress has been made in this area as a result of federal interagency efforts. A new law became effective October 1, 2000, allowing school lunch and SCHIP authorities to share information.

- North Dakota called for federal involvement in working with the U.S. Postal Service to allow school districts to send out information about SCHIP through their bulk mail permit although it may identify insurance companies participating in the program.

- Indiana recommended increased coordination of multiple funding sources (such as the Special Supplemental Food Program for Women, Infants, and Children [WIC], maternal and child health [MCH], and the NSLP), to avoid duplication and maximize resources. Areas for coordination include standardization of eligibility and reimbursement guidelines and assistance with data-sharing.

In addition to improved coordination at the federal level, several states called for additional technical assistance from the federal government:

- Colorado recommended federal leadership in developing and disseminating outreach materials and developing a clearinghouse for state-based information on activities that demonstrate best practices.

- Kentucky recommended federal leadership in developing approaches to measuring outcomes and quality of care (similar to what has been done for outreach and eligibility simplification).

- The District of Columbia requested assistance in developing more precise estimates of the number of uninsured children who are eligible for SCHIP.

Idaho and North Carolina emphasized the need for federal leadership in undertaking aggressive marketing through national media campaigns, especially since media markets may cross over state boundaries. Idaho indicated that it cannot use state dollars to purchase media coverage in out-of-state markets. North Carolina suggested that the federal government explore "product placement" within national television programs (such as "ER" or "Chicago Hope") to highlight why it is important to have health insurance for children.

RECOMMENDATIONS TO MAINTAIN OR INCREASE FLEXIBILITY

Reduce Requirements for SCHIP Programs

In the view of 13 states--Florida, Kentucky, Massachusetts, Minnesota, Missouri, New York, North Carolina, Ohio, Pennsylvania, Utah, Vermont, Virginia, and Wyoming--the Title XXI program has begun to take on a new direction, one that signals less flexibility in designing and implementing SCHIP programs. These states, almost all of which have developed S-SCHIP programs, are concerned that the proposed SCHIP regulations will, one, add to the administrative burden; two, stifle creativity; and, three, increase tensions between the federal government and states. They commented that the proposed SCHIP regulations appeared to be "patterned after Medicaid" (New York) and reflected a "Medicaid mindset" (Ohio). Florida cited three examples of areas where additional requirements not specified in the Title XXI statute have been proposed: (1) lowering cost-sharing levels based on a family's income; (2) exempting Native American children from cost-sharing; and (3) requiring states to implement the Consumer Bill of Rights.

Some states perceived a bias against S-SCHIP programs and recommended that these restrictions be reduced. Five states (California, Florida, Kansas, North Carolina, and Washington) recommended that S-SCHIP programs be allowed to participate in the federal Vaccines for Children program, on a par with M-SCHIP programs. Several states also raised concerns about the policy prohibiting S-SCHIP programs from requiring applicants to submit their Social Security number (SSN). They note that the SSN facilitates matching against Medicaid eligibility records and verifying income reporting.

Other recommendations included allowing S-SCHIP programs to participate in the drug rebate program (again like M-SCHIP programs); compensating states for lost revenues due to prohibitions against cost-sharing for Native American children under SCHIP and giving states the flexibility to change funding sources for the state share of the match without having to obtain an amendment.

One area where S-SCHIP programs are given greater flexibility than M-SCHIP programs is who can determine eligibility. Only state employees are permitted to determine Medicaid eligibility (and, by extension, M-SCHIP eligibility), whereas S-SCHIP programs can rely on employees at health centers, day care centers, schools, and other settings. Illinois advocated that M-SCHIP programs be allowed greater flexibility in making eligibility determinations, similar to the options offered to S-SCHIP programs.

A View from the States: On Maintaining Flexibility in SCHIP

"When Title XXI was authorized, Massachusetts had already given thought to expanding access and was in the process of moving forward. With the new options available under Title XXI, the state was able to pursue these plans even more vigorously. For states not already planning an expansion it is clear that Title XXI provided the impetus to move in the direction of expanding coverage to children. In addition, the political dynamic encouraged states to take on the challenge of moving forward.... In thinking about the future of Title XXI it is important that the flexibility that states have had to design their own programs be maintained. We have concern, however, that the direction of the proposed Title XXI regulations would remove some of this flexibility."

Increase Flexibility Regarding Cost-Sharing

States recommended that HCFA provide increased flexibility to impose cost-sharing for specific services or populations and not cap cost-sharing for higher-income families. Several objectives motivate their recommendations: to ease administrative complexity, to increase parental responsibility, to control program costs, or to emulate private insurance practices. In particular, states would like the flexibility to impose cost-sharing on families whose income is above 100 percent of poverty rather than 150 percent (Alaska and Arkansas) or to impose targeted copayments on M-SCHIP enrollees for services such as inappropriate

emergency room use (Ohio).[2] Other states recommended refinements to cost-sharing policies for SCHIP families above 150 percent of poverty:

- New Jersey requested that HCFA eliminate the 5 percent cost-sharing cap for families with income above 200 percent FPL because they have found that it is difficult to monitor the total income of higher-income families.

- To increase parental responsibility, Montana suggested that the cost-sharing limit remain at 5 percent for families with incomes between 100 and 150 percent FPL (rather than being capped at 2.5 percent of income). Montana also is opposed to other cost-sharing provisions that would deviate from typical commercial practices, such as allowing only one copayment during a single office visit rather than on a per-service basis; prohibiting cost-sharing for laboratory tests and preventive or diagnostic dental services; and allowing noncovered services to be counted against the cost-sharing limit for children with chronic conditions.

- Idaho had proposed a graduated voucher system to help families "become self-reliant from the CHIP program" as their income increases, but this approach was rejected. The state recommended that the federal government review options that states could use to foster increasing parental responsibility for the cost of health insurance as their income increases.

Increase Flexibility in the Definition of Creditable Coverage

Several states also requested additional flexibility in defining "creditable coverage" under Title XXI. Washington found the definition confusing and recommended that HCFA simplify the definition. Other states expressed concern that underinsured children are being excluded.

- Iowa, New Hampshire, and New York questioned the exclusion of children with catastrophic, high deductible insurance who are considered to have creditable coverage and, therefore, are not eligible for SCHIP. As New Hampshire noted, "These policies offer little value to families with children since they do [not] cover preventive and routine care. Yet these families are penalized, while families who have been willing to take a risk in being uninsured qualify. It would be helpful to allow flexibility in the CHIP funding to provide supplemental benefits to these children."

[2]Arkansas' Section 1115 Medicaid waiver program currently charges copayments for families with incomes above 100 percent of poverty.

- California suggested that families without insurance coverage for dental or vision services be allowed to buy into SCHIP for those services.

CONCLUSION

The SCHIP program is exhibiting growing momentum as programs mature and gain visibility. The number of enrollees is rising each quarter, and states are considering new approaches to reach those who are potentially eligible but not enrolled. As mandated by Congress, the state evaluations presented numerous recommendations for improving Title XXI. Four recommendations were mentioned most frequently in the state evaluations. The most common concern is that the 10 percent administrative cap significantly constrains many states' efforts to conduct outreach, particularly among states with S-SCHIP programs that cannot obtain regular Medicaid matching funds for excess expenditures. States offered a number of suggestions, ranging from changing the way the cap is calculated, to removing outreach costs from the cap, to raising the level of the cap.

Second, many states perceive a shift in the direction of the Title XXI program at the federal level, signaling less flexibility, particularly for S-SCHIP programs. This concern is motivated by the perception that the proposed SCHIP regulations reflect a Medicaid orientation, which could add to the costs and stifle creativity among S-SCHIP programs. Specific examples include more stringent limits on cost-sharing for lower-income families, requirements for fraud detection, and requirements to implement the Consumer Bill of Rights in managed care programs.

Third, states reported that they face significant barriers in coordinating with employer-sponsored insurance, an important vehicle for expanding insurance coverage among low-income children and for avoiding crowd-out of private insurance coverage. Areas for improvement include reducing requirements for employer contributions, minimizing waiting periods without health insurance coverage, and easing requirements for health plans (such as benefits and cost-sharing limits).

Fourth, states suggest that they cannot succeed in reducing the number of uninsured low-income children until coverage is expanded to certain omitted groups, such as children of public employees and uninsured parents. Some states believe that uninsured children will not gain coverage until their parents are covered as well.

As the SCHIP program enters its fourth year, states will continue to strive to meet the goal of reducing the number of low-income uninsured children. These recommendations reflect state priorities for improving the SCHIP program.

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APPENDIX A

SUMMARY OF AMENDMENTS TO TITLE XXI STATE PLANS, AS OF AUGUST 1, 2000

TABLE A.1

SUMMARY OF AMENDMENTS TO TITLE XXI STATE PLANS, AS OF AUGUST 1, 2000

State		Approval Date	Effective Date	Description
Alabama	1	8/18/1998		Established the S-SCHIP program
	2	9/28/1999	10/1/2000	Established All Kids Plus, a wrap around for children with special health care needs
Alaska				No amendment
Arizona	1	5/21/1999	5/21/1999	Added four reasons why a child would not be guaranteed an initial 12 months of continuous coverage: 1) failure to cooperate, 2) whereabouts of the child are unknown, 3) child is a patient in an institution for mental diseases, and 4) child voluntarily withdraws from the program
	2	8/23/1999	10/1/1999	Established monthly premiums and increased the income limit to 200 percent FPL
	3	12/1/1999	10/1/1999	Amended the reporting requirements regarding quality indicators, strategic objectives and performance goals to the assurances and reports required by Title XXI. Also clarified that cost sharing of any kind will not be imposed on American Indians and that children who have been terminated from private insurance as a result of reaching the lifetime limit are considered uninsured for Title XXI eligibility purposes
Arkansas	1	Pending		
California	1	6/29/1998	7/1/1998	Established a gross income test for the S-SCHIP program
	2	12/21/1999		Increased enrollment broker fees from $25 to $50 per successful applicant
	3	11/23/1999		Raised the income threshold from 200 to 250 percent of FPL for S-SCHIP, expanded retroactive coverage for medical services from 30 to 90 days prior to enrollment in Healthy Families, and allowed Healthy Families to use the Medi-Cal income disregards
	4	3/6/2000		Allowed a Family Contribution Sponsor to pay a specific child's Healthy Families Program premiums for the first year of enrollment
	5	7/7/2000		Exempted cost sharing for American Indians and Alaskan Native children who meet the eligibility criteria for the Healthy Families Program and provide acceptable documentation of their status
Colorado	1	9/21/1999	9/21/1999	Expanded the upper age limit from 17 to 18
Connecticut	1	7/14/2000	7/14/2000	Provided for the implementation of full mental health parity. Provided Husky Part B coverage to children of municipal employees if dependent coverage was terminated due to extreme economic hardship. Removed children of Federal employees from the list of ineligible children for Husky, Part B. Also exempted American Indian/Alaskan Native children from cost sharing.
Delaware	1	11/23/1999	7/1/1999	Discontinued the six-month waiting period for people who were disenrolled from the program because they failed to pay their premiums
District of Columbia				No amendment
Florida	1	9/8/1998		Expanded eligibility for Healthy Kids from 185 percent of FPL to 200 percent of FPL and added MediKids and CMS
	2	Denied		
	3	3/31/2000		Implemented a pilot for minimal dental benefits in two counties
Georgia	1	4/20/2000	10/1/1999	Modified the reinstatement process to facilitate resuming coverage to children who were cancelled due to non-payment of premiums. Also exempted cost sharing for American Indians and Alaskan Native children who meet the eligibility criteria for the program and provide acceptable documentation of their status.
Hawaii	1	9/22/2000	7/1/2000	Expanded eligibility from 185 to 200 percent of poverty and expanded the age criterion from children age 1 through 5 to all children under age 19
Idaho	1	12/4/1998	7/1/1998	Lowered income threshold from 160 percent of FPL to 150 percent
	2	Pending		
Illinois	1	3/30/2000	8/12/1998	Established the S-SCHIP program and introduced cost sharing
Indiana	1	12/22/1999	1/1/2000	Established the S-SCHIP program

TABLE A.1 *(continued)*

State		Approval Date	Effective Date	Description
Iowa	1	6/16/1999	1/1/1999	Established the S-SCHIP program
	2	3/31/2000	10/1/1999	Established a 20 percent earnings disregard and added Unity Choice from Wellmark Health Plan of Iowa
	3	6/14/2000	3/1/2000	Added John Deere Health Plan in selected counties, removed cost sharing for American Indian/Alaska Native children, and allowed a deduction of capital assets when considering self-employment income
Kansas	1	4/20/2000		Extended coverage to newborns of mothers enrolled for a family member enrolled in S-SCHIP through the end of the current continuous 12-month eligibility period of the family member
Kentucky	1	9/3/1999		Expanded M-SCHIP eligibility from 100 percent of FPL for 14 through 18 year old children to 150 percent of FPL for children ages 1 to 19
	2	Pending		
Louisiana	1	8/27/1999	10/1/1999	Expanded eligibility from 133 percent to 150 percent of FPL
Maine	1	Pending		
Maryland	1	Pending		
	2	Pending		
Massachusetts				No amendment
Michigan	1	6/29/1998		Established a M-SCHIP program for children 16 through 18 through 150 percent of FPL. Reduced family premiums for S-SCHIP to $5 per month regardless of the number of children. Eliminated all copayments for S-SCHIP covered services and required final eligibility determinations to be made by State staff.
	2	Pending		
Minnesota				No amendment
Mississippi		2/10/1999	1/1/1999	Established the S-SCHIP program with an income threshold of 133 percent of FPL
	1	12/17/1999	1/1/2000	Expanded S-SCHIP eligibility from 133 percent of FPL to 200 percent of FPL and introduced cost-sharing elements
	2	Pending		
Missouri	1	9/11/1998		Amended crowd-out policy
Montana	1	Pending		
Nebraska	1	10/13/1998	9/1/1998	Expanded M-SCHIP eligibility from 100 percent of FPL for children ages 15 through 18 to 185 percent of FPL for children under 19 years of age
Nevada	1	Pending		
New Hampshire	1	3/25/1999	1/1/1999	Modified the benefit package
New Jersey	1	5/7/1999	1/13/1999	Shorten the waiting period from 12 to 6 months
	2	8/3/1999	7/1/1999	Introduced income disregards, effectively expanding eligibility to 350 percent of FPL
	3	7/7/2000	7/26/1999	Provided that a child whose gross family income does not exceed 200 percent of FPL (Plans B and C) will be exempt from the 6-month waiting period if the child was covered under an individual health benefits plan or COBRA plan prior to application. Exceptions were also granted in Plans B, C, and D if the child had not been voluntarily disenrolled from an ESI plan during the 6-month period prior to application, or the child loses insurance as a result of a job change, when the insured does not have access to affordable coverage in the new job.
	4	3/16/2000	1/1/2000	Established presumptive eligibility if a preliminary determination by staff of an acute care hospital, FQHC, or local health department indicates that the child meets either NJ KidCare Plan A, B, C or Medicaid program eligibility standards, and the child is a member of a household with a gross income not exceeding 200 percent of FPL
New Mexico	1	Denied		
	2	Pending		

TABLE A.1 *(continued)*

State		Approval Date	Effective Date	Description
New York	1	Denied		Requested retroactive matching funds
	2	9/24/1999	1/1/1999	Expanded M-SCHIP eligibility to children 15 to 18 years in families with incomes at or below 100 percent of FPL (who were not Medicaid eligible prior to March 31, 1997). Expanded S-SCHIP eligibility from 185 percent of non-farm FPL to 192 percent. The amendment also reduced cost-sharing requirements and provided additional benefits to enrollees.
North Carolina	1	1/15/1999		Modified the definition of "uninsured" to allow children formerly covered under the Caring Program for Children, who are eligible for Title XXI, to enroll in SCHIP without a six month waiting period
	2	6/23/1999		Expanded the acceptable sites for delivery of clinic services to include School-Based Health Centers
	3	9/30/1999		Expanded dental services to include flouride applications, sealants, simple extractions, therapeutic pulpotomies, and prefabricated stainless steel crowns
	4	Pending		
North Dakota	1	11/12/1999	10/1/1998	Established the S-SCHIP program
Ohio	1	7/7/2000		Increased the income level for eligibility up to 200 percent of the FPL
Oklahoma	1	3/25/1999	11/1/1998	Accelerated the enrollment of children born prior to October 1, 1983
Oregon	1	Pending		
	2	Pending		
Pennsylvania	1	10/29/1998		Expanded eligibility from 185 percent of FPL to 200 percent
	2	3/7/2000		Established disregards for child care and work expenses
	3	3/7/2000		Added outpatient mental health services, inpatient and outpatient substance abuse services, rehabilitation services, and disposable medical supplies
Rhode Island	1	2/5/1999	To be determined	Expanded eligibility from 250 percent of FPL to 300 percent
South Carolina				No amendment
South Dakota	1	10/29/1999	4/1/1999	Expanded eligibility from 133 percent of FPL to 140 percent
Tennessee				No amendment
Texas	1	11/5/1999	5/1/2000	Established the S-SCHIP program
Utah	1	Denied		
Vermont	1	8/11/1999	7/1/1999	Increased monthly premiums
	2	2/28/2000		Implemented a primary care case management delivery system
	3	Pending		
Virginia	1	Pending		
Washington				No amendment
West Virginia	1	3/19/1999	4/1/1999	Established the S-SCHIP program
	2	Pending		
	3	Pending		
Wisconsin	1	1/22/1999	7/1/1999	Expanded M-SCHIP eligibility from 100 percent of FPL for children ages 15 through 18 to 185 percent of FPL. The parents of children enrolled under this M-SCHIP expansion will be covered at the regular Federal Medical Assistance Percentage (FMAP) using Section 1115 demonstration authority for Title XIX. Enhanced Title XXI FMAP can be used to cover both the parents and the children if cost-effectiveness for family coverage can be demonstrated. Once a family is enrolled, eligibility is retained in the program until family income is above 200 percent of FPL. Children living with a caretaker relative will also be covered if not otherwise covered by Medicaid. The caretaker relative for these children will not be covered under this expansion.
Wyoming				No amendment

NOTE: A number of states have amendments to disregard wages paid by the Census Bureau for temporary employment related to Census 2000 activities. Since these are temporary amendments, they are not listed above.

APPENDIX B

SIMULATED PROGRAM ELIGIBILITY FOR A HYPOTHETICAL FAMILY AT 100, 133, 150, 185, 200, AND 250 PERCENT OF POVERTY

TABLE B.1

SIMULATED PROGRAM ELIGIBILITY FOR FOUR CHILDREN--INFANT AND AGES 5, 10, AND 17--IN A FAMILY OF SIX WITH GROSS FAMILY INCOME OF 100 PERCENT OF THE 1999 FEDERAL POVERTY LEVEL

	Infant	5 year old	10 year old	17 year old
M-SCHIP Only (N = 11)				
Alaska	Medicaid	Medicaid	Medicaid	M-SCHIP
Idaho	Medicaid	Medicaid	Medicaid	Medicaid
Louisiana	Medicaid	Medicaid	Medicaid	M-SCHIP
Maryland	Medicaid	Medicaid	Medicaid	M-SCHIP
Minnesota	Medicaid	Medicaid	Medicaid	Medicaid
Nebraska	Medicaid	Medicaid	Medicaid	M-SCHIP
Ohio	Medicaid	Medicaid	Medicaid	M-SCHIP
South Carolina	Medicaid	Medicaid	Medicaid	M-SCHIP
South Dakota	Medicaid	Medicaid	Medicaid	Medicaid
Tennessee	Medicaid	Medicaid	Medicaid	Medicaid
Wisconsin	Medicaid	Medicaid	Medicaid	M-SCHIP
S-SCHIP Only (N = 6)				
Kansas	Medicaid	Medicaid	Medicaid	Medicaid
Montana	Medicaid	Medicaid	Medicaid	S-SCHIP
North Carolina	Medicaid	Medicaid	Medicaid	Medicaid
Pennsylvania	Medicaid	Medicaid	Medicaid	S-SCHIP
Virginia	Medicaid	Medicaid	Medicaid	Medicaid
Washington	Medicaid	Medicaid	Medicaid	Medicaid
Combination programs (N = 10)				
Alabama	Medicaid	Medicaid	Medicaid	M-SCHIP
California	Medicaid	Medicaid	Medicaid	M-SCHIP
Florida	Medicaid	Medicaid	Medicaid	M-SCHIP
Illinois	Medicaid	Medicaid	Medicaid	M-SCHIP
Indiana	Medicaid	Medicaid	Medicaid	Medicaid
Iowa	Medicaid	Medicaid	Medicaid	M-SCHIP
Maine	Medicaid	Medicaid	Medicaid	Medicaid
Massachusetts	Medicaid	Medicaid	Medicaid	M-SCHIP
New Jersey	Medicaid	Medicaid	Medicaid	M-SCHIP
North Dakota	Medicaid	Medicaid	Medicaid	Medicaid

SOURCE: Mathematica Policy Research simulations based on analysis of Title XXI State Evaluations, Addendum to Table 3.1.1

NOTE: The 1999 Federal poverty level for a family of six is a gross annual income of $22,340 in the 48 contiguous states and D.C., $27,920 in Alaska, and $25,690 in Hawaii (Federal Register 1999). The simulation accounts for any income and child care disregards used by each Medicaid and SCHIP program.

TABLE B.2

SIMULATED PROGRAM ELIGIBILITY FOR FOUR CHILDREN--INFANT AND AGES 5, 10, AND 17--IN A FAMILY OF SIX WITH GROSS FAMILY INCOME OF 133 PERCENT OF THE 1999 FEDERAL POVERTY LEVEL

	Infant	5 year old	10 year old	17 year old
M-SCHIP Only (N = 11)				
Alaska	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Idaho	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Louisiana	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Maryland	Medicaid	Medicaid	Medicaid	M-SCHIP
Minnesota	Medicaid	Medicaid	Medicaid	Medicaid
Nebraska	Medicaid	Medicaid	Medicaid	M-SCHIP
Ohio	Medicaid	Medicaid	Medicaid	M-SCHIP
South Carolina	Medicaid	Medicaid	M-SCHIP	M-SCHIP
South Dakota	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Tennessee	Medicaid	Medicaid	Medicaid	Medicaid
Wisconsin	Medicaid	Medicaid	M-SCHIP	M-SCHIP
S-SCHIP Only (N = 6)				
Kansas	Medicaid	Medicaid	S-SCHIP	S-SCHIP
Montana	Medicaid	Medicaid	S-SCHIP	S-SCHIP
North Carolina	Medicaid	Medicaid	S-SCHIP	S-SCHIP
Pennsylvania	Medicaid	Medicaid	S-SCHIP	S-SCHIP
Virginia	Medicaid	Medicaid	S-SCHIP	S-SCHIP
Washington	Medicaid	Medicaid	Medicaid	Medicaid
Combination programs (N = 10)				
Alabama	Medicaid	Medicaid	S-SCHIP	S-SCHIP
California	Medicaid	Medicaid	S-SCHIP	S-SCHIP
Florida	Medicaid	Medicaid	S-SCHIP	S-SCHIP
Illinois	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Indiana	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Iowa	Medicaid	Medicaid	Medicaid	M-SCHIP
Maine	Medicaid	Medicaid	Medicaid	Medicaid
Massachusetts	Medicaid	Medicaid	M-SCHIP	M-SCHIP
New Jersey	Medicaid	Medicaid	M-SCHIP	M-SCHIP
North Dakota	Medicaid	Medicaid	S-SCHIP	S-SCHIP

SOURCE: Mathematica Policy Research simulations based on analysis of Title XXI State Evaluations, Addendum to Table 3.1.1

NOTE: 133 percent of the 1999 Federal poverty level for a family of six is a gross annual income of $29,712 in the 48 continguous states and D.C., $37,134 in Alaska, and $34,168 in Hawaii (Federal Register 1999). The simulation accounts for any income and child care disregards used by each Medicaid and SCHIP program.

TABLE B.3

SIMULATED PROGRAM ELIGIBILITY FOR FOUR CHILDREN--INFANT AND AGES 5, 10, AND 17--IN A FAMILY OF SIX WITH GROSS FAMILY INCOME OF 150 PERCENT OF THE 1999 FEDERAL POVERTY LEVEL

	Infant	5 year old	10 year old	17 year old
M-SCHIP Only (N = 11)				
Alaska	M-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP
Idaho	M-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP
Louisiana	M-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP
Maryland	Medicaid	Medicaid	Medicaid	M-SCHIP
Minnesota	Medicaid	Medicaid	Medicaid	Medicaid
Nebraska	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Ohio	Medicaid	Medicaid	Medicaid	M-SCHIP
South Carolina	Medicaid	Medicaid	M-SCHIP	M-SCHIP
South Dakota	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Tennessee	Medicaid	Medicaid	Medicaid	Medicaid
Wisconsin	Medicaid	Medicaid	M-SCHIP	M-SCHIP
S-SCHIP Only (N = 6)				
Kansas	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Montana	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
North Carolina	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Pennsylvania	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Virginia	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Washington	Medicaid	Medicaid	Medicaid	Medicaid
Combination programs (N = 10)				
Alabama	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
California	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Florida	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Illinois	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Indiana	Medicaid	M-SCHIP	M-SCHIP	M-SCHIP
Iowa	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Maine	Medicaid	M-SCHIP	M-SCHIP	M-SCHIP
Massachusetts	Medicaid	M-SCHIP	M-SCHIP	M-SCHIP
New Jersey	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
North Dakota	Medicaid	Medicaid	S-SCHIP	S-SCHIP

SOURCE: Mathematica Policy Research simulations based on analysis of Title XXI State Evaluations, Addendum to Table 3.1.1

NOTE: 150 percent of the 1999 Federal poverty level for a family of six is a gross ananual income of $33,510 in the 48 continguous states and D.C., $41,880 in Alaska, and $38,535 in Hawaii (Federal Register 1999). The simulation accounts for any income and child care disregards used by each Medicaid and SCHIP program.

TABLE B.4

SIMULATED PROGRAM ELIGIBILITY FOR FOUR CHILDREN--INFANT AND AGES 5, 10, AND 17--IN A FAMILY OF SIX WITH GROSS FAMILY INCOME OF 185 PERCENT OF THE 1999 FEDERAL POVERTY LEVEL

	Infant	5 year old	10 year old	17 year old
M-SCHIP Only (N = 11)				
Alaska	M-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP
Idaho	Not eligible	Not eligible	Not eligible	Not eligible
Louisiana	Not eligible	Not eligible	Not eligible	Not eligible
Maryland	Medicaid	Medicaid	Medicaid	M-SCHIP
Minnesota	Medicaid	Medicaid	Medicaid	Medicaid
Nebraska	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Ohio	Medicaid	Medicaid	M-SCHIP	M-SCHIP
South Carolina	Medicaid	Not eligible	Not eligible	Not eligible
South Dakota	Not eligible	Not eligible	Not eligible	Not eligible
Tennessee	Medicaid	Medicaid	Medicaid	Medicaid
Wisconsin	Medicaid	Medicaid	M-SCHIP	M-SCHIP
S-SCHIP Only (N = 6)				
Kansas	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Montana	Not eligible	Not eligible	Not eligible	Not eligible
North Carolina	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Pennsylvania	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Virginia	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Washington	Medicaid	Medicaid	Medicaid	Medicaid
Combination programs (N = 10)				
Alabama	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
California	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Florida	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Illinois	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Indiana	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Iowa	Medicaid	Medicaid	M-SCHIP	M-SCHIP
Maine	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Massachusetts	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
New Jersey	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
North Dakota	Not eligible	Not eligible	Not eligible	Not eligible

SOURCE: Mathematica Policy Research simulations based on analysis of Title XXI State Evaluations, Addendum to Table 3.1.1

NOTE: 185 percent of the 1999 Federal poverty level for a family of six is a gross annual income of $41,329 in the 48 continguous states and D.C., $51,652 in Alaska, and $47,527 in Hawaii (Federal Register 1999). The simulation accounts for any income and child care disregards used by each Medicaid and SCHIP program.

TABLE B.5

SIMULATED PROGRAM ELIGIBILITY FOR FOUR CHILDREN--INFANT AND AGES 5, 10, AND 17--IN A FAMILY OF SIX WITH GROSS FAMILY INCOME OF 200 PERCENT OF THE 1999 FEDERAL POVERTY LEVEL

	Infant	5 year old	10 year old	17 year old
M-SCHIP Only (N = 11)				
Alaska	M-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP
Idaho	Not eligible	Not eligible	Not eligible	Not eligible
Louisiana	Not eligible	Not eligible	Not eligible	Not eligible
Maryland	M-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP
Minnesota	Medicaid	Medicaid	Medicaid	Medicaid
Nebraska	Medicaid	M-SCHIP	M-SCHIP	M-SCHIP
Ohio	Medicaid	Medicaid	M-SCHIP	M-SCHIP
South Carolina	Medicaid	Not eligible	Not eligible	Not eligible
South Dakota	Not eligible	Not eligible	Not eligible	Not eligible
Tennessee	Medicaid	Medicaid	Medicaid	Medicaid
Wisconsin	Not eligible	Not eligible	Not eligible	Not eligible
S-SCHIP Only (N = 6)				
Kansas	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Montana	Not eligible	Not eligible	Not eligible	Not eligible
North Carolina	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Pennsylvania	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Virginia	Not eligible	Not eligible	Not eligible	Not eligible
Washington	Medicaid	Medicaid	Medicaid	Medicaid
Combination programs (N = 10)				
Alabama	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
California	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Florida	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Illinois	Not eligible	Not eligible	Not eligible	Not eligible
Indiana	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Iowa	Medicaid	S-SCHIP	S-SCHIP	S-SCHIP
Maine	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Massachusetts	M-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
New Jersey	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
North Dakota	Not eligible	Not eligible	Not eligible	Not eligible

SOURCE: Mathematica Policy Research simulations based on analysis of Title XXI State Evaluations, Addendum to Table 3.1.1

NOTE: 200 percent of the 1999 Federal poverty level for a family of six is a gross annual income of $44,680 in the 48 continguous states and D.C., $55,840 in Alaska, and $51,380 Hawaii (Federal Register 1999). The simulation accounts for any income and child care disregards used by each Medicaid and SCHIP program.

TABLE B.6

SIMULATED PROGRAM ELIGIBILITY FOR FOUR CHILDREN--INFANT AND AGES 5, 10, AND 17--IN A FAMILY OF SIX WITH GROSS FAMILY INCOME OF 250 PERCENT OF THE 1999 FEDERAL POVERTY LEVEL

	Infant	5 year old	10 year old	17 year old
M-SCHIP Only (N = 11)				
Alaska	Not eligible	Not eligible	Not eligible	Not eligible
Idaho	Not eligible	Not eligible	Not eligible	Not eligible
Louisiana	Not eligible	Not eligible	Not eligible	Not eligible
Maryland	Not eligible	Not eligible	Not eligible	Not eligible
Minnesota	Medicaid	Medicaid	Medicaid	Medicaid
Nebraska	M-SCHIP	M-SCHIP	M-SCHIP	M-SCHIP
Ohio	Not eligible	Not eligible	Not eligible	Not eligible
South Carolina	Not eligible	Not eligible	Not eligible	Not eligible
South Dakota	Not eligible	Not eligible	Not eligible	Not eligible
Tennessee	Medicaid	Medicaid	Medicaid	Medicaid
Wisconsin	Not eligible	Not eligible	Not eligible	Not eligible
S-SCHIP Only (N = 6)				
Kansas	Not eligible	Not eligible	Not eligible	Not eligible
Montana	Not eligible	Not eligible	Not eligible	Not eligible
North Carolina	Not eligible	Not eligible	Not eligible	Not eligible
Pennsylvania	Not eligible	Not eligible	Not eligible	Not eligible
Virginia	Not eligible	Not eligible	Not eligible	Not eligible
Washington	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Combination programs (N = 10)				
Alabama	Not eligible	Not eligible	Not eligible	Not eligible
California	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
Florida	Not eligible	Not eligible	Not eligible	Not eligible
Illinois	Not eligible	Not eligible	Not eligible	Not eligible
Indiana	Not eligible	Not eligible	Not eligible	Not eligible
Iowa	Medicaid	Not eligible	Not eligible	Not eligible
Maine	Not eligible	Not eligible	Not eligible	Not eligible
Massachusetts	Not eligible	Not eligible	Not eligible	Not eligible
New Jersey	S-SCHIP	S-SCHIP	S-SCHIP	S-SCHIP
North Dakota	Not eligible	Not eligible	Not eligible	Not eligible

SOURCE: Mathematica Policy Research simulations based on analysis of Title XXI State Evaluations, Addendum to Table 3.1.1

NOTE: 250 percent of the 1999 Federal poverty level for a family of six is a gross annual income of $55,850 in the 48 continguous states and D.C., $69,800 in Alaska, and $64,225 Hawaii (Federal Register 1999). The simulation accounts for any income and child care disregards used by each Medicaid and SCHIP program.

APPENDIX C

NUMBER OF CHILDREN EVER ENROLLED IN SCHIP BY STATE FROM FIRST QUARTER OF FFY 1998 THROUGH SECOND QUARTER OF FFY 2000

TABLE C.1

NUMBER OF CHILDREN EVER ENROLLED IN SCHIP, BY STATE FROM FIRST QUARTER OF FFY 1998 THROUGH SECOND QUARTER OF FFY 2000[a]

State	Type of SCHIP Program[b]	Date SCHIP Enrollment Began[c]	Number Ever Enrolled									
			Federal Fiscal Year 1998				Federal Fiscal Year 1999				Federal Fiscal Year 2000	
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Total			**41,444**	**96,413**	**407,330**	**664,723**	**880,947**	**1,129,606**	**1,407,123**	**1,608,383**	**1,770,448**	**1,809,005**
Number of states reporting			**6**	**10**	**15**	**28**	**40**	**44**	**46**	**46**	**43**	**38**
Number of states NI			**43**	**38**	**33**	**22**	**9**	**3**	**3**	**3**	2	2
Number of states NR			2	3	3	1	2	2	2	2	**6**	**11**
Alabama	COMBO	02/02/98	NI	3,671	6,699	8,106	12,988	17,532	21,229	26,213	29,879	26,866
Alaska	M-SCHIP	03/01/99	NI	NI	NI	NI	NI	2,274	4,878	7,936	NR	NR
Arizona	S-SCHIP	11/01/98	NI	NI	NI	NI	1,316	11,445	16,068	19,924	29,838	34,958
Arkansas[d]	M-SCHIP	10/01/98	NI	NI	NI	NI	NR	NR	NR	913	1,108	1,140
California[e]	COMBO	03/01/98	NI	NR	NR	15,984	39,667	87,587	129,443	178,791	218,856	265,402
Colorado	S-SCHIP	04/22/98	NI	NI	6,797	10,377	12,830	15,135	19,362	20,932	23,388	33,114
Connecticut[e]	COMBO	10/01/97	NR	NR	NR	895	1,889	2,860	3,524	4,478	4,810	5,264
Delaware	S-SCHIP	02/01/99	NI	NI	NI	NI	NI	816	2,577	2,565	3,041	6,552
District of Columbia	M-SCHIP	10/01/98	NI	NI	NI	NI	707	1,317	1,686	1,964	2,225	1,914
Florida	COMBO	04/01/98	NI	NI	27,907	51,664	63,301	78,827	103,723	128,432	136,638	155,969
Georgia[f]	S-SCHIP	01/01/99	NI	NI	NI	NI	639	17,433	64,407	45,789	60,063	74,337
Hawaii	M-SCHIP	01/03/00	NI	NI	NI	NI	NI	NI	NI	NI	NI	NI
Idaho	M-SCHIP	10/01/97	959	2,413	3,593	4,339	4,772	4,672	4,877	5,285	6,414	7,450
Illinois	COMBO	01/05/98	NI	18,193	20,558	22,899	24,938	28,750	33,940	39,099	45,046	50,189
Indiana[g]	COMBO	06/01/97	13,355	14,687	15,653	20,551	24,981	27,063	28,909	30,647	37,644	NR
Iowa	COMBO	07/01/98	NI	NI	NI	4,798	6,293	6,926	8,644	9,896	11,252	11,877
Kansas	S-SCHIP	01/01/99	NI	NI	NI	NI	NI	7,955	11,910	13,882	16,148	18,345
Kentucky	COMBO	07/01/98	NI	NI	NI	5,779	5,467	6,753	7,964	27,766	49,640	73,595
Louisiana[a]	M-SCHIP	11/01/98	NI	NI	NI	NI	3,509	12,503	17,808	20,504	28,739	29,400
Maine	COMBO	07/01/98	NI	NI	NI	3,204	6,272	8,247	9,138	10,180	11,584	12,594
Maryland[b]	M-SCHIP	07/01/98	NI	NI	NI	6,326	10,338	12,889	15,359	16,657	17,519	16,554
Massachusetts	COMBO	10/01/97	844	1,240	2,309	17,378	30,913	41,380	46,867	55,028	58,437	67,087
Michigan[a]	COMBO	04/01/98	NI	NI	4,076	5,224	10,003	14,484	19,568	21,052	21,729	NR
Minnesota	M-SCHIP	09/30/98	NI	NI	NI	NI	9	15	10	6	NR	NR
Mississippi[e]	COMBO	07/01/98	NI	NI	12,433	5,477	8,077	9,719	10,375	10,872	NR	NR

TABLE C.1 *(continued)*

State	Type of SCHIP Program[b]	Date SCHIP Enrollment Began[c]	Number Ever Enrolled									
			Federal Fiscal Year 1998				Federal Fiscal Year 1999				Federal Fiscal Year 2000	
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Missouri	M-SCHIP	07/01/98	NI	NI	NI	10,809	23,950	34,104	42,817	44,190	52,134	55,529
Montana	S-SCHIP	01/01/99	NI	NI	NI	NI	NI	948	924	924	2,459	3,949
Nebraska[a]	M-SCHIP	07/01/98	NI	NI	17	2,115	4,358	5,164	5,665	6,925	6,923	7,382
Nevada	S-SCHIP	10/01/98	NI	NI	NI	NI	2,850	4,436	6,067	7,190	8,354	9,016
New Hampshire	COMBO	05/01/98	NI	NI	3	71	174	1,219	618	2,053	2,403	2,953
New Jersey[a]	COMBO	02/01/98	NI	3,603	9,073	16,614	24,336	31,645	38,326	46,653	57,736	65,896
New Mexico	M-SCHIP	03/01/99	NI	NI	NI	NI	NI	NI	1,168	1,736	2,520	3,705
New York[a,d]	COMBO	04/15/98	NI	NI	219,051	259,999	297,569	330,741	388,038	438,421	479,244	511,787
North Carolina	S-SCHIP	10/01/98	NI	NI	NI	NI	19,649	33,835	45,445	57,420	66,582	69,996
North Dakota[f]	COMBO	10/01/98	NI	NI	NI	NI	87	135	145	134	1,013	1,491
Ohio	M-SCHIP	01/01/98	NI	14,659	30,416	40,804	47,822	51,637	55,737	60,985	63,611	NR
Oklahoma	M-SCHIP	12/01/97	2,837	8,054	11,791	14,746	17,944	22,651	26,288	NR	NR	NR
Oregon	S-SCHIP	07/01/98	NI	NI	NI	6,488	11,930	15,803	16,175	17,472	19,149	21,266
Pennsylvania[f]	S-SCHIP	05/28/98	NI	NI	NI	57,481	71,819	74,046	76,272	82,893	86,252	89,610
Rhode Island	M-SCHIP	10/01/97	2,232	2,476	2,775	2,790	2,855	4,055	4,726	5,752	4,466	7,278
South Carolina	M-SCHIP	08/01/97	21,217	27,417	34,179	40,768	40,154	42,813	46,347	49,469	NR	NR
South Dakota	M-SCHIP	07/01/98	NI	NI	NI	1,047	1,519	1,827	2,180	2,696	3,032	3,391
Tennessee[e]	M-SCHIP	10/01/97	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Texas[g]	M-SCHIP	07/01/98	NI	NI	NI	25,176	37,078	40,358	37,918	34,980	32,109	30,353
Utah	S-SCHIP	08/03/98	NI	NI	NI	2,653	5,128	8,117	10,816	13,697	15,454	17,028
Vermont	S-SCHIP	10/01/98	NI	NI	NI	NI	370	907	1,207	1,483	1,950	2,218
Virginia	S-SCHIP	10/26/98	NI	NI	NI	NI	2,125	8,145	11,793	14,580	19,167	NR
Washington	S-SCHIP	02/01/00	NI	NI	NI	NI	NI	NI	NI	NI	NI	NI
West Virginia	COMBO	07/01/98	NI	NI	NI	161	321	438	2,794	7,569	10,160	12,280
Wisconsin	M-SCHIP	04/01/99	NI	NI	NI	NI	NI	NI	3,391	12,350	21,470	NR
Wyoming	S-SCHIP	12/01/99	NI	NI	NI	NI	NI	NI	NI	NI	262	1,270

SOURCE: Mathematica Policy Research analysis of HCFA's Statistical Information Management System (SIMS) as of June 27, 2000.

TABLE C.1 *(continued)*

NI = State's SCHIP program was not implemented.

NR = State has not yet reported SCHIP enrollment to HCFA, or, if noted, the reported data have not been included due to inconsistencies.

[a]The enrollment data are taken from HCFA's SCHIP reporting system as of June 27, 2000, for all states except Louisiana, Michigan, Nebraska, New Jersey, and New York. For these states, MPR received the following data directly: Louisiana Q2 1999 and Q2 2000 M-SCHIP; Michigan Q1 2000 S-SCHIP; Nebraska Q1 2000 M-SCHIP; New Jersey Q2 1998 through Q2 2000 all SCHIP data; and New York Q1 2000 and Q2 2000 M-SCHIP.

[b]The type of SCHIP program is as of March 31, 2000.

[c]The date enrollment began is taken from the state evaluations submitted by states to HCFA in spring 2000.

[d]Because Arkansas and New York did not report any quarterly M-SCHIP enrollment for the fourth quarter of FFY 1999, data shown here are the ever enrolled in FFY 1999. However, the number ever enrolled for the year is usually higher than the number ever enrolled for the quarter. MPR did not include Arkansas M-SCHIP data for Q1 1999 through Q3 1999 due to data inconsistencies.

[e]Data for the following state programs are not reported, because the quarterly data they provided to HCFA are not complete or appear to have inconsistencies: California M-SCHIP; Connecticut M- SCHIP; Mississippi M-SCHIP; and Tennessee M-SCHIP.

[f]Data for the first quarter of FFY2000 were imputed averaging data from the fourth quarter of FFY1999 and the second quarter of FFY 2000 for the following states: Georgia S-SCHIP, North Dakota M-SCHIP, and Pennsylvania S-SCHIP. MPR also imputed Pennsylvania's data for Q2 1999 by averaging data from Q1 1999 and Q3 1999.

[g]Enrollment in the Texas M-SCHIP program declined because children aged out of M-SCHIP and onto traditional Medicaid. The S-SCHIP program in Texas began in the third quarter of FFY 2000. Beginning in the third quarter of FFY 2000, the type of program for Texas will change to COMBO.

[h]In July 2000, Maryland was authorized to claim enhanced matching retroactively for children enrolled in the state's Section 1115 waiver demonstration. Revised enrollment counts are as follows: FFY 1999, Q1: 39,792; Q2: 29,054; Q3: 55,842; Q4: 63,016; FFY 2000, Q1: 68,707; Q2: 74,437.

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