STATEMENT BY HCFA ADMINISTRATOR NANCY-ANN DEPARLE
CHIP ENROLLMENT NUMBERS

April 8, 1999

Enrolling children in the Children's Health Insurance Program is one of the highest priorities of both President Clinton and Secretary Shalala. We are extremely proud of the partnership between the administration, the congress and the states that has created the opportunity for 51 states and U.S. territories to give health insurance eventually to millions of children who otherwise would not have had regular access to health care services.

To ensure that all families know about CHIP and Medicaid options for their children, the President launched an administration-wide, public and private outreach campaign. It includes hundreds of activities by federal agencies, private corporations, schools, TV and radio networks designed to identify and enroll eligible children in health insurance. Already, states project that they will eventually ensure 2.5 million children when their new CHIP programs are fully implemented; and because of the innovative programs at the federal, state and local level and the fact that states are currently planning to revise and expand their programs, we are confident that we will be able to reach our goal of providing insurance for up to 5 million children through Medicaid and CHIP.

Right now, the Health Care Financing Administration is collecting and analyzing enrollment data that we have received from states with approved CHIP plans. Regardless of the final numbers, hundreds of thousands of children have already been enrolled in the program.

expenditures are FY 1999

DRAFT Q/As on CHIP EXPENDITURES
4/30/99

Q. 1. How much money has been spent on CHIP?

A: Although it is difficult to get a precise number on expenditures for CHIP. As of March of 1999, the federal government has provided at least $375 million to states for CHIP. That's not even counting state Medicaid spending for the first three months of 1999 because they haven't been reported. There is usually a lag on reporting for Medicaid spending. So we expect totals to grow as we receive more reports from the states on their spending. As of the first quarter of 1999, we are on target with CBO estimates. (CBO estimates for 1999: $828 million.)

ramp up would be surprised 1999

To help ensure that eligible children get enrolled in CHIP, and in Medicaid, the federal government recently announced several new outreach initiatives. These include a nationwide toll free number to provide families with essential information; placing the toll free number on corporate products, such as grocery bags and diaper products; airing public service announcements on television; launching a $1.2 million paid radio campaign; enlisting the help of grass-roots organizations; and stepping up activities by federal organizations that interact with low-income families. The toll free number is 1-877-KIDS-NOW and the web site is *www.insurekidsnow.gov*.

BACKGROUND:
Approximately $260 million federal dollars were spent on CHIP for the calendar year ending December 31, 1998. Of this amount, approximately $115 million was spent on Medicaid CHIP expansions. Another $145 million was spent on separate CHIP programs.

Q.2.: Why is it difficult to get a precise number on federal spending for CHIP?

A: It is difficult to get a precise number on expenditures for a specific year because:

- There is a lag in states reporting on their spending. Under the CHIP and Medicaid rules, states have up to two years to file their claims.
- States have three years to spend their allotments for a particular year, the number for expenditures should grow as states use the 1998 allotments in years 1999 and 2000. And, states will use their 1999 allotments in years 2000 and 2001.
- CHIP is a new program; therefore, it may have been difficult for states to set up claims data systems in a timely manner.

Q.3.: What happens if a state does not spend its allotment within the three year period?

A: If a state does not spend all of its money within three years for whatever reason, the funds are reallocated to other states and available for a fourth year for these other states.

TITLE XXI FEDERAL OUTLAYS*

JUNE 1998 THROUGH MARCH 1999

STATE	Jun-98 CHIP	Jul-98 CHIP	Aug-98 CHIP	Sep-98 CHIP	Oct-98 CHIP	Nov-98 CHIP	Dec-98 CHIP	Jan-99 CHIP	Feb-99 CHIP	Mar-99 CHIP	cum total
Alabama						2,189,854.47		24,873,879.53	(23,373,879.53)	1,210,145.53	4,900,000.00
Alaska											-
American Samoa											-
Arizona						236,059.00	288,981.00	396,518.00	602,718.00	791,906.12	2,316,182.12
Arkansas											-
California		82,000.00			1,770,902.12	2,381,975.47	3,411,016.70	32,763,698.45	(27,326,713.09)	8,561,673.12	21,644,552.77
Colorado	277,201.53	515,992.53	170,297.71	544,567.94	465,903.29	571,838.46	593,870.67	760,042.09	424,765.93	1,833,050.73	6,157,530.88
Connecticut											-
Delaware								52,000.00	2,140.00	107,725.00	161,865.00
District of Columbia											-
Florida	132,617.00	392,044.00	8,200.00	1,403,713.00	793,230.00	875,249.00	978,799.00		1,420,246.00	2,446,553.00	8,450,651.00
Georgia						14,084.08	65,817.60	29,512.30	15,138.96	45,821.03	170,373.97
Guam											-
Hawaii											-
Idaho					136,614.00				156,790.00	56,367.00	349,771.00
Illinois											-
Indiana								237,519.00		311,691.00	549,210.00
Iowa						27,050.00	1,333.00				28,383.00
Kansas								245,000.00	353,000.00	538,000.00	1,136,000.00
Kentucky											-
Louisiana											-
Maine					106,349.00	112,365.00	250,351.00	157,815.00	268,973.00	597,513.00	1,493,366.00
Maryland				154,285.00		144,666.00	144,668.00	(9,442.00)	351,047.00	144,666.00	929,890.00
Mass. Blind											-
Massachusetts											-
Michigan						657,827.00		(657,827.00)	275,876.00		275,876.00
Minnesota											-
Mississippi											-
Missouri											-
Montana							45,802.00	60,348.00	80,711.00	70,120.00	256,981.00
Nebraska											-
Nevada					59,768.00	178,523.11	105,980.17	215,905.04	284,858.32	323,012.20	1,168,046.84
New Hampshire											-
New Jersey									595,040.00		595,040.00
New Mexico											-
New York					36,859,043.61	13,588,695.08	44,129,597.77	3,728,260.28	19,257,424.29	33,411,859.35	150,974,880.38
N. Mariana Islands											-
North Carolina					237,445.24	973,661.81	1,603,627.07	2,321,158.26	1,917,267.23	2,361,240.36	9,414,399.97
North Dakota											-
Ohio											-
Oklahoma											-
Oregon		6,695.00	88,970.00	199,976.00	377,249.00	418,911.00	599,792.00	541,396.00	476,785.00	654,659.00	3,364,433.00
Pennsylvania							15,806,572.20		8,167,898.33		23,974,470.53
Puerto Rico										9,722,263.20	9,722,263.20
Rhode Island										2,321,094.00	2,321,094.00
South Carolina		880,864.09	27,483.10	100,534.74	74,509.57	16,379.40	225,639.21	123,926.48	96,265.67	73,016.64	1,618,618.90
South Dakota				20,092.00	2,852.00	56,974.00	17,891.00	14,819.00	12,154.00	16,158.00	140,940.00
Tennessee											-
Texas					38,050.00	52,202.00	1,178,870.00	1,070,686.19	1,307,676.34	1,047,973.00	4,695,437.53
Utah						179,337.67	797,995.12	339,380.88	792,158.03	531,136.42	2,640,010.12
Vermont											-
Virgin Islands											-
Virginia						3,029.94	69,336.97	110,655.10	210,402.10	336,709.20	730,133.31
Washington											-
West Virginia											-
Wisconsin											-
Wyoming											-
TOTAL	409,818.53	1,877,595.62	294,950.81	2,423,168.68	40,921,915.83	22,678,682.49	70,315,940.48	67,375,230.60	(13,631,257.42)	67,514,354.90	260,180,400.52

* INCLUDES S-CHIP AND OPTIONAL MEDICAID ADM CHIP ONLY, DOES NOT INCLUDE M-CHIP BENEFITS

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FY 1998 CHIP-RELATED FEDERAL EXPENDITURES AS REPORTED BY THE STATES ON FY 1998 QER'S* RECEIVED AS OF APRIL 8, 1999

STATE	QUARTER	TITLE XIX		TITLE XXI	QTR TOTAL	CUMULATIVE FY 1998 STATE TOTAL
		PRESUMPTIVE ELIGIBILITY	MEDICAID EXPANSION	CHIP		
AL	2	0	57,809	0	57,809	
AL	3	0	961,518	0	961,518	
AL	4	0	1,170,528	243,317	1,413,845	**2,433,172**
CA	3	0	160,173	0	160,173	
CA	4	0	621,560	1,204,013	1,825,573	**1,985,746**
CO	3	0	0	308,280	308,280	
CO	4	0	0	679,719	679,719	**987,999**
FL	3	0	1,038,763	132,616	1,171,379	
FL	4	0	3,411,991	1,772,917	5,184,908	**6,356,287**
IA	4	0	253,364	22,916	276,280	**276,280**
ID	4	0	1,229,528	136,614	1,366,142	**1,366,142**
IL	2	0	917,979	0	917,979	
IL	3	0	2,201,855	0	2,201,855	
IL	4	0	2,961,824	0	2,961,824	**6,081,658**
MD	4	0	643,006	61,892	704,898	**704,898**
MI	4	0	657,830	0	657,830	**657,830**
NE	4	3,787	313	0	4,100	**4,100**
NJ	4	0	2,946,114	595,040	3,541,154	**3,541,154**
NY	3	0	0	20,111,918	20,111,918	
NY	4	0	0	29,967,047	29,967,047	**50,078,965**
OH	2	0	455,481	0	455,481	
OH	3	0	2,673,608	0	2,673,608	
OH	4	0	5,509,039	0	5,509,039	**8,638,128**
OR	4	0	0	391,947	391,947	**391,947**
PA	4	0	0	10,101,407	10,101,407	**10,101,407**
SC	2	0	4,798,165	0	4,798,165	
SC	3	0	3,738,343	0	3,738,343	
SC	4	0	16,673,394	1,065,866	17,739,260	**26,275,768**
SD	4	0	46,829	5,203	52,032	**52,032**
TX	4	0	1,275,400	33,301	1,308,701	**1,308,701**
WV	4	3,110		0	3,110	**3,110**
TOTAL		6,897	54,404,414	66,834,013	121,245,324	**121,245,324**

***THRU QTR ENDED SEPTEMBER 30, 1998**

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	DOLLARS IN THOUSANDS								
	FY 98	FY 98	FY 98	FY 99	FY 99	FY 99	CUMULATIVE REPORTED		
	CHIP	TXXI CHIP	TOTAL CHIP	MED CHIP	TXXI CHIP	TOTAL CHIP	MED CHIP	TXXI CHIP	TOTAL CHIP
	F/S ACTUALS	F/S ACTUALS	F/S ACTUALS	F/S ACTUALS	F/S ACTUALS	F/S ACTUALS	F/S ACTUALS	F/S ACTUALS	F/S ACTUALS
	THRU Q4/98*	THRU Q4/98*	THRU Q4/98*	Q1/99**	Q1/99**	Q1/99**			
STATE	A	B	C=A+B	D	E	F=D+E	G=A+D	H=B+E	I=G+H
Alabama	2,190	243	2,433	2,028	282	2,310	4,218	525	4,743
Alaska			-			-	-	-	-
American Samoa			-			-	-	-	-
Arizona			-		515	515	-	515	515
Arkansas			-	22	177	199	22	177	199
California	782	1,204	1,986	1,215	6,848	8,064	1,996	8,052	10,050
Colorado		988	988		1,356	1,356	-	2,344	2,344
Connecticut			-			-	-	-	-
Delaware			-			-	-	-	-
District of Columbia			-			-	-	-	-
Florida	4,451	1,905	6,356	4,497	2,742	7,239	8,948	4,647	13,595
Georgia			-		113	113	-	113	113
Guam			-			-	-	-	-
Hawaii			-			-	-	-	-
Idaho	1,229	137	1,366	879	97	776	1,908	234	2,142
Illinois	6,082		6,082	3,801		3,801	9,883	-	9,883
Indiana			-	14,793		14,793	14,793	-	14,793
Iowa	253	23	276	1,195	38	1,233	1,448	61	1,509
Kansas			-			-	-	-	-
Kentucky			-			-	-	-	-
Louisiana			-		314	314	-	314	314
Maine			-			-	-	-	-
Maryland	643	62	705	2,122	81	2,203	2,765	143	2,908
Massachusetts			-			-	-	-	-
Michigan	658		658	1,238	235	1,473	1,896	235	2,131
Minnesota			-			-	-	-	-
Mississippi			-	1,136		1,136	1,136	-	1,136
Missouri			-	1,813	152	1,965	1,813	152	1,966
Montana			-		49	49	-	49	49
Nebraska	4		4	305		305	309	-	309
Nevada			-		510	510	-	510	510
New Hampshire			-	3		3	3	-	3
New Jersey	2,948	595	3,541	2,675	886	3,561	5,622	1,480	7,102
New Mexico			-			-	-	-	-
New York		50,079	50,079		50,902	50,902	-	100,981	100,981
North Carolina			-			-	-	-	-
North Dakota			-	1		1	1	-	1
N. Mariana Islands			-			-	-	-	-
Ohio	8,638		8,638	7,332		7,332	15,970	-	15,970
Oklahoma			-			-	-	-	-
Oregon		392	392		1,318	1,318	-	1,710	1,710
Pennsylvania		10,101	10,101		8,742	8,742	-	18,843	18,843
Puerto Rico			-			-	-	-	-
Rhode Island			-			-	-	-	-
South Carolina	26,210	1,066	26,276	9,412	459	9,871	34,622	1,525	36,147
South Dakota	47	5	52	221	25	246	268	30	298
Tennessee			-			-	-	-	-
Texas	1,275	34	1,309	6,949	2,388	9,337	8,224	2,422	10,646
Utah			-		1,477	1,477	-	1,477	1,477
Vermont			-		25	25	-	25	25
Virgin Islands			-			-	-	-	-
Virginia			-		47	47	-	47	47
Washington			-			-	-	-	-
West Virginia	3		3	36		36	39	-	39
Wisconsin			-			-	-	-	-
Wyoming			-			-	-	-	-
Nation	54,411	66,834	121,245	61,475	79,777	141,252	115,886	146,611	262,497
* Based on QER's through 4th qtr 98 received as of 04/06/99.									
** Based on QER's for 1st Qtr 99 received as of 04/06/99.									
TXXI CHIP columns may include MED CHIP ADM at state option									
CHT0406.xls/bhanczaryk 410-786-2013									
AMOUNTS ARE SUBJECT TO CHANGE.									

GAO
United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

March 12, 1999

The Honorable Donna E. Shalala
Secretary
Health and Human Services

Dear Madam Secretary:

Enclosed are 54 copies of a draft report to the Chairman, House Committee on Commerce and Senator Edward M. Kennedy, Ranking Minority Member, Committee on Health, Education, Labor, and Pensions titled, Children's Health Insurance Program: State Approaches are Evolving (GAO/HEHS-99-65). This report examines the first year of SCHIP implementation, and, in particular, discusses states' (1) use of the statutory flexibility to design their programs, (2) pursuit of statutory options such as extending coverage to adults in families with children, (3) development of innovative outreach strategies designed to enroll eligible children, and (4) tailoring of strategies to avoid the "crowd out" of private insurance and Medicaid coverage by SCHIP.

We would appreciate the opportunity to meet with key departmental staff responsible for this program (HCFA and any others you deem appropriate) by March 26 to obtain oral comments on the draft. Any issues we are unable to resolve at this meeting may be submitted in writing no later than March 31, 1999, and will be printed in the final report. In the meantime, any questions relating to this draft should be addressed to Walter Ochinko, Assistant Director, at (202) 512-7157.

Please note that this draft is subject to revision. As the cover indicates, this copy and all others belong to the General Accounting Office and must be returned on demand. Use of the report is restricted and its publication or improper disclosure should be prevented. We appreciate your cooperation and assistance in this matter.

Sincerely yours,

Kathryn G. Allen

Kathryn G. Allen
Associate Director
Health Financing and Public
Health Issues

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HRSA, 10

United States General Accounting Office

GAO

Report to Congressional Requesters

April 1999

CHILDREN'S HEALTH INSURANCE PROGRAM

State Approaches Are Evolving

Notice: This draft is restricted to official use.

This draft report is being provided to obtain advance review and comment from those with responsibility for the subjects it discusses. It has not been fully reviewed within GAO and is, therefore, subject to revision.

Recipients of this draft must not, under any circumstances, show or release its contents for purposes other than official review and comment. It must be safeguarded to prevent publication or other improper disclosure of the information it contains. This draft and all copies of it remain the property of, and must be returned on demand to, the General Accounting Office.

GAO/HEHS-99-65

B-280578

April 30, 1999

The Honorable Thomas J. Bliley
Chairman, Committee on Commerce
House of Representatives

The Honorable Edward M. Kennedy
Ranking Minority Member
Committee on Health, Education, Labor, and Pensions
United States Senate

An estimated 9 to 11.6 million children were uninsured at some time during 1997, increasing their risk of foregoing routine medical or dental care, immunizations, treatment for injuries and chronic illnesses, and the continuity of care implicit in having a primary care physician. In August 1997, Congress created the State Children's Health Insurance Program (SCHIP) with the goal of significantly reducing the number of low income, uninsured children.[1] Under SCHIP, a state has the choice of (1) expanding Medicaid and thus build upon an existing program, (2) establishing a separate, stand alone program that more closely resembles private, employer-sponsored coverage, or (3) combining these two approaches. SCHIP provides new federal budget authority of about $40 billion over 10 years--enough money to potentially cut the number of uninsured children by half. Prior to SCHIP, approximately 20 million or one-half of all Medicaid beneficiaries were children. In fiscal year 1998, combined federal and state Medicaid expenditures on behalf of children totaled $000 billion.

You asked us to report on the first year of SCHIP implementation, and, in particular, to examine states' (1) initial SCHIP design choices, including the use of the statutory flexibility to design their programs, (2) pursuit of statutory options, particularly extending coverage to adults in families with children, (3) development of innovative outreach strategies to enroll eligible children, and (4) tailoring of strategies to avoid the "crowd out" of both private insurance and Medicaid coverage by SCHIP. To conduct this review, we analyzed available data from research and advocacy groups; state agencies charged with implementing SCHIP; and, the Department of Health and Human Services (DHHS), the federal agency responsible for approving SCHIP plans.[2] Our review focused on a sample of 15 states that used the three available options: California, Colorado, Connecticut, Florida, Massachusetts, Michigan, Missouri, New

[1] Established as Title XXI of the Social Security Act by Public Law 105-33; SCHIP is codified as 42 USCS § 1397aa et seq. (1998).

[2] The Health Care Financing Administration (HCFA) within DHHS has primary responsibility for plan review and oversight.

York, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, and Wisconsin. Overall, the sample reflects geographic diversity as well as a cross section of SCHIP approaches--Medicaid expansions, stand-alone programs, and efforts that combine these two alternatives. Four of our sample states--California, Texas, Florida, and New York--account for almost one-half of all funds allocated for SCHIP in fiscal year 1998. Five states in our sample--Rhode Island, Vermont, New York, Oregon, and Massachusetts--had operated their Medicaid programs under a Section 1115 waiver for a number of years. We conducted our study between May 1998 and January 1999 in accordance with generally accepted government auditing standards.

RESULTS IN BRIEF

States and the federal government have made considerable progress in getting SCHIP up and running—despite the short implementation period and the related challenges of establishing a stand-alone program distinct from Medicaid. However, the current distribution of state approaches does not necessarily indicate whether SCHIP will eventually more closely resemble private insurance or Medicaid.

- SCHIP design choices are currently almost evenly divided between expansions of state Medicaid programs and programs with a more flexible stand-alone component. As of ~~January 18~~ Feb. 17, 1999, ~~49~~ 48 SCHIP plans had been approved, 3 were under review, and ~~3~~ 2 states had not submitted proposals. SCHIP design is ongoing and more states will ultimately embrace a stand alone component that, unlike Medicaid, provides states greater budgetary control over program costs. Key elements of stand-alone components are benefits and cost sharing. For most children, the SCHIP stand alone benefit packages in our sample offer coverage comparable to Medicaid; however, some states did impose limits on service use similar to those applied to adults in Medicaid. With regard to cost sharing, our analysis suggests that cost sharing under SCHIP is generally closer to 1 percent of income than to the 5 percent maximum allowed by the statute.

- A growing number of states are exploring statutory options under SCHIP, including family coverage and insurance coverage through employers. However, the strict statutory requirements of these options have proved difficult to meet. To date only Massachusetts ~~has~~ WI have received approval to use SCHIP funds to cover adults in families with children, ~~and~~ MA's approval ~~that~~ relied on an employer-buy-in, with its own complex prerequisites, to meet the family coverage cost effectiveness test. WI's approval (dual) a Medicaid expansion to cover parents and in certain cases, an employer buy-in to meet the cost-effectiveness test

- Despite concerns about the statutory limits placed on outreach expenditures, many states, including the 15 states in our sample, are developing innovative outreach strategies to widely publicize SCHIP and to provide families with applications and program information. In general, outreach strategies have worked to minimize the burden on both the beneficiary and the state by (1) developing new ways for

families to submit applications such as the mail, facsimile, or the Internet; (2) increasing the number and operating hours of enrollment sites, and; (3) reducing application processing times. While it is too early to judge the success of outreach efforts, some states are reporting that the publicity is not only attracting SCHIP eligible children but also significant numbers of those who were Medicaid eligible but not enrolled.

- States' strategies to avoid crowd out—the substitution of SCHIP for either private insurance or Medicaid—reflect the lack of consensus among states and researchers regarding the significance of crowd-out and the availability of effective tools to deter the phenomenon. To prevent SCHIP from substituting for Medicaid, most states with a SCHIP stand-alone component are using joint applications ~~in addition, they must first screen for Medicaid and refer any children found~~ eligible to ~~that program.~~ State tools to deter the crowding out of private insurance include instituting waiting periods of 1 to 12 months for children with previous private coverage, requiring families to participate in the cost of coverage by paying premiums and copayments, and studying and attempting to measure the extent of crowd out.

BACKGROUND

Medicaid is ~~the~~ one starting point for states' design and implementation of SCHIP. Created in 1965 as Title XIX of the Social Security Act, Medicaid provides health coverage for poor Americans, primarily women and children, but also for individuals who are aged, blind, or disabled. In fiscal year 1998, combined federal and state Medicaid expenditures totaled $ 177.3 billion. Subject to Title XIX requirements as well as DHHS guidance and review, states have latitude in determining what benefits are covered and who is eligible. Financing for Medicaid is provided jointly by states and the federal government under a formula in which poorer states contribute less and wealthier states more to the cost of the program.

Title XXI of the Social Security Act, which established SCHIP, gives states the choice of operating their children's health insurance program as an extension of Medicaid ~~or~~ as a stand-alone program with more flexible rules ~~that~~ also increase financial control over expenditures.[3] SCHIP makes available ~~to~~ states annual allocations that range from a low of $3.2 billion to a high of $5 billion (see Appendix I for state SCHIP allocations for fiscal year 1998 ~~and~~ 1999). Initially, states had until October 1998 to

[3]Unlike a Medicaid expansion, Title XXI does not create an entitlement for a stand alone approach. See 42 USCS § 1397bb(b)(4). Consequently, states have greater control over expenditures—for example, under a stand-alone program, states may set explicit enrollment caps, establish residency requirements, or institute time limits for program participation. See 42 USCS § 1397bb(1)(A).

select a design approach, draft their SCHIP plans, and obtain DHHS approval.[4] With an approved plan, a state could begin to draw down its fiscal year 1998 SCHIP allocation which is based on an estimate of the number of low income, uninsured children in the state. Allocations are available for a 3-year period, at which time any unexpended funds will be redistributed among states that have used their full allocation. SCHIP offers a strong incentive for states to participate by providing an enhanced federal matching rate—for example, the federal government will reimburse at a 65 percent match under SCHIP for a state receiving a 50 percent match under Medicaid. Funding at this enhanced rate is limited to 10 years.

The design approach a state chooses has important programmatic and financial consequences. A state choosing to expand Medicaid must conform its SCHIP program to Medicaid rules for eligibility determination, benefits, and cost sharing. Normally, Medicaid allows no cost sharing for children. A Medicaid expansion also creates an entitlement by requiring the state to continue providing services to eligible children even if the enhanced federal match under SCHIP is exhausted for that state. In contrast, a state that chooses a stand-alone approach is free to introduce some cost sharing and to model the benefit package after Federal Employee Health Benefit Program, state employee coverage, or other private sector models specified in the statute. In addition, a state may limit its own annual contribution, create waiting lists, or stop enrollment once the funds it budgeted for SCHIP are exhausted.

Title XXI targets SCHIP funds at uninsured children in families whose income is too high to qualify for Medicaid but is at or below 200 percent of the federal poverty level (which amounts to $32,900 for a family with two children). The law prohibits coverage of children who already have health insurance even if it is inadequate or expensive. Because of the concern that SCHIP not displace or "crowd out" existing public or private health insurance, states must establish a system that identifies those who qualify for Medicaid and refer them for enrollment in that program. Since children in higher income families with private employer-sponsored coverage may also be eligible, states are required to develop a strategy for discouraging enrollees from substituting SCHIP for existing private coverage.

Finally, the statute allows the coverage of adults in families with children eligible for SCHIP--if a state can show that it is cost effective to do so. The cost effectiveness test requires states to demonstrate that covering both adults and children in a family under SCHIP is no more expensive than covering only the children. States may also elect to cover children whose parents have access to employer-sponsored coverage by subsidizing the families share of the cost of coverage--an option referred to as an "employer buy-in." SCHIP -- as does Medicaid -- allows states to pursue the flexibility offered by Section 1115 waivers; using this waiver authority, HCFA can exempt states

[4] In May 1998, the deadline for securing fiscal year 1998 funding was extended to October 1999.

from many Title XIX or Title XXI requirements, thus allowing demonstration projects likely to assist in promoting program objectives. Since the early 1990s, 18 states have used 1115 Medicaid waivers to move their Medicaid programs closer to a private sector model by implementing managed care for targeted populations, deviating from the Medicaid benefit package, imposing cost sharing on beneficiaries, and covering individuals not traditionally eligible for Medicaid such as low income single adults.[5]

SCHIP DESIGN PHASE STILL EVOLVING

Initial SCHIP design choices are likely to evolve as states continue efforts to incorporate the flexibility afforded under the SCHIP statute. Figure 1 shows the status of the 52 SCHIP plans submitted by states and territories: as of ~~January 19~~, 1999, ~~49~~ had been approved, ~~3~~ were currently under review, and ~~1~~ had not yet submitted proposals.[6] The submissions were almost evenly divided between expansions of state Medicaid programs on the one hand, and stand-alone or combination programs on the other. However, this current landscape should not be used to draw conclusions about whether the program will eventually mirror Medicaid or look more like private sector coverage. HCFA estimated that as many as ~~20~~ initial Medicaid expansions were simply placeholder plans designed to secure access to a state's initial SCHIP allocation, and ~~most~~ of these states ~~plan~~ amendments to expand their initial designs. Two factors have contributed to a longer SCHIP design phase in which many state plans are still incomplete: (1) the challenges in using the statute's flexibility to establish a stand alone program separate from Medicaid and (2) the short implementation lead times.

Figure 1: State SCHIP Design Choices (as of January, 1999)

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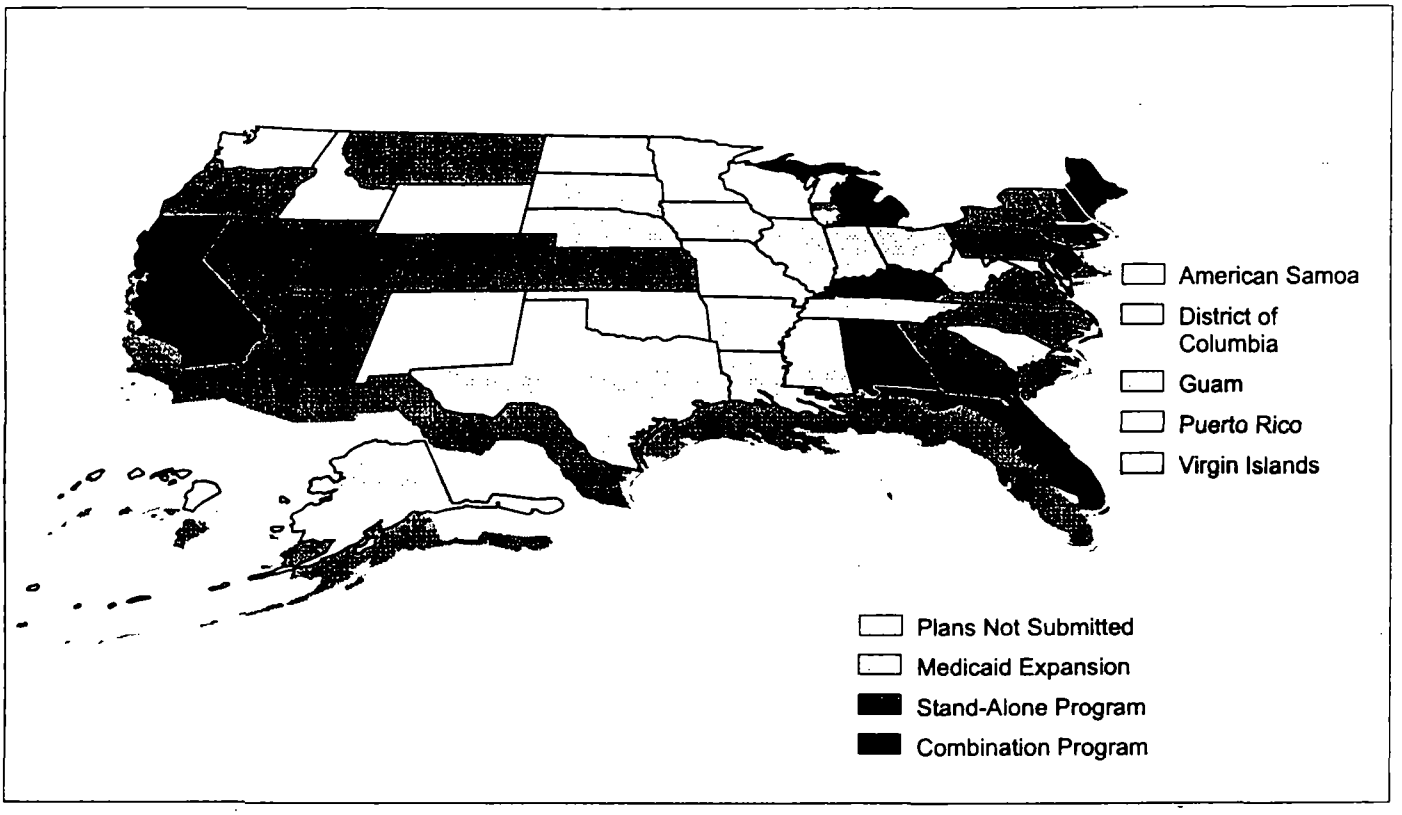
[5] Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs (GAO/HEHS-96-44, Nov. 8, 1995).

[6] DHHS was still reviewing three ~~state~~ plans-those of Guam, ~~Hawaii, and~~ Tennessee ~~and~~ Washington, Wyoming, ~~and~~ the Northern Mariana Islands, ~~and American Samoa had~~ not yet submitted proposals.


American Samoa
District of Columbia
Guam
Puerto Rico
Virgin Islands
Plans Not Submitted
Medicaid Expansion
Stand-Alone Program
Combination Program

The statutory timeframes associated with SCHIP created design and implementation pressures for both DHHS and states. Less than 2 months separated the enactment of Title XXI (August 5, 1997) and the beginning of fiscal year 1998, when the initial $4.2 billion appropriation became available. Moreover, until a May 1998 technical amendment, states were required to have an approved SCHIP plan prior to October 1 of that year in order to secure their initial SCHIP allocation.[7] Given the 90-day review period allowed by the statute, states only had until July 1998 to draft and submit their SCHIP plans to DHHS. As a result, states' focus in the 12 months following the enactment of SCHIP was primarily on understanding the statutory requirements and securing each state's fiscal year 1998 allocation.

The diversity of approaches makes it difficult to generalize about a state's SCHIP program from the descriptive labels attached--Medicaid expansion, stand-alone or a combination of the two. A stand alone program and a Medicaid expansion can be quite similar if the expansion is by a state already operating its Medicaid program under a Section 1115 waiver that allows a state to impose cost sharing and to offer a different benefit package-hallmarks of a stand alone approach. Of the 28 states implementing a SCHIP Medicaid Expansion, 6 are doing so in conjunction with a Medicaid Section 1115 waiver. Additionally, states that elected a stand-alone program such as Oregon and Vermont are actually offering Medicaid benefits, a feature usually associated with a Medicaid expansion. Nor should the number of states with combination programs suggest a commitment to a Medicaid SCHIP approach. The Medicaid expansion portion of a combination program often has a very limited goal in comparison to its stand-alone component. Finally, even the income eligibility criterion selected by a state does not necessarily indicate the program's scope. A state that extends SCHIP coverage to children in families at income levels approaching 200 percent of the federal poverty level may cover relatively few uninsured children while a state with an increase in eligibility to 100 percent may have the potential to enroll hundreds of thousands of uninsured children. For example, Vermont's Medicaid expansion from 225 to 300 percent poverty level is estimated to reach just over 1,000 children; in contrast, Texas' more modest expansion of children aged 14-18 from 17 to 100 percent poverty level could provide coverage to over 160,000 children.

States' initial SCHIP designs grew out of the variety of eligibility levels and benefit choices that previously existed in their Medicaid programs. Reflecting earlier Medicaid expansions, over half of the states in our sample made children eligible for SCHIP in families with incomes as high as 200 to 300 percent of the poverty level.[8]

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[7] The amendment gave states an additional year, until October 1, 1999, to secure their fiscal year 1998 allocation.

[8] Poverty levels of 200 and 300 percent equate to $32,900 and $49,350, respectively for a family of four. States' use of income disregards and provisions of Title XIX to expand poverty level eligibility criteria are discussed more fully in Appendix II.

States with stand-alone components—either separately or in combination with a Medicaid expansion--used their Title XXI flexibility to distance their programs from Medicaid and make SCHIP look more like private insurance. Key components of this approach were the introduction of benefit packages that more closely resembled employer sponsored coverage available in the state and cost sharing. In general, the eight states in our sample with SCHIP stand alone components covered services for five optional benefit categories-prescription drugs, mental health, vision, hearing, and dental. Two states provided no inpatient mental health benefit and one state had no hearing benefit. As is permitted under Medicaid, however, many of the eight states placed limits on the duration of treatment allowed or on the amount of services covered. For the majority of children, such benefit limitations are not likely to result in inadequate diagnosis and treatment. Children with special needs, however, may not receive the full range of services that their conditions might warrant. A few states have developed screening mechanisms to identify children with special needs, offering supplemental benefits to ensure that they receive the full range of necessary treatment.

Cost sharing was an important component of states' stand-alone programs. Most states in our sample used premiums, copayments, or both as a means of incorporating utilization control, invoking personal responsibility, and responding to the potential for crowding out private insurance. In general, most states with a stand alone approach in our sample imposed cost sharing that was closer to 1 percent rather than to the maximum 5 percent of family income allowed under SCHIP. Many of these states told us that they found the administrative burden of monitoring cost sharing out of proportion to the small amounts of cost sharing actually imposed. In particular, ensuring that families did not exceed the statutory 5 percent cap caused considerable concern during the review process as states attempted to limit the administrative burden imposed by tracking a family's health expenditures. Finally, three states—Florida, New York and Pennsylvania—had benefit packages from previously state-funded children's insurance programs "grandfathered" into SCHIP. However, since HCFA determined that cost sharing practices were not considered part of their states' benefit package, ultimately, all three states altered their cost sharing practices. For states operating less traditional Medicaid programs under an 1115 waiver, HCFA has already allowed cost sharing and thus these states had the option of imposing cost sharing under a Medicaid expansion. Only one state in our sample with a Medicaid 1115 waiver elected not to impose cost sharing. For additional information on initial state SCHIP design choices, see Appendix II.

that was consistent with Title XXI cost-sharing limits.

FAMILY COVERAGE AND EMPLOYER SUBSIDY OPTIONS PROVE TO BE DIFFICULT ISSUES

A growing number of states are continuing to explore options that address broader goals, are consistent with Title XXI, and fully utilize their available SCHIP funding. In particular, two options permitted by the statute have generated interest among the

15 states in our sample: (1) family coverage that includes the adults in families as well as the children if it proves "cost effective" to do so, and (2) an employer buy in that helps families access available employer-based insurance by using SCHIP funds to pay the employee share of the cost.[9] An employer buy-in limits SCHIP outlays because many employers subsidize a large share of the cost of providing coverage to workers. To date, efforts to apply these options have been largely unsuccessful; only ~~one~~ state—Massachusetts—~~has~~ been able to use SCHIP funds to achieve family coverage. Other states have been able to combine Medicaid and SCHIP funds in order to provide family coverage to states.

The cost effectiveness standard outlined in Title XXI has proved difficult to attain, because it specifies that the expense of covering both adults and children in a family must be less than the cost of covering only the children. Under these circumstances, cost effectiveness appears possible only when the cost to SCHIP of covering a family is subsidized—either by an employer or through some other means. Massachusetts received approval of its Title XXI family coverage proposal by relying on an employer buy-in—a distinct and equally challenging SCHIP option. Under an employer buy-in, benefits must be equivalent to one of the SCHIP benchmark packages and ~~family~~ cost sharing cannot exceed the statute's limit ~~of 5 percent of income~~. Massachusetts officials believe that HCFA's 1996 approval of a Section 1115 waiver permitting an employer buy-in for their traditional Medicaid program greatly facilitated its use as their family coverage cost effectiveness test.[10] By building upon the employer subsidy inherent in most coverage provided through the workplace, Massachusetts minimized the state subsidy of the cost of parental coverage.

For a few states, the goal of covering low income working families has been facilitated by combining Medicaid and SCHIP funding. For example, Missouri is using SCHIP funds under a Medicaid expansion to cover children and Medicaid dollars for their parents. Connecticut is also in the process of developing a similar family coverage approach. Combining SCHIP and Medicaid funding streams, however, has proven problematic for other states such as Wisconsin and Vermont. Under an earlier proposal, Wisconsin tried to cover parents under Medicaid and children under a SCHIP stand-alone program, an effort that afforded parents an entitlement and their children a capped benefit. Because HCFA would not approve this arrangement, the state switched its program design to a Medicaid Expansion similar to that of Missouri. In the case of Vermont, previous expansions for children in its Medicaid program led

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[9] Eight of the 15 states in our sample are pursuing or plan to pursue the family coverage option using SCHIP funds, primarily by subsidizing employer-based insurance. (See Table II.2)

[10] Massachusetts had the advantage of having spent much of 1995 and 1996 gaining approval for a Section 1115 Medicaid waiver that allowed the state to subsidize family coverage provided by an employer. Thus in reviewing the Massachusetts SCHIP plan, HCFA was not approving a new concept.

to difficulties in adding parents to achieve family coverage. While the state will pursue family coverage options, they currently plan to do so using Title XIX funds.

Although Title XXI provides the opportunity for Section 1115 waivers of Title XXI requirements, HCFA has refused to consider such waivers unless a state's SCHIP program has been operational for at least one year. HCFA's position reflects the demonstration nature of Section 1115 waivers and a concern about not undermining the statutory goal of covering uninsured children. Some states and state advocacy groups would like HCFA to begin allowing states to tailor their SCHIP programs through the use of 1115 waivers. Ultimately, the use and approval of Section 1115 waivers under SCHIP will require a judgement regarding the consistency between state goals to broaden insurance coverage for families and the intent of Title XXI. For additional information on state pursuit of the SCHIP family coverage and employer buy-in options, see Appendix III.

FACILITATING ENROLLMENT IS A KEY COMPONENT OF STATE OUTREACH EFFORTS

States have developed a variety of innovative outreach approaches to overcome enrollment barriers and increase SCHIP participation. Strategies designed to educate families about the availability of coverage for their children and assist in program enrollment are referred to as outreach. Congress recognized the importance of state outreach strategies, a reflection of experience in enrolling eligible children into Medicaid. At the same time, Title XXI also placed limits on the amount of and circumstances under which outreach spending is eligible for federal matching funds. Despite these limitations, states outreach efforts encompass marketing approaches that range from sophisticated media campaigns to more informal, community-based enrollment efforts. While it is too early to judge the success of outreach efforts, some states are reporting that the publicity is not only attracting SCHIP eligible children but also far greater numbers of those who were Medicaid eligible but not enrolled.

States have a significant opportunity under Title XXI to provide health coverage to millions of uninsured children. Nevertheless, state experience with Medicaid demonstrates that eligibility does not necessarily guarantee enrollment. In 1996, about 23 percent, or 3.4 million, of the 15 million children eligible for Medicaid were not participating in the program. Factors that may prevent families from enrolling in Medicaid include: (1) confusion over eligibility, especially in the wake of welfare reform; (2) lack of knowledge about the program; (3) complex eligibility rules that complicate the enrollment process; (4) a belief that participation in the program is unnecessary when the children are relatively healthy; (5) a perceived stigma due to the program's past link with welfare; ~~and~~ (6) language and cultural barriers or concerns about jeopardizing immigration status. Without attention, many of these barriers could also affect SCHIP, undermining states' ability to find and enroll targeted children.

To receive the enhanced SCHIP federal match, total expenditures for outreach, along with administration, direct services,[11] and other health initiatives may be no more than 10 percent of expenditures for the actual provision of benefits. Tying outreach to program expenditures has been problematic for some states as they develop and implement SCHIP stand alone plans. Because the 10 percent cap is based on a state's actual expenditures—and not a state's allotment—outreach spending can only be matched with federal funds if the state has also claimed a significant amount of funds for actual service delivery.[12] For example, California believes that the limit is particularly difficult during the start up phase of its SCHIP stand-alone program when enrollment is low and relatively few services are being provided. California officials believe, however that the limit based on expenditures is a short-term problem and the 10 percent limit may be reasonable once its program matures and expenditures increase. In the mean time, the state has established a $20 million outreach budget and is committing a significant amount of state-only funds. In contrast, states like New York and Massachusetts that "rolled over" enrollment from existing programs already have significant health services expenditures that provides a larger base against which to claim costs associated with outreach efforts. For these states, the link between program expenditures and outreach limits is not a concern. The President's fiscal year 2000 budget includes a provision to ~~remove outreach from the 10 percent cap by~~ establishing an additional separate 3 percent outreach cap.[13] Under this provision, the 3 percent cap would continue to be tied to expenditures. States could still use 10% funds for outreach.

States are making efforts to publicize SCHIP through the use of multi-media campaigns, direct mailings and widespread distribution of applications, community involvement and corporate participation. Strategies to market SCHIP as a "product" have inspired the use of sophisticated media campaigns in some states. Some states have opted to mail SCHIP information directly, using various methods to identify and target families likely to have eligible children. Blanketing school-aged children and their families with program information through local school districts is another outreach technique that some states are finding particularly effective. Other outreach efforts intended to overcome barriers and minimize the burden on beneficiaries

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[11]Examples of direct services include health care delivered by community health centers or through hospitals that receive Medicaid funding under the Disproportionate Share Hospital Program.

[12] HCFA officials acknowledged that this places some states in the position of either deferring outreach expenditures, or committing a significant amount of state-only dollars during program start-up. HCFA has indicated that they are willing to ~~explore~~ work with Congress and the States on a legislative proposal to ensure that States have the administrative funds they need up front to put these programs into place ~~an acceptable technical~~ amendment that would lighten the burden for states.

[13] A portion of the remaining 10 percent administrative cap would be earmarked for improvements in state data systems, data collection, and reporting to the federal government.

include the simplification of eligibility determination and enrollment procedures. All but one state in our sample are streamlining their eligibility processes to some extent by either eliminating burdensome eligibility tests, providing up to 12 months of continuous eligibility rather than conducting monthly redeterminations, and creating shorter and/or joint Medicaid /SCHIP application forms. Strategies to simplify enrollment include allowing families to submit applications through the mail, by telephone, facsimile or over the Internet. Other efforts to facilitate enrollment involve increasing the number, location and operating hours of enrollment sites, reducing application processing time and implementing other measures such as follow up systems to ensure that families do not get "lost " in the process. Further efforts are also being made by some states to focus outreach on the needs of immigrant populations through the use of multilingual application materials and eligibility workers.

Although ~~over 40 percent~~ one-third of SCHIP plans were approved between September and December 1998, many states had not yet begun enrollment by years end. According to HCFA, enrollment in 12 states that had approved SCHIP plans prior to May 1, 1998 totaled 425,000.[14] While preliminary enrollment estimates show that the number of children enrolled in SCHIP varies significantly across states, it is still too early to assess the impact of state outreach efforts. Differences in terms of implementation schedules, preparedness, and eligible populations complicate any comparison across states. For example, California's new stand alone program began enrollment in June 1998; however, early enrollment numbers that are lower than expected has raised concerns among state officials that immigrant families are hesitant to enroll for fear of affecting their residency status. In contrast, Florida, New York, Colorado, and Pennsylvania rolled over enrollees from their previously state-funded children's programs, thus showing an immediate jump in enrollment.

Measuring the progress states make in reducing the number of uninsured children poses challenges. HCFA has worked with states and other interested groups to develop reporting requirements for key program indicators such as expenditures and enrollment. Despite efforts to standardize the way states collect and report data, comparisons across states will be difficult because of differences in eligibility standards, the definition and categorization of income, and discrepancies in estimates of the number of uninsured children, particularly for smaller states. HCFA believes that while states are working hard to get their reporting systems "up-and-running," some will not be able to meet the first reporting deadline set for January 30, 1999. For a number of reasons, this initial enrollment data must be used cautiously in measuring progress across states. First, reported enrollment data will appear low because it was reported as of the end of fiscal year 1998 and more states have begun enrolling children since that date. Second, state outreach efforts and enrollment were initiated at different points in time. Finally, states that had previously funded their

[14] As of September 22, 1998.

own children's health insurance programs had a ready source of program applicants, which will result in significant early SCHIP enrollment. However, this SCHIP enrollment will not result in an overall decrease in the number of uninsured children because previous estimates are likely to have considered these children as insured. Overall, initial efforts to determine the effectiveness of SCHIP in reducing the number of uninsured children are likely to be limited in nature. For additional information on state outreach initiatives, see Appendix IV.

STATES USE DIVERGENT APPROACHES TO ADDRESS CROWD OUT UNDER SCHIP

In an effort to reduce or control "crowd out"--that is the substitution of SCHIP for other public or private health insurance--Title XXI mandates close coordination among SCHIP, private health insurance, and Medicaid.[15] Estimating the extent and impact of crowd out under SCHIP is difficult and has led to diverging viewpoints on whether and how states should develop prevention measures. States held various views on the importance of crowd out--differences reflected during the review of SCHIP plans. While some states originally included crowd out prevention measures in their SCHIP plans, others added measures only after extensive discussion with DHHS.

A review of studies examining previous public health insurance expansions found that they focused on populations quite different from those eligible for SCHIP and were conducted at a time when few states had implemented preventive safeguards. Studies that were national in scope generally found more crowd out than state focused studies. Nationally, estimates of new public insurance participants who gave up their private insurance ranged from 15-17 percent, compared to 5-7 percent displacement for state-focused studies. Most study results also indicated that substitution rates were higher for children, and especially women, at higher income levels. Complicating these estimates, researchers have found that it is difficult to identify how much crowd out is attributable to a public health insurance expansion and how much is caused by other insurance trends occurring simultaneously. For example, during the period from 1988 to 1996, access to employer-based health coverage for lower income families decreased, as did their ability to pay the cost of premiums.[16]

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[15] If a state could elect to provide services to a Medicaid eligible individual under SCHIP, it would receive an enhanced federal matching rate. Thus, the federal government would pay more money to cover an individual under SCHIP than under Medicaid. Consequently, Title XXI prohibits SCHIP from crowding out Medicaid coverage.

[16] See Ellen O'Brien and Judith Feder, How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?, The Kaiser Commission on Medicaid and the Uninsured, September 1998.

Not surprisingly, estimates of expected crowd out under SCHIP also vary. One survey of small, medium, and large businesses that was regionally stratified found that most companies reporting were unlikely to reduce the health coverage offered to employees or dependents as a result of SCHIP.[17] However, other estimates of crowd out ranged from a low of 22 percent up to 40 percent displacement. The latter estimate by CBO is a long-term qualitative assessment that assumes an eventual adjustment in labor markets to the availability of federal subsidies. CBO projected that over time low income workers would receive more compensation in the form of wages and less in the form of health insurance. In fact, CBO analysts suggest that some amount of displacement of private insurance signals the success of SCHIP -- or the trade off between the SCHIP goals of stable insurance coverage for children and crowd out prevention. If children who move in and out of private insurance based on their family's changing jobs and incomes qualify for consistent coverage under SCHIP, their previous private insurance is crowded out. However, these children would theoretically have more reliable access to health coverage and a greater likelihood of receiving both preventive and acute health care, leading to improved health status.

States covering children at higher income levels tended to have more aggressive crowd out strategies. These strategies include waiting periods without insurance and requiring cost sharing similar to private insurance. The SCHIP plans of 12 of the 15 states in our sample included strategies that were intended, either directly or indirectly, to help prevent crowd out. The most popular strategy was to impose a waiting period of between 3 and 12 months before allowing children to enroll in SCHIP. Three states with previous health insurance expansions that resisted incorporating prevention measures agreed to study crowd out and institute waiting periods if they find problems. Some states disagreed with DHHS' concern that subsidizing employer-based health insurance has significant potential for crowd out. The only state to successfully include subsidies for employer based insurance in its SCHIP plan, Massachusetts, WI + MS considered the subsidies as incentives for employees to retain coverage, but conceded that employers may choose to reduce premium contributions.

To prevent the substitution of SCHIP for Medicaid, DHHS' review of state plans led many states to upgrade their Medicaid screening and enrollment strategies and to create closer links between stand-alone programs and Medicaid. Medicaid expansion states were already using the same administrative and application systems for both SCHIP and Medicaid. In contrast, most states with stand-alone components met the screening and enrollment mandate by ~~checking applicants~~ determining eligibility first for Medicaid ~~eligibility~~ + enrolling applicants in that program if eligible.

[17] See Harriette B. Fox and Margaret A. McManus, The Potential for Crowd Out Due to CHIP: Results from a Survey of 450 Employers, The Child Health Insurance Project, Fact Sheet #3, (Washington, D.C: Maternal & Child Health Policy Research Center, March, 1998).

and most of these states are also using a joint application form for both programs. Other Medicaid crowd out prevention tactics that states adopted include using a single agency or entity to screen and track referrals for both programs; developing a coordination plan if two offices were involved; or comparing SCHIP participant lists against Medicaid enrollment files to ensure that children are not already covered. As a result of these screens, several states have found a significant number of Medicaid-eligible children as initial applicants for their SCHIP programs. For example, Massachusetts' SCHIP application process has found 2 Medicaid eligible children for every 1 successful SCHIP application. And, Michigan state officials cited a rate as high as 10 to 1. As SCHIP programs evolve, coordination plans may be complicated by periodic reviews of SCHIP eligibility under which states would be required to shift any children found Medicaid eligible into Medicaid. Some states have tried to address this situation by allowing continuous eligibility for up to 12 months for participants of both Medicaid and SCHIP. Six of our 15 sample states use 12 months of continuous eligibility for SCHIP, while one chose 6 months. For additional information on crowd-out, see Appendix V.

CONCLUSIONS

More than a year after the program's first anniversary, it seems clear that the SCHIP implementation schedule was tight, particularly for states interested in establishing SCHIP programs that are separate from Medicaid. The approximately 12 months initially authorized proved to be challenging, given the need to develop and implement a benefit package and administrative structure essential to operate a SCHIP stand alone program. In view of the tight timeframes, many states opted for placeholder Medicaid expansion plans that secured their initial SCHIP allocation. Thus, the large number of states initially choosing Medicaid expansions does not reflect a commitment to a Medicaid approach as much as the complexity of pursuing a more complicated stand alone option. Although nearly all states have received approval for their SCHIP design, many will need more time to develop a stand-alone component to their initial plans. Since SCHIP is not yet fully operational, any evaluation of its success based on enrollment data alone is clearly premature.

Moreover, in fleshing out their SCHIP designs, states are exploring family coverage and employer buy-in options. By including these options in Title XXI, Congress created the expectation that SCHIP could be used to achieve broader state goals. However, these options have proven difficult to implement. During the initial plan approval phase, HCFA worked with states to help them achieve their goals within the limits of the statute. However, Title XXI not only gives states flexibility in designing their SCHIP programs but also grants HCFA considerable discretion over state plan approval by permitting Section 1115 waivers of Title XXI provisions. Although HCFA has thus far declined to use this waiver authority, the agency's position was not a problem for most states because their initial focus was on submitting a SCHIP design to secure the state's first year allocation. In general, most states were interested in but

unprepared to submit plans that encompassed family coverage or an employer subsidy--options that had challenging requirements.

As states continue to develop plans to fully utilize their SCHIP allocations, the issue of Section 1115 waivers is likely to become a higher priority. As a result, HCFA will have to determine the appropriate balance between state flexibility and the fundamental goal of Title XXI--to reduce the number of uninsured children across the nation. This situation raises a number of issues:

- To what extent should SCHIP be used as a vehicle to achieve broader state goals such as (1) offering seamless coverage to families as a way to reach children, (2) subsidizing employer coverage that varies from generous benefits and minimal cost sharing to its antithesis, and (3) improving the affordability and coverage for low income families who are underinsured?

- For those states that have covered virtually all of their uninsured children or that want to provide family coverage as a way to reach children, to what extent should they be allowed to use their SCHIP allocation for these broader coverage goals rather than triggering a reallocation of funds to states who still have uninsured children?

HCFA's ability to respond to these issues, as well as monitoring the reduction in the number of uninsured through both Medicaid and SCHIP enrollment will be key to assuring the successful implementation of Title XXI.

AGENCY AND STATE COMMENTS

In written comments on a draft of this report, HCFA.....and states....

As arranged with your offices, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of HCFA, appropriate congressional committees, and other interested parties.

If you or your staff have any questions please call me at (202) 512-7114 or Walter Ochinko, Assistant Director, Health Financing and Public Health Issues at (202) 512-7157. Other major contributors to this report were Carolyn Yocom, Karen Doran, JoAnn Martinez, and Behn Miller.

Kathryn G. Allen
Associate Director
Health Financing and
Public Health Issues

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APPENDIX I

SCHIP REQUIREMENTS

The August 1997 enactment of the State Children's Health Insurance Program (SCHIP) launched a major new initiative that allows states to implement innovative approaches to providing health insurance to eligible, low income, uninsured children.[18] In addition to giving states flexibility to design their own programs, SCHIP provides federal budget authority of about $40 billion over 10 years (see Fig.I.1).[19] Funds became available to states on October 1, 1997, less than two months after the passage of SCHIP. The goal of SCHIP is to significantly reduce the number of uninsured children, an estimated 9 to 11.6 million of whom lacked health insurance at some time during 1997. [20] Figure I.2 provides a snapshot of the key demographic characteristics of low income, uninsured families with children, a group less likely to have access to affordable coverage. Children without health insurance are less likely to obtain routine medical or dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses.

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[18]SCHIP was authorized by the Balanced Budget Act of 1997, Public Law 105-33.

[19]In addition to the federal SCHIP appropriation, the Balanced Budget Act also contained funds for several other provisions that affect children's coverage: (1) presumptive Medicaid eligibility that allows enrollment prior to an official eligibility determination; (2) restoration of Medicaid benefits for children who lost their disability status as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; and (3) initiatives to enroll more Medicaid eligible children. The $3.6 billion in funding for these provisions are often included in the $20.3 billion total for the initial five years of the SCHIP program (1998-2002).

[20] The estimate of 9 million children was derived from the 1997 National Survey of America's Families, conducted by the Urban Institute, while the 11.6 million total is derived from the Current Population Survey (CPS) by the Congressional Research Service. The Urban Institute suggests that a significant difference between the National Survey and the CPS is that the CPS does not directly ask respondents if they are uninsured. Instead, the CPS asks respondents whether they or their family members have various types of insurance (e.g. private insurance, Medicaid, CHAMPUS, etc.). Those that do not respond in the affirmative to any type of insurance coverage are counted as uninsured. The National Survey also asks the questions regarding type of insurance, but it goes on to ask directly whether respondents (or their children) are uninsured. The Urban Institute found that a significant number of respondents do report that they have insurance, one they've been asked directly if they are uninsured.

Figure I.1: Annual SCHIP Appropriations, Fiscal Years 1998-2007

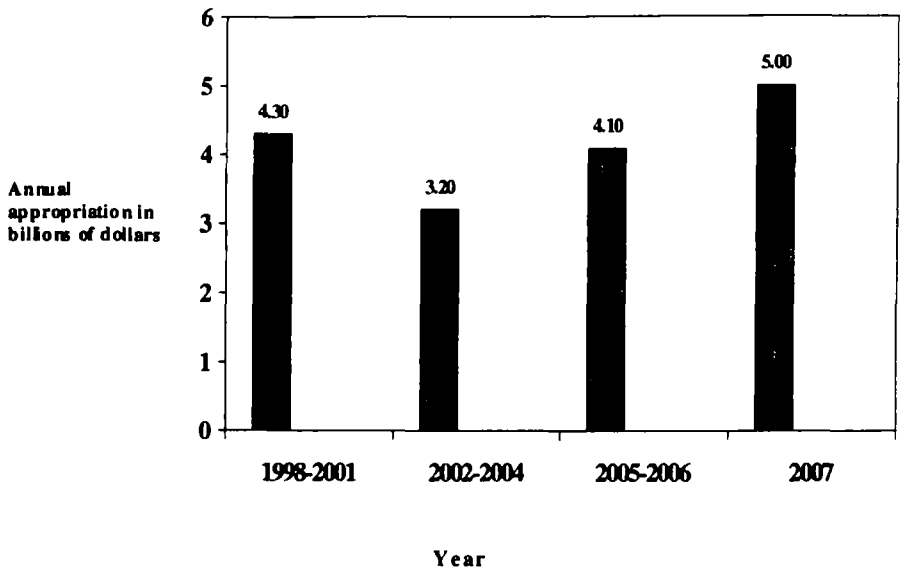

Figure I.2: Key Characteristics of Uninsured Low Income Families with Children

- Most uninsured children live in families with at least one employed adult.
- There is a strong correlation between income and the likelihood of a family having access to and actually participating in employer sponsored health insurance -- the major alternative to public programs such as Medicaid. Lower income jobs offer less access to health insurance and workers have more difficulty affording coverage.
- Children without health insurance tend to be from families where one or both parents are unemployed, are self-employed, are part-time employees, or work for firms that either do not provide dependent coverage or offer this coverage at a price the parents consider unaffordable. Examples of employment that are less likely to offer health insurance include non-union skilled labor, construction, agriculture, childcare, and food service.
- Income and employment volatility place low-income individuals at greater risk of losing employer-sponsored coverage. Compared to higher income workers, those in low wage professions change jobs more frequently, or more often find that their jobs have been converted to less than full-time employment.
- Compared to all other age groups, 12- to 17-year-olds are the least likely to have health care coverage. Additionally, Hispanic children are the most likely to be uninsured. In 1996, 28.9 percent of Hispanic children had no health insurance, while 18.8 percent of African-American children were without coverage. Among white children, 13.9 percent had no health insurance.
- The incidence of uninsurance is higher for families living in the southwestern and south central United States and lower for those in the midwestern and northeastern United States. States with low rates of private health insurance coverage also tend to have more uninsured residents.

STATES GIVEN FLEXIBILITY IN HOW TO EXPAND CHILDREN'S HEALTH INSURANCE COVERAGE

SCHIP is an overlay on the already complex federal-state Medicaid program. In the effort to provide health insurance coverage to children, SCHIP attempts to balance a strong desire for state flexibility to craft programs that best meet local needs against the belief that minimum federal protections are needed for low-income children. Recognizing these conflicting goals, SCHIP provides states with the choice of expanding Medicaid, establishing a new program distinct from Medicaid, or combining these two approaches. Offering three general approaches affords states the

opportunity to focus on their specific priorities. For example, expansions of Medicaid offer Title XIX's comprehensive benefits and administrative structures – but the entitlement status of Medicaid increases the financial uncertainty for states. In contrast, a SCHIP stand-alone component offers a "block grant" approach to covering children, affording states with increased flexibility, opportunities for innovation, and the ability to structure a private sector model of insurance coverage

Each states' SCHIP plan must operate within the parameters of Title XXI, the new section of the Social Security Act that authorizes the program and spells out the rules for receiving federal matching funds. The following description of Title XXI requirements focuses on features of the program that are independent of the design approach selected by a state. A subsequent section then highlights the financial and programmatic consequences that flow from a states decision to pursue either a Medicaid expansion or a stand alone program.

Some SCHIP Requirements
Apply to All State Programs

In general, SCHIP offers a strong inducement for states to participate by increasing the federal financial contribution beyond that available for Medicaid. At the same time, the publicity associated with SCHIP could increase states' Medicaid expenditures by attracting low income families who were not aware that their children are Medicaid eligible. SCHIP seeks to avoid undermining the employer-based system through which most Americans receive their health insurance by focusing on low-income, uninsured children—those who are the least likely to have access to coverage through a family member's job.

- State allotments. Total federal payments to states for SCHIP are specified in statute and allocated to states according to a statutory formula. Initially, the SCHIP allocation formula is based on (1) an estimate of the number of low income, uninsured children in each state and (2) a factor representing state variation in health care costs.[21] Beginning in fiscal year 2001, the formula

[21]Estimates of low income uninsured children are derived from the annual health insurance supplement to the Current Population Survey (CPS), the only nationwide source of information on uninsured children by state. {Q53} The CPS data has a number of well-recognized shortcomings. The Congressional Budget Office notes that state level estimates are generally unreliable and exhibit volatility from year-to-year due to an inadequate sample size, particularly in small states. For example, based on 1994-1996 data, the number of uninsured children in Delaware ranges from 12,000 up to 32,000. The CPS also tends to overestimate those lacking insurance because it under-reports the number of people covered by Medicaid. To address the yearly volatility in CPS estimates, state allocations are based on a 3-year average; however,

changes, gradually shifting funds from states with large numbers of uninsured low-income children toward states with high numbers of low-income children regardless of insurance status. States have 3 years to use each year's allocation, at which time any remaining funds will be redistributed among states that have used all of that year's allocation based on a formula to be developed by HCFA. Table I.1 summarizes fiscal year 1998-1999 SCHIP allocations for our 15 state sample.

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continued concern led the Congress to mandate essentially the same allotments (less additional funds for diabetes) for both fiscal year 1998 and fiscal year 1999.

Table I.1: State SCHIP Allocations and Federal Matching Rates for Fiscal Years 1998 and 1999, GAO State Sample

State	CPS estimate of low income uninsured children (millions)	1998 allocation (millions of dollars)	1999 allocation (millions of dollars)	Enhanced matching rate (percent)	Medicaid matching rate (percent)
MEDICAID EXPANSIONS					
Mo.	97	$51.7	$51.4	72%	61%
R.I.	19	10.7	10.6	67	53
S.C.	110	63.6	63.3	79	70
Tex.	1,031	561.3	558.7	74	62
Wisc.	71	40.6	40.4	71	59
STAND ALONE PROGRAMS					
Colo.	72	41.8	41.6	66	52
N.Y.	399	255.6	254.4	65	50
Oreg.	67	39.1	38.9	73	61
Pa.	200	117.5	116.9	67	53
Vt.[b]	7	3.5	3.5	74	62
COMBINATION PROGRAMS					
Calif.	1,281	854.6	850.6	66	51
Conn.	53	34.9	34.8	65	50
Fla.	444	270.2	268.9	69	56
Mass.	69	42.8	42.6	65	50
Mich.	156	91.6	91.2	68	54

[a] State allocations were announced by HCFA in a letter to state officials dated December 8, 1997. In calculating the allocations, Native American children with access to Indian Health Services programs were counted as insured. Since Title XXI treats such children as uninsured, the allocations were recalculated. As a result, states with Native American populations saw an increase in their SCHIP allocations. The figures included in this table reflect that recalculation. Originally, state SCHIP allocations were to be recalculated annually using an average of CPS data from the last three years. The Omnibus Appropriation Bill of 1998 required that HCFA use the 1998 allocation data for 1999 to avoid further volatility. Although the formula is the same, it is applied against a smaller total appropriation in 1999 ($4.275 billion versus $4.295 billion).

[b]Vermont originally submitted a Medicaid expansion plan, which it withdrew in August, 1998. A new, stand-alone state plan was approved in December, 1998.

Source: HCFA

- Enhanced federal match. State SCHIP expenditures draw down federal funds against the state allotment at a rate that exceeds their current Medicaid matching rate. This enhanced rate results in a national average federal match of 70 percent compared to about 60 percent under Medicaid.[22] Thus, a state with the minimum 50 percent Medicaid match will receive a 65 percent SCHIP match. Similarly, a state with a 70 percent Medicaid match will receive a 79 percent SCHIP match. Table I.2 compares the SCHIP and Medicaid matching rates for our sample. Assuming that states match and drawn down all available funds, total federal/state SCHIP expenditures would total about $57 billion.

- Eligibility income limit. In general, Title XXI targets children in families with incomes at or below 200 percent of the poverty level--$32,900 for a family of four in 1998.[23] Recognizing the variability in state Medicaid programs,[24] the statute allows a state to expand eligibility up to 50 percentage points above its existing Medicaid eligibility standard. However, Medicaid also allows states to establish their own criteria for measuring income for purposes of determining eligibility, making the $32,900 limit subject to variation depending upon state determinations.

- Only uninsured children eligible. To be enrolled in SCHIP, a child must be uninsured. One exception is for children who were covered by a state program that did not receive a federal financial contribution. Underinsured children with poor benefits or expensive health insurance are not eligible for SCHIP. However, a child with only vision or dental coverage is considered to be uninsured. Children eligible for Medicaid are ineligible for SCHIP.

- SCHIP Coordination with Medicaid and other private insurance. Title XXI requirements for coordination with Medicaid and private insurance reflect a

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[22]The formula is based on 30 percent of the difference between a state Medicaid matching rate and 100 percent. However, the enhanced match may not exceed 85 percent. All states receive a minimum allocation of $2 million.

[23]Use of the term "poverty level" refers to the federal poverty guidelines, which are used to establish eligibility for certain federal assistance programs. The guidelines are updated annually to reflect changes in the cost of living and vary according to family size. Guidelines are uniform across the continental United States and slightly higher for Alaska and Hawaii.

[24]For example, Alabama covered children ages 15 to 18 up to 15 percent of the poverty level while Washington state covered this same age group up to 200 percent of the poverty level.

two fold concern that: (1) children be appropriately enrolled in Medicaid if they are eligible, and (2) any coverage provided under SCHIP not displace or "crowd out" other existing health insurance. To ensure coordination with Medicaid, states must have a process to ensure that children identified as Medicaid eligible will be referred to and enrolled in that program. States must also submit to DHHS their strategy for preventing SCHIP from becoming a substitute for either employer sponsored coverage or individually purchased insurance.

- Family coverage or employer subsidy options. Title XXI gives states the option of covering adults in families with children eligible for SCHIP if they can show that it is cost effective to do so. The cost effectiveness test spelled out in the statute requires a state to demonstrate that covering both the adults and children in a family under SCHIP is no more expensive than covering only the children. In addition, a state may elect to cover children whose parents have access to employer sponsored coverage by paying the parent's share of the cost for dependent coverage.

- Maintenance of effort requirements. To ensure that SCHIP funds are used only to provide coverage to those children not previously eligible for Medicaid, Title XXI specifies that state eligibility requirements in effect on March 31, 1997 for Medicaid expansions and June 1, 1997 for stand alone plans may not be reduced in order to qualify children for the enhanced federal matching rate. In addition, Florida, New York, and Pennsylvania were allowed to claim the enhanced federal match for children insured under state funded programs that formerly received no federal funds; however, they must continue to provide state funds at least equal to their expenditures in 1996.

- Waivers and variances. The statute allows states to request an exception to Title XXI provisions under waiver authority provided to the Secretary of DHHS by Section 1115 of the Social Security Act. Section 1115 allows the Secretary of DHHS to waive certain Medicaid—and now SCHIP-- eligibility and funding requirements for demonstrations likely to assist in promoting program objectives.[25] In addition to this general waiver authority, Title XXI permits states to apply for "variances" from three statutory provisions: (1) Secretary approval of health benefits coverage, (2) cost-effective family coverage, and (3)

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[25]Past Section 1115 demonstrations have made significant contributions to the development of Medicaid policy such as school-based services for young children. In 1982, Arizona initiated a Medicaid program under an 1115 waiver that allowed the first statewide Medicaid managed care program. About 17 states now operate some portion of their Medicaid programs under a Section 1115 waiver.

inclusion of community-based delivery systems that would under statute be subject to the 10 percent cap on certain program expenditures. [26]

- Reporting requirements. Title XXI requires various assessments from states that participate in SCHIP. First, each state must annually report on the operation of its SCHIP program in January of each year for the preceding federal fiscal year, including progress made in reducing the number of uncovered low-income children. By March 31, 2000, states must submit an assessment of the effectiveness of the state's SCHIP program in increasing the number of children with coverage. In addition, by December 31, 2001, DHHS must submit to the Congress a report based on evaluations submitted by states, including any conclusions and recommendations that the Secretary of HHS considers appropriate.

SCHIP Design Choice Has Financial And Programmatic Implications

Important consequences, both financial and programmatic, flow from a state's design choice. In general, Medicaid rules apply to a Medicaid expansion while a state implementing a stand-alone program has more control over expenditures, benefits, and beneficiary cost sharing. States expanding Medicaid, however, also gain flexibility under SCHIP because of their ability to continue to claim federal contributions for administrative or outreach costs after reaching the statutory cap on such expenditures at the enhanced match. The key features of Medicaid expansions and stand-alone SCHIP programs that flow from Title XXI requirements as interpreted by DHHS are summarized in Table 1.2.

[26]DHHS uses the term "variances" to distinguish them from exceptions sought under the Secretary's authority to waive Title XXI provisions using Section 1115.

Table 1.2 Key Features of Medicaid Expansions and Stand Alone SCHIP Programs that Flow from Title XXI Requirements

	Medicaid Expansion	Stand Alone
FINANCIAL		
Entitlement	Entitlement--federal funds continue after states exceed their allotment at a regular Medicaid matching rate	No entitlement--federal matching funds cease after a state meets its allotment.
Non-benefit related expenses	When a state reaches the 10 percent expenditure cap on administration, direct services, and enrollment activities, state costs can be matched at its lower Medicaid rate	Expenditures on administration, direct services, and outreach limited to 10 percent of claims for services delivered to beneficiaries
PROGRAMMATIC		
Benefits	Medicaid benefits package, including EPSDT, which is designed to ensure children receive all medically necessary services[27]	Benchmark benefits packages that use private insurance plans as models[a] that have a different standard of coverage than the EPSDT concept of medical necessity
Cost sharing	Limited cost sharing allowed for children	Cost sharing permitted for children in families above 150 percent of the poverty level, up to 5 percent of family income. Similar to Medicaid for those below 150 percent
Eligibility rules	Medicaid eligibility rules apply (i.e. income, residency, and disability status)	State free to establish own eligibility rules, taking into account age, geography, residency, disability status, and access to other coverage
Eligibility determination	State agency must determine eligibility	Eligibility determination and other administrative functions can be privatized
State employee eligibility[b]	Low income state employees eligible	Low income state employees ineligible unless state makes no contribution to the cost of employee dependent coverage
Delivery systems	Use existing Medicaid delivery systems, health plans, and providers	Allows states to develop new contracts with plans and provider networks that may not have previously served Medicaid beneficiaries
Other standards	Medicaid consumer protection and health plan enrollment standards apply	Allows states to establish separate appropriate consumer protection and health plan enrollment standards

[a]In addition, the benefits packages of state funded children's health programs in New York, Pennsylvania, and Florida were grandfathered.
[b]Title XXI prohibits coverage of children "eligible for state employee health benefit plans." This table reflects HCFA's interpretation of SCHIPs it applies to Medicaid expansions and stand-alone programs.

[27]Early Periodic Screening, Diagnosis, and Treatment (EPSDT), a required component of the Medicaid benefit package, requires states to cover treatment for all medically necessary services diagnosed during routine screening. See Figure II.1 for a more detailed description of EPSDT requirements.

OVERVIEW OF THE SCHIP REVIEW AND APPROVAL PROCESS

To qualify for Title XXI funds, states must develop and seek approval for their SCHIP plans from DHHS. Subsequent amendments to SCHIP plans also require DHHS approval. SCHIP plans must detail how the state intends to use the funds, addressing eligibility, cost sharing requirements, health benefits, coordination with Medicaid and private insurance, outreach, and other factors. States electing to expand Medicaid were not required to elaborate on program characteristics which were addressed in their existing Medicaid state plans already on file with DHHS. On the other hand, the development of a state plan for a stand-alone approach understandably requires more documentation. In September 1997, DHHS devised a SCHIP template that identified the key information required to review a state plan. As HCFA gained experience with the SCHIP statute, it provided frequent guidance to states in the form of letters to state ~~Medicaid directors~~ Health officials and, on an ongoing basis, shared answers to questions (Q&A's) frequently raised by states. Letters, guidance, and the Q&As were all posted on the Internet.[31] HCFA plans to issue a formal regulation on the SCHIP statute in 1999.

The statute calls for a prompt federal review of a state's SCHIP plan submission to "determine if the plan substantially complies with the requirements of Title XXI." In general, a plan is approved after 90 days unless it is specifically disapproved by DHHS. However, if additional information is required to complete its review, the Department can "stop-the-clock" until a state response is received. The goal of approving SCHIP plans within 90 days differs from the lack of similar statutory standards with respect to Section 1115 waivers. Furthermore, HCFA officials told us that Title XXI does not allow it to place any conditions on the approval of SCHIP plans--another difference from the broader discretion given to the agency in considering Section 1115 waivers. Rather DHHS must either approve or deny a state SCHIP plan.

The review team within DHHS is diverse, including officials from the Health Care Financing Administration (HCFA), the Health Resources and Services Administration (HRSA), the Assistant Secretary for Planning and Evaluation (ASPE), and the Agency for Health Care Policy and Research (AHCPR). HCFA is the agency within DHHS responsible for managing and monitoring the Medicaid program. Each state is assigned a HCFA Project Officer who serves as a key focal point during the SCHIP review process. HRSA brings an expertise on provider access issues and on outreach. ASPE staff involved in reviewing SCHIP plans contribute their knowledge of public

[31] These documents are available on the HCFA website at www.hcfa.gov.

health and program evaluation. Finally, AHCPR's role is to review state strategies for and offer guidance on quality of care and performance measurement issues. ~~In a few instances~~ the Office of Management and Budget and the Treasury Department have also been involved in developing policy or reviewing SCHIP plans. To expedite the resolution of any policy issues raised during the review process, a steering committee jointly chaired by HCFA and HRSA was established within DHHS.

In a few instances,

APPENDIX II

INITIAL STATE SCHIP DESIGNS EVOLVING AS STATES SEEK TO USE STATUTORY FLEXBILITY

SCHIP design is far from complete. By the end of the first year, nearly all states had submitted SCHIP plans and most had received approval for a Medicaid expansion, a stand-alone program, or a combination of both approaches. For some states, Title XXI came at an opportune time—the state either had a children's health program in place or had plans underway. For these states, their initial design choices were likely to be either a stand-alone or combination program. Other states used Medicaid expansions as "placeholders"—minimal expansions of Medicaid to guarantee access to their first years' SCHIP allocation. Placeholder states generally plan additional SCHIP amendments and HCFA believes that most are likely to incorporate a more flexible stand-alone component. A state's design choice had a significant impact on its benefit package and its ability to introduce cost sharing into SCHIP. For Medicaid expansion states, benefits and cost sharing were limited to those outlined in their state Medicaid plans. States with stand-alone components were primarily interested in imitating private sector insurance; in general, the benefit packages of such states in our sample will prove adequate for the majority of children but may not address the conditions of those with special needs. States with a stand alone component in our sample were able to use cost sharing to achieve utilization control, invoke personal responsibility, and help avoid the displacement of private insurance. Review and approval of cost sharing was particularly complex as states and HCFA attempted to ensure that the appropriate statutory provisions of either Medicaid or SCHIP were properly applied.

SCHIP DESIGN CHOICES: SNAPSHOT OF AN EVOLVING PROGRAM

As of January 19, 1999, only 4 states and territories had not yet submitted SCHIP plans to HCFA and all but three of the 52 plans submitted had been approved.[28] HCFA expects that all states will eventually submit a SCHIP plan. The initial design process for states was driven by the statutorily defined deadline for accessing federal funds and by the more complicated task of developing a stand-alone program. As a result, the initial large number of SCHIP Medicaid expansions does not reflect the ultimate shape of the overall program, and HCFA estimates that a number of states submitted placeholder Medicaid expansions to secure their initial year allotments. The SCHIP programs approved to date reflect the diversity of state approaches and to some extent defy categorization. Thus, some stand alone programs use Medicaid benefits while most combination programs are largely defined by their stand alone component rather than their minimal Medicaid expansions. The majority of states in

[28]Washington, Wyoming, the Northern Mariana Islands, and the American Samoa have not yet submitted plans.

GAO's sample expect to submit or have already submitted a phase II plan amendment.

Medicaid Expansions Appear to Dominate Initial SCHIP Plans

Of the 52 SCHIP plans submitted, 28 were expansions of state Medicaid programs, 14 were stand-alone programs separate from Medicaid, and 10 combine a Medicaid expansion with a stand-alone component. SCHIP design choices are outlined in Table II.1. With 49 plans approved, Guam, Hawaii and Tennessee are still under review.

Table II.1: States' SCHIP design choices as of January 19, 1999

Design Choice	**States and Territories** (Approved and Pending)	**Totals**
Medicaid Expansion	Alaska, Ark., D.C., Guam, Hawaii, Idaho, Ill., Ind., Iowa, La., Md., Minn., Mo., Miss., Nebr., N.Mex., N.Dak., Ohio, Okla., P.R., R.I., S.C., S.Dak., Tenn., Tex., V.I., W.Va., Wisc.	28
Stand-alone Program	Ariz., Colo., Del., Ga., Kans., Mont., Nev., N.Y., N.C., Oreg., Pa., Utah, Va., Vt.	14
Combination Program	Ala., Calif., Conn., Fla., Ky., Mass., Mich., Maine, N.H., N.J.	10

While there currently appears to be a majority of Medicaid expansions, the number of combination programs which have a stand alone component are expected to increase as state program designs continue to evolve. Thus, HCFA estimates that as many as 20 SCHIP Medicaid expansions are "placeholders," that is, minimal expansions in Medicaid eligibility--as small as a five percent increase in the income standard--used to guarantee the first years allocation while allowing time to plan for a stand alone component. For example, Wisconsin submitted a minimal placeholder Medicaid expansion after prolonged negotiations with HCFA over a more complex and extensive combination program.

Moreover, the number of combination programs with both a Medicaid and stand alone component should not necessarily be viewed as evidence that states are embracing a Medicaid approach to SCHIP. Similar to a placeholder plan, the Medicaid component of a combination program often serves a very limited population. For example, Michigan used a Medicaid expansion to standardize its Medicaid income standard for children of all ages. This allowed the state to establish clear lines of eligibility between its Medicaid and SCHIP stand alone program; moreover, it serves to reduce confusion over program eligibility for families with more than one child. Indeed, some

Medicaid expansions--whether placeholders or as part of a combination program--accelerated the expansion of coverage for children aged 14-18 up to 100 percent of the poverty level, an action that federal law already required states to phase in by 2002. For states that used SCHIP to expand Medicaid eligibility in this manner, the combination portion of their SCHIP program disappears in 2002.[29]

In contrast to states that implemented minimal or placeholder plans, a few states -- such as Massachusetts, New York, Florida, and Pennsylvania -- were well positioned to implement a more robust SCHIP plan in a relatively short period of time. Massachusetts had just received approval for a Medicaid 1115 waiver program that allowed the state to subsidize employer sponsored insurance. From the state's perspective, Title XXI was an opportunity to build on this approach by incorporating an additional funding stream and expanding eligibility even further. Similarly, New York, Florida, and Pennsylvania already had state funded child health programs -- and the Congress recognized the efforts made by these states by grandfathering their benefit packages in Title XXI. These states were able to establish their SCHIP programs relatively quickly, by basing eligibility on their existing state-funded program enrollment.

SCHIP Basic Design Choices
Mask Diverse Approaches

The three basic designs permitted by Title XXI -- ~~Medicaid expansion,~~ stand-alone, or a combination of both -- mask a diversity of approaches. As a result, drawing any conclusion about a state's SCHIP program from these descriptive labels, as summarized in Table II.1, can be misleading. Thus, a stand alone program and a Medicaid expansion can be quite similar if the latter approach is selected by a state already operating its Medicaid program under a Section 1115 waiver; such a waiver allows a state to depart from many Medicaid requirements. For example, one state in our sample that elected a stand-alone approach actually offers Medicaid benefits, a feature usually associated with Medicaid expansions. Even a comparison of eligibility levels across states can be misleading. For example, a state that extends coverage to children in families at higher income levels may cover relatively few uninsured children compared to a more modest level of eligibility that may have the potential to enroll hundreds of thousands of uninsured children. In short, the diversity of state Medicaid programs which served as the starting point for SCHIP as well as the variety of approaches taken by states make it difficult to generalize across those approaches. For example:

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[29]Under OBRA 90, the Congress mandated that all children born after September 30, 1983 in families up to 100 percent of the poverty level are eligible for Medicaid. Some states hastened this eligibility by covering children aged 14-18 under SCHIP born before this date. By 2002, these children will age into adulthood and the SCHIP Medicaid expansion component will no longer exist.

- Medicaid expansions encompass very different approaches and levels of eligibility. For example, Rhode Island's Medicaid expansion is based upon its existing 1115 waiver demonstration, which prior to SCHIP covered individuals up to 185 percent of the federal poverty level in a mandatory Medicaid managed care program. Under its SCHIP expansion, eligible beneficiaries up to 250 percent of the poverty level are given a choice between paying premiums or having copayments attached to applicable services.[30] In contrast, Texas' placeholder Medicaid expansion provides insurance to children ages 15-18 in families with incomes from 17 to 100 percent of the poverty level. In addition to this modest expansion and evening out of Medicaid eligibility levels, Texas officials are currently working on a significant amendment to their initial SCHIP plan.

- Stand-alone or combination approaches generally provided states with increased flexibility in designing a SCHIP program. Stand-alone programs are SCHIP designs that -- if the state desires -- can be completely separate from the eligibility, benefits, and other regulations that apply under Medicaid.[31] For example, Colorado's stand-alone program is based on a state-funded program that originally provided outpatient but not inpatient benefits to children. Under SCHIP, Colorado's program has been expanded to cover children aged 0-17 up to 185 percent of the poverty level, with the option to apply for one year's coverage for the child's 18th year. California's SCHIP combination plan expanded Medicaid for children aged 14-19 from 85 to 100 percent of the poverty level and established: (1) an insurance purchasing pool for children with family incomes up to 200 percent of the poverty level and (2) coverage for children under one year of age up to 250 percent of the poverty level. California's design of its SCHIP component was intentionally different from Medicaid; officials indicated that by providing coverage through private sector insurance pools they hoped to acquaint individuals with private pay insurance and avoid any welfare stigma associated with the state's Medicaid program.

- For states that had taken advantage of Medicaid 1115 waivers as a means of introducing flexibility, stand-alone and combination programs served as a means of expanding eligibility yet preserving budgetary control. For example, Oregon's stand-alone SCHIP plan operates as an extension of the state's 1115 waiver program for Medicaid, expanding eligibility to 170 percent of the poverty level.

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[30]In keeping with Title XXI, no copayments for prenatal, well baby, or preventive services are required. Since approval of its SCHIP plan, Rhode Island has submitted an amendment to expand coverage up to 300 percent of the poverty level.

[31]Generally speaking, Medicaid expansions under SCHIP must conform to Title XIX statutory provisions, whereas stand-alone components of SCHIP programs must conform to Title XXI provisions.

Termed a "Medicaid look-alike," Oregon uses a single application and eligibility determination process, provider network, and claims payment system for both SCHIP and Medicaid. Both programs provide the same benefits based upon Oregon's prioritized list of health condition and treatments; however, the stand-alone nature of their SCHIP program allows the state to limit their spending to an amount established by the state by stopping enrollment. Massachusetts' combination approach was designed to provide seamless coverage between the state's Medicaid program, which also operates under an 1115 waiver, and its new SCHIP combination program for eligible families. The coordination of services and funding streams in Massachusetts are summarized in Appendix III, Figure III.1.

Many States Have Submitted Phase II Plan Amendments

SCHIP design choices to date can be considered a snapshot of a rapidly evolving program, for even as states receive approval for plans, some are already designing what might best be characterized as a second phase. Nationwide, 18 plan amendments have been submitted to HCFA, and 8 of these are already approved as of January 19, 1999. Among GAO's sample, 10 of the 15 states expect to submit -- or have already submitted -- a phase II plan amendment. Seeking approval of family coverage, possibly via employer sponsored insurance, and developing stand-alone components to SCHIP are key areas of interest for GAO's sample of states, as shown in Table II.2.

Table II.2: Phase II Amendments to SCHIP, GAO State Sample

Amendment	States[1]
Family coverage	R.I., Conn., Colo., Mich.
Family coverage via employer buy-in	Oreg. S.C.
Employer buy-in for children	Calif., Colo., Fla.
Stand-alone component	S.C., Tex.

[1] Vermont's original SCHIP plan contained family coverage; this plan was withdrawn and the state received approval for a SCHIP plan that only covers children. The state plans to pursue family coverage, but this will most likely occur via Medicaid, not SCHIP.

VARIATIONS IN SCHIP INCOME AND CATEGORIES OF ELIGIBILITY

Just as Medicaid eligibility is tied to income and population categories (i.e., aged, blind, disabled, families with children), Title XXI also contains statutory guidelines

regarding income and identifies certain categories of children that are ineligible for SCHIP. With regard to income, SCHIP allows states to cover children up to 200 percent of the poverty level or 50 percentage points above a states' current Medicaid applicable income level; thus, a state's starting point is highly dependent upon the poverty level previously established in its Medicaid program. Similarly, Title XXI bars participation in SCHIP if the child (1) resides in a state institution, (2) is in a family that is eligible for state employee health insurance, or (3) has existing health insurance coverage. Although the requirements appear clear and binding in their exclusions, Title XXI gives states considerable flexibility in setting income eligibility standards–and some latitude in the treatment of categories of eligibility. For example, neither Medicaid nor SCHIP define how a state counts income; thus, by excluding certain income (referred to as income disregards), state SCHIP plans encompass an eligibility range of 100 to 300 percent of the poverty level.[32] Furthermore, Title XXI's exclusions of categories of children do not apply to Medicaid expansions, which must use Medicaid rules and conditions of eligibility. These issues are even further complicated by states' use of Medicaid Section 1115 waivers, which often fashioned an eligibility system that was more expansive than that of traditional Medicaid. For states with Section 1115 waivers, SCHIP plans tended to be extensions of their Medicaid programs, requiring relatively minor adjustments to incorporate SCHIP into current operations.[33]

Some States Use Income Disregards to Further Expand SCHIP Eligibility

By relying on existing statutory authority, some states have expanded SCHIP eligibility to an effective rate of up to 300 percent of the poverty level. Four states in our sample–Connecticut, Missouri, New York, and Vermont–employed Section 1902(r)(2) of the Social Security Act, which allows states to set income and resource eligibility levels that are less restrictive than those traditionally used by states for Medicaid eligibility. Connecticut officials originally believed that in order to expand SCHIP eligibility above 235 percent of the poverty level (from their Medicaid level of 185 percent), the state would need to apply for an 1115 waiver. However, discussions with HCFA resulted in a strategy of using Title XIX income disregards to effectively raise the state's eligibility level to 300 percent of the poverty level. Similarly, the state of New York used income disregards as a means of increasing the effective

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[32] Income disregards are also common in the Medicaid program; Title XIX also does not dictate how a state defines income for purposes of eligibility determination. Examples of income disregards include a flat percent of income, or income from certain sources such as child support.

[33] While states with Section 1115 waivers expanded their Medicaid operations, many did so via a stand-alone or combination program design. For example, Massachusetts, New York, Oregon, and Vermont all have 1115 waivers under Medicaid, but chose stand-alone or combination SCHIP designs.

income level to 222 percent of the federal poverty level. Table II.3 shows the SCHIP eligibility by federal poverty level for the states in GAO's sample.

Table II.3 Changes in poverty level from Medicaid to SCHIP, GAO sample of states.

SCHIP eligibility by poverty level (income based on a family of 4)	State	Program	Poverty Level By Age			
			<1	1-5	6-14	15-18
High Poverty Level (201 – 300 %) $32,900 - $49,350	Connecticut[a]	SCHIP Medicaid Expansion	--	--	--	185
		SCHIP stand-alone	300	300	300	300
		Medicaid	185	185	185	--
	Missouri	SCHIP Medicaid Expansion	300	300	300	300
		Medicaid	185	133	100	100
	New York	SCHIP stand-alone	222	222	222	222
		Medicaid	185	133	100	61
	Rhode Island[b]	SCHIP Medicaid Expansion	--	--	250	250
		Medicaid	250	250	100	N/A
	Vermont[c]	SCHIP stand-alone	300	300	300	300
		Medicaid	225	225	225	225
Medium Poverty Level (151 – 200 %) $24,675 - $32,899	California[d]	SCHIP Medicaid Expansion	250	--	--	100
		SCHIP stand-alone	--	200	200	200
		Medicaid	200	133	100	82
	Colorado	SCHIP stand-alone	185	185	185	185
		Medicaid	133	133	100	39
	Florida	SCHIP Medicaid Expansion	--	--	--	100
		SCHIP stand-alone	200	200	200	200
		Medicaid	185	133	100	28
	Massachusetts[e]	SCHIP Medicaid Expansion	200	150	150	150
		SCHIP stand-alone	--	200	200	200
		Medicaid	185	133	133	133
	Michigan[f]	SCHIP Medicaid Expansion	--	--	--	150
		SCHIP stand-alone	200	200	200	200
		Medicaid	185	150	150	N/A
	Oregon	SCHIP stand-alone	170	170	170	170
		Medicaid	133	133	100	100
	Pennsylvania	SCHIP stand-alone	200	200	200	200
		Medicaid	185	133	100	39
	Wisconsin	SCHIP Medicaid Expansion	--	--	185	185
		Medicaid	185	185	100	62
Low Poverty Level (100 – 150 %) $16,450 - $24,674	South Carolina	SCHIP Medicaid Expansion	--	150	150	150
		Medicaid	185	133	100	48
	Texas	SCHIP Medicaid Expansion	--	--	--	100
		Medicaid	185	133	100	17

Notes:

[a]Connecticut covers children up to age 16 under Medicaid at 185 percent of the poverty level.

[b]Under its 1115 Medicaid waiver, Rhode Island covered children up to age 7 at 250 percent of poverty and those age 8-13 up to 100 percent of poverty. Effective May 1, 1997, the state expanded coverage to include children age from 8-18 years up to 250 percent of poverty. Because this expansion was implemented after March 15, 1997, it qualifies as an eligible Medicaid expansion under SCHIP.

[c]Vermont eligibility is for children under age 18 (infant to age 17).

[d]California's SCHIP Medicaid expansion covers children age 14-19 up to 100 percent of poverty.

[e]Massachusett's SCHIP Medicaid expansion includes children age 18, an age group of children who previously were not covered under Medicaid.

[f]Michigan's SCHIP Medicaid expansion includes children age 16-18 up to 150 percent of poverty. Previously, these children were covered at the poverty level effective for those eligible for Medicaid as

medically needy (approximately 60-70 percent of poverty). Children age 15 are covered under Medicaid up to 150 percent of poverty.

The difference in prior poverty levels of eligibility across state Medicaid programs affects the degree to which states were able to plan and use their SCHIP allotments. For example, Vermont estimated that under its Medicaid program, they have reached 85 percent of eligible children. A SCHIP program aimed solely at the uninsured would only cover 1,000 additional children. As a result, the state proposed a SCHIP plan that also targeted adults and under-insured children with atypical health care needs. Vermont withdrew its initial application, however, when it became clear that HCFA would not approve these components of its plan using SCHIP funds. In December 1998, HCFA approved a SCHIP stand-alone program to cover Vermont's remaining uninsured children. SCHIP benefits, however, will be the same as those available to the state's Medicaid beneficiaries. Vermont will use Medicaid rather than SCHIP funds to cover underinsured children, and is currently working with HCFA to provide coverage to adults under its Medicaid 1115 waiver.

In contrast, Texas' expansion providing coverage to children ages 15-18 from 17 to 100 percent of the poverty level appears, on the surface, to be more modest than Vermont's. However, Texas officials estimate that the state's initial placeholder plan could provide coverage to close to 163,000 children, and they hope to enroll 57,000 during fiscal year 1999. Like Texas, South Carolina had a modest Medicaid expansion, increasing eligibility from 100 to 150 percent. The state began enrolling children prior to the official start date of SCHIP; the state has enrolled 52,000 children, as of September 1998.[34] This enrollment constitutes approximately half of the state's estimated number of low income uninsured children in South Carolina; furthermore, state officials indicated that this figure does not include an extensive backlog of mail-in applications.

Poor Insurance Coverage Poses
Concerns For Some States

As states finalize their initial SCHIP designs, concerns about equity have been raised. Of particular concern are low-income individuals who already have insurance of lesser quality or higher cost than that offered by SCHIP -- and thus are not eligible for coverage under Title XXI. State approaches to SCHIP, as well as variability in the quality of insurance coverage, have posed equity concerns, especially regarding children who have inadequate insurance and state employees who may be ineligible for SCHIP. Title XXI expressly prohibits coverage to individuals who are covered

[34] South Carolina began implementing its SCHIP Medicaid expansion prior to fiscal year 1998, the first year in which SCHIP funds were available. However, because the expansion was approved prior to the dates cited in Title XXI, the program now operates as a SCHIP Medicaid expansion.

under a group health plan or under health insurance coverage as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HCFA officials noted that HIPAA has a very broad definition of insurance coverage, meaning that individuals with minimal insurance coverage cannot be deemed eligible for SCHIP.

The HIPAA designation of coverage has posed varying levels of concern for states. Massachusetts officials told us that insurance reform in their state has eliminated "bad" policies – that is, those that provide only minimal catastrophic coverage. However, other states have expressed concern that the statute does not discriminate between good and poor coverage, and thus unfairly penalizes an individual who purchased a minimal insurance policy such as catastrophic coverage. Under these circumstances, some states would deny immediate SCHIP coverage to a low income family that purchased inadequate health care coverage, while a family of a similar poverty level that did not ~~avail~~ purchase insurance would qualify for SCHIP without any restrictions or waiting period. A few states have taken the approach of defining access – that is, whether an individual can obtain insurance through an employer – as the point of eligibility for SCHIP. In this case, while there is no disparity of treatment between insured and uninsured individuals, there is also a smaller pool of individuals eligible for SCHIP. Rhode Island employs a hybrid approach that provides eligibility workers with guidelines regarding affordability of coverage—a policy less than $150 for a child or $300 per month for a family. However, eligibility workers can use their own discretion in deciding if the cost of available coverage is prohibitive for a child or family; in these cases, the worker can deem the individual eligible for SCHIP.

Although Title XXI appears to expressly prohibit states from enrolling children of state employees eligible for its health benefits plan, states' SCHIP design choices have led to some exceptions. A state that selects a Medicaid expansion is subject to Medicaid rules of eligibility, while the SCHIP statute governs any stand-alone approach. Under Medicaid, individuals qualifying for participation cannot be excluded on the basis of their insurance status; hence, Medicaid expansions can include state employees or other insured individuals. Thus, for the 28 states with Medicaid expansions, there is no prohibition on state employees who meet the state poverty guidelines for Title XXI. In the case of stand-alone or combination programs, however, the restrictions are tighter. If the state contributes nothing to the cost of dependent coverage, then state employees can enroll in SCHIP; nationwide, two states do not contribute to health benefits for their employees' dependents, Mississippi and North Carolina. Thus, SCHIP eligibility for state employees and their dependents has resulted in different outcomes depending upon each state's design choice under SCHIP, and other special circumstances regarding state employee insurance. Some states, state associations, and interest groups have raised concerns about the state employee prohibition in SCHIP stand-alone components, pointing out the disparity in treatment across states and the fact that the prohibition does not apply to federal or other categories of government employees.

except that insured individuals cannot ~~receive~~ receive enhanced match under CHIP they will get regular FMAP.

COMPARABILITY OF MEDICAID AND SCHIP STAND ALONE BENEFIT PACKAGES IS DIFFICULT TO ASCERTAIN

In contrast to SCHIP programs that are modeled after Medicaid, Title XXI allows states to impose additional conditions and limits on benefits by authorizing a private sector-based, benchmark benefit package for those implementing a stand-alone approach. For the majority of children, such limits and conditions are not likely to interfere with ensuring adequate diagnosis and treatment. Children with special needs, however, may not receive the full range of services that their conditions might warrant. To guard against this possibility, some states have developed screening tools similar to EPSDT as a means of identifying children with special needs and ensuring they receive the full range of necessary treatment. Other states have not confronted the problem of these children and, like the Medicaid program, have instituted prior authorization requirements or service limits for certain treatments or services. Finally, the states with stand-alone programs in GAO's sample generally included benefits similar to Medicaid, but did impose differences in the duration of treatment allowed or the number and amount of services covered.

Stand Alone Programs Reflect Full Range of Title XXI Options

Figure II.2 explains the four benefit package standards available to states implementing a stand-alone SCHIP program—benchmark coverage, benchmark equivalent coverage, existing comprehensive state coverage, and Secretary approved coverage. As shown by Table II.4, states in GAO's sample with a stand-alone component used the full variety of options offered under SCHIP. Four states used benchmark coverage -- three based upon their state employee benefits program and one based upon FEHBP. Two states adopted a benchmark equivalent, incorporating the basic and additional benefits cited in Title XXI. Finally, three states in GAO's sample had benefit packages that were grandfathered into Title XXI, and two state received approval by the Secretary for an alternative benefit package.

Figure II.2: SCHIP Benefit Package Standards for Stand Alone Programs

Benchmark Coverage
- The standard Blue Cross/Blue Shield option offered in the Federal Employees Health Benefits Program (FEHBP);
- Health benefits coverage generally available to state employees; or
- Coverage under an HMO with the largest commercial non-Medicaid enrollment in the state involved.

Benchmark-Equivalent Coverage
- Basic Coverage
  - Inpatient and outpatient hospital services;
  - Physicians' surgical and medical services;
  - Laboratory and x-ray services; and
  - Well-baby and well-child care, including age-appropriate immunizations.
- Aggregate actuarial value that is equivalent to a benchmark coverage package.
- Substantial (75 percent) actuarial value for additional optional services
  - Coverage of prescription drugs;
  - Mental health services;
  - Vision services; and
  - Hearing services.

Existing Comprehensive State Coverage (Grandfathered benefit plans)
- State-funded child health programs in New York, Florida, or Pennsylvania.

Secretary-Approved Coverage
- Coverage that the Secretary determines will provide appropriate coverage for targeted low-income children.

Table II.4: Coverage Basis for 10 States with Stand Alone Programs, GAO Sample

Basis for Required Scope of Health Insurance Coverage[a]	State
Benchmark Coverage	Calif., Conn., Mass., Mich.
Benchmark-Equivalent Coverage	Colo.
Existing Comprehensive State Coverage	Fla., N.Y., Pa.
Secretary Approved Coverage	Oreg., Vt.

[a]Excludes the Medicaid expansion portions of combination programs, which by definition offers benefits identical to a state's Medicaid plan.

Coverage Requirements for SCHIP Stand Alone Programs Are Based on Private Sector Standards

Benefit comparisons between Medicaid expansions and SCHIP stand alone programs are complex because of the numerous services involved, the ability of states to place limits on covered services, and the availability of EPSDT under Medicaid (see Fig. II.1). Both Medicaid and the benchmark approaches available to states that pursue a stand alone component to their SCHIP program include: (1) mandatory coverage for a

series of basic services for children, such as physician visits, inpatient hospitalization, laboratory and x-ray, and well-baby/well-child care; and (2) optional coverage for prescription drug, dental, mental health, vision and other services. In addition, states may impose conditions and limits on the benefits offered under a Medicaid expansion or a SCHIP stand alone program. For example, dental benefits might exclude routine preventive care and only cover any restoration necessary due to an accident. Or, inpatient mental health services may be limited to a dollar amount or number of days of services.

Figure II.1: Medicaid EPSDT Requirements

EPSDT Minimum Requirements
- Comprehensive physical and mental health developmental history;
- Comprehensive physical exam;
- Appropriate immunizations for a child's age and health history;
  - Laboratory tests, including lead blood level assessment appropriate for age and risk factors; and
- Health education.

EPSDT Also Requires Diagnosis and Treatment For
- Defective vision, including eyeglasses;
- Relief of pain and infections, restoration of teeth, and maintenance of dental health;
- Hearing defects, including hearing aids; and
- Other conditions discovered through screening, regardless of coverage by the state's Medicaid plan.

However, Medicaid--and therefore Medicaid expansions--use a special standard to determine the appropriate level of services available to children that is based upon a broad definition of medical necessity. In general, Medicaid, through its EPSDT component, requires states to cover any treatment to cure or stabilize a condition diagnosed during routine screening—regardless of whether the benefit is actually covered under the state's Medicaid program and regardless of any limits placed on the benefit. Private insurance, in contrast, does not expand benefits to meet the needs of an individual; hence a private plan would not include a benefit because an individual's condition would improve as a result of receiving treatment for an uncovered service. While implementation of EPSDT is difficult to measure, federal studies have generally found state efforts to be inadequate. Nonetheless, the EPSDT requirement provides an avenue for legal review and appeal to ensure that children receive necessary services and thus, in theory, guarantees a coverage level beyond that of a state's Medicaid benefit package.

Some SCHIP Stand Alone Programs Include Screening and Diagnostic Procedures Similar to EPSDT

Some SCHIP stand-alone programs included screening and diagnostic procedures similar to EPSDT, in part as a means to identify children with special health care needs. Connecticut's SCHIP plan contains a screening and referral service intended to

provide children with special behavioral or medical needs any extra services they might require. Connecticut officials indicated that the state was interested in a SCHIP benefit package that looked like a commercial insurance model with defined limits on services. However, officials indicated that experience with Medicaid managed care showed that there were problems in applying a commercial model when serving individuals with extreme health needs. As a result, the state devised an enhanced benefit package for children found to have particular physical or behavioral health needs. For example, a SCHIP eligible child with behavioral health needs that are not covered under its commercial HMO would receive services through a program developed by the Yale Child Study Center, which provides in-home mental health services.

Florida and Massachusetts also employ screening mechanisms as a means of identifying children with special needs. Florida recently received approval for a SCHIP plan amendment that provides approximately 300 children with special needs the opportunity to receive Medicaid benefits. These children have chronic or potentially chronic physical or developmental conditions, and also include a number of children with serious emotional disturbances or substance dependency. Similar to Medicaid enrollees with similar conditions, SCHIP eligible children will receive covered services through a capitated managed care arrangement that will be administered by Title V.[35] In Massachusetts, children with physical, mental or developmental disabilities are enrolled into Medicaid, regardless of whether they would otherwise qualify for SCHIP. These children participate in the state's Section 1115 waiver for persons with disabilities, receiving treatment and services from fee-for-service providers.

Although providing less extensive coverage than EPSDT, some states have employed other mechanisms to attempt to serve children whose health care needs are more than routine. For example, Michigan officials told us that their SCHIP stand-alone package includes well-child recommendations by the American Association of Pediatrics. With the exception of cost-sharing provisions, officials noted that there is little difference between the state's Medicaid and SCHIP benefit packages. However, Michigan did attempt to improve access to services by increasing physician, dental, and other provider payments in its SCHIP stand alone component in hopes of enticing additional provider participation. Although the state's Medicaid program covers dental services, few dentists currently participate. Michigan officials' view the SCHIP payment increases as a test to see if access to covered services is actually improved.

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[35]Title V, the Maternal and Child Health Services Block Grant, offers formula grants that require a state match of $3 in funds or resources for every $4 in federal funds received; a minimum of 30 percent of funds must be used to support programs for children with special health needs. Title V also supports activities under Special Projects of Regional and National Significance and Community Integrated Service Systems.

Most Stand Alone Programs Cover Optional Benefits But Vary in the Limits Imposed

The subset of states in GAO's sample with a stand-alone component generally offers the same five optional benefits under their SCHIP programs, namely prescription drugs, mental health, vision, hearing, and dental services. As shown in more detail in Table II.5, sample states with stand-alone benefit packages covered these benefits, but usually with certain exclusions or limits on services. Only New York did not offer inpatient mental health services, which is covered for Medicaid eligible children. In remaining cases, benefits were offered, but usually with certain exclusions or limits on services. SCHIP limitations on benefits for children represent a departure from the Medicaid program, primarily because EPSDT in Medicaid requires that children with medical needs be afforded services. In general, however, most non-Medicaid SCHIP programs include routine services such as physician services, prescription drugs, laboratory and radiological services without stated limits. Mental health, substance abuse, ancillary therapies, and other specialized services generally are provided on a more limited basis.

Table II.5: SCHIP Benefits for Stand Alone Components, GAO Sample of States

Optional Service	State	Limits on Services (yearly basis unless noted)
Prescription Drugs	California	Covered
	Colorado	Covered, with copayments
	Connecticut	Covered
	Florida	Covered, generics only unless physician specifies
	Massachusetts	Covered
	Michigan	Covered, generics only unless physician specifies
	New York	Covered, generics only if acceptable to health plan
	Pennsylvania	Covered
Mental Health	California	Inpatient 30 day limit; outpatient 20 visits
	Colorado	Inpatient 45 day limit; outpatient 20 visits
	Connecticut	Outpatient 30 visits; supplemental services available[1]
	Florida	Inpatient 15 day limit; outpatient 20 visits
	Massachusetts	Inpatient 28 day limit; outpatient 25 visits
	Michigan	Inpatient 365 day limit; outpatient covered
	New York	Outpatient 20 visits
	Pennsylvania	Inpatient 90 day limit; outpatient 50 visits
Vision	California	Exams; eyeglasses only after cataract surgery
	Colorado[2]	Covered, with a $2,000 DME maximum
	Connecticut	Covered, with up to $100 per year for eyeglasses
	Florida	Covered
	Massachusetts	Covered, one set of glasses or contacts per year
	Michigan	Covered, one set of glasses every 2 years
	New York	Covered
	Pennsylvania	Exams and lenses 6 months, frames every 12 months
Hearing	California	Exams and hearing aids covered
	Colorado	Covered, with a $2,000 DME maximum
	Connecticut	Short-term coverage only
	Florida	24 visits within a 60 day period for each condition
	Massachusetts	Services for speech, hearing, and language disorders
	Michigan	Exams and hearing aids covered every 36 months
	New York	Hearing aids covered
	Pennsylvania	Exams and hearing aids every 2 years as authorized
Dental	California	Covered
	Colorado	Covered, with a $2,000 DME maximum
	Connecticut	Covered
	Florida	Treatment of injuries only
	Massachusetts	Accidental injury
	Michigan	Covered, with a $600 annual limit
	New York[3]	Treatment of injuries only
	Pennsylvania	Covered

[1] Connecticut screens children for referral to its Behavioral Health Program, which provides Medicaid coverage for children with special needs.
[2] Colorado's DME maximum combines vision, hearing, dental, and other equipment into the $2,000 maximum.
[3] New York plans to expand its dental benefits.

The Medicaid and SCHIP benefits of three states—Colorado, Oregon and New York—demonstrate the different approaches taken by states as well as the specific state circumstances that contributed to their benefit decisions.

- Colorado's stand alone SCHIP benefit package has many of the same features as its Medicaid program, but imposes more limits on the use and scope of services. The state devised two benchmark-equivalent plans under SCHIP, creating one for counties with HMO participation and a second component for rural areas in the state which do not have access to managed care systems. Thus, children in counties with HMO participation have access to the full range of basic and optional services. Counties without HMO participation use a provider network that will reimburse primary care physicians under capitation and specialty, inpatient, and pharmaceutical providers on a fee-for-service basis. Compared to services provided through an HMO, provider network benefits are more limited; in particular they do not include dental services.

- Coverage under Oregon's stand-alone program expressly mirrored the benefits offered under its Medicaid Section 1115 waiver.[36] State officials determined through public hearings and testimony that citizens considered Oregon's Medicaid benefit package to be richer than any possible benchmark plan, in part because it offers full mental health and preventive dental care.[37]

- The benefit package from New York's existing state financed program for uninsured children was grandfathered into the SCHIP program and initially contained limits on services and several exclusions that were generally more restrictive than its Medicaid program. State officials noted that the original goal of its state program was to cover as many children as possible within state budgetary limits. New York originally focused on primary and preventive care and provided very limited benefits for mental health, dental, and hearing services. The state recently passed legislation to amend its SCHIP plan to include dental care, eyeglasses and other vision care, speech and hearing, durable medical equipment, and inpatient mental health, alcohol and substance abuse services beginning on January 1, 1999, thus narrowing the gap between Medicaid and SCHIP benefits.[38]

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[36] Through the use of a Section 1115 waiver, Oregon redefined its Medicaid benefit package, creating a prioritized list of services and conditions that are eligible for Medicaid reimbursement. Oregon's SCHIP stand-alone benefits package uses the same prioritized list of services and conditions as the state's Medicaid program.

[37]Under Oregon's Section 1115 waiver, EPSDT requirements were waived; however, most EPSDT-mandated services are covered under Oregon's Medicaid program.

[38] As of January 19, 1999, New York has not submitted a SCHIP plan to HCFA regarding these benefit changes.

COST SHARING: OPPORTUNITIES AND CHALLENGES

Traditional Medicaid does not allow cost sharing for services provided to children. Thus, the incorporation of cost sharing in both stand-alone SCHIP plans and the Medicaid expansions of several states operating their programs under 1115 waivers represents a departure from the norm. Most states in our sample with a stand alone component included cost sharing provisions as yet another way to mirror private insurance. These states generally viewed cost sharing as creating a sense of ownership for beneficiaries that, in contrast to welfare related public assistance, is more reflective of private sector insurance. In general, the cost sharing imposed by 11 states in our sample appears to be closer to 1-2 percent of income for a family with two children than to the 5 percent permitted by Title XXI. Indeed, about half of these states impose no cost sharing for families at 150 percent of the poverty level ($24,675). The review and approval of cost sharing provisions was necessarily complex, as both states and HCFA ensured that the appropriate statutory provisions of either Medicaid or Title XXI were properly applied. In particular, ensuring that families did not exceed allowable spending caused considerable concern during the review process as states struggled to limit the administrative burden imposed in tracking a family's health expenditures. Finally, states with grandfathered benefits learned that the statute did not treat cost sharing as part of their states' benefit package; ultimately, all three states had to alter their cost sharing practices.

Cost Sharing Provisions Differ For Medicaid and SCHIP

With the exception of preventive services, which are exempt from cost sharing under SCHIP, a states design choice greatly affects the degree to which families can be asked to contribute to the cost of coverage for their children. Generally, a state with a traditional Medicaid program that elects a SCHIP Medicaid expansion is not allowed to impose premiums, deductibles, copayments, or other similar charges for children. ~~States operating less traditional Medicaid programs under a Section 1115 waiver have the option of imposing cost sharing under a SCHIP Medicaid expansion if HCFA had already allowed cost sharing under the waiver~~. For SCHIP stand-alone programs, cost sharing may ~~begin~~ be imposed for children in families at or below 150 percent of the poverty level. ~~Below this poverty level, states are subject to Medicaid rules for premiums and copayments, which are generally disallowed for children.~~ Children in families above 150 percent of the poverty level can be charged premiums or other cost sharing -- as long as the total does not exceed 5 percent of aggregate annual family income.

The two major types of cost sharing -- premiums and copayments -- can have different behavioral effects on participation in a health plan. Generally, premiums are seen as restricting entry into a program, whereas copayments affect the utilization of the

services within the program. Studies of Medicaid programs operating under Section 1115 waivers and of state-funded health programs demonstrate that premiums can affect the level of program participation. In particular, one study found that when premiums reach 7 percent of a family's income, participation drops to less than 10 percent of eligible families.[39] Copayments are generally seen as a "brake" on the use of services because they reduce the frequency of physician visits. However, significant cost sharing may cause individuals to defer treatment, resulting in more severe conditions.

States Often Implemented Cost Sharing to Mirror Private Sector Insurance Practices

Thirteen of the fifteen states in GAO's sample can impose cost sharing provisions under SCHIP either by virtue of being a stand alone component or because of a Section 1115 Medicaid waiver.[40] Of those 13 states, all but two included cost sharing in their SCHIP plans, as shown in Table II.6. Oregon, which asks beneficiaries to contribute to the cost of coverage under its Section 1115 waiver, chose not to do so under SCHIP. During negotiations with HCFA, Pennsylvania dropped a $5 copayment for prescriptions that had been part of its previous state-funded children's health insurance program. Seven states are charging both copayments and premiums while four states are only requiring the latter. A majority of states have opted to charge a per-child premium, but many have imposed a total limit on the amount of premiums a family would pay.[41] For example, in New York, per-child premiums for a family with four children would exceed the allowable maximum premium; thus the family's premium would be equivalent to three children. States' in our sample had a uniform rationale for imposing cost sharing—to mirror private sector insurance.

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[39]The Use of Sliding Scale Premiums in Subsidized Insurance Programs, Leighton Ku and Teresa A. Coughlin, TheUrban Institute, March 1997.

[40] States with Medicaid expansions – whose Medicaid program does not charge premiums or copayments – are barred from imposing cost sharing. Hence, South Carolina and Texas cannot charge copayments under SCHIP.

[41]California, Colorado, Connecticut, Massachusetts, New York, and Rhode Island are charging per child premiums. Florida, Michigan, Missouri, Vermont, and Wisconsin are charging per family premiums.

Table II.6 Cost Sharing under SCHIP, GAO State Sample

Cost-Sharing Efforts	State
No Cost Sharing	Oreg., Pa.
Premiums and Copayments	Calif., Colo., Conn., Fla., Mo., R.I.,[a] Vt.
Premiums Only	Mass.,[b] Mich., N.Y., Wisc.

[a] Rhode Island allows individuals to choose between paying premiums or paying copayments.
[b] Massachusetts may provide coverage by subsidizing employer based insurance; in these circumstances, a family may be charged premiums and copayments.

Cost sharing was central to California's efforts to create a system that parallels private health insurance. California charges different premiums depending upon a family's poverty level and families that prepay their premiums for three months get a fourth month free. Copayments are established by the state's insurance board and are generally set at $5 for most services. California officials told us that cost sharing was a magnet to participation in SCHIP, noting that of the individuals applying for SCHIP who were deemed Medicaid eligible, only 25 percent gave permission for their application to be sent to Medicaid.

California was unable to obtain approval for varying levels of cost sharing across different plans. The state had proposed establishing a set premium assistance amount based on the insurance plans offering the lowest cost combination of health, dental and vision plans for a particular geographic area. Eligible individuals could choose a higher priced plan--but only if willing to increase their contribution because the state subsidy would remain the same. Officials cited a two-fold reason for this approach, (1) there is an amount above which the federal government and the state should not pay to support insurance costs; and (2) SCHIP families deserve to have as many health plan choices as possible. State officials indicated that HCFA was very concerned about bias, believing that families might press themselves to pay higher premiums on the assumption that higher cost meant better coverage. Ultimately, California withdrew this element of its cost sharing proposal, but state officials said that, as a result, some health plans withdrew from SCHIP participation. California officials characterized the loss of this segment of their SCHIP plan as putting a large hole in their efforts to make SCHIP a path to private insurance. Officials believed that allowing beneficiaries choice over plans—even those that were higher cost—was an important educational effort that would afford individuals the opportunity to make informed choices once they were purchasing their own insurance.

Michigan ultimately balanced its interest in modeling private insurance with the desire to ensure that eligible families enroll and use SCHIP. State officials indicated that Michigan wanted its SCHIP to (1) appeal to working families by avoiding any perceived welfare stigma, (2) preserve the ability to alter program design to control

costs and expenses, and (3) make it easier for people to transition to employer based insurance. Originally, Michigan required premium and copayments for families above 150 percent of the poverty level. Premiums ranged from $8-$15 per month depending upon the number of children and copayments were generally $5. However, the Michigan state legislature decreased the premium to a flat rate of $5 per family per month and eliminated three $5 copayments. Michigan officials stated that the monthly premium is costly to collect, but it is part of the state's belief system that the program should operate like private insurance.

While states with traditional Medicaid programs -- such as South Carolina and Texas -- are generally not permitted to include cost sharing provisions in their SCHIP Medicaid expansions, most states with Medicaid 1115 waivers did incorporate cost sharing. For example, Rhode Island's Medicaid 1115 waiver allows individuals to choose between paying premiums or copayments for eligible children. Missouri, Vermont and Wisconsin wanted to use a Medicaid 1115 waiver as the basis for their SCHIP program -- and all planned to include cost sharing. For Missouri, cost sharing provisions were a matter of equity, particularly at higher levels of poverty. Thus, the state has copayments with exemptions for preventive care beginning at 185 percent of the poverty level, and premium assistance amounts are based upon what state employees in Missouri pay for their care. Vermont's approved plan includes a $10 copayment per office visit as a means of increasing physician and other provider payments for services. Wisconsin planned to charge premiums beginning at 150 percent of the poverty level that would total approximately 3 - 3.5 percent of a family's income.

Cost Sharing Under SCHIP Appears to Be Minimal for GAO Sample

Based on our analysis, none of the eleven states in our sample required cost sharing that is likely to reach the maximum 5 percent of income permitted by Title XXI, as shown in Table II.7.[42] To determine the amount of SCHIP cost sharing imposed by states, we estimated copayments for a typical healthy family with two children enrolled in SCHIP. For a family at 150 percent of the federal poverty level, total estimated cost sharing ranged from a low of $60 per year in Michigan (.2 percent of income) to a high of $864 per year in Wisconsin (3.5 percent of income). Five of the eleven states that imposed cost sharing under SCHIP charged families at this income

[42]Table II.7 provides our estimate of SCHIP copayments for a family consisting of two healthy children between the ages of 6 and 14 years old. Many health services have recommended schedules of usage, but most are exempted for cost sharing under SCHIP. GAO imputed the type and number of visits for eye, hearing and dental care, and derived estimates for outpatient physician visits and prescriptions (except oral contraceptives) from the National Center for Health Statistics' National Ambulatory Medical Care Survey.

level nothing to enroll their children. In general, copayments account for a small percent of the total out of pocket costs.

Some disparity across income levels exists, depending upon how states applied premiums and copayments. Several states in the sample used a single premium level and copayment schedule for all families that did not increase as income increased. This resulted in families with higher incomes paying a smaller percentage of their income for cost sharing in some states, such as Florida, Michigan, Massachusetts, and Rhode Island. In contrast, Colorado's, Wisconsin's, and California's plans ensure that those at higher income levels pay about the same percentage of family income in cost sharing as those at lower income levels.

Table II.7: Estimated Cost Sharing as a Percent of Family Income, GAO Sample

State	$24,675 Annual Income (150 percent of poverty) 5 percent limit = $1,234		$30,433 Annual Income (185 percent of poverty) 5 percent limit = $1,522		$41,125 Annual Income (250 percent of poverty) 5 percent limit = $2,056	
	Estimated Cost Sharing ($)	Percent of Income	Estimated Cost Sharing ($)	Percent Of Income	Estimated Cost Sharing ($)	Percent of Income
Calif.	$212	.9%	$260	.9%		
Colo.	318	1.3	398	1.3		
Conn.					643	1.6
Fla.	213	.9	213	.7		
Mass.[a]	309	1.3	309	1.0		
Mich.	60	.2	60	.19		
Mo.			54	.18	788	1.9
N.Y.			216	.7		
R.I.			68	.2	68	.16
Vt.					228	.5
Wisc.	864	3.5	1065	3.5		

NOTE: Shaded cells indicate that no cost sharing is required at that income level; blank cells indicate there is no SCHIP eligibility at this income level.

[a]Massachusetts' SCHIP plan covers adults at some income levels, but adult cost sharing is not subject to the 5 percent of income cap, and therefore is not included in this estimate.

Cost Sharing Creates Tracking Requirements for States

SCHIP cost sharing provisions gave states additional flexibility compared to Medicaid but imposed a limit on the amount states could actually charge. Thus, any cost

sharing that was not predictable -- such as copayments -- created the need for the family, the state, or the health insurance plans to track spending. As noted earlier, eleven states in our sample elected to impose cost sharing, including eight that charged both premiums and the more-difficult-to-estimate copayments. With respect to tracking copayments, states worked out a number of approaches ranging from requiring individuals to keep receipts to mandating that health plans monitor cost sharing.

HCFA's review of Colorado's plan raised the issue of how the state would track family expenditures to ensure that the 5 percent aggregate limit was not exceeded. Working with HCFA, state officials established a method to identify for providers those families who are exempt from further copayments. Known as the "shoebox method" the approach requires families to keep track of receipts; when copayments reach the 5 percent of income allowed under Title XXI, the family notifies the state which places a sticker on the health card to indicate exemption from further copayments.

Massachusetts also adopted the shoebox method to track family expenditures, but with the added complexity of incorporating this methodology into its premium assistance program for employer sponsored insurance. The state originally set premium assistance levels at 1-2 percent of family income and believed that this would ensure that no family exceeded the 5 percent cost-sharing limit. However, because levels of cost sharing will vary across different employer sponsored plans, HCFA raised concerns that families might exceed the limit. To resolve this issue, Massachusetts adopted the shoebox method. The state now plans to inform families of the 5 percent limit, as they are determined eligible for the program. Once a family submits proof of expenses totaling 5 percent of family income, the state notifies the health plan and requests that further copayments be billed to Massachusetts SCHIP. State officials describe this process as administratively difficult because of the number and variety of health plans with which employers' contract and for which the state might have to generate copayments. Issues such as (1) whether to send payments to the health plan or the family, and (2) how the state will process copayments payments are still unresolved.

In contrast, the state of Connecticut placed the burden of tracking family expenditures on the health plans. Connecticut's SCHIP plan included state legislation which cites a maximum annual aggregate cost sharing of $650 for children in families with income levels between 185-235 percent of the poverty level and $1,250 for families from 235-300 percent of the poverty level. These annual limits equate to around 2-4 percent of aggregate family income. Participating health plans are charged with tracking family payments to ensure that spending does not exceed the required amount.

States With Grandfathered Benefit Packages
Had to Change Cost Sharing Provisions

States with grandfathered benefit packages -- Florida, Pennsylvania and New York -- had to alter their cost sharing provisions in order to conform to SCHIP statutory requirements. For example, Florida was required to lower several copayment amounts and its premiums for subsidy families in order to meet limits included in the federal legislation. While Title XXI does allow states to petition the Secretary to approve an alternative cost-sharing schedule, Florida chose not to pursue this option. State officials indicated that there was tremendous internal pressure to implement Title XXI within state imposed deadlines; as a result, they were concerned that a waiver process might draw out the review of their plan. Pennsylvania wanted to continue to charge a $5.00 copayment for prescriptions, a provision that was part of its state funded children's program. Like Florida, state officials interpreted Title XXI as including this copayment in the grandfathered benefits package. Ultimately, the state removed this copayment from its plan as a result of the review process.

Incorporating New York's long-standing children's health program into SCHIP provisions was a challenging task for state officials. New York's state-funded program was started in 1990 and was based on a partnership between government and private insurers to provide subsidized private health insurance coverage to children. New York had cost sharing provisions which HCFA determined were not in compliance with Title XXI requirements, the most controversial being a $25 penalty for inappropriate emergency room use which HCFA considered to be an excessive copayment. New York officials stated that they had numerous discussions with HCFA regarding the $25 charge, first reducing it to a $10 fee and ultimately dropping copayments from its SCHIP plan. As with Colorado and several other states, HCFA raised the issue of how New York planned to track annual aggregate expenditures. New York officials estimated that a child at 150 percent of the poverty level would have to visit a physician on a daily basis for a period of one year in order to exceed the 5 percent cap. Thus, from the state's perspective, a tracking system was unnecessary. State officials indicated that HCFA was not persuaded. New York initially placed the administrative burden of tracking expenditures on the health plans. However, the state legislature removed all copayments -- including inappropriate emergency room use -- effective January 1, 1999. State officials indicated that this was done at the request of insurers who believed that the administrative burden of collecting $2 and $3 copayments would be far greater than the revenue collected.

APPENDIX III

EARLY STATE EFFORTS TO USE SCHIP FAMILY COVERAGE AND EMPLOYER SUBSIDY OPTIONS

Having secured approval for their fiscal year 1998 SCHIP allocations, a growing number of states are exploring two options permitted by the statute: (1) family coverage that includes the adults in families as well as the children, and (2) an employer buy in that helps families access available employer-based insurance by using SCHIP funds to pay the employee share of the cost.[43] An employer buy-in limits SCHIP outlays because many employers subsidize a large share of the cost of providing coverage to workers. The Title XXI requirement to demonstrate the cost effectiveness of covering adults as well as children in a family underscores the need for some type of subsidy. To date, only Massachusetts has received approval for family coverage under SCHIP, demonstrating cost effectiveness by relying on an employer buy-in option approved under a previous Medicaid 1115 waiver. However, achieving family coverage through an employer buy in can further complicate plan approval and implementation because of the complex benefit and cost sharing requirements imposed by Title XXI. HCFA has so far declined to use its Section 1115 waiver authority to facilitate state family coverage goals. HCFA believes that it is inappropriate to use this demonstration authority to waive Title XXI requirements prior to a state's implementation of its SCHIP program. In part, this stance reflects a concern about not undermining the statutory goal of covering uninsured children.

FAMILY COVERAGE OPTION UNDER SCHIP REQUIRES EXTERNAL SUBSIDY

Although the goal of SCHIP is to provide uninsured children with health insurance coverage, a state can elect to cover the entire family--both the parents/custodians and their children if it is cost effective to do so. The cost effectiveness test for family coverage specifies that the expense of covering both adults and children in a family must be less than the cost of covering only the children. Under these circumstances. cost effectiveness appears possible only when the cost to SCHIP of covering a family is subsidized—either explicitly by employer contributions or implicitly through pooling of SCHIP eligibles with less expensive beneficiaries. Massachusetts received approval of its Title XXI family coverage proposal by relying on an employer buy-in—a distinct and challenging SCHIP option. Under an employer buy-in, benefits must be equivalent to one of the SCHIP benchmark packages and family cost sharing cannot exceed the statute's limit of 5 percent of income.

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[43] Eight of the 15 states in our sample are pursuing or plan to pursue the family coverage option using SCHIP funds, primarily by subsidizing employer-based insurance. (See Table 2.2)

Figure III.1 Massachusetts' SCHIP

Massachusetts' coverage of low-income individuals is based upon a Medicaid 1115 waiver, approved by HCFA in April 1995 and the state legislature in 1996. The Massachusetts 1115 waiver covers children under age 19 and their parents, individuals with disabilities, and long-term unemployed adults with incomes at or below 133 percent of the poverty level. Perhaps one of the most complex plans, Massachusetts weaves Medicaid and SCHIP funds to provide coverage to children and adults, using poverty level and access to insurance as key determinates of the funding stream that will be applied to an individual or family unit. SCHIP continues provisions of the 1115 waiver up to 200 percent of the poverty level.

Under the SCHIP Medicaid expansion component, services are extended to 150 percent of the poverty level for children (including those with disabilities) and 200 percent for pregnant women and infants. At 151 - 200 percent of the poverty level, Massachusetts implements a family assistance program which subsidizes family contributions to employer based insurance coverage. A child's eligibility for SCHIP determines which funding stream -- Medicaid or SCHIP -- is used. Thus, SCHIP funds are used for the following conditions:

- Children in families with access to employer sponsored health insurance that meets a basic benefit level, families contribute 1-2 percent of their gross family income towards premiums for employer sponsored family coverage. Assuming cost-effectiveness, the state provides any additional premium assistance required above the family contribution.

- Children in families that do not have -- or do not have access to -- employer sponsored health insurance, families contribute not more than 2 percent of their gross income to participate in a benefit package similar to that of Medicaid (excluded benefits include non-emergency transportation, long term care, and EPSDT).

Medicaid funds are available for premium assistance if a low-income family has already availed themselves of employer sponsored insurance or if the employer sponsored benefits package is less generous than the SCHIP stand-alone and thus is not equivalent to a Title XXI benchmark package.

Massachusetts officials believe that HCFA's 1996 approval of a Section 1115 waiver permitting an employer buy-in for their traditional Medicaid program greatly facilitated its use as their family coverage cost effectiveness test.[44] Massachusetts' cost-effectiveness test for family coverage built upon the employer subsidy inherent in most coverage provided through the workplace, thus minimizing the state subsidy of the cost of parental coverage. Because HCFA conditions the employer buy-in on a firms payment of at least 60 percent of the cost of family coverage, the state's subsidy of the remaining 40 percent of the premium is less than the full cost of covering children under its Medicaid program. The use of the employer buy-in option to cover families was facilitated by HCFA's flexibility on the comparability of employer offered benefits with those of SCHIP. Under Title XXI, an employer's coverage must be actuarially equivalent to a SCHIP benchmark package. HCFA agreed to a state certification of comparability based on a rough comparison of covered benefits in lieu of a time consuming and expensive actuarial test for each employer. HCFA said that this approach was a common sense way to implement the statutory requirement given the costly nature of actuarial assessments. Despite HCFA's flexibility, Massachusetts

[44] Massachusetts had the advantage of having spent much of 1995 and 1996 seeking approval for a Section 1115 Medicaid waiver that allowed the state to subsidize family coverage provided by an employer. Thus in reviewing the Massachusetts SCHIP plan, HCFA was not approving a new concept.

officials characterized the agency's approval of family coverage as a compromise: uninsured families with access to employer sponsored coverage will be eligible for SCHIP; on the other hand, low income families who may be struggling to afford coverage through their employer will only be eligible for a buy-in using Title XIX money.

HCFA has found other cost effectiveness tests proposed by states to be inconsistent with the Title XXI statute. HCFA categorized these cost effectiveness tests as "hypothetical" in nature--particularly compared to that of Massachusetts. For example, HCFA rejected a comparison of the costs of SCHIP managed care coverage for an entire family to Medicaid fee-for-service costs to cover children. A second effort to establish cost effectiveness compared family coverage under Title XXI to the cost of an average commercial rate for child-only coverage.[45] Despite requests from states, HCFA has not issued any guidance on family coverage in order to remain open to creative state ideas for meeting what others characterized to us as a strictly interpreted, difficult test.

SOME STATES ACHIEVING FAMILY COVERAGE BY USING TITLE XIX FUNDS FOR ADULTS

States wishing to cover the parents of SCHIP eligible children have been able to do so by using Title XIX funds. In general, adults do not qualify for Medicaid coverage unless they are in families with children or are aged, blind, or disabled. After enactment of SCHIP, Missouri simultaneously negotiated a Medicaid Section 1115 waiver to cover parents with Title XIX funds and a SCHIP Medicaid expansion for the children of such families using Title XXI funds. State officials indicated that their goal was to connect children and families into one seamless program via two different funding streams. While noting that the inclusion of adults into their Title XIX waiver greatly complicated the review process for SCHIP, state officials indicated that family coverage was an important state goal. Missouri's Medicaid approach commits the state to spending beyond the amount of their SCHIP allotment if necessary, a situation that other states may find less palatable.

Connecticut also plans to implement family coverage using Medicaid funding. The state initially discussed a Title XXI cost effectiveness test for family coverage but in the end decided that meeting the test was too difficult. Connecticut now plans to use a provision of the welfare reform law that creates a new eligibility category for parents and allows states to apply income and resource disregards to qualify higher income

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[45]These types of cost effectiveness comparisons are difficult because there are very few health insurance plans covering only children. See Health Insurance for Children: Private Individual Coverage Available, but Choices Can Be Limited and Costs Vary (GAO/HEHS-98-201, August 5, 1998).

adults.[46] As with Missouri, the state will receive its regular Medicaid matching rate for these parents.

WISCONSIN AND VERMONT SOUGHT RELIEF FROM TITLE XXI REQUIREMENTS

HCFA has worked with states to find other ways to achieve their goal of covering adults in families with children. For states such as Missouri and Connecticut that are not opposed to using both the Title XIX and Title XXI funding streams, the goal of covering families is achievable. For other states, however, ensuring that the goals of Title XXI and their own goals were consistent with each other has proven more problematic. Wisconsin's SCHIP proposal and the initial plan submitted by Vermont demonstrate the difficulty of building flexibility into a program that is an overlay of Medicaid. These two states were interested in Section 1115 waivers of SCHIP requirements to reconcile the requirements of Title XIX and Title XXI. Thus far, HCFA has refused to consider the use of Section 1115 to waive SCHIP requirements.

Vermont's and Wisconsin's Family Coverage Proposals

Prior to SCHIP, Vermont covered adults up to 150 percent of the poverty level and children up to 225 percent. Vermont wanted to use a SCHIP Medicaid expansion that would amend its Medicaid Section 1115 waiver program to cover low-income uninsured and underinsured children and families. According to HCFA, family coverage under Title XXI must address the "family unit." Thus, if a child is already on Medicaid, a parent can only qualify for Medicaid, not SCHIP. This situation resulted in a coverage gap for those parents whose children were already being served by Medicaid.[47] Although this interpretation prevented Vermont from covering lower income parents, the state could have included higher income adults in families with children under SCHIP but was concerned about crowd out at higher income levels. Vermont also wanted to include underinsured children whose coverage is prohibited by Title XXI. Due to earlier coverage expansions, the state estimates that there are fewer than 1,500 remaining uninsured children. At the same time, many children in the state have poor coverage. Consequently, the state proposed using a portion of its Title XXI allocation on underinsured children to cover dental, vision care, and other benefits not available to them. Vermont withdrew its initial SCHIP plan and has since received approval for a stand alone program to cover uninsured children up to

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[46]Jocylen Guyer and Cindy Mann, "Taking the Next Step," Center on Budget and Policy Priorities, August 20, 1998.

[47] Concerns regarding the family unit were never resolved, thus the validity of the cost-effectiveness test submitted by Vermont was never fully tested.

300 percent of the poverty level. The state will use Medicaid funds to improve coverage for underinsured children.

Wisconsin applied for a Section 1115 waiver under Medicaid to cover parents and proposed implementing a stand-alone SCHIP program for children to limit expenditures to the amount of its allotment.[48] The state wanted to maintain budgetary control over SCHIP program expenditures while rationalizing coverage for low income, working families, most of whom did not have access to health insurance. While conceptually covering the same individuals as Missouri and Massachusetts, Wisconsin has been unable to gain approval for its plan. State and HCFA officials indicated that part of the difficulty is in splitting the family unit between two different funding streams, particularly when the entitlement status is different across programs. In particular, by splitting parents into Medicaid and children into a SCHIP stand-alone component, the parents were being afforded an entitlement that was being denied to their children--a situation HCFA would not approve. Wisconsin ultimately received approval for its SCHIP plan, but only after changing from a stand-alone component to a Medicaid expansion design. Wisconsin's proposal now affords an entitlement to both children and adults, a design similar to Missouri's proposal.

HCFA Questions Timing of Requests for Section 1115 Waivers

In September 1997, shortly after the enactment of SCHIP, HCFA informed states that "it would be reasonable for states to have experience in operating their new Title XXI programs before designing and submitting demonstration proposals. Without experience in implementing Title XXI, it would be very difficult for HCFA to review and evaluate the merits of any waiver proposal."[49] In elaborating on this statement, HCFA informed us that a state should have one year of operational experience with its SCHIP program and complete an evaluation before requesting an 1115 waiver. HCFA believes that every demonstration requires a baseline from which to measure change; without first implementing a SCHIP program, a state lacks the requisite baseline. Moreover, HCFA takes seriously SCHIP's goal of providing insurance to uninsured, low-income children, a goal that it does not want to see circumvented by the waiver process.

HCFA believes that it is inappropriate to use Section 1115 to waive Title XXI requirements prior to a state's actual implementation of a SCHIP program—a policy that reflects the demonstration nature of Section 1115 waivers and a concern about

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[48]Though Wisconsin did not want to create a new entitlement, the state planned to (1) use its Medicaid benefit package and (2) allow family income to increase up to 15 percent over the original 185 percent of the poverty level without eliminating eligibility for coverage.

[49]HCFA "Dear State Letter," September 12, 1997.

not undermining the statutory goal of covering uninsured children. States and advocacy groups contend that there is no longer any merit in postponing use of such waivers now that most states have secured their fiscal year 1998 SCHIP allocations.

Established to test program innovations, Section 1115 allows the Secretary of DHHS to approve demonstrations likely to assist in promoting program objectives. Past demonstrations have made significant contributions to the development of Medicaid policy.[50] Title XXI stipulates that the provisions of Section 1115 of the Social Security Act relating to waiver authority "shall apply in the same manner as they apply to a state under title XIX [Medicaid]." According to HCFA, the Section 1115 waiver authority applies equally to Medicaid expansions and stand alone programs and is very broad. Thus, it allows the Secretary to waive any of the numerous provisions related to Medicaid state plan requirements including eligibility, benefits, and cost sharing.

States and advocacy groups would like HCFA to begin allowing states to tailor their SCHIP programs through the use of 1115 waivers. Citing a study that suggests children are more likely to be insured when their parents are also offered health benefits, Wisconsin contents that family coverage is consistent with SCHIP.[51] Some states also view an employer buy-in as consistent with effort to prevent the substitution of public programs for employer provided health insurance. Ultimately, the use and approval of Section 1115 waivers under SCHIP will require a judgement regarding the consistency between state goals and the intent of Title XXI.

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[50] Section 1115's broad waiver authority has been used extensively by HCFA to allow the implementation of statewide managed care programs that operate under rules different from traditional Medicaid. As of December 1998, 17 states operate their Medicaid programs under such a waiver. Through Section 1115, states have been allowed to change the Medicaid benefits package, charge certain recipients more than nominal cost sharing, and cover individuals who were not traditionally eligible for Medicaid such as low income single adults.

[51] Kenneth E. Thorpe and Curtis S. Florence, "Covering Uninsured Children and Their Parents: Estimated Costs and Number of Newly Insured," The Commonwealth Fund, July 1998.

APPENDIX IV

INNOVATIVE STATE OUTREACH STRATEGIES CRITICAL TO THE SUCCESS OF SCHIP

Many states, including the 15 in our sample, are developing innovative outreach strategies to widely publicize SCHIP and to provide families with applications and program information.[52] Some states have adopted sophisticated media campaigns to market SCHIP like a product, a development attributed in part to the greater likelihood of targeted children having working parents. Outreach strategies have worked to minimize the burden on both the beneficiary and the state by eliminating onerous documentation requirements that in turn allow the introduction of shorter application forms. States with a large number of low-income immigrants are also implementing outreach efforts geared toward these populations. Finally, some states are implementing measures to help them evaluate which outreach strategies are the most effective, for example, school based initiatives, local community designed efforts, or general media campaigns. While it is too early to judge the success of outreach efforts, some states are reporting that the publicity is not only attracting SCHIP eligible children but also far greater numbers of those who were Medicaid eligible but not enrolled. Although Title XXI recognizes the importance of outreach, it also places a limit on the amount of federal matching funds that are available. The inclusion of outreach within the prescribed limit has been problematic for stand-alone programs with significant start-up costs.

SCHIP EMPHASIZES OUTREACH WITHIN PRESCRIBED LIMITS

As a new program, Title XXI underscores the importance of identifying and enrolling eligible children by requiring each state to include an outreach strategy in its SCHIP plan. Despite this emphasis on outreach, however, the statute also limits outreach spending and certain other spending to 10 percent of a state's actual expenditures on benefits. Thus, the statute ties outreach expenditures directly to enrollment. For states such as New York, with state funded children's programs that pre-dated SCHIP and thus populations already receiving services, the spending limitation on outreach has not been a particular problem. It has, however, been problematic for

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[52] In their Medicaid outreach efforts, many states have been cognizant of barriers to enrollment that include confusion over eligibility, lack of program knowledge, complex eligibility rules, belief that participation is not necessary when children are healthy, potential stigma, and language and cultural barriers to participation. To overcome these barriers, states have applied strategies under Medicaid that are also relevant to their SCHIP efforts. For more detailed information on the barriers to Medicaid enrollment see Medicaid: Demographics of Nonenrolled Children Suggest Outreach Strategies (GAO/HEHS-98-93, March 20, 1998).

other states, particularly those with a stand alone SCHIP component, that are incurring substantial start-up costs and lack the enrollment necessary to fully claim their outreach expenditures.

In addition to the Title XXI requirement that each state include an outreach strategy in its SCHIP plan, other provisions in the BBA gave states additional tools to facilitate the enrollment and coverage of children in both Medicaid and SCHIP. One new option known as "presumptive eligibility" allows states to extend immediate Medicaid or SCHIP coverage to children until a formal determination of eligibility is made. Under this option, a "qualified entity"[53] may use preliminary information to presume that a child is eligible for benefits if the family income does not surpass the state's applicable income eligibility levels.[54] A second option allows states to provide beneficiaries with continuous eligibility in the state's Medicaid or SCHIP program for up to 12 months without a re-determination of continued eligibility. The continuous eligibility option is aimed at reducing the difficulties associated with intermittent program eligibility and coverage due to changes in a family's financial circumstances.

Since the enactment of SCHIP, HCFA has also emphasized the importance of effective outreach strategies. It issued guidance to the states in January 1998 that reviewed the outreach options already available to states under Medicaid as well as new strategies for reaching and enrolling targeted children. Additionally, in February 1998, the President signed an Executive Memorandum establishing a multi-agency effort to enroll uninsured children in SCHIP. In response, the Vice President announced new approaches that federal agencies are taking to identify and enroll targeted children into the program. Finally, the President's fiscal year 2000 Budget is proposing to expand the use of a special $500 million Medicaid outreach fund, originally ear-marked for state costs associated with outreach for children losing welfare. This proposal, if passed, will allow states to use the fund for outreach activities geared to all uninsured children, not just those affected by the delinking of Medicaid from welfare.

While every state SCHIP plan contains a strategy to reach targeted children, some states have expressed concern that SCHIP funding limitations on outreach contradict

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[53] Under the Balanced Budget Act, "qualified entities" are specified as health care providers of items and services under the state's Medicaid plan (including the Indian Health Service and Tribal and urban Indian health care providers) as well as entities that make eligibility determinations for Head Start, the Special Nutritional Program for Women, Infants and Children (WIC), and child care subsidies under the Child Care and Development Block Grant.

[54] After a child is determined presumptively eligible by a qualified entity, the child's family is then required to apply for the program formally by the last day of the month following the month in which the presumptive eligibility determination was made.

the priority attached to this critical statutory requirement. Under Title XXI, a state may receive federal matching funds for certain expenditures to the degree that they do not exceed 10 percent of the state's total expenditures for health benefits under SCHIP. The capped expenditures include costs relating to administration of the program, outreach, and certain other health-related activities. Essentially, the goal of the 10 percent cap is to preserve as much SCHIP funding as possible to pay for health insurance for children.

The inclusion of program administration and outreach within this cap, however, has been problematic for some states as they develop and implement their SCHIP plans. In particular, some states with a stand-alone component have found the 10 percent cap difficult to work with given the magnitude of start up costs and low enrollment in the early stages of their programs. For example, California officials noted that while the cap may be reasonable once a program is underway, it is impossible to stay within the 10 percent limit while conducting outreach and other activities that precede actual service delivery. As a result, California has committed significant unmatched state start-up funds. Colorado officials also indicated that the 10 percent limit is problematic because of the state's smaller population and low initial enrollment, but it may be more viable once the program is established and service expenditures increase. Both states noted that the legislation's inclusion of outreach within the 10 percent cap is counter to presidential efforts for increased outreach, as addressed above.[55] HCFA has tried to be flexible in addressing state concerns, for example, suggesting that a state withhold claims for administration and outreach until there is sufficient program enrollment. HCFA officials told us that they are exploring the feasibility of a statutory amendment to address the problem with start-up costs, similar to the series of Title XXI technical amendments made since its enactment in August 1997.[56]

While the stand alone components of California's and Colorado's programs have experienced difficulties with the 10 percent limit, other states with similar approaches have not. This situation may be due, in part, to the individual states' starting points or baselines. For example, New York is rolling over enrollment from its prior state-funded program and expects to spend between $15 - 16 million on health care services each month, the state will have a significant basis to draw down the federal match for outreach costs. States without similar, significant SCHIP expenditures will have more difficulty recouping the cost of their outreach efforts.

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[55] President's Budget proposes outreach outside of 10 percent cap.

[56] For example, amendments have extended the period of time for states to secure their fiscal year 1998 SCHIP allocations and adjusted maintenance of efforts dates included in the legislation that, unintentionally, had an adverse impact on a few states.

OUTREACH STRATEGIES FOCUS ON PUBLICITY, SIMPLIFICATION AND TARGETING

The development of effective and appealing marketing has become a priority under SCHIP. In addition to implementing approaches suggested by HCFA, some states have developed unique strategies to publicize SCHIP and to change community perceptions that had previously hindered Medicaid enrollment. Outreach measures also encompass efforts to simplify state eligibility procedures, streamline program applications, and opt for the presumptive and continuous eligibility provisions. Some states are also focusing on the diverse and specialized needs of the populations they intend to reach, such as immigrants. Lastly, while it may be too early in the program to identify the most effective outreach strategies, some states are implementing measures to help them identify which efforts appear to be the most successful.

Publicizing SCHIP

In an effort to overcome the informational barrier to enrollment, states have initiated a variety of methods to publicize SCHIP. State approaches include the use of multi-media campaigns, direct mailings and widespread distribution of applications, community involvement, and corporate participation. In addition to disseminating information about available programs, some states have also taken steps, even prior to the enactment of SCHIP, to address the Medicaid stigma issue in an attempt to improve perceptions of publicly sponsored health insurance programs. As Congress intended and states have already experienced, the publicity about SCHIP has already resulted in the enrollment of additional Medicaid eligible children.

Media Campaign. In an effort to publicize SCHIP, states are using media such as posters, newspapers, billboards, radio, and television. In SCHIP advertisements, states typically provide toll free numbers and, in some instances, website addresses to assist potential enrollees in receiving an application or other information about the program. Most states, including those in our sample, are including some sort of media campaign in their SCHIP programs, but the approaches vary significantly depending on the states' budgets and community needs.

For instance, California is implementing a statewide multi-media approach that includes advertising in English and Spanish through the use of television and radio. Additionally, the state is using billboard and transit advertisements, posters, pamphlets and other promotional materials in ten threshold languages. California is spending $9 million on traditional media out of its $21 million outreach budget. Michigan reported that it will spend $750,000 on a professional media campaign that includes television, radio and print media. The state plans to have a base level of media coverage throughout the year, but will increase media activity at certain times such as at the beginning of a new school year.

Distribution of Program Information and Applications. Other efforts to inform the public about a state's SCHIP program involve the widespread distribution of SCHIP applications and materials though schools, the mail, and other venues. For instance, 14 of the 15 states in our sample reported that they will be using the local school system in their outreach efforts. Although South Carolina mailed out over 500,000 copies of its bright yellow application accompanied by a letter from the governor within the first few months of its program, state officials reported that the distribution of applications throughout state school system proved to be the most effective strategy so far. SCHIP program materials are also being placed in other organizations such as child care centers, Head Start programs, child support enforcement agencies, community action programs, refugee resettlement programs, family preservation and support programs, and Social Security offices.

Additionally, some states are identifying and targeting families that are likely to have eligible children by coordinating with other programs. For example, Florida plans to send information directly to families that receive food stamps. Other targeted distribution strategies include mailing information to families that fall below a certain income threshold determined by the SCHIP program. Thus, Connecticut is planning a direct mail campaign to all families with incomes under 300 percent of the poverty level.

Community Involvement. States are developing outreach approaches in concert with local organizations such as churches and social service agencies that are familiar with the community and understand its needs. Community based organizations are able to disseminate information on SCHIP by "word of mouth," often a more effective outreach tool for targeted communities than government officials. The following states in our sample are involving community-based organizations for outreach in innovative ways:

- California is enlisting the assistance of (1) community-based groups such as Parent-Teachers Associations, YMCAs, religious organizations, and (2) other entities such as insurance agents and tax preparers. The state approached tax preparers as a group that may be able to identify children eligible for SCHIP because many low income families do not prepare their own tax returns. After state provided training, these groups help inform potential enrollees about the program and assist families in completing application forms. To compensate for their effort, the state pays a $50.00 "application assistance fee" to trained entities involved in a successful SCHIP or Medicaid enrollment.[57] State officials indicated that as of September 1998, approximately 40 percent of California's applications

[57]Originally, the state proposed an application assistance fee of $50 but lowered the amount to $25 when the state began SCHIP implementation. In November 1998, the state restored the fee to $50, an effort to boost lower than expected enrollment in its SCHIP program.

had been "assisted."

- Massachusetts is using social service agencies, religious and civic leaders, and schools to conduct outreach activities. The state will provide "mini-grants" varying from $10,000 - $15,000 to community -based organizations that facilitate the enrollment of "hard to reach" populations.

- South Carolina and New York have found that grassroots efforts and community organizations are also effective in publicizing the availability of SCHIP. These organizations are distributing information and reaching parents in non-traditional locations such as movie theaters and laundromats (South Carolina) and adult learning centers, tenant organizations, and beauty salons (New York). Both states are also utilizing ministers and local churches to pass out information to congregations.

Corporate Partnerships. In addition to community groups, states are finding ways to utilize the private sector in their efforts to spread the word about SCHIP. Michigan's stand-alone program is working with KMART stores throughout the state that have agreed to display SCHIP applications at their "community issues" bulletin boards. Publicity will also be strategically placed near displays of school clothes and in the pharmacy section of the store. Michigan is also working with the Meijers supermarket chain in Grand Rapids. While the store does not allow displays, it will include SCHIP information in a shopping guide that is mailed to 2 million families. California is also working to place its toll free SCHIP phone number on grocery bags and coupons. Additionally, the state has obtained corporate sponsorships with local supermarkets and drug stores. California officials believe that corporate partnerships will complement to the state's paid media advertising strategy. Other private sector initiatives transcend state boundaries. For example, Bell Atlantic is establishing and operating a toll free phone number nationwide to assist families in reaching enrollment centers. Additionally, the diaper company, Pampers, will provide this toll-free number and other information about health insurance options to first-time mothers.

Addressing the Stigma Issue. SCHIP has refocused attention on the Medicaid-welfare stigma issue and state efforts to overcome this barrier to participation in publicly sponsored health insurance programs. Prior to the heightened outreach efforts under Title XXI, some states had already endeavored to project a more positive image of their medical assistance programs. The most visible effort was to re-invent the program with a new name. Oregon Medicaid was re-christened the "Oregon Health Plan" when its Section 1115 waiver was approved in 1993; the state's SCHIP stand-alone program also operates under that name. On the other hand, California is an example of a state that has not changed the name of its Medicaid program; its SCHIP stand-alone program is called "Healthy Families" while Medicaid continues as Medi-Cal. Other stand-alone programs with names distinct from Medicaid include the

MIChild program in Michigan and the Florida Healthy Kids program.

Other approaches to destigmatizing Medicaid include advertising SCHIP as a program intended for working families, using an alternative enrollment site or mechanism that eliminates the need to submit an application at a local welfare office, or issuing identification cards for program participants that are free of any perceived "welfare stigma." For example, South Carolina has issued an ID that closely resembles private health insurance identification cards. In contrast, Oregon has no unique Medicaid or SCHIP identification card. Instead, every beneficiary receives a card from the health insurance plan they choose—one identical to the card issued to an individual with employer sponsored health insurance.

Some states are concerned about perceived beneficiary stigma attached to their Medicaid programs and believe that families will prefer to enroll their Medicaid eligible children in the state's stand alone program with its private health insurance persona. For example, Florida has suggested that some families might even falsify their incomes to avoid enrolling in Medicaid. California reports that 75 percent of SCHIP applicants who are found eligible for Medicaid refuse to allow the state to refer their applications to Medicaid. In addition to the stigma that endures among recipients, a few states in our sample told us that Medicaid has a negative image among some providers who are unwilling to serve beneficiaries. Thus, Michigan Medicaid offers dental benefits but has few participating dentists, which may be due in part to the low Medicaid reimbursement rates. In an effort to attract dentists to its SCHIP stand alone program, the state has raised the rate it will reimburse those dentists. While this creates a two-tiered system in terms of dental benefits, the state is waiting to determine if the enhanced rate improves access and the actual delivery of services.

Simplifying Eligibility Determination and Enrollment Procedures

In a September 1998 letter to the states, HCFA acknowledged the need for safeguarding program integrity in order to ensure that only those who are eligible receive program benefits. Nevertheless, HCFA maintained that burdensome application and enrollment processes are a substantial impediment to successful enrollment in both SCHIP and Medicaid. In fact, almost half of Medicaid application denials are for procedural reasons, such as incomplete documentation, rather than because an applicant fails to meet the state's eligibility criteria. While simplification measures are occurring under SCHIP, some states were already streamlining both their Medicaid eligibility rules and enrollment procedures.[58]

[58]According to the Center on Budget and Policy Priorities, as of November 1998, 41 states had shortened their Medicaid applications, 36 states allowed individuals to apply by mail, and 40 had simplified their Medicaid eligibility process by eliminating

Streamlining the Eligibility/ Application Process

To overcome the barrier of a long, complicated SCHIP eligibility determination process, states are (1) eliminating burdensome eligibility tests, (2) shortening the length of applications, (2) using joint SCHIP/Medicaid applications, and (3) opting for a period of continuous eligibility.

Eliminating Burdensome Eligibility Tests. Dropping an asset test reduces the complexity of the eligibility determination process for families and, in some cases, the documentation requirements. In our 15 state sample, 11 have eliminated the asset test from their SCHIP applications. (See Table IV.1) States are also allowing families to self report their income with verification by the state as follow up. Additionally, some states are reducing verification and documentation requirements that exceed federal requirements. For example, Rhode Island has significantly reduced the number of documentation requirements that were in place when Medicaid and welfare eligibility were linked.

Shortening Applications. State efforts to simplify eligibility procedures gave them the opportunity to consider the use of shorter SCHIP applications. The length of the resulting applications vary. Some states such as Florida, Missouri, and South Carolina reduced their applications to a single page, front and back. Missouri, in particular, was able to shorten its application by narrowing it to health coverage only and removing other social services from that particular form. Massachusetts' SCHIP application consists of four pages with four supplements that may apply to the applicant depending on specific circumstances such as the presence of a disability, access to insurance, an absentee parent, and immigration status. In late 1998, California decided to shorten its application form after considerable criticism of its 28 page booklet that contained a 12 page application with separate forms for the state's stand alone program, Medicaid, and a Medicaid program for pregnant women. California officials explained that the form, while lengthy, was designed to avoid the inappropriate enrollment of Medicaid eligible children and to minimize the amount of follow-up information needed. In response to adverse feedback about the onerous nature of the application, the state developed a revised 4 page joint application for its Medicaid and stand alone SCHIP programs.

Combining SCHIP/Medicaid Applications. In addition to shortening the form, eight states in our sample are using a single application for both SCHIP and Medicaid. (See Table IV.1) This approach not only simplifies the application process for families, but also reduces paperwork for the states. Additionally, joint SCHIP-Medicaid

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an asset test. Center on Budget and Policy Priorities, Steps States Can Take to Facilitate Medicaid Enrollment of Children, November 1, 1998.

applications help states accomplish seamless coverage for children that may move between programs due to changes in family circumstances. For instance, Connecticut is marketing its stand-alone and Medicaid programs together under a new name and has developed a four page application for both programs. [illegible] for a joint application under one program name to create a [illegible] masks for potential enrollees the fact that there are two se

Continuous Eligibility. Because Medicaid benefi [illegible] to frequent eligibility re-determinations and interrupted Med [illegible]ating income, some states are opting to provide up to 12 [illegible]ibility in an effort to prevent coverage interruptions. As not [illegible]udget Act of 1997 allowed states to guarantee a longer pe[illegible] coverage, regardless of changes in the family's finan[illegible]of the 15 states in our sample have implemented continuo[illegible] 6 to 12 months. (See Table IV.1)

Table IV.1: Eligibility and Enrollment Initiatives for (

Initiatives	CA	CO	CT	FL	MA	MI	MO	NY	[illegible]	PA	RI	SC	TX	VT	WI
No asset test	✔		✔	✔	✔	✔	✔	✔		✔	✔	✔		✔	✔
Combined SCHIP/Medicaid applications[1]	✔	✔	✔	✔	✔	✔		✔	✔						
Continuous eligibility	✔	✔	✔	✔[2]		✔	✔				✔[2]	✔			
Presumptive eligibility under SCHIP[3]		✔	✔		✔	✔	✔	✔	✔						

[1]Medicaid expansion states are not reflected as having developed joint applications because this design choice mandates that they use the same application for SCHIP and Medicaid. Missouri, Rhode Island, South Carolina, Texas, and Vermont are all Medicaid expansion states.
[2]Florida, Oregon and Rhode Island have continuous eligibility is for 6 months; all other states are for 12 months.
[3]States adopting the presumptive eligibility option may be applying it to their separate stand alone programs or their Medicaid expansions under SCHIP.

Streamlining the Enrollment Process

States are implementing several options to simplify the enrollment process for families with children. These include utilizing the mail, telephone, and internet for enrollment; offering additional enrollment sites; reducing the amount of time it takes to enroll children; and, introducing other innovative enrollment initiatives.

Mail-in, Telephone and Internet Enrollment. By introducing mail-in applications states are eliminating the need for applicants to take time off from work as well as any transportation costs and stigma associated with visiting a social services office. Some states are also extending the use of the mail-in option to eligibility re-determinations. States are also exploring other options to further simplify the submission of Medicaid and SCHIP applications, such as accepting applications by telephone or facsimile. In Colorado, applications are available for families to fill out on-line via the Internet. This approach may be particularly effective for community-based organizations that assist families with enrollment since many low income families may not have access to a computer at home.

Additional Enrollment Sites. As an added convenience for applicants, states are increasing the number and type of sites where enrollment can take place. Locating eligibility workers in places other than welfare offices to help families with the initial processing of applications is commonly referred to as outstationing. Popular outstationing sites include locations where workers frequently come into contact with families such as schools, child care centers, churches, Head Start centers, WIC sites, local Tribal organizations, and Social Security offices. Outstationing is an increasingly important strategy, given that welfare offices no longer play the key role that they did when welfare and Medicaid were more closely linked.

Presumptive Eligibility Further Expands Enrollment Sites. Some states are also utilizing the presumptive eligibility option to increase the number of enrollment sites. Presumptive eligibility allows a child to receive coverage under Medicaid or SCHIP immediately, without the delays associated with the normal application process. In addition to traditional Medicaid providers, other entities such as WIC agencies, Head Start programs, and agencies that determine eligibility under the Child Care and Development block grant can "presume" eligibility for services until a formal application is submitted and reviewed. Four states in our sample have chosen to use presumptive eligibility in their SCHIP programs, while 5 states are using presumptive eligibility for Medicaid. (See Table IV.1)

Reducing Enrollment Timeframes. Some states are striving to shorten the amount of time it takes to process an application once it reaches the appropriate SCHIP or Medicaid office. For example, the goal of California's stand-alone program is to complete eligibility determinations ten days after a completed application is submitted. The state also plans to commence coverage ten days after the application is deemed complete. Prior to the enactment of SCHIP, Massachusetts developed a computer program to determine Medicaid eligibility. The state's data entry approach to determining eligibility reduced the processing time from 3 weeks to 3 days. Massachusetts characterized the development of computerized enrollment as time consuming and expensive, but worthwhile.

Other Innovative Enrollment Initiatives. Some states are further streamlining their enrollment processes by instituting a follow-up system to contact families that--for various reasons--do not complete the application process. For example, Massachusetts is attempting to initiate follow-up with such families and complete applications over the telephone. Other efforts to ensure that families do not "fall between the cracks," include the development of an effective referral system between the SCHIP office, the state Medicaid agency, and other federal and state entities that frequently come in contact with low income families. For example, Connecticut's enrollment vendor records daily the number of Medicaid referrals made. Additionally, the state has developed a tracking system to follow referrals once they reach the State's Department of Social Services. States striving to simplify enrollment procedures for families even further are offering telephone interviews or are providing transportation vouchers to assist families with reaching the eligibility office for a face-to-face interview. Some states, such as Massachusetts, are extending their office hours so that applicants are not required to take time off from work to apply.

Targeting Outreach to Specific Populations

Research indicates that Hispanics, U.S.-born children of foreign parents, and immigrant children are more likely to be uninsured despite being Medicaid eligible. Given these statistics and the renewed efforts under SCHIP to actively recruit the uninsured, states with large Hispanic and/or foreign born populations are implementing outreach strategies geared toward reaching these diverse groups.[59] Most directly, some states are offering multi-lingual applications and program materials and toll free phone lines in appropriate languages. California is providing applications and materials in ten threshold languages that include: English, Spanish, Farsi, Vietnamese, Laotian, Cantonese, Armenian, Hmong, Cambodian and Russian. Colorado and Rhode Island are also providing SCHIP materials in both English and Spanish. Additionally, states are increasing the number of multi-lingual eligibility workers and staff able to provide program information and answer applicants questions.

The diversity of these targeted populations has also influenced state efforts to market SCHIP. For example, Colorado officials noted that they are implementing different marketing approaches to meet the needs of Native American and Hispanic people living in rural areas. The state is also working with the Colorado Migrant Health Program to develop specific outreach activities for migrants statewide. Texas officials similarly noted that outreach efforts will vary by region and by the ethnic population

[59]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) requires immigrants who arrive on or after August 22, 1996, to be in the United States for 5 years before receiving any Federal means-tested benefits such as Medicaid and SCHIP.

being targeted. In Houston, there is a large southeast Asian immigrant population and outreach in this area must be culturally sensitive and language appropriate. Additionally, state officials noted that they must identify the type of media that is most effective within the particular group targeted; for example, individuals in areas of the state that border Mexico may be more responsive to television advertisements than to print media.

Despite targeted outreach efforts, some states remain concerned that "hard to reach" populations will continue to be under served by both Medicaid and SCHIP. Michigan officials noted that citizen children of foreign born parents may be particularly difficult to reach due to the family's fear that information collected will be shared with the Immigration and Naturalization Service (INS) or other federal agencies, and may jeopardize their ability to remain in the U.S. California shares this concern and believes that its current enrollment figures have suffered due to fears among immigrants that participation will adversely affect their efforts to become citizens. California officials have requested but not received an answer from the INS regarding whether the receipt of SCHIP or Medicaid benefits would result in being deemed a "public charge." The term, "public charge" is used by INS to describe immigrants who currently are or will be dependent on the receipt of public benefits.[60] While HCFA sent a letter to state Medicaid directors in December 1997 stating that aliens legitimately receiving Medicaid benefits were not indebted to the state,[61] INS has not clarified this issue with formal guidance.[62] California officials believe that the state will continue to experience difficulty reaching targeted immigrant children until the INS issues a clear written statement on the relationship between lawful receipt of Healthy Families benefits and public charge determinations.

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[60]An alien may be prevented from entering the United States if a determination is made that the individual is likely to become a public charge. For aliens already in the United States, deportation may result if that person has become a public charge, however, this rarely occurs. Current laws and regulations do not specify whether the receipt of Medicaid benefits would deem someone a public charge.

[61]The HCFA letter also informed states that "[t]he Medicaid program has no authority to collect repayments of benefits from current or former beneficiaries except in cases where those benefits were fraudulently received or an overpayment has occurred." Letter from Sally Richardson to State Medicaid Directors, December 17, 1997.

[62]While the State Department specifically identified WIC (Women, Infants and Children) as a program that should not be considered when making public charge determinations, the receipt of past, present and future Medicaid benefits has not been addressed by the State Department or the INS.

Mechanisms In Place to Identify
Effective Outreach Strategies

Because only 12 states have more than 6 months of implementation experience, it is still too early to identify the most successful outreach strategies. Some states, however, are establishing mechanisms to help them better target their outreach activities. For example, Colorado's SCHIP application contains a question that asks how the applicant heard about the program and where they received the application. Those calling in for information are also asked similar questions. In the early stages of South Carolina's program, the state placed different colored applications at various locations such as schools, providers and churches, in order to determine where each application originated. A South Carolina official indicated that the majority of applications came from schools, allowing the state to better focus its outreach efforts.

Although a state may find that specific outreach approaches are more effective than others, New York's experience suggests that the level of expenditures may also be an important factor. State officials told us that its state funded children's health program allocated a small amount of money for marketing and outreach--less than 10 percent of the appropriation. After New York increased its funding of marketing and outreach under SCHIP, new monthly enrollment jumped to 19,000 children in July 1998 compared to 2,000 just one year earlier.

PREMATURE TO DRAW CONCLUSIONS
FROM PRELIMINARY ENROLLMENT DATA

States are not required to begin reporting SCHIP enrollment data to HCFA until late January 1999. The first report will cover enrollment during fiscal year 1998—that is, October 1, 1997 through September 30, 1998. DHHS officials told us that the initial reliability of this data may be poor given the developing status of state data systems. However, states will have additional time to fine tune their data systems since about 40 percent of SCHIP plans were approved between September and December 1998 and many have not yet begun enrollment. ~~HCFA anticipates that~~ The States estimate that enrollment will ~~take several years to~~ by the end of FY 2000 reach an estimated 2.5 million children. An important factor influencing the enrollment growth rate is that many states' program designs are still evolving and do not yet fully utilize their SCHIP allotments.

As of December 1998, only 7 states had more than 6 months of SCHIP implementation experience. According to rough estimates collected informally by HCFA, enrollment in 12 states that had approved SCHIP plans prior to May 1, 1998 totaled 425,000 as of September ~~22~~ 29, 1998. (See Table IV.2) While preliminary enrollment data shows that the number of children enrolled in SCHIP varies significantly across states, it is still too early to assess the impact of state outreach efforts. Differences in terms of implementation schedules, preparedness, and eligible populations complicate any comparison across states. For example, California created

a new stand alone program that only began enrollment in June 1998 and a significant number of the state's uninsured children are immigrants whose families are hesitant about the impact of enrollment on their residency status. In contrast, Florida, New York, Colorado, and Pennsylvania rolled over enrollees from their previously state-funded children's programs. Finally, many states in our sample told us that a significant number of those applying for SCHIP have been determined to be Medicaid eligible, ranging from 2 to 1 in Massachusetts to 10 to 1 in Michigan.

Table IV.2:

State	Date Enrollment Began	Enrollment as of 9/22/98	Total Number of Low-Income Uninsured Children at or Below 200 % FPL for FY 1998[a]
Ala.	Medicaid – 2/98 Stand Alone – 9/98		154,000
Calif.	Medicaid – 3/98 Stand Alone – 7/98		1,281,000
Colo.	Stand Alone – 4/98		72,000
Conn.	Medicaid and Stand Alone – 7/98		53,000
Fla.[b]	Medicaid and Stand Alone: Phase I – 4/98 Phase II – 7/98		444,000
Ill.	Medicaid – 1/98		211,000
Mich.	Medicaid – 7/98 Stand Alone – 5/98		156,000
Mo.	Medicaid – 9/98		97,000
N.J.	Medicaid and Stand Alone – 3/98		134,000
N.Y.[b]	Stand Alone – 4/98		399,000
Ohio	Medicaid – 1/98		205,000
S.C.	Medicaid – 8/1/97 (state funded until 10/1/97)		110,000

[a] The Bureau of the Census provided the number of uninsured children in each state for FY 1998 by developing an arithmetic average of the number of low-income children and low-income children with no health insurance as calculated from the three most recent March supplements to the Current Population Survey (1994, 1995, and 1996) prior to FY 1998.

[b] Indicates that the state rolled over populations into SCHIP from previously state funded health insurance programs for children.

APPENDIX V

DESPITE DIVERGENT VIEWS, STATES TAKE STEPS TO AVOID CROWD OUT

State and federal efforts to avoid crowd out reflect some of the divergent views regarding the significance of this phenomenon as well as differences over whether effective tools exist that could dampen or deter crowd out. The concern over crowd out—that is the substitution of newly-created public coverage perceived to be less costly or more generous, for already existing health insurance—arises in part out of Title XXI's statutory mandate for close coordination between SCHIP, private health insurance, and Medicaid. The concern is two-fold:

- For existing private health insurance, that individuals will drop their employer-based or individually purchased coverage, or that employers will effectively reduce their health coverage for employees.[63]

- For Medicaid, that children who are currently Medicaid-eligible but not enrolled may be attracted to SCHIP by new state outreach efforts, or that states may enroll Medicaid eligibles in SCHIP to take advantage of the enhanced federal matching rate.

States responded to the coordination mandate with a variety of measures to address the potential crowd out of both Medicaid and private insurance. To ensure that SCHIP does not become a substitute for Medicaid, most states with a stand-alone component are using joint applications and must first screen for Medicaid and ~~refer~~ enroll any children found eligible to that program. With regard to private insurance, state crowd out mitigation tools for SCHIP mirror strategies adopted in previous state funded health insurance programs and suggested by researchers.

ACCESS OF TARGETED FAMILIES TO OTHER INSURANCE UNDERLIES CROWD OUT CONCERN

Quantifying the potential extent and impact of crowd out under SCHIP is difficult, in part because the results of previous crowd out studies cannot be directly used to predict SCHIP crowd out experience. Studies examining previous public health insurance expansions focused on Medicaid populations quite different from those eligible for SCHIP and not subject to crowd out prevention strategies. National studies found crowd out occurring at higher levels than did state-focused studies -- 15-

[63]Employers may reduce their premium contributions or provide less service coverage. See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" The Quarterly Journal of Economics, 111(2) (1996), pp. 391-430.

17 percent compared to 5-7 percent for the latter. Another complication is the problem of separating the impact of public insurance expansions from other insurance trends occurring at the same time. Finally, no studies have determined which of the many existing crowd out prevention measures are the most successful and under what state conditions they should be applied.

Despite these uncertainties, researchers believe that substitution of private insurance is more likely to occur when public programs serve individuals at higher income levels, who are more likely to have access to and are able to afford some level of employer-sponsored or individually purchased insurance.[64] Congressional concern about SCHIP's potential for crowd out also arises from the higher incomes of targeted families with children—between 100-200 percent of the poverty level--who often are referred to as near-poor or low income working families. One study highlights the potential for crowd out among the near poor. As shown in Figure 5.1, the report found that more than twice as many near-poor children as poor children were covered by private insurance.[65] Underscoring the potential for crowd out, 10 states in our sample will cover children living in families with incomes at 200 percent of the poverty level or greater (See Appendix II, Table II.3). While children in families with higher incomes will be more likely to have, or to have access to, employer-based dependent insurance, these families also may be attracted to the lower-cost public programs if they find the purchasing power of their wages declining and premiums increasing.

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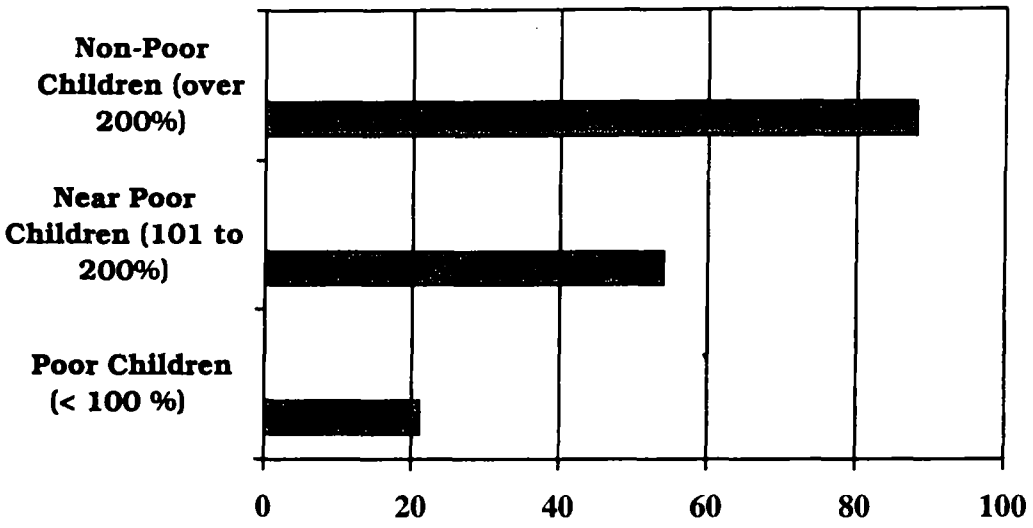
[64] See Deborah J. Chollet, Michael Birnbaum and Michael J. Sherman, Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience, p. 17, and Ellen O'Brien and Judith Feder, "How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?" The Kaiser Commission on Medicaid and the Uninsured, September 1998.

[65]Percentages derived from Kenneth E. Thorpe and Curtis S. Florence Covering Uninsured Children and Their Parents: Estimated Costs and Number of Newly Insured (New York: The Commonwealth Fund, July 1998). Tabulations are from the March 1997 *Current Population Survey*, and insured status does not include coverage under Medicaid, CHAMPUS, or Medicare.

Figure V.1: Children with Employer Sponsored or Other Private Insurance, by Federal Poverty Level, 1996



Estimates of possible crowd out as well as views on the importance attached to crowd out differ. The Urban Institute's projection of crowd out ranges from 22-36 percent of SCHIP enrollees.[66] In analyzing the SCHIP legislation, the Congressional Budget Office (CBO) offered a long term assessment that 40 percent of ultimate SCHIP participants would have had some other form of insurance coverage. CBO based its projection both on a review of crowd out under earlier Medicaid eligibility expansions, and on the anticipated reaction of labor markets to SCHIP. Over time, CBO concluded, labor markets will adapt to the existence of federal subsidies, with low-income workers receiving more compensation in the form of wages and less in the form of health insurance. In fact, CBO analysts suggest that some amount of displacement of private insurance is inevitable in the trade off between the SCHIP goals of stable insurance coverage for children and crowd out prevention. Under this scenario, if children who move in and out of private insurance based on their families' changing jobs and incomes qualify for consistent coverage under SCHIP, then their previous private insurance is crowded out. However, these children gain more

[66]The Urban Institute estimated that if 20 percent of families dropped their employer's dependent coverage to enroll children in SCHIP, then about 36 percent of all new SCHIP participants would be substituting their private insurance for public coverage. If 10 percent dropped coverage, then the crowd out would amount to 22 percent of the new SCHIP children. See Lisa Dubay, Session 5: Exploring Potential for "Crowd Out" Under CHIP, presentation at the Agency for Health Care Policy and Research Workshop, "CHIP: Implementing Effective Programs and Understanding Their Impacts," (Portland, Oreg.: September, 1998).

reliable access to health coverage and a greater likelihood of receiving both preventive and primary health care, leading to improved health status.

According to a January 1998 telephone survey of 450 businesses conducted by the Maternal & Child Health Policy Research Center, most companies are unlikely to make significant changes in the health coverage offered to employee dependents as a result of SCHIP.[67] Availability of new public insurance for low income children would persuade 7 percent of those surveyed to stop offering dependent health insurance coverage. Another 5 percent said they would consider dropping coverage, while 12 percent would not drop coverage, but would increase the cost or decrease the value of dependent health insurance. When the employers likely to drop coverage were informed that children would have to wait 3 months to be eligible for public coverage, the number willing to eliminate coverage fell from 7 to 3 percent. Only 1 percent of businesses would drop coverage if the waiting period was 6 months, and none of the employers would drop coverage if children had to wait 12 months for new public insurance.

In addition, a number of studies indicate that some crowding out of private insurance may have a less negative impact than expected. While some researchers believe that crowd out leads to problems in assuring that public dollars serve targeted populations, and may actually increase the cost of public insurance programs, analyses by the Urban Institute show that the costs of crowd out from the expansions of the late 1980s and early 1990s did little to increase overall Medicaid costs,[68] and suggest that crowd out will not siphon off a significant portion of SCHIP funds. Moreover, some states have pointed out that prohibiting insured children from participating in SCHIP does not take into account the quality of their existing

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[67]The survey was conducted as part of a larger study of employer-based coverage of dependent children. The sample consisted of an equal distribution of small, medium, and large businesses and was regionally stratified. Small businesses included those with 10 to 99 employees, medium-sized businesses were those with 99 to 1,000 employees, and large businesses had more than 1,000 employees. The sample included a significant proportion of businesses most likely to employ low and moderate wage workers. See Harriette B. Fox and Margaret A. McManus, The Potential for Crowd Out Due to CHIP: Results from a Survey of 450 Employers, The Child Health Insurance Project, Fact Sheet #3, (Washington, D.C: Maternal & Child Health Policy Research Center, March, 1998).

[68]See David M. Cutler and Jonathan Gruber, "The Effect of Medicaid Expansions on Public Insurance, Private Insurance, and Redistribution," American Economic Review 1996; 86(2): 378-83; Deborah J. Chollet, Michael Birnbaum, and Michael J. Sherman Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience, Monograph for The Robert Wood Johnson Foundation. October 1997; John Holahan "Crowding Out: How Big a Problem?" Health Affairs 16(1) (1997), pp. 204-206.

insurance coverage, which may be much more limited than either Medicaid or the SCHIP benchmark plans. For example, Alabama officials said the state is "rife with poor coverage," including catastrophic plans with large deductibles that provide no incentive for preventive care. Finally, some researchers who attempted to estimate the extent of crowd out suggested that there may be benefits in the health improvements gained when expanded public insurance that encourages improved use of preventive care substitutes for limited private coverage.[69]

HCFA CROWD OUT SCRUTINY FOCUSED ON HIGH RISK SCHIP DESIGNS

While Title XXI requires states to address crowd out, Congress provided no direction to HCFA or the states on how to do so. In fact, Title XXI somewhat limits states' ability to employ higher cost sharing or benefit limitations, tools used previously to prevent crowd out. As noted in Appendix II, states must follow either Medicaid or SCHIP restrictions on cost sharing, depending on the state plan design and child's family income level. However, several states, including Arkansas and Nevada, have indicated a preference for gradually increasing cost sharing levels for children in families with higher incomes. They suggest that SCHIP limits on cost sharing for higher income families makes their contributions artificially low compared to those in the private market, thereby reducing incentives to keep private coverage. States are required to use one of several benchmark benefit packages outlined in Title XXI. For some states with employer-based coverage less generous than SCHIP coverage, the relative richness of these benchmark packages contributes to the crowd out concern.

As a consequence of Title XXI's limited direction on crowd out, HCFA guidance to states was developed based on the available research, and has evolved as the agency gained more experience in reviewing state plans. On February 13, 1998, the agency issued guidance for states who elected to provide coverage directly through a stand-alone program or a Medicaid expansion, and a separate mandate for states electing to subsidize employer-sponsored group health plans. Regarding the former, HCFA imposed no specific crowd out mechanisms; rather, it indicated that states, especially those with higher income eligibility levels, must address crowd out of private insurance in some manner. States were put on notice that HCFA would later review crowd out efforts and might require states to alter their plans if crowd out proved to be a problem. Because HCFA believes there is greater potential for substitution when states attempt to subsidize employer-based coverage, the letter spells out a specific 5-point mandate for states who pursue this option. (See Figure V.2) As indicated in the guidance, the most scrutiny was directed toward those programs with eligibility at higher poverty levels and to those proposing or considering employer subsidies, which tend to be stand-alone and combination plans. However, HCFA officials said that any

[69]David M. Cutler and Jonathan Gruber "Medicaid and Private Insurance: Evidence and Implications," Health Affairs 1997; 16(1):194-200.

Medicaid expansion raising income eligibility to higher levels also will be held to crowd out prevention requirements. During SCHIP plan review, HCFA was sensitive to the different needs and circumstances prevalent among states, agency officials told us. For example, states were free to chose different time frames for their waiting periods and will design their own crowd out studies.

Figure V.2: HCFA Crowd Out Requirements for State's Subsidizing Employer Based Coverage

HCFA requires states subsidizing employer-sponsored group health plans under their SCHIP programs to incorporate provisions that are "substantially equivalent" to the following:

- adopting a 6 to 12 month waiting period during which children must have no existing insurance;
- allowing subsidies only where the employer covers at least 60 percent of the employee cost;
- demonstrating cost-effectiveness of family coverage, where the cost is no greater than the cost of covering the children alone;
- ensuring that the employer pays the highest level of premium possible; and
- requiring a crowd out study to help demonstrate cost effectiveness.

CROWD OUT STRATEGIES REFLECT DESIGN CHOICES AND PREVIOUS STATE EXPERIENCE

Among the 15 states in our sample, strategies to avoid crowd out varied, depending on program design and poverty level eligibility standards. Title XXI allows all participating states to impose a waiting period, but generally only states that select a stand-alone approach may use cost sharing or the SCHIP benefit design to discourage crowd out. Unless operating with an 1115 waiver, states that elect to expand Medicaid must offer the Medicaid benefits package and may not introduce cost sharing for most children. State strategies also differed depending on their level of concern regarding crowd out, which often was influenced by previous experience with a state-funded children's health insurance program. At issue for some states was the level of crowd out that could be considered acceptable and, thus, not serious enough to address. While several states said they developed their crowd out strategies because of local concern, others included prevention measures only as a result of the legislative mandate or HCFA's review. In general, states covering children at higher income levels tend to have more aggressive crowd out strategies

Wide Range of State
Views About Crowd Out

The SCHIP plans of 13 of the 15 states in our sample include strategies that are intended, either directly or indirectly, to help prevent crowd out. Each of these 13 state's SCHIP programs has income eligibility levels greater than 150 percent of the poverty level.[70] In two states, Texas and South Carolina, the Medicaid expansions were at low enough poverty levels (100 percent and 150 percent, respectively) that significant crowd out was not considered likely.

States in our sample ranged from exhibiting either a deep concern about crowd out to a conviction, in part based on previous experience, that crowd out was unlikely to be a problem. For example, Missouri, a Medicaid expansion state raising its eligibility level to 300 percent of poverty, had serious concerns about crowd out and instituted broad-ranging preventive measures, including a 6 month waiting period and cost sharing. In a unique provision, the state requires those children whose family incomes are between 225-300 percent of the poverty level to wait 30 days after enrollment before accessing health care services. State officials believe this will prevent people from "shopping for health care" only at times of illness.

Several other states agreed to mitigation plans or crowd out studies only after discussion with HCFA. Connecticut's crowd-out provision -- a 6 month waiting period without employer-sponsored insurance -- was a response to federal directives and was developed by studying the tactics of other states and charting a mid-course. Connecticut officials said the state built "flexibility" into its prevention strategies by establishing 10 exceptions to its waiting period requirement and including a provision to increase the waiting period to 12 months if crowd out is identified as a serious problem.[71] Most states with waiting periods also allow some exceptions, though they are not as extensive as in Connecticut in most of our sample states. Connecticut also will coordinate with employers to "audit" 20 percent of its applicants to ensure that they did not drop available coverage; if needed, the state will expand the audit process to 50 percent of applicants.

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[70]A July 1998 HCFA report also shows that those states with higher eligibility levels have more extensive crowd out prevention components. Of the 23 states profiled, the 15 with higher income levels planned waiting periods or studies. The remaining eight states planning only to monitor the situation were covering children with family incomes at or less than 150 percent of the poverty level.

[71] Exceptions include the loss of employment due to factors other than voluntary termination; a change to a new employer that does not provide a dependent coverage option; and discontinuation of health benefits to all employees by the applicant's employer.

States Choose Waiting Period
Most Often As Prevention Strategy

The crowd out strategy most often adopted by states in our sample was to impose a waiting period, as shown in Table V.1.[72] The assumption is that parents will not want currently-covered children to go without health insurance for several months, and as a result will be discouraged from dropping private coverage. California initially has selected a 3-month waiting period that will be increased to 6 months if the state finds it is covering substantial numbers of children previously covered under employer-sponsored plans. In contrast, Rhode Island had implemented crowd out provisions in 1994 when it received approval to expand eligibility and operate its Medicaid program under a Section 1115 waiver. The state continued to require a 12 month waiting period when it expanded the program to incorporate SCHIP, and requires applicants to be not only uninsured but without access to affordable insurance prior to applying for SCHIP.[73] Of the four states conducting studies to determine if SCHIP programs either resulted in or increased crowd out, all will impose some type of waiting period if the studies find sufficient crowd out exists.

[72]Notably, even Medicaid expansion plans were allowed to implement waiting periods. A HCFA official said imposing a waiting period on the "targeted low income children" eligible under SCHIP does not violate Medicaid entitlement rules because the eligibility focus is on the child's income level, rather than on the Medicaid eligibility categories. In effect, SCHIP Medicaid expansions can require different eligibility criteria for children to participate in the program than those of regular Medicaid programs.

[73]Rhode Island describes affordable coverage as costing less than $150 per month for premiums for an individual or less than $300 per month in premiums for a family.

Table V.1: State Crowd Out Strategies, GAO Sample of States

Strategy	State
Waiting period with no insurance	
■ 1 month	Vt.
■ 3 months	Calif., Colo., Wis.
■ 6 months	Conn., Mich., Mo., Oreg.
■ 12 months	R.I.
Crowd-out study and implement waiting period or access limits if needed	Fla., Mass., N.Y., Pa.
Cost-sharing (premiums or co-pays)[a]	Calif., Mo., N.Y.
Compare SCHIP enrollment to data on private coverage	Mass., Mich., Pa.
State insurance regulation	Calif.

[a]South Carolina and Texas noted plans to use cost sharing in proposed Phase II components as a means of crowd-out prevention. Neither state's current Medicaid expansion imposes cost sharing.

Two of these states, Florida and New York, had found low levels of substitution in studies of their previous state-funded children's health programs, and questioned how much priority they should place on the issue. The third state, Pennsylvania, did not have a previous crowd out study but also disagreed with the importance attached to crowd out during the review of state SCHIP plans. In the end, all three states finally complied with HCFA's request to include prevention components in their plans. HCFA expressed concern that the existing evaluations might poorly predict SCHIP substitution effects because those children targeted under SCHIP had higher incomes than those already in their state funded programs. Under the agreement reached with HCFA, Florida will conduct a crowd out study after 6 months of enrollment, and will add a 3 month waiting period if crowd out is greater than that found previously. Florida officials also decided to fully study and re-evaluate crowd out after 36 months of operation. New York agreed to study crowd out for 9 months and impose a waiting period or restrictions for children with insurance access if more than 8 percent of SCHIP enrollment is attributed to crowd out. New York also had argued that a waiting period served to "penalize" a child for actions taken by a parent or employer to drop private coverage. For example, the state was opposed to making a child with asthma wait 6 months for care. Finally, after studying both Florida's and New York's mitigation plans, Pennsylvania agreed to take crowd out action if at least 12 percent of SCHIP enrollment is the result of crowding out of private insurance.

While 11 states in our sample require participants to pay either premiums and/or copayments (See Appendix II, Table II.6), only three characterized their cost sharing provisions as intended to prevent crowd out. Cost sharing helps to narrow the cost

difference between public and private insurance, reducing the likelihood that lower out of pocket costs for SCHIP would attract individuals with existing insurance. In addition to waiting periods and cost sharing, some states are using other methods to prevent crowd out. A few states asserted that eliminating or limiting dental coverage within benefits packages may make the plan less attractive to families with existing insurance. Several states indicated they plan to periodically check their SCHIP enrollment with private insurers to identify and disenroll or deny coverage to those who have or have recently dropped private coverage. For example, Pennsylvania provides SCHIP benefits through five state grantees — an HMO and 4 subsidiaries of large health insurance providers. These grantees will compare SCHIP applicants' names against their commercial subscribers to determine if they have other coverage. Michigan is considering whether to contract with Blue Cross/Blue Shield to compare its applicants with their commercial enrollees and with Medicaid. This venture would allow the state to review coverage for about 75 percent of people with health insurance in Michigan. To protect its public programs, California passed insurance regulations that prohibit insurance agents from referring children covered by employee plans to the state's stand-alone program.[74] The state also makes it an unfair labor practice for an employer to either refer a covered employee to SCHIP, or to change the employee's coverage or cost sharing to induce enrollment in the state program.

Several state officials expressed concern that HCFA did not use consistent standards among states for crowd out studies. HCFA officials acknowledged that crowd out scrutiny evolved as they gained more review experience. Agency representatives said they intentionally did not set specific crowd out study standards in order to consider each state's previous crowd out research and expectations of SCHIP impact. For example, New York's previous study, which was conducted when the state provided only outpatient care and not the hospitalization included in the SCHIP expansion, found only a 2 percent crowd out effect. HCFA, however, believed that the expansion of both the poverty level and benefits under New York's SCHIP stand-alone would increase crowd out. After negotiations, the state agreed that an 8 percent crowd out effect would trigger prevention measures. In contrast, Florida's earlier crowd out study had indicated a 10 percent crowd out effect under its previous state program. Therefore, Florida's waiting period should be triggered if the same level, or higher, crowd out occurs with its SCHIP program, HCFA officials said.

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[74]In addition to California, Rhode Island had previously enacted legislation that prohibits employers from dropping coverage for lower income employees who might be eligible for publicly-funded programs, while maintaining insurance coverage for higher-income employees. The law includes civil penalties and extends a federal requirement that only applies to employers who choose to bear the financial risk of offering coverage themselves to firms who rely on an insurance company to bear the risk.

States Face Crowd Out Scrutiny If
They Explore Employer-Based Options

Although HCFA views crowd out as particularly worrisome for states that elect to subsidize employer based insurance, states as well as some analysts view such subsidization as helping to preserve employer based coverage. To date, only Massachusetts has received approval for the employer-subsidy option under its SCHIP program, though several other states have expressed interest in this option for future SCHIP amendments. Massachusetts believes that the incentives for employees to drop workplace coverage are removed with their premium assistance program; the SCHIP stand-alone program covers low income families with access to employer insurance who have not enrolled, while the state's 1115 Medicaid waiver can assist those who already pay for employer coverage. State officials said that their challenge will be to educate families that they do not have to drop existing employer coverage in order to be eligible for premium assistance. Massachusetts is more concerned about the response of employers, who may have an incentive to reduce their premium contribution, thereby increasing the public subsidy, or to drop dependent coverage entirely. The state will conduct a survey of employers to track contribution levels and other state insurance trends. If it finds evidence of employer-connected crowd out practices, Massachusetts will attempt to develop corrective action plans. California, which is planning to submit an employer subsidy amendment, told us that keeping children in their parent's employer-based insurance program ameliorates crowd out by providing an affordable option to families. With the SCHIP subsidy, families are able to buy the previously unaffordable dependent coverage offered at their workplace.

COORDINATION REQUIREMENTS SEEK TO
LIMIT SCHIP'S CROWDING OUT OF MEDICAID

Title XXI also reflects an expectation that SCHIP may substitute for traditional Medicaid coverage. There were misgivings that states would have an incentive to enroll Medicaid-eligible children into SCHIP, since the federal financial match is higher for the new program. Children's advocates were concerned that Medicaid-eligible children incorrectly enrolled into a stand-alone program would have less generous benefits or would find themselves dropped from coverage when or if SCHIP funding ended because the program, unlike Medicaid, is not an entitlement. As a result, state coordination efforts were mandated to ensure that children who qualify for Medicaid are enrolled in that program, rather than in a SCHIP program, and that their applications are fully processed for Medicaid when they are not eligible for SCHIP. HCFA's plan review process led some states to upgrade their screening strategies to check children first for Medicaid eligibility and to create closer links between stand-alone and Medicaid programs.

The possibility of SCHIP substitution is highlighted by the large numbers of Medicaid-eligible children now without health insurance. As noted in Appendix IV, nearly one-fourth of the children who currently are Medicaid-eligible are not enrolled. For example, California has estimated that while it has 400,000 children eligible for its stand-alone program, another 600,000 children are eligible but not enrolled in its Medicaid program. States' unenrolled Medicaid-eligible children may be likely to apply for SCHIP programs if they are attracted by the new outreach efforts that states have developed to attract SCHIP-eligible children and families. CBO estimated that, nationwide, the "outreach effect" of SCHIP will increase Medicaid spending by $2.4 billion over the first five years of SCHIP enrollment because of an increased enrollment of 460,000 Medicaid-eligible children each year.[75]

Title XXI contains three provisions aimed at preventing SCHIP from substituting for Medicaid coverage. First, states must include assurances in their program plans that they will develop Medicaid coordination strategies. Secondly, as implemented by HCFA, maintenance of effort provisions for Medicaid eligibility apply to both Medicaid expansion and SCHIP stand-alone plans. States with stand-alone components cannot adopt income and resource methodologies for Medicaid children that are more restrictive than those in effect on June 1, 1997. Medicaid expansion programs cannot use the SCHIP enhanced match rate for any child that would have been eligible for Medicaid under standards in effect on March 31, 1997. Finally, any child who applies for SCHIP must be screened for Medicaid and then enrolled, if found eligible. Missouri officials listed the strong coordination requirements in the legislation as a factor that supported the decision to fold SCHIP into an application for a Section 1115 waiver and an expanded Medicaid program.

HCFA's approach during plan review was to query states closely and require assurances regarding plans to screen and enroll Medicaid-eligible applicants. HCFA asked 8 of our 15 sample states for more information about how they intended to meet the screening and enrolling requirement and a few states amended or revised planned screening processes to meet HCFA's requirements. In response to HCFA's review, for example, Pennsylvania developed a common application form and initial Medicaid screening to ensure Medicaid enrollment. Colorado had developed a non-automated screen to prevent Medicaid-eligible children from enrolling in its previously state-funded insurance program. Because HCFA did not consider it adequate for SCHIP, the state hired a Medicaid consultant to create a new computer-based program to screen applicants. Even with this computerized method, Colorado officials characterized the screening process as time-consuming and administratively costly.

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[75]Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies (GAO/HEHS-98-93, March 20, 1998).

States Find Initial Screen for
Medicaid Eligibility Meets Mandate

Coordination with Medicaid is easier for a Medicaid expansion state because SCHIP is administratively part of its Medicaid program. On the other hand, some stand-alone programs expended significant time and expense to create new administrative structures and find ways to connect them with Medicaid. The most practical way for states with stand-alone components to meet the screening and enrollment mandate is to check first for Medicaid eligibility. The states in our sample with stand-alone components have all included screens for Medicaid eligibility as the first step in the eligibility determination process. They are also using a joint application form for both programs. All but three of the 48 states whose applications had been submitted to HCFA by October 8, 1998, were using or planning to use a single application for regular Medicaid and SCHIP-related applicants.[76]

Some states are also using a single agency or entity to screen and track referrals for both programs, or are developing a coordination plan if there are two offices involved. For example, Michigan and Connecticut use a private contractor to accept applications for both the expanded Medicaid and the new stand-alone programs and refer appropriate applications to the state Medicaid eligibility agency. Connecticut's Single Point of Entry Servicer will take all applications, determine whether a child may be eligible for Medicaid through an on-line interface with the state's eligibility system, and if needed, send the application to the Department of Social Services (DSS) for final eligibility determination. The contractor keeps daily logs of referrals to DSS and the state has a tracking system to follow referrals once they reach the DSS office. In Colorado, the stand-alone administrator and Medicaid office developed an agreement that each will forward applications for children who appear to qualify for the other's program. Other states, including California and New York, will compare SCHIP participant lists against Medicaid enrollment files to ensure that children are not already covered.

As anticipated under the enabling legislation, several states have found a significant number of Medicaid-eligible children as initial applicants for their new SCHIP programs. Connecticut expects that up to 50 percent of all applicants to its stand-alone program will be Medicaid-eligible, while New York officials believe anywhere from 20 to 40 percent of the approximately 170,000 children already in its existing state program will be found Medicaid-eligible. New York's request for retroactive funding for its state-turned-SCHIP program was denied in large part because it previously lacked an extensive Medicaid screening and enrollment process. HCFA

[76]HCFA reported that Colorado, Florida, Montana, Nevada, and North Carolina, all with stand-alone programs, are not using joint applications. However, Colorado and Florida indicated in interviews that they have adopted joint applications.

indicated that it will not include Medicaid eligible children's expenses in a retroactive payment for health expenses since October, 1997. New York has requested an "indefinite continuance" of its appeal, which is before an administrative law judge. Other states have reported finding applicants inflating income in order to qualify for SCHIP rather than Medicaid, or refusing to continue the application process to avoid Medicaid enrollment.

As SCHIP programs evolve, coordination plans may be complicated by the income volatility seen among many low-income families due to fluctuation in paychecks and changing employment. Periodic reviews of SCHIP eligibility will result in states shifting any children found Medicaid eligible out of SCHIP and into Title XIX. This suggests that at redetermination of eligibility there could be significant movement in and out of stand-alone and Medicaid programs. The changes may result in either health care coverage lapses as children move into and out of programs or in situations where states use SCHIP funds to cover individuals whose changed income has made them ineligible. States may offset these problems by choosing to allow continuous eligibility for up to 12 months for participants of both Medicaid and SCHIP programs. Six of our 15 sample states use 12 months of continuous eligibility for SCHIP programs, while Florida and Rhode Island have a 6-month allowance. Additionally, California has instituted a 1-month continuing eligibility transition period from Medicaid to the combination SCHIP programs to give those who lose Medicaid eligibility time to enroll in the SCHIP program while continuing to receive health coverage. For children who become eligible for Medicaid because of high medical expenses, Michigan will allow these children to remain enrolled in SCHIP to ensure continuity of care. Finally, HCFA officials noted that if families found that their children were later Medicaid eligible, they could request their status be changed from that of SCHIP to Medicaid eligibility. A family whose circumstances worsened might do this in order to avoid copayments or premiums.

Appendix VI

Key SCHIP Design Characteristics of GAO Sample (as of 2/99)

State	FY 1998 SCHIP Allocation (millions)	Initial Design Approach	Maximum Income Eligibility[1] (% FPL)	Stand-alone Coverage Basis[2]	Cost-Sharing Practices
Calif.	$854.6	Combination	$32,900 (200%)	Benchmark	Premiums, Copayments
Colo.	41.8	Stand-Alone	$30,433 (185%)	Benchmark-Equivalent	Premiums, Copayments
Conn.	34.9	Combination	$49,350 (300%)	Benchmark	Premiums, Copayments
Fla.	270.2	Combination	$32,900 (200%)	Existing State Coverage	Premiums, Copayments
Mass.	42.8	Combination	$32,900 (200%)	Benchmark	Premiums, Copayments
Mich.	91.6	Combination	$32,900 (200%)	Benchmark	Premiums
Mo.	51.7	Medicaid Expansion	$49,350 (300%)	N/A	Premiums, Copayments
N.Y.	255.6	Stand-Alone	$36,519 (222%)	Existing State Coverage	Premiums
Oreg.	39.1	Stand-Alone	$27,965 (170%)	Secretary Approved Coverage	None
Pa.	117.5	Stand-Alone	$32,900 (200%)	Existing State Coverage	None
R.I.	10.7	Medicaid Expansion	$41,125 (250%)	N/A	Premiums, Copayments
S.C.	63.6	Medicaid Expansion	$24,675 (150%)	N/A	Cost sharing not permitted by Title XXI
Tex.	561.3	Medicaid Expansion	$16,450 (100%)	N/A	Cost Sharing not permitted by Title XXI
Vt.	3.5	Stand-Alone	$49,350 (300%)	Medicaid benefits	Premiums, Copayments
Wis.	40.6	Medicaid Expansion	$30,433 (185%)	N/A	Premiums

Major Amendments (interested, planning, or submitted)		Eligibility, Enrollment Simplification[3]	Crowd Out Strategies[4]	Enrollment (thousands)
Employer Buy-In (EBI) coverage, family coverage	Stand Alone Component			
Submitted, EBI for children	N/A	No Asset Test Continuous Eligibility	Waiting Period, Cost-Sharing, Insurance Regulation	Xx, xxx
Planning, EBI for children Interested, family coverage	N/A	Medicaid Presumptive Eligibility Continuous Eligibility	Waiting Period	
Planning, family coverage	N/A	Medicaid Presumptive Eligibility No Asset Test Continuous Eligibility	Waiting Period	
Submitted, EBI for children	N/A	No Asset Test Continuous Eligibility	Crowd Out Study	
None	N/A	Medicaid and SCHIP Presumptive Eligibility No Asset Test	Crowd Out Study, Compare Enrollment With Private Data	
Interested, family coverage	N/A	SCHIP Presumptive Eligibility No Asset Test Continuous Eligibility	Waiting Period, Compare Enrollment With Private Data	
None	None	Medicaid Presumptive Eligibility No Asset Test Continuous Eligibility	Waiting Period, Cost Sharing	
None	N/A	SCHIP Presumptive Eligibility No Asset Test	Crowd Out Study, Cost Sharing	
Planning, family coverage	N/A	Medicaid and SCHIP Presumptive Eligibility Continuous Eligibility	Waiting Period	
None	N/A	No Asset Test Continuous Eligibility	Crowd Out Study, Compare Enrollment With Private Data	
Submitted, family coverage	None	Continuous Eligibility	Waiting Period	
Interested, family coverage	Planning	No Asset Test Continuous Eligibility	None	
None	Planning	None	None	
None	N/A	No Asset Test	Waiting Period	
None	None	No Asset Test	Waiting Period	

Notes

[1] States may increase eligibility up to 50 percentage points above current Medicaid eligibility levels, or to 200 percent of the Federal Poverty Level (FPL). Some states waive consideration of certain portions of income to effectively increase their eligibility level above 200 percent.

[2] For a description of benchmark covergage options see Fig. II.2 in Appendix II.

[3] For description of state approaches to simplifying eligibility and enrollment, see Appendix IV.

[4] For a description of state strategies to prevent the substitution of SCHIP for either Medicaid or private health insurance, see Appendix V.

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