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SCHIP Turns Five: Gaining Ground, But Not Enough

Ian Hill, The Urban Institute

Introduction

Five years into SCHIP, evaluations have provided early positive evidence regarding SCHIP's success, and rates of uninsurance among children appear to have been reduced

In 1997 Congress enacted the State Children's Health Insurance Program (SCHIP) with bipartisan support, as Title XXI of the Social Security Act. The program allows states to extend health insurance coverage to children not eligible for Medicaid, provides a higher federal match than Medicaid, and was funded for 10 years at $40 billion.

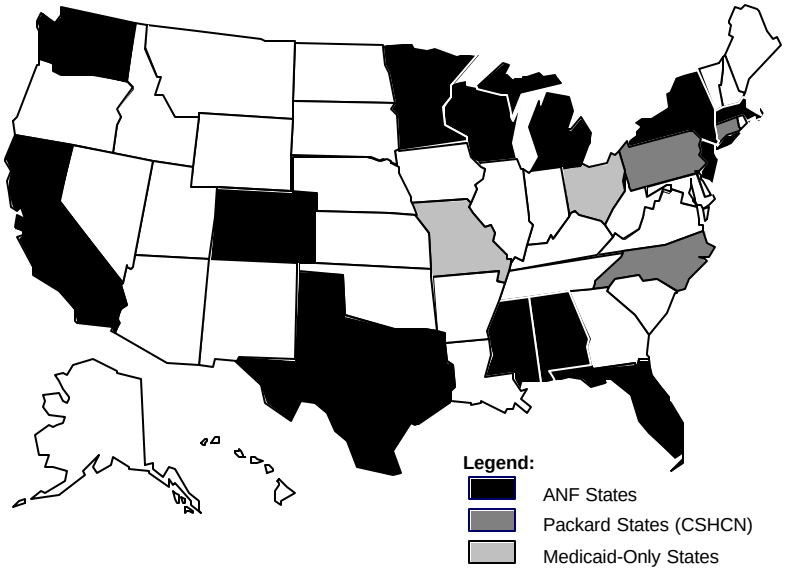
SCHIP gives states the opportunity to expand insurance coverage to uninsured children whose family income is too high to qualify for Medicaid. States may cover these children by expanding Medicaid (in which case they must extend open-ended "entitlement" to eligible children), creating a separate program, or using a combination of the two methods. Five years into SCHIP, evaluations have provided early positive evidence regarding SCHIP's success, and rates of uninsurance among children appear to have been reduced. This report will review the evidence to date of program accomplishments, barriers encountered, and challenges that lie ahead.

The Urban Institute's SCHIP Evaluation

Since SCHIP's inception, the Urban Institute has been engaged in an evaluation of the program as part of its Assessing the New Federalism (ANF) Project. This multi-year evaluation, which is jointly funded by the Robert Wood Johnson Foundation, the David and Lucille Packard Foundation, and the Kaiser Commission on Medicaid and the Uninsured, looks at Medicaid and SCHIP nationally, but examines program implementation more closely in 13 "focal" states, including Michigan (see Figure 1, map of study states).

The qualitative component, directed by the author, relied on site visits to the focal states[37] conducted between 1999 and 2001, as well as periodic telephone interviews with state and local officials. The quantitative component, directed by Lisa Dubay and Genevieve Kenney, relies on the National Survey of America's Families and the Current Population Survey.

Figure 1: Study States for the UI/SCHIP Evaluation



What has been accomplished?

States have taken advantage of SCHIP's flexibility to expand health insurance coverage.

The Title XXI statute creating SCHIP afforded states great flexibility in designing their child health programs, and within approximately two years, all 50 states and the District of Columbia had implemented programs[38]

The Title XXI statute creating SCHIP afforded states great flexibility in designing their child health programs, and within approximately two years, all 50 states and the District of Columbia had implemented programs.[38] States also had the option to:

1. Choose program models (Medicaid expansion, separate program, or combination approach),
2. Set eligibility limits up to 200% of ***Federal Poverty Level*** (FPL) or higher,
3. Engage in outreach and recruitment activities, and
4. Simplify enrollment procedures.

Those who used Medicaid expansion programs were required to adopt the full benefit package mandated under Medicaid, but states that created separate programs could adopt a more limited benefit package, as long as it met any one of several federally-identified "benchmark" plans. Separate programs could also impose cost sharing at significantly higher levels than those allowed by Medicaid, cap enrollment, and adopt various strategies to prevent SCHIP from "crowding out" existing private health insurance.[39]

How states have used this flexibility

Eligibility has included the near poor. Two thirds of the states set their income eligibility thresholds at 200% of FPL or above; 27 (including Michigan) adopted expansions to 200% of FPL. Thirteen states chose to cover children in families with higher incomes, the highest being New Jersey at 350% of FPL. Importantly, SCHIP has generally equalized eligibility for coverage across

children of different age groups[40] because historically Medicaid has had more generous coverage policies for younger children. [This is true of Michigan's SCHIP program, which expands the *Healthy Kids* Medicaid program to include children 16-18 years old whose family incomes are between 100% and 150% of FPL.]

Medicaid-Separate Program Options. Sixteen states opted to expand Medicaid, and thirty-five chose to create separate programs, either alone or in combination with Medicaid expansions. Policymakers in states that chose Medicaid expansions generally held high opinions of their Medicaid programs, and saw them as the most efficient and effective means for increasing coverage.[41] Those who chose separate programs were spurred by a desire to create programs that were "more like private insurance." Those who adopted "combination" programs [as did Michigan] tended to begin with small Medicaid expansions followed by adoption of much larger separate programs.[42]

Outreach and enrollment has been emphasized. In response to encouragement from the federal Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) states have invested unprecedented resources in outreach and enrollment simplification. They have employed strategies such as:

- Statewide public education campaigns
- Targeted community-based efforts to reach and enroll families
- Streamlined enrollment with many states using
    - Short and simple application forms to jointly determine eligibility for SCHIP and Medicaid
    - Application by mail
    - Dropping assets tests
    - Reducing the documentation families must submit with the application.

[Michigan allows online application for MIChild and concurrently screens for Medicaid eligibility. Documentation requirements are reduced.] While simplification of Medicaid enrollment has not kept pace with SCHIP, there has been significant "spillover" of these policies to Medicaid.[43, 44]

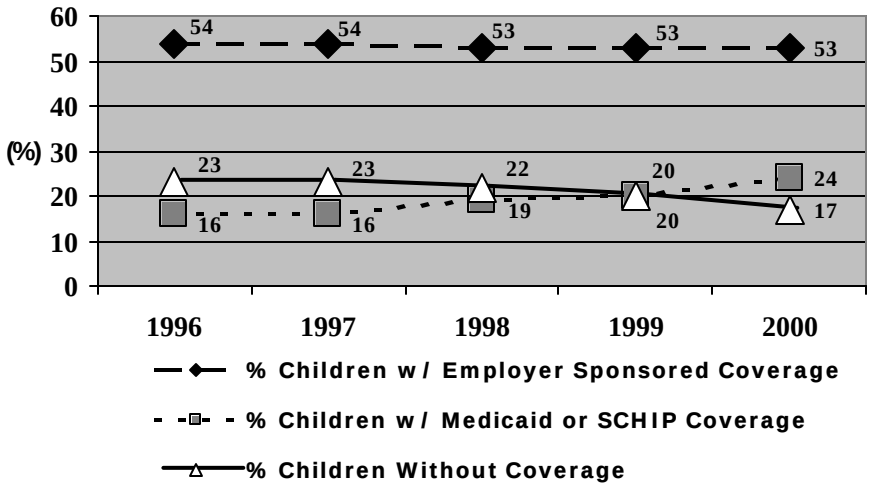
States have adopted generous benefits coverage. Although states creating separate programs had the option to provide a narrower benefit package than that offered by Medicaid, evidence indicates that SCHIP separate programs cover a broad range of preventive, primary and acute care services.[45] One-third of states with separate programs cover the full benefit package of Medicaid, and six others ensure that Medicaid-equivalent coverage is extended to children with special health care needs. In other states, the benefits most often left out are those often needed by children with special health care needs, suggesting that gaps may exist in services for this group.[46, 47]

Use of managed care is nearly universal and is often credited with helping to achieve "good" access to care.[48]

Cost-sharing, where used, appears to be affordable for most families. In general, cost sharing for separate programs, such as premiums and copayments, are well below the maximum allowable limit of 5% of total family income. Qualitative data from focus groups suggest cost sharing measures are "affordable."[49]

"Crowd-out" does not appear to be a problem. States creating separate programs were required to take measures to prevent "crowd-out" of existing employer-based coverage. The majority used initial waiting periods (usually three or six months) for enrollment of those children who were previously insured by private insurance. Exceptions were made for job loss. [In Michigan,

Figure 2 - Coverage Gains Have Occurred for Children
Uninsurance Rate Dropping for Near Poor Children



Source: 1997 through 2001 Current Population Survey
Near poor defined as 100 to 200% FPL
Chart does not include CHAMPUS/Medicare and other insurance

the waiting period is 6 months, except in the case of job loss.] These waiting periods were intended to reduce substitution.

Since SCHIP was enacted in 1997, rates of uninsurance have dropped among children, especially among children in low-income households.[50] In particular there have been substantial declines in the rates of uninsurance among children in "near poor" [100-200% of FPL] families[51]

Following SCHIP, coverage gains have occurred for children.

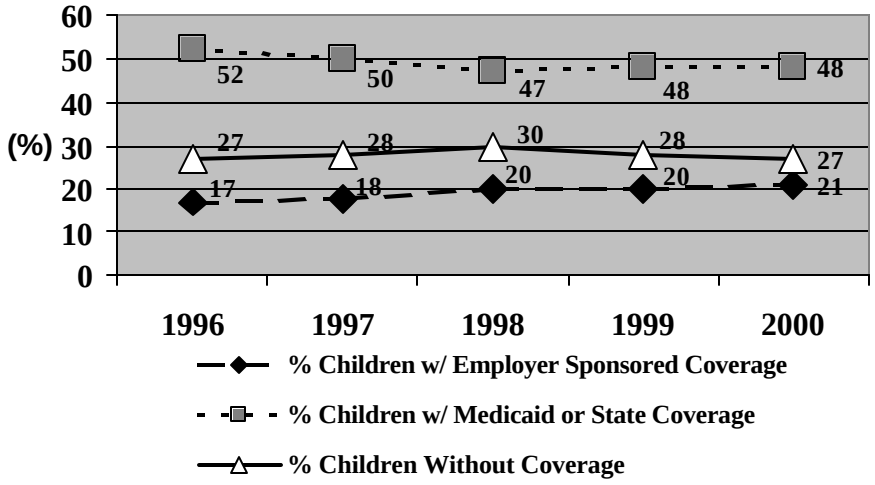
Since SCHIP was enacted in 1997, rates of uninsurance have dropped among children, especially among children in low-income households.[50] In particular there have been substantial declines in the rates of uninsurance among children in "near poor" [100-200% of FPL] families.[51]

Between 1996 and 2000 the rate of uninsurance among this group declined 33% nationally from 23.3 to 17.5 %, probably reflecting increased participation in Medicaid and new SCHIP enrollment as a result of outreach activities and eligibility simplification. During this period, the share of near-poor children covered by SCHIP or Medicaid increased by 7.6 percentage points while the rate of those covered by employer, CHAMPUS/Medicare and other private insurance remained constant. Since 2000, the economic slowdown has resulted in more individuals lacking health insurance because of job losses; however, data from the Current Population Survey indicate that between 2000 and 2002, the rates of insurance coverage for children have held steady.

However, too many children in the United States still are uninsured. Nationally, some 2.7 million near-poor children remain uninsured. The vast majority of these children are eligible for SCHIP or Medicaid.

Awareness of public health insurance programs is increasing. Recent data indicate that low-income families with uninsured children are becoming more familiar with public insurance programs. A significant increase occurred nationally between 1999 and 2002 in the number of these families who had heard of their state's SCHIP program ($p<.10$); in addition among those who had heard of public insurance programs, more understood that a child can participate in the insurance programs without receiving welfare.

Figure 3 - Uninsurance Rate Stagnating for Poor Children



Source: 1997 through 2001 Current Population Survey
Poor defined as below 100% FPL
Chart does not include CHAMPUS/Medicare and other insurance

What has not been accomplished?

In spite of early positive trends in increasing health coverage among near-poor children, the target group for SCHIP, there are signs that the program is not helping to reduce the rates of uninsurance among poor children.

The rate of uninsurance among *poor* children is stagnating.

While the increasing rates of insurance coverage among children in near-poor families is a major accomplishment of SCHIP, the situation for poor families (those with incomes below 100% of FPL) is much less encouraging. In fact, from 1996 to 2000 the uninsurance rate in this group stagnated at 24.9 % for children who were citizens, despite the fact that all were eligible for Medicaid or SCHIP in 2000 (see Figure 3).[52]

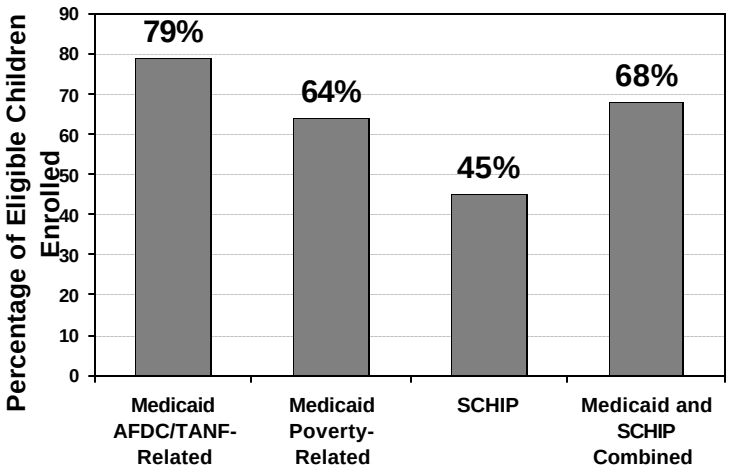
Poor children constitute 21% of all children, but almost 46% of uninsured children.[53] Since states have used SCHIP to make many more uninsured children eligible for public health insurance, only 23% of all uninsured children and only 16% of poor children are not eligible for public insurance.[54]

Importantly, many more uninsured children are eligible for Medicaid than for SCHIP. Of the 8.9 million uninsured children in the US in 1999, for example, 52% were eligible for Medicaid but only 25% were eligible for SCHIP. The highest participation rates among eligible children were among those children who received Medicaid because of their participation in the Temporary Assistance to Needy Families (TANF) program, while rates were lower among higher income children not receiving TANF who were Medicaid-eligible or those who were eligible for SCHIP (see Figure 4).

It is evident that accomplishing further reductions in uninsurance rates will require increasing participation in Medicaid as well as SCHIP.

Figure 4: Participation in Public Health Insurance Programs Varies Across Program Type

(Citizen Children Age 0 to 17, Excluding Private Coverage, 1999)



Source: 1999 National Survey of America's Families.

Note: Simulation uses income and insurance distribution from the 1999 NSAF and Medicaid and SCHIP eligibility rules in place as of July 1999.

Continuing barriers to participation

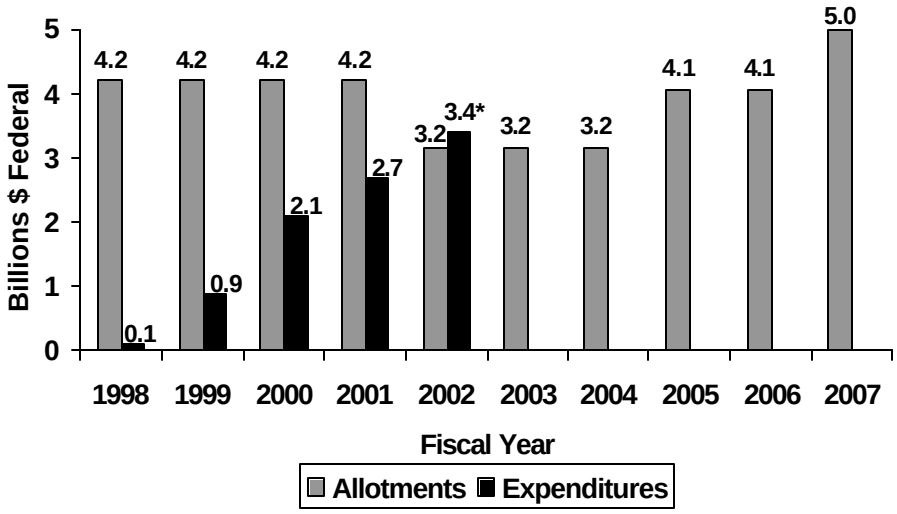
Reasons for nonparticipation. Recent analyses indicate that the causes of uninsurance among eligible children who are not enrolled are complex.[55, 56]

Parents give various reasons for not enrolling their children, including:

- Knowledge gaps, such as:
    - Lack of awareness of the program
    - Not knowing their children are eligible
    - Believing that participation in welfare is required for Medicaid/SCHIP enrollment
- Administrative hassles, including:
    - Complicated application forms and documentation requirements
    - Lack of transportation
    - Language barriers
- Not wanting public insurance or believing it is not necessary

Retention and re-enrollment of eligible children. Despite recent gains in SCHIP enrollment, states are struggling to retain families once enrolled. Retention rates of less than 50% are not uncommon. Enrollment/re-enrollment processes may pose particular problems for poor families. Recent research[57] indicates that the families of many eligible children without coverage have experience with the programs. For example, one study found that 29% of low-income uninsured children had either recently disenrolled from public coverage or had begun, but not completed, the enrollment process during the previous year. Increasing participation may require further simplifications to Medicaid

Figure 5: SCHIP Funds Plentiful to Date, But May Run Short



SCHIP expenditures for FY '02 based on projections

enrollment and use of community-based outreach workers [see snapshots of the Eastside Access Partnership and Covering Kids, for local outreach examples].

What challenges lie ahead?

SCHIP funds may run short.

SCHIP was funded with approximately $40 billion in federal funds for fiscal years 1998 to 2007. Although an average of $4.0 billion per year was allocated, the allotment started at $4.2 billion (see Figure 5), then dipped to $3.1 billion for FY 2002, 2003, and 2004, returning to the higher level for the last years. In addition, states were given 3 years to spend each year's allotment, after which time unspent funds would be redistributed to states whose spending outstripped their allotments. This policy had the effect of fully funding the program shortly after start up and then reducing funds just as most programs were fully implemented. As shown in Figure 5, spending in the first 3 years was far below the allotments, but by FY 2002 it had caught up.

The Congressional Budget Office projects that there will be federal funding shortfalls in SCHIP in the coming years due to lower allotments and the fact that, after three years, unspent funds can be redistributed to other states.

States are facing the first fiscal crisis in a decade.

As the US economy has encountered the first downturn since the early 90's many states, including Michigan, are facing severe budget shortfalls. Few states are considering revenue enhancements as a solution to the crisis, but spending cuts are a major strategy for budget balancing.[58]

How has SCHIP fared as states face budget crises?

As part of the ongoing qualitative evaluation of SCHIP, the Urban Institute conducted telephone surveys of SCHIP directors in the 13 ANF states (see Figure 1) during the summer/fall of 2002 and again in the fall of 2003. These interviews explored whether states were enacting or considering changes in SCHIP that would reduce eligibility, outreach, or benefits, or increase cost sharing by families.

Last year, the evaluation team found that SCHIP had "dodged the first budget axe." **This year, preliminary analysis of the data indicates that more cuts have been enacted, but SCHIP has fared relatively well.** In 2003 the following changes were made in response to budgetary restraints:

- One third of the study states reduced the upper income thresholds or capped eligibility
- Over half the study states imposed more restrictive enrollment procedures, such as:
  - Reinstating assets tests
  - Reducing enrollment periods from 12 months to 6 months
  - Shortening the renewal grace period
- One quarter of the states reduced outreach even further (this was already occurring in 2002)
  - Some states, including Michigan, eliminated the application assistance fee provided to community groups who help enroll children
- One quarter cut benefits, such as dental, vision and hearing services
  - Texas, Alabama, and Florida used this option
  - Texas made the most severe cuts
- Over half the states raised cost-sharing amounts
- One state imposed more stringent crowd-out prevention safeguards
- Half the states froze or reduced provider reimbursement

Overall, the cuts that were made to SCHIP programs tended to "chip at the edges" rather than make drastic changes in eligibility or benefits. States tended to cut coverage to parents first, while keeping benefits to children relatively intact

[Michigan had originally considered folding the MIChild separate program into Medicaid Healthy Kids because of a large premium increase requested by Blue Cross/Blue Shield of Michigan (BC/BSM), the largest provider of MIChild. In late summer of 2003 the state and BC/BSM reached an agreement to partner in subsidizing MIChild for two years].

Overall, the cuts that were made to SCHIP programs tended to "chip at the edges" rather than make drastic changes in eligibility or benefits. States tended to cut coverage to parents first, while keeping benefits to children relatively intact. In many cases states viewed these changes as "choosing the lesser of evils." Many "cuts" were described as small and reasonable, and must be placed in context. For example, while several states increased premiums, the increases were proportionally much smaller than those of private insurers during the same period.

On the other hand, some state chose to freeze enrollment rather than erode other aspects of the program. These states believed that it was more important to preserve the integrity of the program by temporarily closing the program to new enrollments rather than make changes to the package. Enrollment caps were designed as temporary measures to reduce enrollment to target levels.

In spite of the budget difficulties, some states continued to enhance their SCHIP programs.

In spite of difficult economic times:

- **Half of the study states continued to simplify enrollment, for example:**
  - Michigan is expanding its electronic enrollment process and developing preprinted renewal forms
  - California is instituting "***express lane" eligibility*** and ***presumptive eligibility*** for all children receiving free/reduced lunch
- **Two states increased outreach**
- **Two states added new benefits:**
  - Minnesota instituted a mental health benefit
  - New York added emergency transportation and hospice care
- **One state reduced crowd-out prevention safeguards**

Why is children's health coverage so resilient?

In spite of states' fiscal crises, reductions in SCHIP have been relatively mild. There are a number of reasons that states give for the resilience of these programs:

- **SCHIP (and Medicaid for children) are viewed as successfully addressing a critical need**
- **SCHIP is protected by its small size relative to Medicaid**
- **Policymakers like programs they can control (rather than entitlement programs)**
- **The high federal match rate for SCHIP makes it hard to justify cuts**
- **Policymakers do not want to cut programs that explicitly benefit children**

Further progress will be dependent on the ability of states to enroll additional children

How can we maintain or enhance our progress?

As the Urban Institute's SCHIP evaluation has demonstrated, much progress has been made in increasing health coverage of children, particularly children of the near-poor. This progress can be attributed to active outreach for SCHIP that has also identified many children eligible for Medicaid. However, many eligible children remain without public insurance coverage.

Further progress will be dependent on the ability of states to enroll additional children. Toward that end, we make the following general **recommendations**:

- **States should maintain or increase efforts to help families enroll more easily in the program.**
- **States should enhance education programs to help families understand the benefits of preventive health care, and of the available health programs for low-income families.**

Also, it is important to note that health coverage is merely one means to reach our ultimate goal: healthier children. More research is needed to investigate the complex relationship of health coverage to issues of access, quality and health outcomes.

Additional policy alternatives are discussed in the Policy Alternative and Recommendations section of this brief.