

SCHIP and Medicaid Enrollment: What's Next?

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ALLIANCE FOR
HEALTH REFORM

As Congress gears up to consider the future of the State Children's Health Insurance Program (SCHIP) in 2007, the program has shown considerable success, with a monthly average of 4.2 million children covered by the program in 2005—double the 2000 figure. (See chart, "Medicaid and SCHIP Enrollment.")

Steady gains in children's coverage were achieved, despite the fact that the last five years have been characterized by widely varying economic performance among the states, and a rise in the number of uninsured adults.

Some of the gains in children's coverage were due to vigorous outreach and enrollment activities at state and local levels.

But the job is far from complete. National estimates are that 6.5 million low-income children still lacked health insurance in 2004, a majority of whom are likely eligible for SCHIP or Medicaid.

Widespread signs of trouble appeared on state budget horizons after Sept. 11, 2001. Economic contractions helped produce sharp state revenue shortfalls. The effects on SCHIP and Medicaid outreach programs were noticeable. Many state initiatives to enroll more children were downsized in 2002–2003. Many states shifted from expansion to trying to hold the line on initial coverage gains, while others went farther by freezing enrollment, or even cutting back on the number of children covered.

More recently, as state economies and revenues have rebounded, fewer states are taking steps to discourage easy access to coverage.

1997–2001: SCHIP's Early Successes

Enacted in 1997, SCHIP provides coverage for children whose families earn too much to qualify for Medicaid, but who cannot afford private coverage. Unlike Medicaid,

funding for SCHIP is capped: Congress authorized \$40 billion of funding for the program over 10 years.

In terms of both spending and number of children covered, SCHIP is much smaller than Medicaid. In FY 2004, the federal government and the states spent \$58.5 billion on children enrolled in Medicaid, whereas \$6.6 billion was spent on children enrolled in SCHIP. The average monthly number of children in Medicaid was 21.2 million in 2004, compared to 3.9 million covered by SCHIP.

SCHIP is designed to cover children in families with incomes up to 200 percent of the federal poverty level (the FPL is \$20,000 for a family of four in 2006), while Medicaid covers children in families with lower incomes. Most states reach the 200 percent level. New Jersey has the most generous income eligibility, covering children up to 350 percent of poverty. Other eligibility criteria, such as asset tests, periodic in-person interview requirements and residency verification rules, are applied at state discretion.

Funding for outreach and enrollment is allowed but not required as a part of each state's SCHIP administrative budget. As state SCHIP programs were ramping up during the late 1990's, many states designed enrollment procedures that were simpler than those used for Medicaid. Some of the ways initial enrollment and re-enrollment were made easier included:

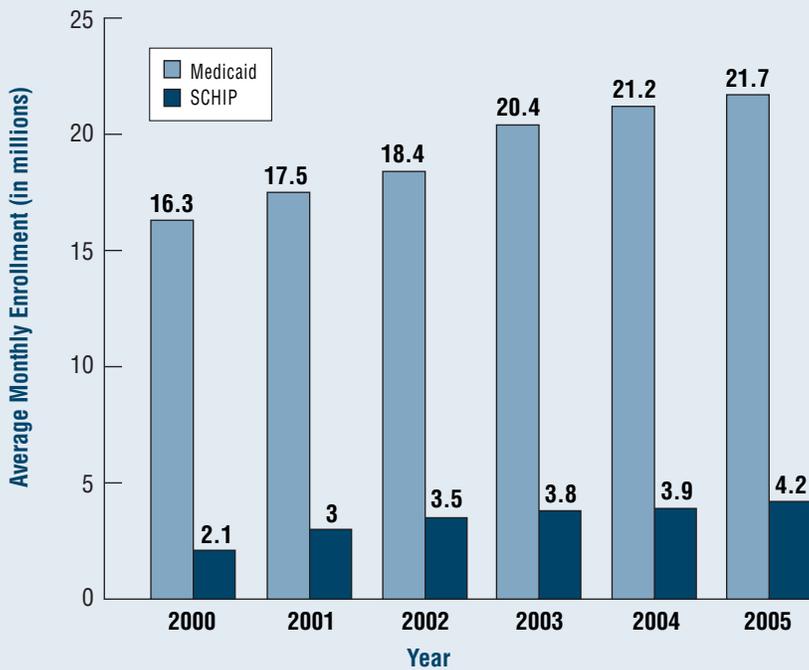
- ▲ **Eliminating asset tests:** In contrast to Medicaid, most SCHIP programs decided not to use an asset test to determine eligibility, instead relying on income, age, and insurance status. Asset tests tend to be complex and difficult for families to understand and provide documentation for.
- ▲ **Streamlining applications:** Shorter, simpler forms were developed, and a

Fast Facts

- ▲ An estimated 6.5 million low-income children lacked health insurance in 2004. Most are believed to be eligible for coverage under either Medicaid or SCHIP.
- ▲ SCHIP is designed to cover children in families with incomes that are low but above the level that would make them eligible for Medicaid.
- ▲ Outreach efforts have contributed to the enrollment of millions of children in Medicaid and SCHIP. A monthly average of 4.2 million children were covered by SCHIP in 2005—double the 2000 figure.
- ▲ In 2003–2004, many states took action to make it more difficult for children and families to enroll in SCHIP and Medicaid, such as increasing premiums and requirements for verification of family income.
- ▲ By mid-2005, nine states had reversed earlier cutbacks among 20 states that had expanded access for children and parents.
- ▲ Medicaid is a much larger program than SCHIP. In FY 2004, the federal government and the states spent \$58.5 billion on children enrolled in Medicaid, while \$6.6 billion was spent on children enrolled in SCHIP.

This issue brief, prepared by the Alliance for Health Reform with support from the Robert Wood Johnson Foundation, examines state efforts to find and enroll children who are eligible for coverage in the State Children's Health Insurance Program (SCHIP) and Medicaid, and includes selected material from an Alliance/Foundation Capitol Hill briefing on the subject.

Medicaid and SCHIP Enrollment, 2000–2005



SOURCE: U.S. Department of Health and Human Services statistics (2003,2004,2005). (www.cms.hhs.gov)

majority of states allowed families to mail in applications instead of requiring in-person interviews traditional for Medicaid.

- ▲ **Simplifying documentation or verification rules:** Some states eliminated requirements that parents provide residency documentation and proof of children's ages. Nine, including Alabama and Michigan, allow applicants to "self declare" income.
- ▲ **Guaranteeing a full year of coverage:** As of July 2005, 16 states had opted to provide 12 months of "continuous eligibility" to children, even if their economic circumstances change. This has been particularly helpful for working families who experience difficulties in re-enrolling their children every few months and whose employment status may change during the year.

Private Sector Involvement

With the advent of SCHIP, most states made substantial new investments in grassroots outreach and enrollment programs. These were often coordinated with private organizations that assisted with such activities as general publicity, education, advertising, and recruitment.

California trains "certified application assisters" to enroll beneficiaries in Medicaid and SCHIP. The program prohibits trained assisters from engaging in marketing activities on behalf of HMOs, or taking other actions to steer applicants to specific plans. The program pays assis-

ters a \$50 fee for each eligible child enrolled.

The largest of the privately funded outreach efforts is the Robert Wood Johnson Foundation's *Covering Kids & Families* program. This national initiative has established statewide projects in every state and the District of Columbia, as well as in more than 140 local communities.

Activities have been wide-ranging. In many states, program representatives attend local school and health fairs to promote Medicaid and SCHIP and in some cases to enroll eligible families. In other states, the program sponsors radio broadcasts, mailings, and publication of brochures for schools to distribute to children. Local organizations such as the Boys and Girls Club frequently post information about how to sign up for Medicaid and SCHIP.

Another national program, the *Express Lane Eligibility* effort by the Children's Partnership, publishes research and works with states to connect uninsured children who are enrolled in other public programs—such as the school lunch program and food stamps—to SCHIP and Medicaid. Alaska, Arkansas, and Connecticut are among those states in which school districts now routinely provide information about Medicaid and SCHIP with school lunch applications.

Amerigroup, a multi-state managed care company, has conducted outreach to families who may be eligible for coverage under Medicaid or SCHIP in different states. According to Sandra Nichols, who administers programs in the District of Columbia for the company, outreach activities vary from state to state because rules for enrollment differ. New York's "facilitated enrollment" program, for example, supports trained "community enrollment counselors" from community-based groups, social service agencies, and health care organizations who provide information about enrollment and renewal, determine eligibility, and assist families in filling out applications.

The types of initiatives detailed above have successfully reached thousands of families. Earlier political and policy developments—notably a series of federal statutory changes to Medicaid in the 1980s and 1990s—have also played a key role in rising enrollment trends among children.

Post-2001: New Obstacles to Outreach and Enrollment

In recent years, state outreach and enrollment efforts have been subject to budget cuts. Donna Cohen Ross of the Center on Budget and Policy Priorities conducts annual surveys of state Medicaid and SCHIP directors. From mid-2003 to mid-2004, the survey found, 23 states took some action to make it harder for children and

families to enroll in SCHIP and Medicaid. Specifically, 16 states increased premiums, eight implemented new procedural barriers (often reimposing previous, more restrictive rules) and eight froze children's enrollment.

Among the barriers imposed were requirements for income verification (such as producing a W-2 form or the prior year's tax return); formal documentation of insurance status from the employer; shorter coverage guarantees, generally six months instead of one year; imposition of waiting periods before benefits became effective after eligibility was approved; requirements for documentation of other benefits received, such as Social Security and child support; and proof from parents that their children have no access to any type of employer-based coverage.

By comparison, between July 2004 and July 2005, trends became somewhat more positive. During that period, 20 states took steps to simplify eligibility and enrollment procedures, while just 14 took steps that impeded access to health coverage for children, such as freezing enrollment, cutting eligibility, or increasing premiums. (See chart, "States Easing vs. Impeding Enrollment for SCHIP and Medicaid.") As Cohen Ross puts it, "simplification efforts and the outreach activities work in tandem to facilitate enrollment."

But Greg Martin, an analyst formerly with the National Conference of State Legislatures who is now with the American Academy of Family Physicians, argues that "states have proven effective at outreach and enrollment. However, they need to know that federal funds are secure....[I]t's all about keeping promises to kids."

At least one state has not only reached out to Medicaid and SCHIP-eligible children but has also expanded children's coverage beyond SCHIP. In November 2005, Illinois launched a program proposed by Gov. Rod Blagojevich to provide health insurance coverage to *all* uninsured children in the state—both through stepped-up efforts to identify children who are already eligible for either SCHIP or Medicaid, and by providing coverage to children whose families have higher incomes. These families will pay a monthly premium and co-pays for physician visits, as well as some prescription drug costs.

In comparison with SCHIP, the revenue fluctuations that affected states beginning in late 2001 had a different impact on Medicaid. In large part, this is because Medicaid's structure as an individual entitlement offers states fewer options to restrict access and impose higher cost-sharing, and offers more legal protections for beneficiaries. Specifically, states have a legal obli-

gation to enroll low-income families in Medicaid if an application is completed correctly and the family meets income and other eligibility criteria. Consequently, enrollment tends to rise during economic downturns, when more people fall into poverty and become eligible for benefits.

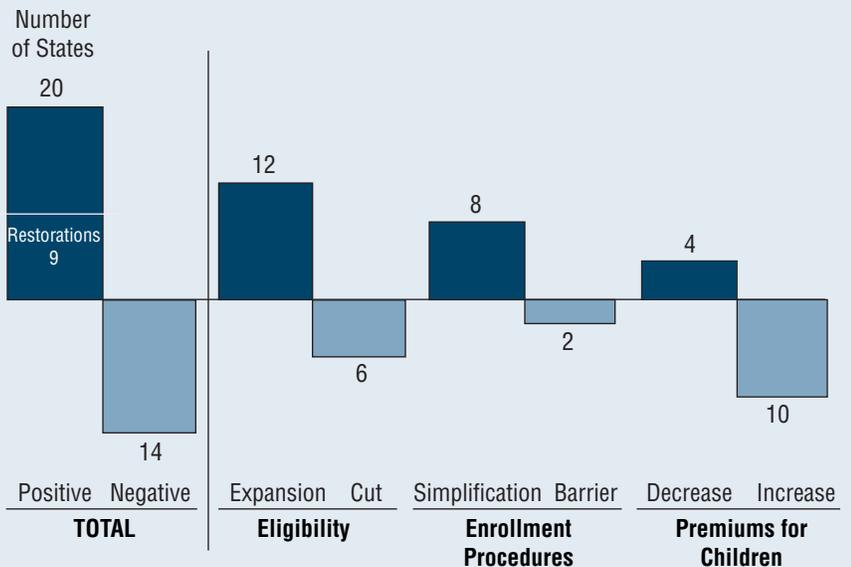
Between fiscal years 2002 and 2005, annual enrollment growth dropped from a high of 10 percent to four percent, with a three percent projected growth rate for FY 2006.

SCHIP's Cloudy Crystal Ball

The picture ahead for SCHIP is far from clear. The Deficit Reduction Act of 2005 (DRA) made only a few changes to the program. One was to provide \$283 million in additional SCHIP allotments to those states whose funding under current law would not pay for the enrollment they expect in FY 2006. In addition, Congress stipulated that new projects using SCHIP funds cannot provide coverage to non-pregnant childless adults. Federal Medicaid spending of all types is slated to be reduced by \$7 billion over five years. President Bush's proposed budget for FY 2007 requested additional Medicaid spending reductions of \$1.5 billion over five years.

The DRA also includes a new Medicaid requirement that all applicants produce verification of citizenship, generally either a birth certificate or a passport, and a driver's license.

States Easing vs. Impeding Enrollment for SCHIP and Medicaid, July 2004 to July 2005



Note: Some states took more than one positive action, more than one negative action, or both positive and negative actions.

SOURCE: Kaiser Commission on Medicaid and the Uninsured (2005). (www.kff.org/medicaid/7393.cfm)

Advocates argue that this is likely to prove problematic for many low-income families.

Much more work lies ahead, as Congress gears up for a debate over possible additional Medicaid changes and reauthorization of the SCHIP program. At the state level, recent activity predicts a mixed outlook for SCHIP, as states try to strike the right balance among maintaining income eligibility thresholds, imposing administrative barriers that restrict enrollment, and making changes in premiums, co-payments, and provider reimbursement levels.

In a preview of difficult discussions that lie ahead, a 2005 survey of state SCHIP directors prepared by the National Academy for State Health Policy found that directors believe the program's funding formula is flawed—allocating funds based on both the number of low-income children and the number of low-income *uninsured* children in a given state.

“[T]he more successful a state is in enrolling children in SCHIP—thereby changing them from uninsured to insured

status”—the smaller the state's funding allocation becomes,” the report states.

Another issue is whether SCHIP should be changed to allow states to use funds to “wrap around,” or supplement, employer coverage for low-income families. Under current law, states can provide SCHIP coverage only to children who do not have another source of insurance.

In the area of outreach specifically, there is a proposal in the Administration's FY 2007 budget to make \$100 million a year available for “Cover the Kids” outreach grants.

At the Alliance briefing, NCSL's Greg Martin argued that until state legislators get a clearer picture of the future of Medicaid and SCHIP funding, their primary focus will be maintaining coverage, not outreach and enrollment. The major question on everyone's mind, he said, is: “Will there be enough to go around?”

(For the sources used in this publication, click on the title of this issue brief at www.allhealth.org under “Publications.”)

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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