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Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?

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Summary

Congress has shown an on-going commitment to improving children's access to health care as demonstrated through eligibility expansions of the Medicaid program since the 1980s, and the introduction of the State Children's Health Insurance Program (SCHIP) in the fall of 1997. The majority of poor and near poor children are financially eligible for one of these programs.

Until recently, there was general disappointment with the implementation progress under SCHIP, due to low enrollment rates early in the program. Furthermore, after steady increases in the early 1990s, Medicaid caseloads showed an aggregate decline between 1995 and 1997. By FY2000, the pace of enrollment under SCHIP had improved, and data for 1998-1999 suggest that the decline in Medicaid participation may be reversing.

States have instituted a variety of outreach activities to bring eligible children into these two programs. Substantial progress has been made in simplifying the application and enrollment process under SCHIP, and also to a lesser extent under Medicaid. Budget limitations require state administrators to think carefully about their choice of outreach and enrollment facilitation strategies. However, current research assessing the cost-effectiveness of these strategies is inconclusive. Future state and federal evaluations of both Medicaid and SCHIP may start to identify what works, what does not, for whom, and at what cost.

Outreach funding is structured very differently under Medicaid and SCHIP. Medicaid does not have a specific limit on program spending for outreach, although the federal matching rate for such administrative activities can be lower than that for direct services. To date, there has been relatively low use by states of a special \$500 million fund for Medicaid outreach to children losing welfare. For federal matching purposes under SCHIP, there is a limit on spending for administrative expenses including outreach and education. This cap in a given fiscal year is 10% of the amount states actually spend on benefits, rather than 10% of appropriated levels. Recent legislation changes SCHIP outreach funding.

Medicaid and SCHIP enrollment patterns are affected by complex interactions between economic trends, federal and state policies, program administrative procedures, and beneficiary perceptions. These interactions result in enormous enrollment variability across states, suggesting that some solutions may need to be state-specific. Given significant reductions in Medicaid enrollment among adults with children, some have argued that providing Medicaid and SCHIP to whole families may be a more effective mechanism for reducing the number of low-income children without health insurance than the current fractured set of eligibility rules. Further simplification of such rules, streamlining enrollment processes, and additional outreach are also important to improving coverage rates. These goals must be balanced with budget constraints that may result from any future economic downturns that may increase the number of individuals eligible for, and enrolling in these programs.

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Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?

Overview

Research indicates that children are healthier when they get medical care. Health insurance improves access to these services. Congress has shown an on-going commitment to improving access to health care for poor and near-poor children. This commitment has been demonstrated through expansions of the Medicaid program since the 1980s and the establishment of the State Children's Health Insurance Program (SCHIP) in the fall of 1997.

Nonetheless, recent trends in insurance coverage among children are cause for concern. The number of children covered by health insurance rose to 86% in 1999. Still, 10.8 million children – 14% of all children under age 19 – were without health insurance in 1999, down from 11.9 million uninsured children in 1998.¹ In the 106th Congress, several bills were passed (and signed into law) to further expand eligibility for children under Medicaid, and to change existing provisions that govern outreach funding under SCHIP.

This report provides general background information on the current status of eligibility, enrollment, and outreach issues for children under Medicaid and SCHIP. We analyze recent enrollment statistics and factors contributing to those trends. Several issues concerning enrollment facilitation and outreach strategies are also discussed, including: (1) current approaches used by states under Medicaid and SCHIP, (2) research on effectiveness and cost-effectiveness of outreach and enrollment facilitation, (3) current funding for outreach under Medicaid and SCHIP, and related privately-financed efforts, and (4) legislative changes made during the 106th Congress to major outreach and eligibility provisions under Medicaid and SCHIP.

¹CRS Report 97-975 EPW, *Health Insurance Coverage of Children*, by Madeleine Smith.

Eligibility and Enrollment of Children Under Medicaid and SCHIP

Major Medicaid Eligibility Pathways for Children

Medicaid is a means-tested entitlement program. To qualify, applicants' income and resources² must be within program financial standards. These standards vary considerably among states, and different standards apply to different population groups within a state. With some exceptions, Medicaid is available only to persons with very low incomes. In addition, Medicaid eligibility is subject to *categorical restrictions*. That is, it is available only to low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children.

The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those for whom coverage is mandatory and those that states may elect to cover. Examples of *major mandatory coverage groups for children* include:

- Those meeting the financial and categorical criteria under the former Aid to Families with Dependent Children or AFDC program (as of July 16, 1996), even if they do not qualify for cash grants under the new Temporary Assistance for Needy Families (TANF) program.³ Income standards here are typically well below the federal poverty level (FPL). For example, the maximum AFDC payment levels on July 16, 1996 ranged from 15% of the 1998 FPL in Alabama to 81% in Connecticut. The median level nationwide was 45%.⁴
- Children under age 6 years (and pregnant women) with family incomes below 133% FPL.
- In FY2001, children between the ages of 6 and 17 years living in families with income up to 100% FPL.

²For most eligibility categories in most states, individuals must have resources (also called assets) valued at less than a specified amount (typically \$1,000 for an adult with one or more dependent children) to be eligible for Medicaid. States determine what items constitute countable resources and how those countable items are valued. Resources such as homes and wedding rings are generally not counted, regardless of their value. Other types of resources, such as cars, savings accounts and savings bonds, are generally counted. However, the entire value of these countable resources may not be considered. For example, up to \$1,500 in equity value of the first car may be disregarded. (See Schneider, et al. *Medicaid Eligibility for Families and Children*. Washington, D.C., The Kaiser Commission on Medicaid and the Uninsured, September 1998.)

³Within certain federal restrictions, states may modify these financial standards for AFDC-related groups (e.g., make such standards more or less restrictive than those in place on July 16, 1996).

⁴See Appendix Table 1 in Schneider, et al. *Medicaid Eligibility for Families and Children*. Washington, D.C., The Kaiser Commission on Medicaid and the Uninsured, September 1998.

- Disabled children meeting the disability and income criteria for the Supplemental Security Income (SSI) program.⁵

Examples of *major optional coverage groups for children* include:

- Infants under age one year (and pregnant women) whose family income is no more than 185% FPL.
- The medically needy, persons who do not meet the financial standards for cash assistance programs but meet the categorical standards and have income and resources within specified medically needy limits established by the states. The income limits here can be as high as 133 and 1/3% of the corresponding AFDC payment standard (in effect on July 16, 1996, or as subsequently modified). Some children qualify for this coverage group when medical expenses are subtracted from family income and the net amount falls below the specified income standard.

Transitional or extended benefits are available to families who lose Medicaid eligibility due to increased earnings or child support payments.⁶ States have the option of continuing Medicaid eligibility for current child beneficiaries for up to 12 months without a redetermination of eligibility. States are also allowed to extend Medicaid coverage to children under 19 years of age on the basis of “presumptive” eligibility until formal determinations are completed.

In addition to SCHIP (discussed below), other provisions in federal law allow states to extend Medicaid eligibility to children beyond federal requirements. For example, states have used less restrictive methodologies for determining countable income permitted under Section 1902(r)(2) of the Social Security Act to cover children in higher income families. States may also obtain special waivers of eligibility rules under Section 1115 of the same Act to cover new groups and/or change income criteria.

The first four columns of **Table 1** display Medicaid income eligibility criteria as a percentage of the FPL by age group and state. These criteria were in effect prior to implementation of SCHIP, which provides funding to states to cover children at income levels higher than those in place under their Medicaid programs. Overall, by early 1997, many states had expanded Medicaid eligibility for selected subgroups of

⁵States may use more restrictive eligibility standards for Medicaid than those used for SSI if they were using those standards on January 1, 1972 (before implementation of SSI). These states may vary in their definition of disability, or in their standards related to income or resources. Currently 11 states use these more restrictive standards.

⁶Specifically, when Medicaid eligibility via old AFDC rules is lost due to hours of or income from employment, or loss of a time-limited earned income disregard (and the family qualified for Medicaid on the basis of old AFDC rules in at least 3 of the preceding 6 months), states are required to continue Medicaid for the subsequent 6 months. States must extend Medicaid for an additional 6 months for families that were covered during the entire first 6-month period, and are earning below 185% FPL. Finally, certain families who lose Medicaid because of increased child or spousal support are eligible for a 4-month extension of coverage if they received Medicaid in at least 3 of the preceding 6 months.

children beyond the federal mandates. For example, 33 states had exceeded the federal minimum of 133% FPL for infants. Likewise, nine states extended eligibility for children ages 1 through 5 above this same mandatory minimum. Finally, 25 states moved beyond the federal mandate of 100% FPL and/or age requirements for children ages 6 and older.

Eligibility for SCHIP

Since the enactment of Medicaid in 1965, the State Children's Health Insurance Program represents the largest federal effort to provide health insurance coverage to uninsured, low-income children. SCHIP was established by the Balanced Budget Act of 1997 (BBA 97) under a new Title XXI of the Social Security Act. This block grant program provides funding to states to provide children with health insurance that meets specific standards for benefits and cost-sharing, or through their Medicaid programs, or through a combination of both.⁷ Like Medicaid, SCHIP is a federal-state matching program. The federal medical assistance percentage (FMAP) that determines the federal contribution towards Medicaid spending ranges from 50% to 76.82% across states in FY2001. The enhanced FMAP for SCHIP ranges from 65% to 83.77%.

Title XXI defines SCHIP-eligible children as those who are not eligible for Medicaid or covered under a group health plan or other insurance. The law requires that states cover children in families with incomes that are either: (1) above the state's Medicaid financial eligibility standard but less than 200% of the FPL, or (2) in states with Medicaid income levels for children already at or above 200% FPL, within 50 percentage points over the state's current Medicaid income eligibility limit for children.

Not all targeted low-income children will necessarily receive medical assistance under SCHIP for two reasons. First, the law does not establish an *individual* entitlement to the benefits of the SCHIP program.⁸ Instead, it entitles *states* with approved SCHIP plans to a pre-determined, annual federal allotment based on a formula set in law. Second, each state can define the group of targeted low-income children who may enroll in SCHIP. Title XXI allows states to use the following factors in determining eligibility: geography, age, income and resources, residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to other health insurance, and duration of eligibility for SCHIP coverage.

⁷Under limited circumstances, states have the option to purchase a health benefits plan that is provided by a community-based health delivery system, or to purchase family coverage under a group health plan as long as it is cost-effective to do so.

⁸The one exception to this rule is when a state chooses to implement a Medicaid expansion under SCHIP. Children enrolled in SCHIP through a Medicaid expansion are entitled to Medicaid benefits as long as they continue to meet these specific eligibility criteria (even if SCHIP itself terminates) or until the state is granted approval to eliminate the eligibility category created by the Medicaid expansion under SCHIP.

As of December 11, 2000, the Health Care Financing Administration (HCFA) had approved SCHIP plans for all 50 states, the District of Columbia and five territories. Twenty-one states expanded their Medicaid programs for children, 16 used separate state programs to provide children with health insurance, and 19 combined a Medicaid expansion and a separate state program. The upper income limit for Medicaid expansions and separate state programs under SCHIP has reached 350%⁹ of the poverty level in one state (**Table 1**).

While expansions in coverage have been achieved for children of all ages under SCHIP, the most significant increases in eligibility have benefitted older adolescents. Under Medicaid in FY2001, states must cover children ages 6 to 17 in families with incomes up to 100% FPL. The age of mandatory coverage increases to 18 in 2002. Under SCHIP, most states have taken advantage of the opportunity to cover older teens in families with incomes up to 100% FPL (or often higher) *sooner* than required under Medicaid. Such states will receive an enhanced federal matching rate through SCHIP to finance the care provided to these older adolescents (until mandatory coverage under regular Medicaid applies).

Recent Trends in Program Enrollment Among Children Under Medicaid and SCHIP

There is some recent evidence and considerable speculation that both Medicaid and SCHIP may be underutilized by currently eligible children. Analyses of 1994-1997 national survey data indicate that 21 to 42% of all uninsured children under 18 years of age are eligible for Medicaid but not enrolled.¹⁰ The U.S. General Accounting Office (GAO)¹¹ found that, in 1997, compared to Medicaid-enrolled children of similar ages, uninsured children eligible for, but not enrolled in, Medicaid were more likely to be in working families, Hispanic and either U.S.-born to foreign-born parents or foreign-born themselves. They were also more likely to live in the West and the South – 73% of all uninsured Medicaid-eligible children nationwide resided in these regions. In a more recent analysis,¹² in 1999, there were 7.1 million

⁹For determining income eligibility for SCHIP and Medicaid, some states apply “income disregards.” These are specified dollar amounts subtracted from gross income to compute net income, that is then compared to the applicable income criterion. Such disregards *increase* the *effective* income level above the stated standard. State SCHIP plans do not consistently report use of income disregards, nor whether the stated income standards include or exclude such disregards.

¹⁰See Table 7 in Lewis, K., M. Ellwood, and J. Czajka. *Counting the Uninsured: A Review of the Literature*. Washington, D.C., The Urban Institute, June 1998. The wide variation in the estimate of uninsured children eligible for Medicaid is due to methodological differences across reviewed studies in definitions of the target population, data sources and statistical analysis models.

¹¹U.S. General Accounting Office. *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*. GAO/HEHS-98-93, March 1998. Washington, 1998. (Hereafter cited as GAO, *Medicaid: Demographics of Nonenrolled Children*)

¹²Broadus, M., and Ku, L. *Nearly 95 Percent of Low-Income Uninsured Children Now are* (continued...)

uninsured children under 19 years of age living in families with incomes below 200% of the federal poverty level. Of this group, 6.7 million, or 94% would have met their state's eligibility criteria under Medicaid or SCHIP based on the rules in place as of July 2000.

While current eligibility rules under these two publicly financed programs permit coverage for most low-income children, during the 1990s, actual enrollment fluctuated for a number of reasons. Between 1990 and 1995, Medicaid participation increased an average of 7.6% per year.¹³ These increases were the result of a combination of factors. During this period, the economy was weak, increasing the number of low-income individuals and families who qualified for Medicaid. In addition, during the latter half of the 1980s, Congress established the new poverty-related eligibility categories for pregnant women and children which continued to produce significant enrollment increases during the early 1990s. Similarly, coverage of new groups of disabled children resulted from expansions of eligibility for the Supplemental Security Income (SSI) program¹⁴ which in turn confers automatic Medicaid eligibility in most states.

Trends in Medicaid enrollment changed by the mid-1990s (**Table 2**). A total of 41.3 million people in the 50 states and the District of Columbia were enrolled in Medicaid during 1996, a small decrease from the total of 41.7 million people enrolled in 1995. By 1997, enrollment had declined to 40.6 million. The rate of continuing decline in Medicaid participation had slowed by 1998, during which there were 40.4 million enrollees.

Enrollment patterns for this period varied by eligibility group. Between 1995 and 1998, the total number of able-bodied adults (typically parents) and children on Medicaid fell (with one exception described below), while the number of aged beneficiaries stayed roughly constant, and the number of disabled of all ages rose slightly. As shown on **Table 2**, for adults and children, reductions were greatest among those eligible for Medicaid via welfare or cash-related pathways. However, these losses were partially offset by increases in enrollment through other eligibility pathways.¹⁵

¹²(...continued)

Eligible for Medicaid or SCHIP. Washington, D.C., Center on Budget and Policy Priorities, December 6, 2000.

¹³Information presented here on trends in Medicaid enrollment and welfare participation during the early 1990s is taken from Ku, L., and Bruen, B. *The Continuing Decline in Medicaid Coverage* (Series A, No. A-37), Washington, D.C., The Urban Institute, December 1999.

¹⁴For example, the Supreme Court's 1990 decision in *Sullivan v. Zebley* broadened SSI eligibility for children, particularly those with learning disabilities.

¹⁵Other enrollment is likely to be a combination of new beneficiaries and individuals who no longer qualify for Medicaid via old AFDC rules (after welfare reform), but who continue (or reinstate) their Medicaid coverage through alternative pathways such as poverty-related eligibility categories, medically needy groups, transitional Medicaid, or through §1115 waiver (continued...)

Over this 4-year period, adults qualifying for Medicaid via cash-related groups fell 36%, while enrollment in other groups rose by nearly 24%, yielding a net loss for adults of 10%. There was a small increase in the number of adults between 1997 and 1998. New York had added 300,000 adults to its Medicaid program via an expansion of its §1115 waiver to include the state's pre-existing Home Relief (health insurance) program. In addition, Massachusetts added thousands of adults to Medicaid through an 1115 waiver implemented in 1998. When these two state-specific expansions are discounted, nationwide enrollment of adults actually dropped by approximately 400,000 in 1998.¹⁶

Declines in enrollment were also observed for children, but the losses were less severe. Between 1995 and 1998, children qualifying for Medicaid under cash-related groups dropped by 32%, while other Medicaid enrollment increased by 25%, resulting in a smaller net reduction for children of nearly 5%. These patterns of enrollment loss for adults and children reflect the fact that more Medicaid eligibility pathways exist for children, and these pathways use more generous income criteria, compared to eligibility options for nondisabled adults.

The declines in Medicaid caseloads for adults and children between 1995 and 1998 are likely the result of several concomitant events. During this period, an improved economy and higher employment rates increased the number of individuals not meeting income-related criteria for Medicaid eligibility. However, there has been considerable speculation that the primary cause of the drop in Medicaid participation has been federal welfare reform under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). But in fact, prior to enactment of PRWORA, both Medicaid and welfare caseloads had already begun to fall, and most states had already implemented major welfare reform initiatives under waivers of federal law. Moreover, PRWORA included provisions to prevent the automatic loss of Medicaid coverage due to the loss of cash assistance. However, as the data reported above suggest, these provisions may not have been completely effective. TANF exit studies do not directly assess reasons for the drop in Medicaid enrollment, but some of the possible contributing factors identified in these studies include, for example, failure to identify eligible families, lack of awareness of the availability of continuing Medicaid coverage, and agency errors. In addition, some caseload declines may have resulted from family members no longer being eligible for Medicaid.¹⁷

¹⁵(...continued)
programs.

¹⁶Unpublished Urban Institute analysis (results will be forthcoming in a report to be published by the Kaiser Commission on Medicaid and the Uninsured).

¹⁷See Greenberg, M. *Participation in Welfare and Medicaid Enrollment*. Washington, D.C., Kaiser Commission on Medicaid and the Uninsured, September 1998. Another study on this issue is Health Management Associates. *The Dynamics of Current Medicaid Enrollment Changes*. Washington, D.C., Kaiser Commission on Medicaid and the Uninsured, October 1998.

Other research¹⁸ documents related reasons why families do not enroll their children in Medicaid, including:

- families lack knowledge of Medicaid and its eligibility criteria;
- families may not perceive a need for Medicaid due to good health and alternative sources of care;
- some have concerns about quality of care and low levels of provider participation limiting access;
- cultural differences, language barriers and immigration policies may prevent some families from enrolling in Medicaid;
- for many, Medicaid has a negative image associated with its historical ties to cash assistance and thus the stigma of dependency; and,
- the enrollment process itself, with long forms and extensive documentation, can be a barrier.

A recent analysis published by the Kaiser Commission¹⁹ examining monthly Medicaid enrollment patterns in the 50 states and the District of Columbia suggests that the decline in Medicaid participation may be reversing itself. Comparing December of 1998 to December of 1999, Medicaid enrollment grew by 1.1 million, or 3.6%, with 43 states and the District of Columbia experiencing growth. As with the 1995-1998 trends reported previously, this analysis revealed enormous variability in enrollment across states.

Even though overall enrollment rose, patterns of enrollment within eligibility groups in this study mirrored national results reported for the 1995-1998 period. Enrollment among the aged and disabled (data from 43 states) steadily increased by 1.6% for the year ending December 1998, and 1.8% for the year ending December 1999. For families, children and pregnant women, continuing large decreases in cash-related enrollment were offset by increases in enrollment through other eligibility pathways. For example, among the 21 states with data for families, children and pregnant women, cash-related enrollment declined by 18.9% over the year ending December 1998 and by 16.6% over the year ending December 1999. In contrast, among 22 states with data, poverty-related groups experienced an increase of 9.4% in 1998 and 14.0% in 1999. On April 7, 2000, HCFA instructed states to institute necessary policy and procedural changes to identify, enroll, and re-enroll families and children who may have been improperly denied coverage under, or terminated from Medicaid. Of most concern are beneficiaries who are denied Medicaid due to

¹⁸GAO, Medicaid: Demographics of Nonenrolled Children; and the Kaiser Commission on Medicaid and the Uninsured. *Medicaid and Children; Overcoming Barriers to Enrollment, Findings from a National Survey*. Washington, D.C., January 2000.

¹⁹Ellis, E., Smith, V., and Rousseau, D. *Medicaid Enrollment in 50 States*. Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured. October 2000. This study is based on monthly enrollment reports for the months of June and December of 1997, 1998 and 1999. These point-in-time estimates do not match official HCFA data which describe the number of persons ever enrolled in a given fiscal year. Estimates from this study are smaller than HCFA's official counts of enrollees. In addition to examining overall trends in enrollment by state, this study also analyzed enrollment changes by eligibility group, however, data were not available from some states for each category.

ineligibility for TANF, lose Medicaid when TANF ends, or lose transitional Medicaid without proper notice or redetermination. States were directed to focus also on children inappropriately dropped from Medicaid after they lost SSI payments due to changes in SSI disability rules under welfare reform. States are required to develop a timetable for redeterminations and conducting additional eligibility reviews as necessary for these target populations.

Concerns about underutilization have also been raised about SCHIP. SCHIP faces all the start-up issues confronting a relatively new program that is just over 3 years old. Early enrollment estimates from HCFA²⁰ indicated that nearly 1 million children (982,000) were enrolled in SCHIP under 43 operational state programs as of December 1998. More recently, HCFA reported that nearly 2 million children (1,979,450) were enrolled in SCHIP during FY1999 under 53 operational state programs.²¹ Over 1.2 million of these children were served by separate programs and almost 700,000 were enrolled in Medicaid expansions. On January 5, 2001, the Clinton Administration announced that enrollment in the SCHIP program reached approximately 3.3 million children during FY2000, with 2.3 million children enrolled in separate state programs, and a little more than 1 million children enrolled in Medicaid expansion programs.²² Subsequent to the enactment of BBA 97, CBO estimated that SCHIP would cover an average of 2.3 million children per year after 1999.²³ The Clinton Administration's goal was to enroll 5 million children in SCHIP by FY2002.

Spending projections in the first 2 years of the program are consistent with HCFA's enrollment figures and fall well below total federal appropriation levels. Federal spending in FY1998 totaled less than \$500 million. Federal spending in FY1999 totaled approximately \$1 billion. Program spending is expected to accelerate over time. CBO estimates that federal SCHIP spending will total approximately \$2 billion for FY2000 and \$3 billion for FY2001²⁴ (although these estimates may be revised in CBO's new FY2001 baseline as a result of new enrollment data). For each of these years, total annual federal appropriation levels are approximately \$4.3 billion.²⁵

²⁰Health Care Financing Administration. *A Preliminary Estimate of the Children's Health Insurance Program Aggregate Enrollment Numbers Through December 31, 1998* (background only). April 20, 1999.

²¹Health Care Financing Administration. *The State Children's Health Insurance Program, Annual Enrollment Report, October 1, 1998-September 30, 1999* (no date).

²²Bureau of National Affairs. HCFA Releases Final SCHIP Rule, As Clinton Notes 70% Participation Increase. *Health Care Daily Report*, v. 6, no. 5, January 8, 2001.

²³U.S. Congressional Budget Office. *Expanding Health Insurance Coverage for Children Under Title XXI of the Social Security Act* (CBO Memorandum). February 1998.

²⁴U.S. Congressional Budget Office. *The Budget and Economic Outlook: An Update*. July 18, 2000. Washington, GPO, 2000.

²⁵In general, annual allotments for each state will remain available for a period of 3 years. The period of availability for the FY1998 allotments ended as of October 1, 2000. Unspent funds for both FY1998 and FY1999 will be redistributed according to provisions contained

(continued...)

Federal law requires that eligibility for Medicaid and SCHIP be coordinated when states implement separate SCHIP programs. In these circumstances, applications for SCHIP coverage must first be screened for Medicaid eligibility. CBO estimates that the “outreach effect” of SCHIP will increase Medicaid enrollment by 460,000 children each year for FY1998 through FY2002. As a result, Medicaid spending is also expected to increase a total of \$2.4 billion over this same 5-year period.²⁶ The Kaiser study described previously suggests that SCHIP is in fact facilitating Medicaid enrollment. Comparing monthly enrollment counts for December 1998 to December 1999, total Medicaid participation increased by 1.1 million. Twenty-seven percent of this increase was due to enrollment via expansions of Medicaid through SCHIP.

Enrollment Facilitation and Outreach Strategies

Successful enrollment penetration among all potential Medicaid and SCHIP eligible children will depend at least in part on two different, but interrelated activities – enrollment facilitation and outreach. How is enrollment facilitation different conceptually from outreach? The former includes strategies to simplify and expedite the eligibility determination and enrollment process (e.g., allowing applications to be submitted by mail or fax, eliminating resource or asset tests). The latter includes strategies to market the program to the target population so they will perceive the benefits of participation and initiate the application process (e.g., advertising through radio, television and print media, establishing toll-free hotlines).²⁷ Some activities can be classified as both (e.g., placing eligibility workers in non-welfare settings frequented by the target population, involving local businesses and community-based organizations in outreach and enrollment efforts).

Ideally, mechanisms to simplify and expedite enrollment for families with eligible children are put into place prior to launching targeted outreach strategies.²⁸ In practice, however, both types of activities may evolve and occur in tandem over time as barriers to enrollment and outreach are identified, and solutions are designed and implemented.

²⁵(...continued)

in newly enacted legislation (P.L. 106-554). For a complete discussion of redistribution issues, see CRS Report RS20628, *State Children’s Health Insurance Program (SCHIP): Funding Changes in the 106th Congress*, by Evelyne Baumrucker.

²⁶GAO, *Medicaid: Demographics of Nonenrolled Children*.

²⁷National Governors’ Association, Center for Best Practices, and the National Conference of State Legislatures. *State Children’s Health Insurance Program, 1999 Annual Report*, 1999. (Hereafter cited as National Governors’ Association, *State Children’s Health Insurance Program*.)

²⁸Alliance for Health Reform. *Health Coverage: Outreach to Uninsured Kids*. May 1998.

Outreach and Enrollment Facilitation Strategies Used by States Under Medicaid and SCHIP

In an analysis of SCHIP state plans and amendments as of September 30, 1999 for the 50 states, the District of Columbia, and five territories,²⁹ eight common outreach strategies to market SCHIP to targeted populations were identified. Nearly all jurisdictions:

- involve health care providers in their educational efforts (54 jurisdictions);
- conduct radio, TV and print media campaigns to educate the target population (53 jurisdictions);
- develop partnerships with schools to reach eligible children (52 jurisdictions);
- use toll-free hotlines (52 jurisdictions); and,
- place eligibility workers in strategic locations such as sporting events, tax assistance sites, or free health clinics (50 jurisdictions).

One-half to two-thirds of jurisdictions also:

- use a family-friendly website (39 jurisdictions);
- work with local employers to promote SCHIP (34 jurisdictions); and,
- involve the business community in their outreach efforts (32 jurisdictions).

Accurate identification of the target population upon which to focus outreach efforts is extremely difficult. Participation in other government programs may provide a vehicle for such identification. Using data from the 1997 National Survey of America's Families, the Urban Institute³⁰ estimates that 73% of all uninsured children who live in families with incomes below 200% FPL participate in the National School Lunch program, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Food Stamp program, or the Unemployment Compensation program. Among these programs, the National School Lunch program has the greatest penetration rate, serving roughly 60% of such children. In late 1999, President Clinton asked the Secretaries of HHS and Agriculture to identify effective school-based outreach strategies for possible replication throughout the country.³¹

With respect to enrollment facilitation, federal law stipulates few documentation requirements for determining eligibility under Medicaid, and even fewer requirements under SCHIP.³² And the burden of required verification lies with state agencies rather

²⁹National Governors' Association, *State Children's Health Insurance Program*.

³⁰Kenney, G., J. Haley, and F. Ullman. *Most Uninsured Children are in Families Served by Government Programs* (Policy Brief, Series B, No. B-4), Washington, D.C., The Urban Institute, December 1999.

³¹U.S. Dept. of Health and Human Services. *Report to the President: Interagency Task Force on Children's Health Insurance Outreach*, October 12, 1999.
[<http://www.hrsa.gov/childhealth/report.htm>] Also see HCFA letter to SCHIP State Health Officials regarding school-based outreach, September 8, 2000.

³²HCFA letter to SCHIP State Health Officials regarding application and enrollment
(continued...)

than with families, although states may choose to shift some of this responsibility to families. States must obtain the Social Security number of children applying for Medicaid – such information is *not* required under SCHIP. Income and assets may be established through self-declaration under both programs. However, under Medicaid only, subsequent to initial application, states must request information from other federal and state agencies to verify applicants' income and resources – such verification is *not* required under SCHIP. For both programs, children who are citizens may establish their citizenship through self-declaration; states are permitted to require further verification as a condition of eligibility. Children applying for either program who are qualified aliens must present documentation of their immigration status, which states must then verify with the Immigration and Naturalization Service. In sum, under Medicaid and even more so under SCHIP, states have enormous flexibility in facilitating application for and enrollment in these programs.

According to a recent national survey,³³ many states have implemented (or plan to implement) one or more enrollment facilitation strategies for children under Medicaid and SCHIP. In general, while substantial progress had been made to simplify and expedite enrollment, specific policies and procedures are more likely to have been adopted in separate SCHIP programs than in Medicaid programs (**Table 3**). Detailed findings from this study include the following:

- At the initial application stage, the majority of states with separate SCHIP programs have implemented joint Medicaid/SCHIP enrollment forms (87%). States are less likely to use joint applications at redeterminations (44%).
- The majority of all states have dropped asset tests (Medicaid-82%, separate SCHIP-97%) and eliminated face-to-face interviews (Medicaid-78%, separate SCHIP-97%). In most cases, as with initial applications, states forego face-to-face interviews when redetermining eligibility (Medicaid-84%, separate SCHIP-100%).
- Subsequent to initial application, about one-fourth of Medicaid programs (27%) and over two-thirds of separate SCHIP programs (69%) provide 12 months of continuous coverage without regard to changes in family income. These same states provide 12 months of continuous enrollment at redetermination of eligibility.
- A small number of states allow presumptive eligibility³⁴ under Medicaid (16%) and SCHIP (13%).

³²(...continued)

simplification, September 10, 1998.

³³Ross, D., and Cox, L. *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey*. Washington, D.C., The Kaiser Commission on Medicaid and the Uninsured, October 2000.

³⁴Presumptive eligibility allows children whose family income appears to be below the state's Medicaid income guidelines to enroll temporarily in Medicaid, until a final formal determination of eligibility is made. At the time of the survey summarized in the text, there was no explicit presumptive eligibility provision in SCHIP law. Nonetheless, through other Title XXI authority, HCFA allowed states to implement similar procedures under this program. A recent law makes Medicaid presumptive eligibility provisions applicable to separate (non-Medicaid) SCHIP programs.

- Few programs allow self-declaration of income (Medicaid-20%, separate SCHIP-22%) during the eligibility determination process.

Finally, in some states, the application, enrollment and redetermination procedures may depend on the point of entry into Medicaid or SCHIP. The findings described above typically characterize state processes associated with joint applications used to determine initial eligibility for Medicaid or separate SCHIP programs. Families initially applying for health coverage through Medicaid or welfare offices, particularly those families seeking coverage for adults as well as children, are likely to encounter a different, often more complicated application, enrollment and redetermination process.

Research on Effectiveness and Cost-Effectiveness of Selected Outreach and Enrollment Facilitation Strategies

Since the initiation of SCHIP a little over 3 years ago, states have struggled to develop and implement the “right” combination of outreach strategies and enrollment facilitation processes to maximize program participation. The advent of SCHIP has also focused attention on a variety of Medicaid enrollment issues.

Anecdotal evidence about the best combination of strategies to increase enrollment abounds in newspaper articles, speeches and the research literature. Given the unscientific nature of this type of evidence, it is perhaps not surprising that resulting conclusions about which states are or will be successful are often inconsistent. And such conclusions change over time as state strategies evolve. Since anecdotal evidence has many limitations, what types of data are better? How do we determine the effectiveness of different outreach and enrollment strategies? And finally, what are the costs associated with effective outreach and enrollment activities – what strategies provide the biggest bang for the buck?

To answer these questions, in the summer of 1999, we searched the research literature for studies examining the effectiveness or cost-effectiveness of various outreach and enrollment facilitation strategies used to bring families or children into basic health care programs. While a large number of studies were identified initially for possible inclusion in our analysis, we found few well-designed studies from which reliable and valid conclusions could be drawn. And those analyses were only indirectly related to our purpose – rather than assessing changes in rates of program enrollment among non-participants as a result of outreach, these studies examined changes in use of specific preventive services (e.g., well-child visits and immunizations) subsequent to outreach targeting children already enrolled in a health care program or physician practice group. Results from studies examining the effectiveness of outreach in increasing use of key preventive services among program participants may not be generalizable to outreach aimed at increasing program enrollment.³⁵ Service utilization may be a less complicated process than the process

³⁵Barents Group LLC. *Review of the Literature on Evaluations of Outreach for Public Health Insurance and Selected Other Programs (Final Report)*, prepared for the Agency for Healthcare Quality and Research (Contract No. 290-96-0004). Washington, D.C., Barents (continued...)

of applying for coverage under Medicaid or SCHIP. In addition, the perceived (and actual) benefits of service use may be more immediate and obvious than benefits associated with qualifying for health insurance.

Finally, it was difficult to compare findings and draw conclusions from the few well-designed studies that we did find because they: (1) assessed different outreach strategies (e.g., home visits, telephone contacts, letters), (2) used different comparison groups (e.g., interventions were sometimes compared to no intervention or alternative strategies), (3) focused on different populations of children, and typically did not stratify results by subgroup (e.g., infants versus school-age children) to pinpoint variations in outreach effectiveness, and (4) measured different outcomes to evaluate the impact of a given outreach strategy (e.g., percent of eligibles reached/contacted versus percent of eligibles enrolled). Reported costs per “successful” case reached, enrolled or served varied dramatically across the few studies that attempted to quantify such cost-effectiveness. The variations in reported costs per successful case were due both to the modest effectiveness of outreach strategies investigated and the wide variability in the components included in calculating outreach costs (e.g., labor, computer hardware and software purchases, travel, training, office space rental, supplies).

Our conclusions about the status of research in this area were confirmed by a comprehensive review of the literature sponsored by the Agency for Healthcare Research and Quality (AHRQ).³⁶ This review concluded that very few outreach interventions have been evaluated, and that completed evaluations provide minimal scientific evidence about the absolute effectiveness, relative effectiveness³⁷ or cost-effectiveness of different outreach and enrollment facilitation strategies for programs such as Medicaid and SCHIP. However, the analysis did identify three well-designed studies suggesting that simplified application procedures, aggressive outreach and/or presumptive eligibility for pregnant women positively impacted timely enrollment into Medicaid.

While it may be desirable to isolate and quantify the effectiveness of a given component of outreach or enrollment facilitation strategy, in the real world, states are implementing multiple activities simultaneously, making such assessments extremely difficult. It may be more practical and useful to assess the effectiveness of common combinations of strategies that may have broad application.

Current law requires an evaluation of each state’s SCHIP program, designed to assess effectiveness in achieving the goals of the program. This evaluation was due in early 2000. To assist states in meeting this requirement, the National Academy for State Health Policy, a non-profit forum for state policy leaders, developed a model framework for the 2000 evaluation report. Because this model framework was

³⁵(...continued)

Group LLC, February 18, 2000.

³⁶Ibid.

³⁷Studies of absolute effectiveness compare an intervention to a control (no intervention). Studies of relative effectiveness compare two or more interventions to each other.

designed to meet all statutory reporting requirements, HCFA encouraged states to use it, and all states and territories did so.

We conducted an informal review of these evaluation reports,³⁸ examining objectives related to reducing the number of uninsured children and improving SCHIP and Medicaid enrollment, as well as methods and indicators used to assess outreach effectiveness. In general, the reported data are not typically tied to specific outreach or enrollment facilitation efforts. That is, the analyses reported describe overall success/failure of all activities (and other factors) combined. A wide variety of measures are reported, for example, percent of the targeted population enrolled, volume of hot line calls received subsequent to a media campaign, number of applications distributed and returned by source, specified geographic areas, and/or income groups.

Despite the use of a uniform reporting template, definitions of numerators and denominators for these measures, and time frames for analysis, varied widely, making direct comparisons among states extremely difficult. In assessing the percent of the target population enrolled, establishing a denominator—the estimate of eligible uninsured children—is clearly a major problem for many states. There are few reliable data sources, especially for small states for which major national surveys such as the Current Population Survey (CPS)³⁹ or the Survey of Income and Program Participation (SIPP) are inadequate. In response, some states have or are planning to conduct state-specific surveys to derive alternative estimates.

Additional evaluation data will be available in the near future. P. L. 106-113 authorizes a new 10-state federal evaluation that will include an assessment of effective and ineffective outreach and enrollment practices for both Medicaid and SCHIP; an analysis of Medicaid eligibility rules and procedures that are a barrier to enrollment in Medicaid, and how coordination between Medicaid and SCHIP has affected enrollment under both programs; and an analysis of disenrollment patterns and factors influencing this process. The Secretary must submit the results of this evaluation to Congress no later than December 31, 2001.

³⁸Annual state SCHIP reports for FFY1998 are available for most states. Because SCHIP had just gotten started during this fiscal year, information on the effectiveness of outreach and enrollment processes in these reports are at best preliminary. States were allowed to combine their FY1999 annual reports and the 2000 evaluation reports as one comprehensive document.

³⁹CPS improvements are planned to remedy this situation. P.L. 106-113 included funding to support the collection of reliable annual state-by-state estimates on the number of children without health insurance, beginning in FY2000, and for each year thereafter.

Current Funding for Outreach Under Medicaid and SCHIP

From a policy standpoint, outreach funding issues differ between Medicaid and SCHIP. For Medicaid, the main question is whether and how states are using administrative funds to reach and enroll eligible children. For SCHIP, the main issue is whether current limitations on outreach funding are a barrier to identification and enrollment of eligible children.

Medicaid does not have a specific limit on the proportion of program spending devoted to administrative activities such as outreach, although the federal matching rate for such administrative expenses can be lower than that for direct services.⁴⁰ In addition, there is a special \$500 million fund established under the 1996 welfare reform legislation that provides higher federal matching rates for certain types of administrative expenses associated with Medicaid outreach to children losing welfare. This fund became available in FY1997.⁴¹

Despite the availability of these funds with federal matching rates of either 75% or 90% (depending on the outreach activity and allotment spending),⁴² 45 states received only \$195.6 million or 40% of the \$500 million fund as of June, 2000.⁴³ According to a 1999 survey of 40 states,⁴⁴ many have used (or plan to use) this fund to support activities that qualify for a 90% match from the federal government, including for example, developing and disseminating new publications (19 states), training (18 states), outreach (16 states), outstationing of Medicaid eligibility workers

⁴⁰Administrative expenses are generally matched at the rate of 50%. In FY2000, 41 of 56 states and territories had federal matching rates for services higher than 50%. In FY2001, 42 of 56 states and territories had federal matching rates for services higher than 50%.

⁴¹P.L. 106-113 lifted the FY2000 sunset on this fund and removed the requirement that states use this fund for administrative costs incurred only during the first 12 quarters subsequent to the effective date of their welfare reform programs.

⁴²The \$500 million fund is divided into two allocations for every state: a base allocation which is the same for all states (\$2 million) and a secondary allocation that is distributed across the states based on four weighted factors. These factors include: (a) state AFDC-related caseload (60%), (b) state Medicaid administrative expenses (20%), (c) SSI childhood disability case reevaluations (10%), and (d) SSI immigrant caseload (10%). States may receive reimbursement at a 90% federal matching rate for expenditures claimed against their base allocation, and either 75% or 90% federal matching rate for expenditures claimed against their secondary allocation, depending on the type of activity. Examples of activities matched at 90% include public service announcements, placement of eligibility workers in new locations, and development and dissemination of new publications for at-risk populations. Activities that may be matched at either 90% or 75% (depending on whether claims are made against the base or secondary allocation, respectively) include, for example, hiring new eligibility workers for eligibility determinations related to welfare reform only, designing new eligibility forms, and eligibility system changes.

⁴³Families USA. *TANF \$500 Million De-Linking Fund*. [http://www.familiesusa.org/tanf_500.htm]

⁴⁴Darnell, J., H. Lee, and J. Murdock. *Medicaid and Welfare Reform: States' Use of the \$500 Million Federal Fund*. Washington, D.C., The Kaiser Commission on Medicaid and the Uninsured, October 1999.

(14 states), community activities (e.g., meetings and speeches; 14 states), public service announcements (13 states) and educational activities (12 states). Twenty-six of 40 states were also expecting to receive a 75% match for making necessary changes to their eligibility systems.

Why has the \$500 million fund been underutilized to date? Findings from the aforementioned 1999 survey of 40 states identify several issues. These states indicated that initial confusion about the appropriate uses (and previously applicable dates of expiration) of the \$500 million fund created barriers to utilization. The regulations⁴⁵ delineating both the types of outreach expenses that qualify for enhanced matching and the required documentation for reimbursement are very complicated and thus, may also be burdensome. HCFA has issued a series of letters to State Medicaid Directors (most recently in early January 2000) to clarify permissible uses of this fund and proper claiming procedures. States also reported that competing priorities (e.g., implementation of SCHIP, Y2K, Medicaid managed care) and other external factors (e.g., need for legislative approval to implement new strategies) were obstacles to designing and implementing Medicaid outreach and enrollment activities.

Outreach funding under SCHIP is structured very differently from Medicaid and thus raises a different set of issues. For federal matching purposes under SCHIP, there is a limit on spending for administrative expenses including outreach and education. This limit or cap in a given fiscal year is equal to 10% of the amount states actually draw down from their allotments to cover benefits under SCHIP, as opposed to 10% of the appropriated level.

The current law allows flexibility in seeking federal payments for expenditures associated with outreach for SCHIP. For states that expand Medicaid under SCHIP, federal financial participation for related administration and outreach expenditures may be claimed either through Medicaid or SCHIP. To maximize federal payment, all states have the option to delay claiming administrative expenses under SCHIP up to 2 years from the date of the expenditure for the service. This option is designed to allow states with low benefit expenditures in the early years of the program to receive payments for associated administrative expenses over time at the enhanced federal matching rate.

The administrative costs of the Medicare and Medicaid programs rarely exceed 5% of total program costs. Based on that percentage, it would seem logical that a ceiling of 10% of program costs would be sufficient to administer an established program. Nonetheless, states have expressed concern over the SCHIP administrative funding cap and their ability to do comprehensive outreach to achieve enrollment goals, especially early in the program.

Administrative costs tend to be higher during the initial start-up of a new program, compared with the costs of running an existing program. During the first 2 years after SCHIP was enacted, many states in the start-up phase of their programs

⁴⁵Medicaid Program; Allocation of Enhanced Federal Matching Funds for Increased Administrative Costs Resulting From Welfare Reform. *Federal Register*, v. 62, no. 93, May 14, 1997. p. 26545-26550.

found the 10% cap to be particularly burdensome. In an August 6, 1998 letter to State Health Officials, HCFA acknowledged that the 10% cap presented a problem for states. Indeed, of the 15 states that reported any administrative spending in FY1998, 6 reached the ceiling and claimed the full 10% of total spending for administrative costs.⁴⁶ By 1999, the portion of national SCHIP spending claimed for administrative costs had declined as a percentage of total program spending. To address state concerns about the cap on administrative spending under SCHIP, the 106th Congress passed legislation (incorporated into P.L. 106-554) that stipulates a redistribution formula for unspent FY1998 and FY1999 funds. This new provision further permits states that did not spend their full FY1998 allotments (within required time limits) to use up to 10% of retained FY1998 funds under the new redistribution formula specifically for outreach activities. These outreach funds are above and beyond funding available under the 10% cap for all SCHIP administrative expenses. States have until the end of FY2002 to use the retained funds.

Privately Funded Outreach Initiatives and Coordination with Medicaid and SCHIP

To supplement public funding, private funding has become available to help states implement new outreach initiatives targeted at children and adolescents. For example, the Robert Wood Johnson Foundation (RWJF) has established a new grant program called Covering Kids. This program will make a total of \$47 million available to states over 3 years, starting in 1999. The funds are intended to help design and conduct outreach activities that identify and enroll eligible children into Medicaid and other programs such as SCHIP, to simplify enrollment processes, and to coordinate existing coverage programs for children. As of July 2000, 50 states and the District of Columbia have received Covering Kids project grants. In general, states are not the recipients of these grants. Instead, the program provides grants to coalitions of community groups that will administer and implement the outreach and enrollment activities. While RWJF has not yet published an official tabulation of the specific outreach and enrollment strategies implemented by grantees across the country, the Covering Kids website [<http://www.coveringkids.org>] provides a variety of resources on these topics.

Legislative Changes to Major Outreach and Eligibility Provisions Under Medicaid and SCHIP

President Clinton's FY2001 budget included several initiatives that would have affected the Medicaid and SCHIP programs.⁴⁷ The 106th Congress made changes in line with some of the Clinton Administration's proposals (summarized below). The subset of the Clinton Administration's proposals aimed primarily at improving coverage for families and children would have: (1) replaced SCHIP with a new

⁴⁶CRS tabulations of Form HCFA-21C data.

⁴⁷These proposals are outlined in *Clinton-Gore Administration Unveils Major New Health Insurance Initiative* (January 19, 2000). CBO provides a detailed analysis of these proposals and alternative budget estimates in *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001* (April 2000).

FamilyCare Program that would have provided health insurance to parents of children enrolled in Medicaid or SCHIP, and included financial incentives to cover whole families at higher income levels, (2) expanded Medicaid and SCHIP eligibility to 19- and 20-year-olds at state option,⁴⁸ (3) restored the option to provide full Medicaid eligibility to immigrants who lost coverage under welfare reform (including pregnant women, children and disabled immigrants regardless of date of entry into the US), (4) allowed states to use SCHIP funds to cover immigrant children, and (5) made transitional Medicaid coverage permanent and simplified state and family requirements to promote enrollment. In addition to these eligibility proposals, new outreach initiatives proposed by the Clinton Administration would have: (1) allowed School Lunch Programs to share participant information with Medicaid, (2) expanded sites authorized to presumptively enroll children in Medicaid and SCHIP to include schools, child care resource and referral centers, homeless programs, and other sites, and (3) required states to institute under Medicaid the same simplified enrollment procedures as those used under SCHIP.

Several bills were introduced in the 106th Congress that would have extended eligibility or facilitated continuous coverage, broadened outreach, simplified enrollment processes, and/or changed funding for such activities under Medicaid and SCHIP. Four such pieces of legislation were passed by the 106th Congress and signed into law. The first was the *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999* (BBRA 99; H.R. 3426) included by reference in the *Consolidated Appropriations Act for FY2000* (H.R. 3194) that became Public Law 106-113. Among other Medicaid provisions, this law permanently extended the availability of the \$500 million Medicaid fund established to assist with the administrative costs of new Medicaid eligibility activities resulting from welfare reform. Second, the *Foster Care Independence Act of 1999* (P.L. 106-169) gave states the option to extend Medicaid coverage to former foster care recipients between 18 and 20 years of age.

In a move to eliminate a barrier posed by the Agriculture Department's former policy guidance, the *Agriculture Risk Protection Act* (H.R. 2559, P.L. 106-224) now permits schools to share income and other relevant information when determining eligibility for free or reduced-price meals in the School Lunch Program with state Medicaid and SCHIP agencies for the purpose of identifying and enrolling children in these two programs. This law also established a one-state pilot project under which administrative funds for the WIC program can be used to help identify and enroll eligible children in Medicaid and SCHIP.

The most far reaching piece of legislation was the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA; H.R. 4557) that became P.L. 106-554. This law made several important changes affecting eligibility, outreach and enrollment under Medicaid and SCHIP.

⁴⁸Under current law, individuals who are 19 or 20 years of age can qualify for Medicaid if they are pregnant, disabled or meet welfare-related standards (i.e., are adults with dependent children). Some individuals in this age group who were formerly in foster care are also eligible for Medicaid. SCHIP eligibility is limited to those under 19 years of age.

With respect to Medicaid, P.L. 106-554 extended by 1 year (to September 30, 2002) the availability of transitional medical assistance for families no longer eligible for Medicaid on the basis of meeting former AFDC rules. It also added several entities to the list of those qualified to make Medicaid presumptive eligibility determinations for children, including for example, schools, child support enforcement agencies, certain programs for the homeless, and federally funded housing assistance programs. (Prior Medicaid law defined qualified entities to include Medicaid providers, Head Start programs, WIC programs, and agencies that determine eligibility for subsidized child care.) In addition, a technical amendment in this law exempted from a general upper income limit rule those adolescents aging out of foster care who are eligible for Medicaid under the Foster Care Independence Act of 1999 (as well as certain women eligible for Medicaid under the Breast and Cervical Cancer Treatment Act of 2000).

Significant changes were also made to SCHIP under P.L. 106-554. Prior law required that unused SCHIP funds be redistributed only to those states that spend their full allotments for a given fiscal year within a specified time frame. P.L. 106-554 extends the availability of unused funds from FY1998 and FY999 (through the end of FY2002) and redistributes these unused funds among both those states that spend and those that do not spend their full original allotments for these years. As previously described, P.L. 106-554 also permits certain states to use up to 10% of retained FY1998 funds for outreach activities. Finally, the new law clarifies states' authority to conduct presumptive eligibility determinations, as defined in Medicaid law, under separate (non-Medicaid) SCHIP programs.

Conclusions

Recent trends in insurance coverage among children (and others) have shown some improvements. Expansions of eligibility under Medicaid in the last two decades, and the advent of SCHIP in late 1997, have significantly increased the opportunities for coverage among poor and near poor children. HCFA reported continued increases in SCHIP enrollment in FY1999, rising to 3.3 million children during FY2000. Other data for 1998 and 1999 suggest that the decline in Medicaid caseloads that began in the mid-1990s may have started to reverse itself. Despite these improved opportunities, there were an estimated 6.7 million low-income children eligible for, but not enrolled in either of these two programs in 1999. These enrollment patterns are affected by complex interactions between economic trends, federal and state policies, program administrative procedures, and beneficiary perceptions. These interactions result in considerable enrollment variability across states, suggesting that at least some solutions will need to be state-specific.

Under both Medicaid and SCHIP, states face a number of challenges in reaching and enrolling the current target populations, most notably the working poor and near-poor, two-parent families, and immigrants. Medicaid faces the additional challenge of preventing previously enrolled individuals who remain eligible from dropping out of the program. Retention issues are beginning to surface under SCHIP as well.

Some policy makers have argued that providing Medicaid and SCHIP to whole families may be a more effective mechanism for reducing the number of low-income children without health insurance than the current fractured program structure. In recent years, able-bodied adults, typically parents of eligible children, experienced severe enrollment losses under Medicaid. Some of this loss was inadvertent, but the fact remains that there are few eligibility pathways into Medicaid, and even more restrictions under SCHIP, for providing coverage to low-income adults with children. Further simplification of eligibility rules, streamlining of enrollment processes and additional outreach are also important to reducing the number of low-income, uninsured children. Recent progress in these areas may be starting to take hold.

State budget limitations under Medicaid and SCHIP require state administrators to think carefully about their choice of outreach strategies and enrollment facilitation efforts. Cost-effectiveness should be a key consideration in making these choices. The existing research literature does not adequately pinpoint such strategies, but future evaluations at the state and federal level may fill this information gap. States may require a large investment of both time and money to evaluate the effectiveness of their outreach methods and enrollment simplification procedures, and to subsequently apply those lessons to their Medicaid and SCHIP programs.

SCHIP and Medicaid generally received continuing support from the 106th Congress. However, in recent months, there have been some signs that the economic growth enjoyed for the past several years may be slowing down. An economic downturn may increase the number of individuals eligible for Medicaid and SCHIP. Current SCHIP funding levels can probably absorb some of such an increase, but a huge influx of new enrollees into Medicaid could severely strain both federal and state budgets as was the case in the early to mid-1990s when major Medicaid reform was considered. If an economic downturn takes place, the 107th Congress may be faced with difficult domestic policy and funding choices. The goal of reducing the number of children without health insurance must be balanced with budget constraints that may result from any future economic downturns.

Table 1. Income Eligibility Standards for Medicaid and SCHIP
(By Percentage of the Federal Poverty Level)

State ^a	Medicaid standards in effect 3/31/97 ^b (lower income boundary for SCHIP)				Medicaid SCHIP- expansion program approved as of 12/11/00 ^c	Separate SCHIP approved as of 12/11/00 ^c
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Alabama	133%	133%	100%	15%	100% (ages 17 thru 18)	200% (ages 0 thru 18)
Alaska	133%	133%	100%	100%	200% (ages 0 thru 18)	n/a
Arizona	140%	133%	100%	30%	n/a	200% (ages 0 thru 18)
Arkansas ^d	133%	133%	100%	18%	100% (born after 9/30/82 and before 10/1/83)	n/a
California	200%	133%	100%	82%	100% (ages 17 and 18)	250% (ages 0 thru 18)
Colorado	133%	133%	100%	37%	n/a	185% (ages 0 thru 18)
Connecticut	185%	185%	185%	100%	185% (ages 17 and 18)	300% (ages 0 thru 18)
Delaware	133%	133%	100%	100%	n/a	200% (ages 0 thru 18)
District of Columbia	185%	133%	100%	50%	200% (ages 0 thru 18)	n/a
Florida ^e	185%	133%	100%	28%	100% (ages 17 and 18) 200% (ages 0 thru 1)	200% (ages 1 thru 18)
Georgia	185%	133%	100%	100%	n/a	200% (ages 0 thru 18)

State ^a	Medicaid standards in effect 3/31/97 ^b (lower income boundary for SCHIP)				Medicaid SCHIP- expansion program approved as of 12/11/00 ^c	Separate SCHIP approved as of 12/11/00 ^c
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Hawaii	185%	133%	100%	100%	200% (ages 0 thru 18)	n/a
Idaho	133%	133%	100%	100%	150% (ages 0 thru 18)	n/a
Illinois	133%	133%	100%	46%	133% (ages 6 thru 18)	185% (ages 1 thru 18)
Indiana	150%	133%	100%	100%	150% (ages 1 thru 18)	200% (ages 0 thru 18)
Iowa	185%	133%	100%	37%	133% (ages 6 thru 18)	200% (ages 0 thru 18)
Kansas	150%	133%	100%	100%	n/a	200% (ages 0 thru 18)
Kentucky	185%	133%	100%	33%	150% (ages 1 thru 18)	200% (ages 0 thru 18)
Louisiana	133%	133%	100%	10%	150% (ages 0 thru 18)	n/a
Maine	185%	133%	125%	125%	150% (ages 1 thru 18)	185% (ages 1 thru 18)
Maryland	185%	185%	185%	100%	200% (ages 0 thru 18)	300% ^f (ages 0 thru 18)
Massachusetts	185%	133%	114%	86%	150% (ages 1 thru 18) 200% (ages 0 thru 1 and pregnant teens)	200% (ages 1 thru 18)
Michigan	185%	133%	100%	100%	150% (ages 17 and 18)	200% (ages 0 thru 18)

State ^a	Medicaid standards in effect 3/31/97 ^b (lower income boundary for SCHIP)				Medicaid SCHIP- expansion program approved as of 12/11/00 ^c	Separate SCHIP approved as of 12/11/00 ^c
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Minnesota	275%	275%	275%	275%	280% (below age 2)	n/a
Mississippi	185%	133%	100%	34%	100% (ages 17 and 18)	200% (ages 0 thru 18)
Missouri	185%	133%	100%	100%	300% (ages 0 thru 18)	n/a
Montana	133%	133%	100%	40.5%	n/a	150% (ages 0 thru 18)
Nebraska	150%	133%	100%	33%	185% (ages 0 thru 18)	n/a
Nevada	133%	133%	100%	31%	n/a	200% (ages 0 thru 18)
New Hampshire	185%	185%	185%	185%	300% (ages 0 thru 1)	300% (ages 1 thru 18)
New Jersey	185%	133%	100%	41%	133% (ages 6 thru 18)	350% (ages 0 thru 18)
New Mexico	185%	185%	185%	185%	235% (ages 0 thru 18)	n/a
New York ^c	185%	133%	100%	51%	100% (ages 17and 18)	192% (ages 0 thru 18)
North Carolina	185%	133%	100%	100%	n/a	200% (ages 0 thru 18)
North Dakota	133%	133%	100%	100% (thru age 17)	100% (18 year olds)	140% (ages 0 thru 18)
Ohio	133%	133%	100%	33%	200% (ages 0 thru 18)	n/a

State ^a	Medicaid standards in effect 3/31/97 ^b (lower income boundary for SCHIP)				Medicaid SCHIP-expansion program approved as of 12/11/00 ^c	Separate SCHIP approved as of 12/11/00 ^c
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Oklahoma	150%	133%	100%	48%	185% (thru age 17)	n/a
Oregon	133%	133%	100%	100%	n/a	170% (ages 0 thru 18)
Pennsylvania ^e	185%	133%	100%	41%	n/a	200% (ages 0 thru 18)
Rhode Island ^g	250%	250% (thru age 7)	100% (ages 8 thru 14)	100%	250% (ages 8 thru 18)	n/a
South Carolina	185%	133%	100%	48%	150% (ages 1 thru 18)	n/a
South Dakota	133%	133%	100%	100%	140% (ages 0 thru 18)	200% (ages 0 thru 18)
Tennessee ^h	--	--	--	16%	100% (ages 17 and 18)	n/a
Texas	185%	133%	100%	17%	100% (ages 17 and 18)	200% (ages 0 thru 18)
Utah	133%	133%	100%	100% (thru age 17)	n/a	200% (ages 0 thru 18)
Vermont	225%	225%	225%	225%	n/a	300% (ages 0 thru 17)
Virginia	133%	133%	100%	100%	n/a	185% (ages 0 thru 18)
Washington	200%	200%	200%	200%	n/a	250% (ages 0 thru 18)
West Virginia	150%	133%	100%	100%	n/a	200% (ages 0 thru 18)

State ^a	Medicaid standards in effect 3/31/97 ^b (lower income boundary for SCHIP)				Medicaid SCHIP-expansion program approved as of 12/11/00 ^c	Separate SCHIP approved as of 12/11/00 ^c
	Age 0 to 1	Ages 1 thru 5	Ages 6 thru 14	Ages 15 thru 18		
Wisconsin	185%	185%	100%	45%	185% (ages 6 thru 18)	n/a
Wyoming	133%	133%	100%	55%	n/a	133% (ages 6 thru 18)

Source: Health Care Financing Administration. *The State Children's Health Insurance Program, Annual Enrollment Report, October 1, 1998-September 30, 1999*. Baltimore, Health Care Financing Administration, January 11, 2000. Medicaid expansion and separate state expansion program eligibility limits were updated to reflect amendments approved as of 12/11/00.

^a The Territories are not included in this table. Due to the unique nature of their SCHIP plans, the U.S. Territories and jurisdictions may cover existing Medicaid populations with SCHIP funds, but only after their Medicaid funding caps are reached.

^b SCHIP contains a provision that a child's family income must exceed the Medicaid income level that was in effect on March 31, 1997 in order for that child to be eligible for SCHIP-funded coverage. If approved, the proposed rule (published in the *Federal Register*, v. 64, no. 215, Monday, November 8, 1999) will change that date from March 31, 1997 to June 1, 1997 — a change that will affect the eligibility in a few states. On January 5, 2001, the Department of Health and Human Services released the final rule implementing comprehensive program requirements and administrative procedures for SCHIP. The final SCHIP rule is scheduled to be published in the January 11, 2001 *Federal Register* and will become effective 90 days after publication.

^c Reflects upper eligibility level of SCHIP plans and amendments approved as of December 11, 2000. Upper eligibility is defined as a percent of the federal poverty level (FPL), which, in 1999, is \$16,700 for a family of 4. In general, states with Medicaid expansion SCHIP programs must establish their upper eligibility levels net of income disregards. States with separate SCHIP programs can establish their upper eligibility levels on a gross income basis or net of income disregards.

^d Arkansas increased Medicaid eligibility to 200% FPL effective September 1997 through section 1115 demonstration authority.

^e These states had state-funded programs that existed prior to SCHIP. Title XXI permitted children previously in these state-funded programs to be covered under SCHIP and requires these states to maintain their previous level of state spending.

^f Maryland's Expansion to 300% was approved but will be implemented on July 1, 2001.

^g Rhode Island has implemented its program to 250% of the FPL. The state also has an approved amendment (February 5, 1999) in place to further expand the program to 300% of the FPL.

^h Under its section 1115 demonstration, Tennessee has no upper eligibility level. The currently approved SCHIP plan covers children born before October 1, 1983 in the expansion group and who enrolled in TennCare on or after April 1, 1997.

Table 2. National Medicaid Enrollment Levels, FY1995-FY1998

Type of beneficiary	Enrollment levels (thousands)				Percent change			
	FY1995	FY1996	FY1997	FY1998	1995-1996	1996-1997	1997-1998	1995-1998
Adults	9,600	9,255	8,583	8,643	-3.6	-7.3	0.7	-10.0
Cash related	5,399	4,934	4,082	3,452	-8.6	-17.3	-15.4	-36.1
Other	4,202	4,321	4,501	5,190	2.8	4.2	15.3	23.5
Children	21,630	21,259	21,058	20,665	-1.7	-0.9	-1.9	-4.5
Cash related	11,236	10,474	8,931	7,640	-6.8	-14.7	-14.5	-32.0
Other	10,393	10,785	12,127	13,025	3.8	12.4	7.4	25.3
Aged	4,115	4,117	4,114	4,090	0.0	-0.1	-0.6	-0.6
Cash related	1,847	1,840	1,813	1,783	-0.4	-1.5	-1.7	-3.5
Other	2,268	2,278	2,301	2,306	0.4	1.0	0.2	1.7
Disabled	6,333	6,664	6,836	6,984	5.2	2.6	2.2	10.3
Cash related	5,025	5,268	5,331	5,448	4.8	1.2	2.2	8.4
Other	1,308	1,396	1,505	1,536	6.7	7.8	2.1	17.4
Total Medicaid	41,677	41,295	40,591	40,381	-0.9	-1.7	-0.5	-3.1

Source: Unpublished Urban Institute (UI) estimates based on data from HCFA 2082-reports (12/14/00). Percent change calculations estimated by the Congressional Research Service (CRS). Does not include the U.S. Territories. Figures may not sum to totals due to rounding. Enrollees are defined as people who sign up for Medicaid for any length of time in a given fiscal year. Due to variations in the duration of enrollment periods, the reported number of enrollees tends to be higher than point-in-time estimates and the enrollment distributions may differ substantially from those based on point-in-time estimates. “Cash related” refers to enrollees who receive AFDC (prior to welfare reform), SSI, or mandatory state cash supplements, or who qualify for Medicaid via old AFDC rules (after welfare reform). “Other” includes all other enrollees, primarily the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. Some states may include Title XXI program (SCHIP) enrollees in their HCFA-2082 forms, though this should not be the case.

Note: For data quality reasons, we elected to summarize UI’s analysis in this report, rather than official HCFA-2082 data (named for the label on the reporting form). States generate 2082 data from their Medicaid administrative files using a standard format accompanied by instructions from HCFA. Historically, these official data have contained some classification errors and missing information. The magnitude of these problems varies by state and fiscal year. UI edited HCFA’s 2082 data to minimize these data problems. In particular, for the analysis summarized here, UI reassigned cases classified as “unknown” or “other” for basis of eligibility into the adult, children, aged and disabled categories. UI replaced missing data when possible. Other state- and year-specific edits were also performed. To inform this editing process and derive alternative counts, they performed distributional analysis on other 2082 data elements, contacted state officials to identify appropriate adjustments, and substituted other state data when available. Thus, UI’s numbers do not match official HCFA data for fiscal years 1995 through 1998.

Table 3. Selected Enrollment, Verification and Redetermination Strategies for Children Under Medicaid and SCHIP, July 2000

Selected strategies	Medicaid (50 states and the District of Columbia)	Separate SCHIP programs (32 states)
Simplification criteria at initial application		
Joint application for Medicaid and SCHIP	N/A ^a	28 (87.5%)
No face-to-face interview	40 (78.4%)	31 (96.9%)
No asset test	42 (82.4%)	31 (96.9%)
Presumptive eligibility ^b	8 (15.7%)	4 (12.5%)
12-months continuous eligibility ^c	14 (27.4%)	22 (68.8%)
Self-declaration of income as verification ^d	10 (19.6%)	7 (21.9%)
Redetermination procedures		
Joint application for Medicaid and SCHIP	N/A ^a	14 (43.7%)
No face-to-face interview	43 (84.3%)	32 (100%)

Source: Ross, D., and Cox, L. *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey*. Washington, D.C., The Kaiser Commission on Medicaid and the Uninsured, October 2000.

Note: The “Medicaid” column indicates the number of states that have adopted a particular strategy for their children’s Medicaid program. It includes all 50 state Medicaid programs and the District of Columbia, regardless of whether the state implemented a Medicaid expansion, a separate SCHIP program, or a combination of the two, with its SCHIP allotment.

The “Separate SCHIP Programs” column indicates the number of states that have adopted a particular strategy for their SCHIP-funded, separate state program. It includes 32 states (AL, AZ, CA, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, ME, MA, MI, MS, MT, NV, NH, NJ, NY, NC, ND, OR, PA, TX, UT, VA, WA, WV, and WY). The remaining 19 states have chosen to use their SCHIP allotment to expand Medicaid exclusively and are not included in this column.

^a A joint application for Medicaid and SCHIP is only relevant in the 32 states that have both Medicaid and separate SCHIP programs. See column 3.

^b Presumptive eligibility allows children whose family income appears to be below the state’s Medicaid income-eligibility guidelines to enroll temporarily in Medicaid, giving families time to complete the formal application process. While several states have adopted a presumptive eligibility procedure for their separate SCHIP programs, the rules under the Medicaid presumptive eligibility option do not necessarily apply.

- ^c States have the option to continuously enroll children in Medicaid for up to 12 months, without regard to changes in their family income. Families are not obliged to report changes in their circumstances that may occur before the end of the 12-month enrollment period. This option applies for both initial enrollment and redetermination periods. The states reporting 12 months of continuous eligibility at initial application also provide 12-month redetermination periods.
- ^d Federal Medicaid rules require states to verify information on the application form through various data exchanges with other agencies (for example, the Social Security Administration and the state agency that administers unemployment insurance). Federal law, however, does *not* require *families* to supply third-party verification of information provided in the application, except in one situation – when the person seeking coverage is not a citizen, documentation of the non-citizen’s immigration status is required. Otherwise, states have the flexibility to determine documentation requirements and can allow self-declaration of income and assets.