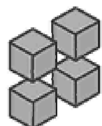
The Child Health Program Impact Series



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SCHIP Programs More Likely to Increase Children's Cost Sharing than Reduce Their Eligibility or Benefits to Control Costs

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The State Children's Health Insurance Program (SCHIP) would seem to be a natural target for cuts as nearly all states struggle to address budget shortfalls, which in 5 states were projected in 2003 to exceed more than 20% of their general fund budgets for FY 2004.T[1] Yet, SCHIP continues to be a politically popular program for governors and legislators alike, both because of the coverage it provides to such a significant segment of the child population -- some 6 million children in 2003, up from 3 million in 2000[2] -- and because of the general federal matching funds it offers. As a result, virtually all states have protected their SCHIP programs from reductions in eligibility levels, although there are some that have moved to restrict benefits or control enrollment and many that are requiring greater financial contributions by families. At the same time, however, there are several states that have expanded their SCHIP programs through changes in eligibility, enrollment, or benefits.

To obtain current information about the impact of budget problems on SCHIP programs, we contacted SCHIP directors in the 50 jurisdictions operating SCHIP programs in March 2004 (all states but Tennessee) and asked about policy changes made in 2003 or the first quarter of 2004 in the areas of eligibility, enrollment, benefits, and cost sharing. This study, which was a follow-up to one we conducted in 2002,[3] had a 100% response rate and found that over the last 16 months 24 states made policy changes in these areas, 20 of which were cost-cutting measures, as shown in Table I.

These 20 states are:

- ALABAMA -- separate program covering children up to 200% of the federal poverty level (FPL);
- ALASKA -- Medicaid program covering children up to 175% FPL;
- ARIZONA -- separate program covering children up to 200% FPL;
- COLORADO -- separate program covering children up to 185% FPL;
- CONNECTICUT -- separate program covering children up to 300% FPL;
- FLORIDA -- combination program covering children up to 200% FPL;
- GEORGIA -- separate program covering children up to 235% FPL;
- KANSAS -- separate program covering children up to 200% FPL;
- KENTUCKY -- combination program covering children up to 200% FPL;
- MARYLAND -- combination program covering children up to 300% FPL;
- MASSACHUSETTS -- combination program covering children up to 200% FPL;
- NEBRASKA -- Medicaid program covering children up to 185% FPL;
- NEW HAMPSHIRE -- combination program covering children up to 300% FPL;
- NEVADA -- separate program covering children up to 200% FPL;

- NEW JERSEY -- combination program covering children up to 350% FPL;
- NORTH CAROLINA -- separate program covering children up to 200% FPL;
- TEXAS -- separate program covering children up to 200% FPL;
- VERMONT -- separate program covering children up to 300% FPL;
- WISCONSIN -- Medicaid program covering children up to 185% FPL;[4]
- WYOMING -- separate program covering children up to 185 FPL.[5]

Controls on SCHIP Eligibility and Enrollment

Only 2 states revised their SCHIP income eligibility standards,[6] in one case lowering it and in another raising it, so that the total number of states setting their SCHIP eligibility levels at 200% of poverty or higher remains at 39.[7] Alaska, the state experiencing the largest budget shortfall, 36%, lowered its SCHIP eligibility level from 200% of poverty to 175% of poverty,[8] while Illinois, a state with a lower but still significant shortfall of 16%, actually increased its eligibility level from 185% of poverty to 200% of poverty. (Information about other SCHIP eligibility policies, including asset tests, continuous eligibility, and presumptive eligibility is available on the Kaiser Family Foundation's website and is current as of April 2003.)

With respect to enrollment policies,[9] we found that 4 states chose to freeze SCHIP enrollment while 2 states took steps to expand their existing enrollment. Florida, a state reporting no budget shortfall, closed SCHIP enrollment 9 months ago and now has a waiting list of more than 100,000 children. Colorado froze SCHIP enrollment 4 months ago, when it was confronting a 6.5% budget shortfall, and is not maintaining a waiting list. Maryland and Alabama both instituted freezes -- Maryland, 8 months ago and Alabama, 6 months ago -- but neither discontinued enrollment completely. Maryland decided several months after adopting the policy to limit the freeze only to applicants with no prior experience in Medicaid or SCHIP, a group estimated to comprise less than a quarter of all applicants. Alabama has twice taken children off its waiting list, enabling 60% of those eligible to enroll, and will do so again in April and May, although, 5,000 children are currently waiting to be enrolled. When it elected to freeze enrollment, Maryland was confronting a 7.8% shortfall; information on the budget shortfall in Alabama is not available.

TABLE I. STATE COST-CUTTING MEASURES

States	Eligibility	Enrollment	Benefits	Cost Sharing	
				Premiums	Copayments
AL		X		X	X
AK	X				
AZ				X	
CO		X			
CT				X	
FL		X	X	X	
GA				X	
KS				X	
KY				X	
MD		X		X	
MA				X	
NE			X		
NV				X	
NH				X	X
NJ				X	
NC					X
TX			X	X	X
VT				X	
WI				X	
WY			X		X

Montana and Utah, which faced little or nothing in the way of a general fund budget gap, are the 2 states that chose to expand SCHIP enrollment. In Montana, where eligibility had been completely frozen, all applicants were enrolled from the waiting list in November 2003 when the governor allocated increased funding for the program, but the waiting list has since been reinstated. In Utah, a larger federal SCHIP allotment enabled the state to increase its enrollment cap 9 months ago from 24,000 to 28,000 per month.

Changes in Benefits

Among the 36 states operating separate SCHIP programs,[10] we found that only 3 states adopted benefit reductions as a means of cutting costs while 2 states actually added benefits. Texas, faced with a general fund shortfall of 12%, made the most changes, eliminating coverage completely for chiropractic services, dental services, vision services, skilled nursing facility care services, hospice care, and tobacco cessation programs and reducing its previously generous mental health and substance abuse benefits to reflect more typical SCHIP behavioral health benefits[11] (30 days of inpatient mental health services, 30 outpatient mental health visits, 5 days of inpatient detoxification/stabilization services for substance abuse, 30 days of residential treatment for substance abuse, and 30 outpatient substance abuse visits).[12] Wyoming, which was not experiencing a budget deficit, changed its separate SCHIP program from a Medicaid look-alike program to one with more limited benefits, eliminating coverage for personal care, hearing aids, and its "EPSDT" provision and, with certain condition exceptions, limiting mental health inpatient services to 21 days and outpatient services to 20 visits, while capping coverage for dental services at $750, inpatient and outpatient substance abuse services combined at $6,000, and ancillary therapy services combined at $500. Changes in this state reportedly were unrelated to fiscal issues. Florida, another state not anticipating a budget deficit, elected to cap its dental coverage at $750 per year. Nebraska, which has a Medicaid SCHIP program, not a separate program, but was confronting a 13.6% budget shortfall, revised its Medicaid dental benefit so that orthodontia would be covered only for handicapping malocclusions.

Two other states, Utah and Virginia, expanded their benefits while facing relatively low budget gaps, 2.3% and 8.8%, respectively. Utah added restorative dental services and Virginia added community-based mental health services, including targeted case management, crisis intervention, day treatment, and in-home services.

Increases in Cost-Sharing Requirements

Compared to eligibility, enrollment, and benefit changes, increased cost-sharing requirements were a far more common strategy used by states to control costs, as shown in Tables II and III. Seventeen of the 20 states adopting cost-cutting measures chose this approach because, according to SCHIP directors, it not only offsets some of the states' costs but also brings SCHIP programs more in line with commercial coverage. Twelve states introduced or increased premiums, 2 states introduced or increased copayments, and 3 states introduced or increased requirements for both types of cost sharing. No state reported reducing its existing cost-sharing requirements.

Of the 15 states revising their premium policies, 3 were not facing budget shortfalls, while the remainder had projected budget gaps ranging from 2.7% (Kentucky) to 25% (Arizona). Four of the 15 states (Alabama, Connecticut, Kentucky, and Maryland) adopted premium requirements for families whose children previously were exempt from such charges. In each case the new monthly premiums, as large as $37 in Maryland, affected children in families with incomes between either 151% or 185% and 200% of poverty, but in Alabama the premium, though very small, was also imposed on children in families below 151% of poverty. Two of these states (Alabama and Connecticut) along with 11 others (Arizona, Florida, Georgia, Kansas, Massachusetts, Nevada, New Hampshire, New Jersey, Texas, Vermont, and Wisconsin) increased their existing monthly premium charges, which only in 2 states, Georgia and Nevada, affected children in families with incomes below 151% of poverty, and the charges were relatively small. Although the increases ranged from 10% in New Jersey to 50% in Alabama and Kansas,[13] the resulting amounts were usually no more than $20 per month. The largest premium amounts, ranging from $45 in New Hampshire to $110 in New Jersey, were generally imposed on families with much higher incomes. Even with these premium policy changes in place, 21 states -- 10 of the 36 separate programs and 11 of the 14 Medicaid programs -- still charge no premiums, and most of those with premiums still charge $20 or less for children in families with incomes below 200% of poverty.

Of the 5 states that chose to revise their copayment policies, budget deficits were not an issue in one state but ranged from 6% to 14% among the others. In 3 states (Alabama, North Carolina, and Wyoming) requirements were applied for the first

time to children in families with incomes below 151% of poverty. Each of these states began charging copayments of $1, $3, or $5 for prescription drugs with the highest charge in each state imposed for non-preferred brand name drugs, and 2 began charging for outpatient services -- $3 in one state for dental and physician visits and $5 in the other for all outpatient visits. In 2 of these states (Alabama and North Carolina) and 2 others (New Hampshire and Texas), charges were increased for families already subject to copayment requirements. Only Texas imposed higher charges for families with incomes below 151% of poverty, requiring them to pay $5 for office visits, but all 4 states raised at least some charges for families with incomes above 151% of poverty or, in the case of New Hampshire, above 186%. New Hampshire raised copayments for physician services to $7, and Texas raised them for all outpatient visits to $10. Alabama introduced charges for allergy testing ($10) and treatment ($5) and, along with North Carolina, increased copayments for non-preferred brand name drugs to $10. Overall, these copayment changes leave 26 SCHIP programs -- 14 of the 36 separate programs and 12 of the 14 Medicaid programs -- with no copayment requirements and the majority of the other 24 states charging children in families with incomes below 200% of poverty $5 or less for physician visits and nothing for inpatient hospital services.

Future of the Program

Unless states' budget situations improve, and forecasts for fiscal year 2005 are that they will not,[14] more SCHIP program cuts are likely. Five states reportedly are considering increasing cost-sharing obligations, one may reduce eligibility levels, and another might cap enrollment, but these changes are not certainties. In Florida, however, just-signed legislation is set to restrict program enrollment, despite the fact that the state has a projected surplus of nearly 8% for the end of this fiscal year,[15] by limiting enrollment to twice a year and allowing the governor to disenroll children if the program has future budget deficits. Idaho, which is also projected to have a surplus at the end of this fiscal year, although smaller than that in Florida, is increasing its SCHIP eligibility level effective July 1st from 150% to 185% of poverty. Children in families with incomes below 150% will remain in its Medicaid SCHIP program while those in the higher income group will enroll in a newly created separate program that will charge monthly premiums and copayments for emergency room services and prescription drugs.

Conclusions

Despite enormous fiscal difficulties, states have largely protected their SCHIP programs for children in 2003 and so far in 2004. No state eliminated its SCHIP program, and only a handful of states sought to reduce benefits or to reduce enrollment through lowered eligibility levels or enrollment freezes, though certainly outreach efforts have been curtailed in many states. Of the 20 states that made program cuts over the last 16 months, all but 3 chose to require larger financial contributions by families, and 5 states (Alabama, Florida, Maryland, Texas, and Wyoming) raised cost sharing along with capping enrollment or reducing benefits.

Overall, most of the 20 states that adopted policies to decrease their SCHIP expenses were ones that faced projected budget shortfalls for FY 2004, but there were exceptions; 5 of the states reporting program cuts did not have a projected budget gap for FY 2004. In fact, 3 of the 5 states making more than one program change were among those not facing a deficit; only Maryland and Texas reported budget shortfalls. Interestingly, among the 5 states confronting the largest general revenue budget gaps, only 3 implemented SCHIP cost-saving measures -- Arizona and Kansas increased cost-sharing obligations and Alaska reduced eligibility.

It remains to be seen what effect the most common cost-saving strategy of requiring greater cost sharing will have on program costs and also on program enrollment. It may be that premium increases, even moderate ones, will deter families from enrolling in SCHIP, choosing instead either to spend down to the medically needy eligibility level and obtain Medicaid coverage or simply to go without coverage.

TABLE II. SCHIP PREMIUM INCREASES, JANUARY 2003-MARCH 2004

States	Monthly Premium Amounts	
	Previous	Current
Alabama		
<151% FPL	$0	$4.17
151%-200% FPL	$4.17	$8.33
Arizona		
176%-200% FPL	$15	$20
Connecticut		
185%-235% FPL	$0	$30
236%-300% FPL	$30	$50
Florida		
151%-200% FPL	$15	$20
Georgia[1]		
101%-235% FPL	$7.50	$10
Kansas		
151%-175% FPL	$10	$20
176%-200% FPL	$15	$30
Kentucky		
151%-200% FPL	$0	$20
Maryland		
186%-200% FPL	$0	$37
Massachusetts		
151%-200% FPL	$10	$12
States (Cont'd.)		
Nevada		
<151% FPL	$3.33	$5
151%-175% FPL	$8.33	$11.67
176%-200% FPL	$16.67	$23.33
New Hampshire		
186%-250% FPL	$20	$25
251%-300% FPL	$40	$45
New Jersey		
151%-200% FPL	$15	$16.50
201%-250% FPL	$30	$33
251%-300% FPL	$60	$66
301%-350% FPL	$100	$110
Texas		
151%-185% FPL	$15	$20
186%-200% FPL	$18	$25
Vermont		
225%-300% FPL	$50	$70
Wisconsin		
151%-185% FPL	3%	5%[2]

TABLE III. SCHIP COPAYMENT INCREASES, JANUARY 2003-MARCH 2004

States	Copayments	
	Previous	Current
Alabama		
<151% FPL		
Generic Rx	$0	$1
Preferred brand name Rx	$0	$3
Nonpreferred brand name Rx	$0	$5
Dental visits	$0	$3
Physician visits	$0	$3
X-ray	$0	$3
All inpatient stays	$0	$5
ER services	$0	$5
151% - 200% FPL		
Generic Rx	$1	$2
Preferred brand name Rx	$3	$5
Nonpreferred brand name Rx	$3	$10
X-ray	$0	$5
All inpatient stays	$5	$10
Allergy testing	$0	$10
Allergy treatment	$0	$5
States (Cont'd.)		
New Hampshire		
186%-300% FPL		
All outpatient visits	$5	$10
ER visits	$25	$50[3]
North Carolina		
<151% FPL		
Generic and brand name Rx with no generic	$0	$1
Brand name with available generic	$0	$3
151%-200% FPL		
Generic and brand name Rx with no generic	$6	$1
Brand name with available generic	$6	$10
Texas		
151%-185% FPL		
All outpatient visits	$5	$7
Wyoming		
134%-185% FPL		
All outpatient visits	$0	$5
ER visits	$0	$5
Generic Rx	$0	$3
Brand name Rx	$0	$5

[1] In Georgia, the monthly premium applies only to children older than age 6. There is no charge for younger children.
[2] This is 5% of a family's net income, after earned income disregards and deductions for dependent care costs, work-related expenses, and child support.
[3] In New Hampshire, the copayment for emergency room visits is waived if the child is admitted.

Source: Information was obtained by the Maternal and Child Health Policy Research Center based on contacts with state SCHIP directors in March 2004.

Endnotes

[1] All information presented in this issue brief on budget shortfalls was reported by the National Conference of State Legislatures and pertains to the highest projections made in 2003 for fiscal year 2004. NCSL Fiscal Affairs Program. *State Budget Update: April 2003.* Washington, DC: National Conference of State Legislatures, 2003.

[2] Center for Medicaid and Medicaid Services. FY 2003 *Number of Children Ever Enrolled in SCHIP by Program Type, January 22, 2004.* http://www.cms.hhs.gov.schip/enrollment/schip03.pdf. March 17, 2004.

[3] Fox HB, Reichman MR, and McManus MA. *Few States Report SCHIP Program Cuts Before End of FY 2002.* Washington, DC: Maternal and Child Health Policy Research Center, 2002.

[4] In Wisconsin, children in families with incomes up to 185% of poverty are eligible for the state's SCHIP program, but once enrolled, they may remain in the program until their family's income increases to 200% of poverty.

[5] Wyoming's program changes reportedly are unrelated to fiscal difficulties.

[6] We asked states only about changes in their income eligibility standards. We did not ask about changes in how they calculated income. Nor did we ask about changes in asset tests. Texas, for example, has retained its income eligibility standard but affected eligibility by eliminating earnings, child care, and child support deductions.

[7] Mann C. *Children's Health Insurance Coverage: 5 Years After SCHIP.* Alliance for Health Reform Presentation, September 12, 2002. http://www.allhealth.org/recent/audio_09-12-02/CindyMannSCHIP.pdf.

[8] Alaska froze its income eligibility level at 175% of poverty, as calculated in 2003, with no future cost-of-living adjustment.

[9] We asked states only about policies pertaining to freezes or caps. We did not ask about issues related to recertification.

[10] We include Arkansas' SCHIP program in this group because it is a Medicaid expansion program but operates under an 1115 waiver to offer a limited benefit package.

[11] In Texas, mental health and substance abuse benefits prior to 2003 included 45 days of inpatient and residential mental health treatment, 60 days for partial hospitalization services, 60 outpatient mental health visits, 14 days for inpatient detoxification/stabilization services, 60 days for residential substance abuse treatment, 6 months per year for outpatient substance abuse services, and 12 weeks per year for intensive outpatient substance abuse rehabilitation.

[12] Texas had originally reduced mental health and substance abuse benefits in 2003 to include only one outpatient diagnostic visit, 6 medication management visits, and consultation in an inpatient or emergency setting after stabilization of an emergency condition. Benefits were increased in February 2004 but not to prior levels.

[13] Kansas had originally increased premiums in 2003 from $10 to $30 for children in families with incomes between 151% and 175% of poverty and from $15 to $45 for children in families with incomes between 176% and 200% but reduced them in September 2003 to $20 and $30, respectively.

[14] NCSL Fiscal Affairs Program. *State Budget Update: February 2004.* Washington, DC: National Conference of State Legislatures, March 2004.

[15] Ibid.

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