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Few States Report S-CHIP Program Cuts Before the End of FY 2002

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Despite the enormous fiscal pressures most states are facing and the substantial reduction in federal appropriations,[1] it appears that relatively few S-CHIP programs will see significant budget reductions in the current fiscal year. This is because governors and state legislatures typically are hesitant to cut such a popular health care program that may already be considered lean and are reluctant to lose the generous federal matching dollars attached to it. Also, in a few states, S-CHIP programs have been able to avoid the impact of state budgetary problems because they are supported by special sources of funding not linked to general revenue.[2] At the same time, states with S-CHIP expenditures exceeding their federal allotments will be able to rely on unspent funds from earlier years or the reallocation of funds unused by other states.[3]

To understand the S-CHIP program impacts that might result from state budget shortfalls during fiscal year 2002, the Maternal and Child Health Policy Research Center conducted a brief survey of S-CHIP program directors in November and December of 2001. We obtained responses from 48 states, including the District of Columbia; only Arkansas, Connecticut, and Vermont did not participate. Future fact sheets will present findings from surveys examining state budget impacts on other programs serving children and adolescents.

Our survey of S-CHIP program directors found that of the 48 states reporting, only 9 had either made, or were anticipating making, changes to their S-CHIP programs in order to reduce costs. An additional 2 states, however (Wisconsin and New Mexico), said their states were experiencing significant budgetary problems but they could not at the time of the survey report the specific impact of these problems on their SCHIP programs.

The 9 states reporting S-CHIP program cuts are:

- CALIFORNIA -- non-Medicaid program covering children up to 250% of the federal poverty level (FPL); [4]
- FLORIDA -- non-Medicaid program covering children up to 200% FPL; [4]
- GEORGIA -- non-Medicaid program covering children up to 235% FPL;
- IDAHO -- Medicaid expansion program covering children up to 150% FPL;
- MISSISSIPPI -- non-Medicaid program covering children up to 200% FPL; [4]
- MONTANA -- non-Medicaid program covering children up to 150% FPL;
- RHODE ISLAND -- Medicaid expansion program covering children up to 250% FPL;
- SOUTH CAROLINA -- Medicaid expansion program covering children ages 0-1 up to 185% FPL and children ages 1-18 up to 150% FPL; and
- UTAH -- non-Medicaid program covering children up to 200% FPL.

These states are not dissimilar from other states with respect to the type of S-CHIP programs that they

operate; that is, like states overall, about a third of these states enroll children into Medicaid-only programs. However, compared to states overall, these states are somewhat more likely to have income eligibility ceilings lower than 200% of poverty, and significantly more likely to be in the West and in the South (in fact, of the 9, 4 are in the West and 4 are in the South).

Three of the 9 states (California, Georgia, and Mississippi) reported that although they did not actually anticipate an S-CHIP budget shortfall in the current fiscal year, they were making changes now to avoid more serious cutbacks in subsequent years. Each of the 3 states was experiencing significant budgetary deficits in the state as a whole. These were due to revenue shortages and, in 2 of the states, also to increased expenditures. California reported that its overall state deficit could reach as high as $14 billion.

The other 6 states (Florida, Idaho, Montana, Rhode Island, South Carolina, and Utah) reported that S-CHIP spending cuts were being made expressly because of anticipated shortfalls in their fiscal year 2002 budgets, although only 2 could estimate the magnitude of the anticipated cuts. Montana reported that it would cut between 2.6% and 5% of its budget, and Utah estimated a cut less than 2.5%.

Five of the 6 states (all but Rhode Island) told us that the S-CHIP program cuts were the result of general budget shortfalls in the state, in most instances due to lower than expected revenue. Rhode Island reported that the cuts were due to larger than anticipated S-CHIP caseloads, and Utah mentioned this as well. Rhode Island is the only state whose S-CHIP expenditures are projected to exceed the total of its fiscal year 2002 allotment, its unspent funds from previous years, and reallocated funds from other states.

STATE COST-CUTTING MEASURES

States	Administration	Enrollment	Benefits	Cost Sharing	Other
CA	X				
FL		X			
GA					
ID	X				
MS		X			
MT	X	X			
RI		X		X	X
SC	X	X	X		X
UT	X	X	X	X	

Reductions in Administrative Spending

When the 9 states were asked what measures they were taking or planning to take to reduce S-CHIP expenditures before the end of fiscal year 2002, 5 of the 9 (California, Idaho, Montana, South Carolina, and Utah) said they would be reducing administrative spending. California, for example, reported a 15% reduction in state support that would affect training, travel, supplies, and special projects. Montana reported that vacant positions would remain open for a minimum of 4 months, while Utah reported that a half-time position was being eliminated.

Controls on S-CHIP Enrollment

Six of the 9 states reporting program changes to control costs (Florida, Mississippi, Montana, Rhode Island, South Carolina, and Utah) said they would be implementing some policy or action aimed at reducing the number of children who could potentially participate in their S-CHIP programs. An additional state (Idaho) reported that this remained a distinct possibility.

Of the 6 states taking definite actions to curtail program participation, 5 (all except Montana) said they are terminating aggressive outreach efforts. Utah reported that it will also be closing enrollment to all new S-CHIP participants. Montana, which had already capped enrollment and stopped its outreach campaign, reported that it will be maintaining the cap and not removing any of the children from its current waiting list. One other state, however (Florida), said that it will institute an enrollment cap when and if it becomes necessary, and another (Idaho) said that it was considering a cap as an option. None reported that they would be lowering their income eligibility ceilings, but, again, in Idaho the option is under consideration.

Reductions in Benefits

Two of the 9 states introducing cost-cutting measures (Utah and South Carolina) reported that they would be reducing or eliminating benefits provided to S-CHIP participants. Utah will be eliminating all dental benefits. South Carolina will be eliminating a number of dental procedures that would be required by some children.

Increases in Cost Sharing Requirements

Two of the 9 states making cost-cutting changes (Utah and Rhode Island) reported that they would be increasing cost-sharing requirements for program participants. Utah is introducing a $5 premium for children in families with incomes up to 150% of the federal poverty level and a $10 premium for children in families with incomes between 150% and 200%. The state is also increasing copayment obligations for all participants -- for some services requiring copayments where none were previously applied and for other services raising the copayment amounts charged.[5] Rhode Island is introducing premiums for children in families at or above 150% of the federal poverty level. In addition, increases in cost sharing are under consideration in Idaho**.**

Other Measures to Achieve Budget Reductions

Only 2 of the 9 states (South Carolina and Rhode Island) reported that they would be implementing other cost-cutting measures before the end of fiscal year 2002. South Carolina reported that it will decrease the reimbursement rates to primary care providers for certain evaluation and management CPT codes, and also reduce rates for durable medical equipment, dental care, and some psychology services. In addition, options to cut pharmacy expenditures have also been pursued in South Carolina as they presumably have in other states. Rhode Island reported that is will make enrollment in its Medicaid employer premium assistance program mandatory for all children in families who have access to qualifying employer-sponsored coverage.

Effects on Planned Program Expansions

When we asked the 9 states if they anticipate that budgetary problems will have an effect on planned S-CHIP expansions, including waiver applications, 2 (Georgia and South Carolina) responded affirmatively. Georgia reported that it will not implement a Medicaid expansion that would have covered children up to 150% of the federal poverty level and allowed about 100,000 S-CHIP children to become eligible for Medicaid. The expansion had been passed last session. South Carolina reported that it has cancelled plans to implement a legislatively approved expansion that would have covered children up to 165% of the federal poverty level.

Another 2 states told us that they were no longer considering possible program expansions. In Idaho, ways to cover children in families up to 200% of the federal poverty level are no longer being explored and, in Utah, serious discussion of expanding coverage to adults has been dropped.

Overall, it does not appear that many states will be taking steps to cut back on their S-CHIP expenditures in the current fiscal year. Only 9 states reportedly are adopting cost-cutting measures and -- except for Utah, Montana, and South Carolina -- most are not making any major program changes.

The outlook is likely to be quite different, however, beginning in fiscal year 2004, when some states will find that the federal funds needed to sustain S-CHIP enrollment at projected levels will be less than the total amount they will receive from their annual federal allotment combined with unspent funds from previous years or reallocated funds from other states. If the economy does not rebound, states probably will be unable to compensate for this decrease in federal funding and might find themselves forced to scale back their S-CHIP caseloads at a time when the number of eligible children would likely exceed current projections. Moreover, even before fiscal year 2004, some states might elect to implement enrollment caps or other cost-saving measures to address shortages in state general revenue. Whether and when states will scale back their S-CHIP programs remains to be seen, but future reductions in S-CHIP participation are clearly a strong possibility.

Endnotes

[1] When Congress enacted the Balanced Budget Act of 1997 creating the S-CHIP program, it authorized $40 billion for states over a 10-year period, but stipulated that in fiscal year 2002 the annual appropriations would be reduced by more than $1 billion and would remain at that level for the next 2 fiscal years. This amounts to a 26% reduction in federal support.

[2] Colorado's S-CHIP program, for example, is being protected from an overall state budget deficit by $10 million that was designated from the Tobacco Settlement towards the S-CHIP state match.

[3] The Balanced Budget Act provided that states would have 3 years in which to use a given fiscal year's federal S-CHIP allotment. After 3 years any unspent funds would be redistributed to states that had used their full allotment. The Medicare, Medicaid, and S-CHIP Benefits Improvement Act, enacted in December 2000, extended the amount of time that states could use most, though not all, of their unspent FY 98 allotment for an additional year through the end of FY 02. The 39 states that did not spend all of their FY 98 funds were able to keep 65% of their unspent funds, while the 12 states that had used their full allotment received the remaining 35%. These 12 states are Alaska, Indiana, Kentucky, Maine, Maryland, Massachusetts, Missouri, New York, North Carolina, Pennsylvania, Rhode Island, and South Carolina.

[4] The S-CHIP programs in these states (California, Florida, and Mississippi) are essentially non-Medicaid programs, although they do provide Medicaid coverage to 18-year-olds in families with incomes up to 100% of the federal poverty level. Florida also covers infants in families between 185 and 200% of poverty.

[5] For families at or below 150% FPL, the following copayment requirements were added: $2 for laboratory services, $2 for X-rays, and $5 for hospital inpatient/outpatient physician services. The copayment for non-formulary prescription drugs was increased from $2 to $5. For families between 151% and 200% FPL, the following copayments were added: $5 for laboratory services less than $50, $5 for X-rays less than $100, and $15 for inpatient hospital physician visits. In addition, the following copayments were increased: from $10 to $15 for office or urgent care visits, from $30 to $35 for emergency room visits, and from $4 to $5 for formulary prescription drugs.

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