

medicaid
and the uninsured

PRESERVING RECENT PROGRESS ON
HEALTH COVERAGE FOR CHILDREN AND
FAMILIES: NEW TENSIONS EMERGE
A 50 STATE UPDATE ON ELIGIBILITY, ENROLLMENT,
RENEWAL AND COST-SHARING PRACTICES IN MEDICAID
AND SCHIP

Executive Summary

Prepared by

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For the past several years, states have vigorously expanded eligibility and simplified enrollment and renewal procedures in Medicaid and the State Children's Health Insurance Program (SCHIP). As a result, millions of low-income children and, to some extent, their parents have gained easier access to health coverage, and enrollment has increased. This report presents the findings of a survey of eligibility rules, enrollment and renewal procedures, and cost-sharing policies implemented in the 50 states and the District of Columbia in 2002 and the early part of 2003. It is part of a series of surveys conducted over the last three years by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured to track the strategies states are using to facilitate enrollment in health coverage programs (Tables ES 1 and ES 2 highlight trends).

Recently, severe financial stress has been taking its toll on both state budgets and on low-income families. Just when states are feeling the pressure to curb spending, more families, reeling from the effects of the weak economy, are becoming eligible for health coverage programs. The survey revealed new tensions emerging as states have responded to this dilemma. In some respects, public health coverage programs were protected; in other respects, they have been hit hard. Despite facing their most serious budget problems in decades, states generally demonstrated strong support for continuing eligibility expansions for children and, to a large extent, they did not retreat from simplified procedures adopted in the past. There were some significant setbacks, however. Most striking was that coverage for low-income working parents — which expanded much more slowly than coverage for low-income children — was deeply reduced in several states. The persistent, and now widening, disparity between the level of coverage for children and parents can be attributed in large part to the high federal minimum eligibility standards for children as compared to the standards for parents, and to the enhanced federal matching funds available through SCHIP to bolster states' efforts to expand children's coverage; no enhanced match exists for parent coverage (Figure 1).

In addition to retracting eligibility for parent coverage, some states reinstated policies that imposed increased reporting and verification requirements on families, making it more difficult for eligible people to enroll in coverage. Actions that roll back income eligibility or that impose administrative obstacles to enrollment have the same effect — they diminish participation. Reverting to an enrollment process that many families found complicated and intrusive in the past is likely to hurt participation over the long-term by deterring eligible families from applying for coverage and damaging public support for the program.

Specific survey findings include:

For the most part, states maintained income-eligibility for children (Figure 2). As of April 2003, 39 states make coverage available to children in families with income at 200 percent of the federal poverty line or higher; 44 states disregard assets in determining eligibility for children's health coverage; and 20 states do not require children to be uninsured for a period of time before they can enroll in Medicaid or SCHIP. During the survey period, two states (Illinois and Oregon) enacted modest coverage expansions and one state (Tennessee) reduced the income-eligibility level for children. In addition, one state (Nebraska) changed the way income is

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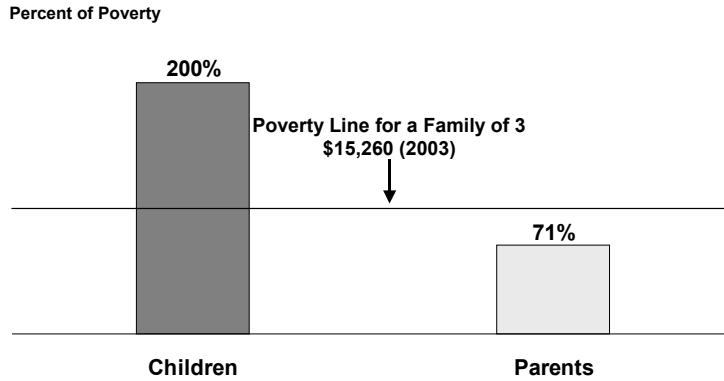
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Figure 1

Median Medicaid/SCHIP Income Eligibility Threshold for Children and Parents, April 2003

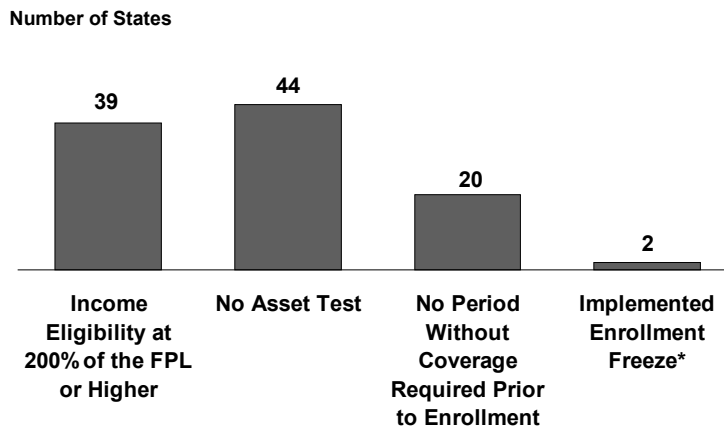


Note: Eligibility levels for parents based on the income threshold applied to a working parent in a family of 3.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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Figure 2

Eligibility for Children's Health Coverage Programs, April 2003



* In addition, in TN enrollment is closed to some but not all of the children eligible under the state's waiver.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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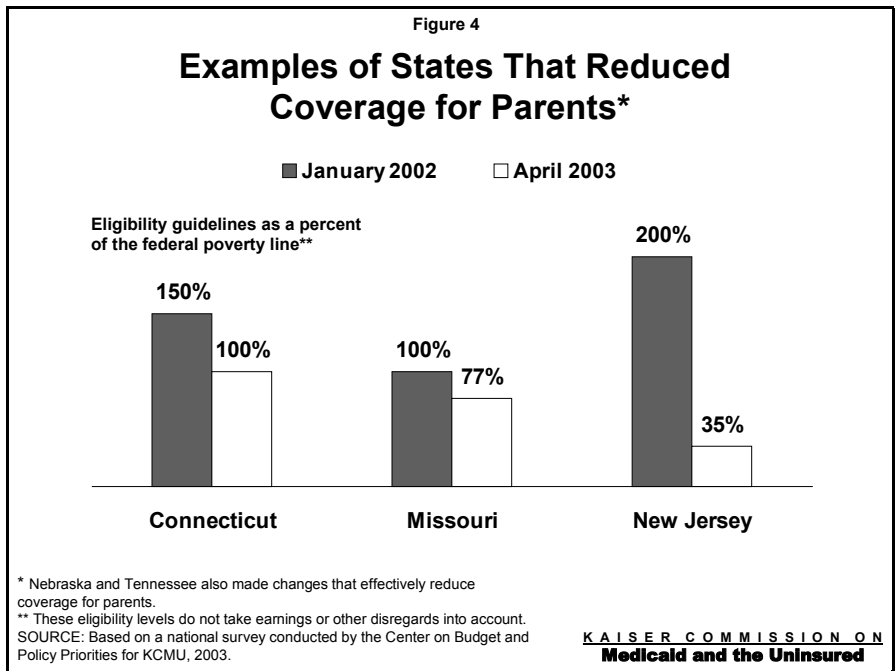
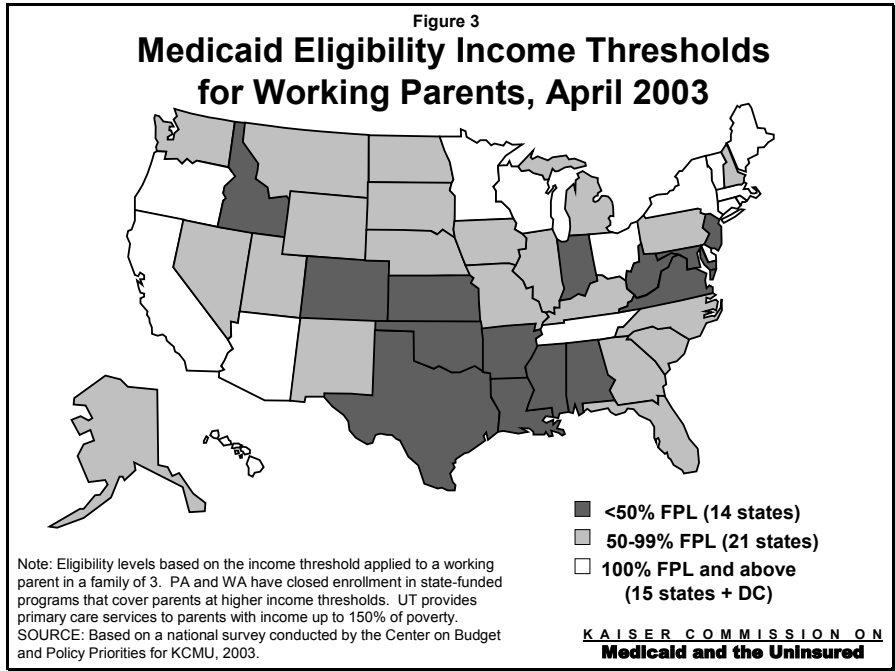
calculated, affecting the ability of some children to qualify for coverage. Two states (Montana and Utah) froze enrollment, for at least some period of time, in their separate SCHIP programs due to the unavailability of state funds.

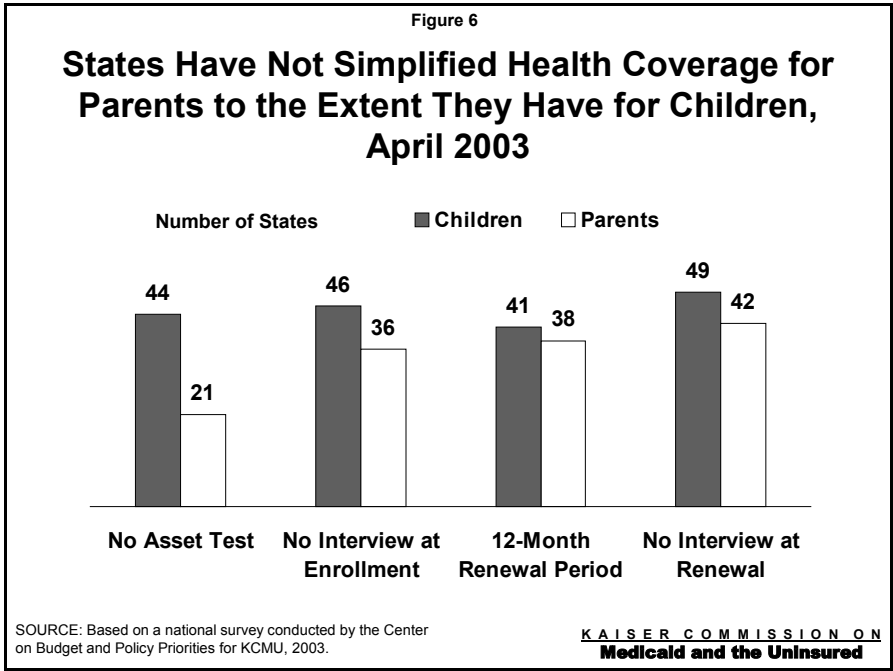
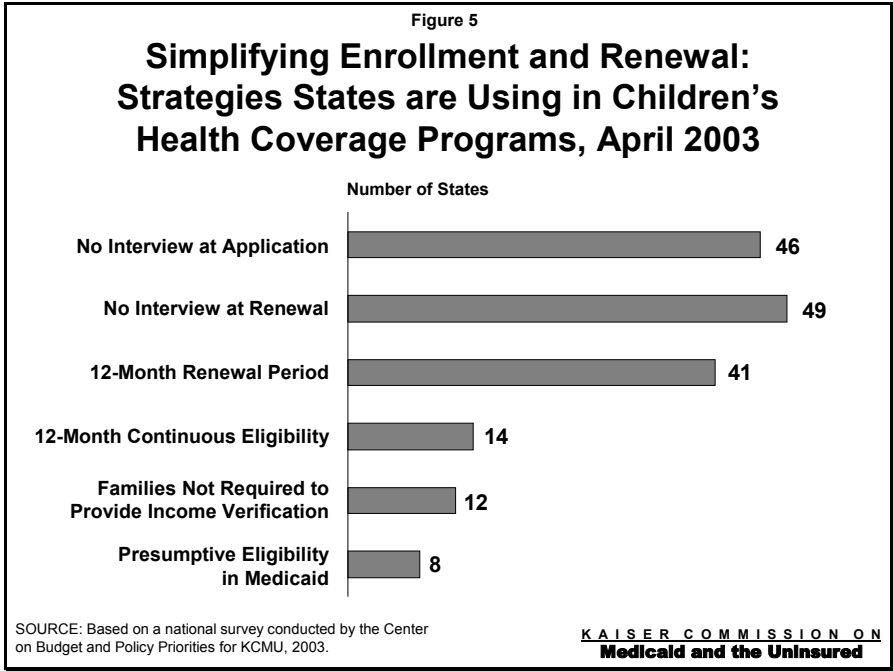
Parent coverage suffered a substantial setback (Figures 3 and 4). Five states (Connecticut, Missouri, Nebraska, New Jersey and Tennessee) reduced access to health coverage for low-income parents. Some states deeply reduced income eligibility during the survey period, in some cases to income levels well below the federal poverty line. Nebraska changed the way income is calculated, rendering many parents ineligible. On the other hand, two states (Arizona and New York) implemented parent expansions that had been enacted prior to the survey period. As of April 2003, 16 states cover parents with income at or above the federal poverty line; in 14 states, working parents with income at just half the federal poverty line, a mere \$636 per month for a family of three, earn too much to qualify for Medicaid. The ramifications of cutting health coverage eligibility for parents are serious. Such programs provide critical support to parents working in low-wage jobs not likely to provide employer-based coverage. The loss of parent coverage also is likely to have repercussions for children, who are more likely to be enrolled in health coverage and receive preventive care when their parents also are covered.

Unlike in prior years, during which states showed virtually unwavering progress in the direction of simplifying enrollment and renewal procedures, states took steps forward and backward in the survey period. While 13 states adopted at least one new simplification measure considered in this survey, five states rescinded one or more of them. As of April 2003, 46 states do not require a face-to-face interview for families applying for children's coverage, 34 of the 35 states with separate SCHIP programs use a single application form for both Medicaid and SCHIP (19 of these 35 states use a joint *renewal* form for the two programs), 41 states allow children to renew coverage annually as opposed to more frequently, and 12 states do not require families to provide pay stubs or other verification of their income. Also, eight states have implemented presumptive eligibility for children eligible for Medicaid, allowing a child to be temporarily enrolled in health coverage pending a final eligibility determination. Some of these states also have adopted presumptive eligibility in their separate SCHIP programs. Two states have implemented the option for their separate SCHIP programs only.

Three states rescinded 12-month continuous eligibility for children, withdrawing the guarantee of uninterrupted coverage for a full year and increasing the likelihood that eligible children will lose coverage due to additional reporting requirements (Figure 5). In 2002, the number of states implementing the 12-month continuous eligibility option for children in Medicaid and SCHIP fell from 17 to 14. Connecticut, Indiana and Nebraska rescinded the option. Children in states that dropped the option are now more vulnerable to suffering gaps in health coverage. States may be losing some administrative cost-savings previously achieved by not having to process families' paperwork as frequently and by not having to re-enroll eligible children who lost coverage because their families were unable to meet increased reporting and verification requirements.

While some progress was made, disparities between the level of simplification in enrollment and renewal procedures for children and parents persist (Figure 6). Parents still have a harder time obtaining and renewing health coverage than do children. As a result, families





have more difficulty obtaining and retaining coverage than do children applying separately from their parents. During the survey period, eight states adopted simplified enrollment and renewal procedures in their parent coverage programs that helped to ameliorate these discrepancies somewhat. As of April 2003, 25 states allow parents and children to apply for coverage using a single application. A greater number of states have dropped the requirement that families have a face-to-face interview when applying for children's coverage (46 states) than for parents' coverage (36 states); a greater number of states have dropped the face-to-face interview for renewing children's coverage (49 states) than for renewing parents' coverage (42 states); and a greater number of states allow children to renew coverage every 12 months (41 states) than allow parents to do so (38 states).

States are increasingly turning to cost-sharing as a way to contain costs in their health coverage programs (Figures 7 and 8). States' policies on premiums and co-payments vary, however research indicates that premiums can depress participation rates in public programs for low-income individuals. Co-payments also can reduce the use of needed services. As of April 2003, 31 states impose premiums or annual enrollment fees for children's health coverage and 22 states require a co-payment for non-preventive physician visits, emergency room care, inpatient hospital care, and/or prescription drugs for children in families with income at the income levels examined in the survey.

In states with premiums, the monthly cost for two children in a family with income of 151 percent of the federal poverty line ranges from \$8 to \$70 per month. In states with co-payments, non-preventive physician visits range from \$3 to \$15, emergency room care from \$5 to \$50, inpatient hospital care from \$5 to \$100, and prescription drugs from \$1 to \$20. In addition, a number of states impose penalties on families that fail to pay their premiums, making it more difficult for them to re-enter the program after being disenrolled.

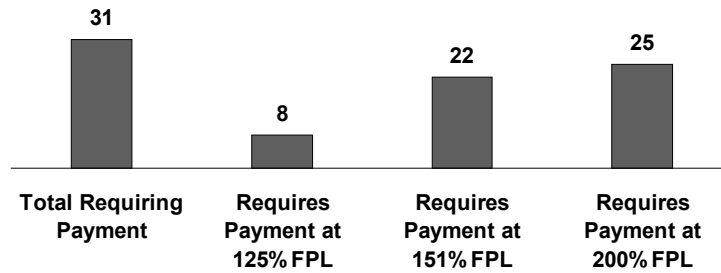
States have taken other steps that are likely to have an adverse effect on enrollment. Although the survey did not address the status of outreach activities, many state officials interviewed acknowledged that spending on promotional campaigns and community-based application assistance has been curtailed or eliminated. This is likely to impede families' ability to complete application and renewal forms and procedures. In addition, while the survey did not specifically examine cuts to state administrative budgets, some state officials indicated that workforce reductions and hiring freezes are contributing to delays in processing applications and conducting eligibility determinations. Such delays are likely to be compounded by policies that increase reporting and verification requirements for families.

Policies adopted during the most recent state legislative season after the survey period indicate a further erosion of health coverage for low-income children and parents is occurring, although some states have been able to stave off harmful cuts, at least temporarily. States such as Texas, Maryland, Washington and Florida have passed legislation and may already be implementing reductions in eligibility, reinstatement of administrative obstacles to enrollment and renewal or enrollment freezes. Other states, such as Ohio, Minnesota and Missouri, recently took advantage of the temporary increase in the federal matching rate for Medicaid, made available under the Jobs and Growth Tax Relief

Figure 7

Premiums or Enrollment Fees in Children's Health Coverage Programs, April 2003

Number of States



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

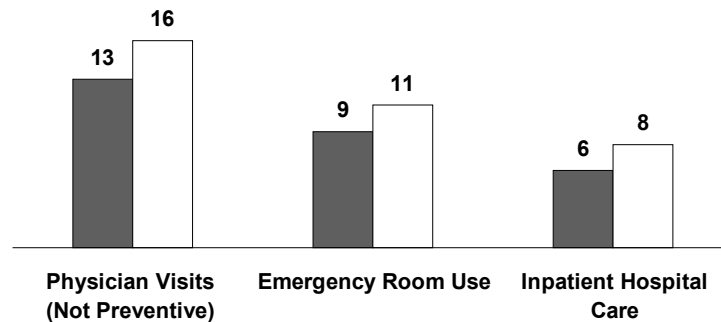
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Figure 8

Co-payments for Selected Services in Children's Health Coverage Programs, April 2003

Number of States

■ Family Income at 151% FPL □ Family Income at 200% FPL



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2003.

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Reconciliation Act of 2003, to avoid or postpone cuts that would have reduced eligibility for parents seeking health coverage and scaled back services for beneficiaries.

The pressure on states to adopt more cost-saving measures in their health programs will likely continue, as the state budget picture is not expected to improve dramatically in the near term. States are considering not only reducing income-eligibility levels, but also imposing new administrative requirements that will diminish participation by making health programs less accessible to eligible people. Either approach would erode the progress that has been made toward reducing the number of uninsured children and families. The \$20 billion in fiscal relief states will receive from the recently signed federal tax legislation, half of it channeled through Medicaid, could help them avoid or postpone cuts in health programs, at least temporarily. By increasing the federal Medicaid matching rate, the legislation lowers states' share of the costs associated with the program. Thus, there will be less need for reductions in Medicaid spending. Moreover, cutbacks in Medicaid will save the state less than estimated before the matching rates changed and will lead to a greater loss of federal funds to the state.