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Policy Brief #1: State SCHIP Design and The Right to Coverage

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Executive Summary

This Policy Brief¹ is the first in a series of reports examining the design of state SCHIP programs as they near full implementation status. It explores, whether states in their enabling legislation establishing separate SCHIP programs confer upon eligible children an individual legal right to health insurance benefits (i.e., an individual entitlement) under *state* law, similar to the entitlement that Medicaid eligible children enjoy under federal law. The question of whether states guarantee necessary health coverage for low-income children through the creation of an individual entitlement is fundamental to the study of state policy making under SCHIP.²

As of the fall of 2000,

- Among the 34 separate SCHIP programs, none created an individual entitlement to SCHIP coverage as a matter of state law.
- Among the 34 states with separate SCHIP programs, 33 enacted separate legislation that can be analyzed (Oregon's expansions were authorized by the state under its existing §1115 demonstration program). Of these 33 states, 9 laws appear to mandate expenditures for eligible children up to fixed, authorized funding levels. This approach could be expected to be interpreted by courts as

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¹ This study, funded through a cooperative agreement from the Health Resources and Services Administration (HRSA) [R40 MC 00165-03], is part of the Children's Health Insurance Research Initiative (CHIRI), which is co-funded by the Agency for Healthcare Research and Quality (AHRQ), the David and Lucile Packard Foundation and HRSA.

² Sixteen states and the District of Columbia used their federal SCHIP allotments exclusively to expand their Medicaid programs, thereby extending to all eligible children the federal Medicaid individual entitlement.

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requiring a state to provide SCHIP benefits to individual eligible children up to specified levels of state funding (“a restricted right to coverage”).

- In the remaining 24 states, the enabling legislation authorizing the state’s program either expressly or by implication does not provide any legal right to coverage. Two-thirds of the laws (16 states) explicitly state that nothing in state law should be deemed to create an entitlement; the remaining one-third (eight states) use legislative language that is so broadly drafted that under standard judicial principles, the legislative language used probably would not support a claim of a right to coverage, either through an individual entitlement or a restricted right to coverage, even where the state has funds available for coverage.

The findings from this study are important in understanding state policy choices and priorities in the context of health coverage for low-income children. They suggest that when given the option, states tend to avoid the creation of a legally enforceable right in the case of pediatric health coverage. Even where, as in the enactment of SCHIP, Congress indicates a willingness to support the continued guaranteed right to coverage among children by giving states an option to use their SCHIP funds to do so, most states elected an alternative to the traditional Medicaid approach of open-ended entitlement. Furthermore, only a minority of states with separate SCHIP programs appear willing to authorize spending on children under what could be characterized as a capped entitlement, thereby guaranteeing eligible children a right to coverage up to authorized spending levels. Most states with separate programs appear to have retained discretionary control over the actual level of expenditures they might be required to undertake during a year, regardless of authorized state funding levels or the fact that the federal government has guaranteed a specified financial allotment to the states. In these states enrollment could be frozen legally, despite the fact that funds remain available for coverage of eligible children.

If low-income children are to be guaranteed health coverage as a matter of law, this study indicates that such an entitlement necessarily would arise from the existence of a mandatory federal individual entitlement rather than from separate state decisions to entitle low-income children to coverage as a matter of state law.

Introduction

This Policy Brief is part of a multi-year study designed to explore “separate” SCHIP programs (i.e., programs that operate under the separate statutory authority of the federal SCHIP statute rather than as part of an expanded state Medicaid plan).³ The study will examine the nature of the assistance conferred by states under separate programs, as well as questions of coverage and service delivery, including eligibility standards, the use of managed care arrangements, and benefit design.

The larger study of which this Policy Brief is a part has two purposes. The first is to assess how states use their devolutionary authority under the federal SCHIP legislation to structure new approaches to children’s health coverage and to assess the extent to which these new structures resemble or depart from traditional Medicaid design principles. The second is to consider the implications of separate SCHIP program design choices for children with special health needs (i.e., children with significant activity limitations whose health costs can be expected to exceed pediatric norms).

This Policy Brief examines whether in establishing separate SCHIP programs, states in their enabling legislation elect to give eligible children a legal right (i.e., a legal entitlement) to SCHIP benefits. The right to coverage is perhaps the most fundamental hallmark of Medicaid program design and thus offers a logical “jumping off” point for this Policy Brief series.

Background

The threshold question in the design of publicly funded health coverage is whether the program will provide an individual entitlement to benefits. Where a policy decision is to guarantee the receipt of benefits among eligible individuals, such a decision is commonly referred to as conferring a “legal right” to the assistance. The means for achieving this policy goal is the creation of an individual legal entitlement.

In the area of federal health policy, individual entitlements can be found in the federal tax laws that create health care-related tax benefits (such as the right not to be taxed on employer contributions to health insurance no matter how large). They also exist within the federal Medicare and Medicaid programs. States similarly have the authority to establish legal entitlements to direct or tax-funded benefits consistent with the constraints of their own constitutions, even though the federal government may not elect to do so.

An individual entitlement guarantees that a benefit will be available for eligible persons who need it and qualify for it. In the case of Medicare and Medicaid, this means that as a matter of

³ Under recently published HCFA regulations, a separate state SCHIP program is one that as implemented operates under Title XXI of the Social Security Act rather than Title XIX (Medicaid).

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federal law, coverage must be furnished to persons who meet program eligibility criteria and cannot be arbitrarily denied, reduced or terminated. As a result, an individual entitlement carries a number of important implications.

From a budgetary standpoint, an individual entitlement most typically has no fixed upper limits on authorized spending; consequently, assistance (whether tax subsidies or direct expenditures) will be available at whatever level is necessary to carry out the purpose of the program. The effect of such a guarantee of assistance is to override any upper limits on program spending that a legislature might have (at least preliminarily) contemplated for the program. An entitlement also can be restrictive if it includes a fixed upper limit on total authorized spending. In a “restricted right to coverage” situation, a legal right to benefits would exist up to the authorized amount. Expenditures for eligible persons would continue up to the full authorized program level.⁴

Individual entitlements also have legal consequences. Historically, courts have permitted beneficiaries of individual entitlements the right to bring private legal actions to enforce their rights. In some cases (such as Medicare) the legal right to enforce the entitlement is spelled out directly in the statute.⁵ In other cases (e.g., insurance contracts written under state law, Medicaid coverage), courts will “imply” a right of legal action from the very existence of a clear right to the benefits itself.⁶ In the case of individual entitlements (i.e., entitlements with no fixed upper limits), courts have ordered the provision of assistance up to legally required levels, regardless of whether such a level of assistance would exceed estimated expenditure program limits.⁷ In the case of a restricted right to coverage, the obligation to extend benefits to an individual would exist up to the authorized spending level.

As a result of the ability of eligible individuals to enforce their legal right to benefits, entitlement-related spending tends to rise automatically as claims against the guarantee are made. Lawmakers can reduce or eliminate individual entitlements only by legislatively altering the terms of the entitlement itself. The most recent example of this type of alteration was the 1996 repeal of the Aid to Families with Dependent Children (AFDC) program, which operated as both a state and individual legal entitlement, and its replacement with the

⁴ *Vanderbilt Hospital v. Newsom*, 653 F.2d 1100 (6th Cir. 1981).

⁵ §205(g) of the Social Security Act, 42 U.S.C. Sec. 405(g); Sec. 1812 of the Social Security Act, 42 U.S.C. § 1395d.

⁶ *Wilder v Virginia Hospital Association*, 496 U.S. 498 (1990) (federal Medicaid law creates a legally enforceable right to reasonable hospital payments). Contrast *Suter v Artist M*, 503 U.S. 347 (1992) (federal child welfare laws create no legally enforceable right to a reasonable level of child welfare services).

⁷ See, e.g., *Alabama Nursing Home Association v. Harris*, 617 F.2d 388 (5th Cir. 1980), which has been relied on by virtually all of the federal courts that ever have considered the issue of whether legislatively set expenditure limits can defeat the ability of beneficiaries to enforce their rights under a public benefit entitlement.

Temporary Assistance to Needy Families (TANF) program, which entitles *states* (up to a specified limit) but not individuals, to assistance.⁸

The SCHIP statute, like TANF, entitles states to payments up to a specified authorized level. At the same time, the statute explicitly does not create an individual entitlement in eligible children.⁹ The statute expressly provides that “nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a state child health plan.”¹⁰ SCHIP programs administered under the federal SCHIP statute thus contain no federal individual entitlement.

Unlike TANF however, the federal SCHIP statute gives states discretion in certain critical choices where the issue of a federal entitlement is concerned. Under SCHIP, a state may, at its discretion, use its federal allotment (either in whole or in part) to expand Medicaid, thereby extending a federal individual entitlement to coverage to additional eligible children. Alternatively, a state can establish a “separate” program that operates directly under the authority of the SCHIP statute itself and thus outside of the reach of federal entitlement law.

In the case of states that choose to establish separate programs either in whole or in part, there are further choices that bear on the issue of entitlements. As a matter of *state* law, a state could elect to establish its separate program as an individual entitlement; alternatively, a state might structure its program to create a restricted legal right to coverage (i.e., an entitlement up to authorized funding levels). A third option would be to legislate a program that establishes neither an individual entitlement nor a restricted right to coverage but instead retains discretion on the part of state officials to not expend all authorized funds and defer coverage for eligible children, even where funding technically remains available.

It might seem self-evident that separate state SCHIP programs never would operate as legal entitlements since states wishing to take this approach would instead use their allotments simply to expand Medicaid. However, this assumption overlooks other compelling reasons why a state might elect to operate a separate program. A state might create a separate program in order to be able modify the existing Medicaid benefit package or to use different eligibility or cost sharing rules from those found in Medicaid. States that maintain separate programs still might wish to confer a legal right to coverage among all eligible children or alternatively, to confer a legal right to coverage up to authorized spending levels (i.e., a restricted right to coverage). For these reasons, the existence of a separate SCHIP program should not be equated as a policy matter with the absence of any right to coverage, even though adoption of a separate program does mean the absence of an individual entitlement under *federal* law. As a result, the question of whether states elect to create health entitlements for children is a

⁸ Changing the eligibility age for Social Security benefits from 65 to 67 and a half, effective 2022, also provides an example of changing the terms of an entitlement, though Social Security remains an uncapped entitlement for those who meet the revised eligibility criteria. See §216(1)(1) of the Social Security Act, 42 U.S.C. § 416(1)(1).

⁹ Sara Rosenbaum, et al., “The Children’s Hour: The State Children’s Health Insurance Program,” *Health Affairs*, January/February 1998.

¹⁰ §2102(b)(4) of the Social Security Act; 42 U.S.C. §1397bb(b)(4).

research question that exists apart from other questions related to the structure of separate programs.

Methods

In this nationwide, point-in-time study, researchers collected and analyzed state legislation creating separate SCHIP programs. Data collection and analysis took place during the summer and fall of 2000 and included analysis of both enabling legislation as well as relevant, separate legislation appropriating state funds.¹¹ Lawyers experienced in welfare law and legislative analysis then created a legal entitlement typology against which to measure the state statutes. Under this typology, each state's legislation reviewed was classified into one of four possible categories:

1. Express individual entitlement: the legislation explicitly creates an entitlement.
2. Implied entitlement: the legislation is silent on entitlement intent, but based on welfare case law and legal theory, can be characterized as having been drafted in an entitlement fashion (e.g., the legislation describes categories of children eligible to receive assistance; in addition, it may authorize the expenditure of funds on a "such sums as may be necessary" or "within available appropriations" basis).
3. Express non-entitlement: the legislation expressly states that the benefits are not to be considered an entitlement.
4. Implied non-entitlement: the legislation is silent on the entitlement but, based on prior welfare case law, can be construed as failing to create a legal entitlement. In such a case, the legislation might consist simply of an annual appropriation to an agency to administer a program. Alternatively, the legislation might fail to include either a specific description of children to be assisted or legislative language authorizing the expenditure of such sums as are necessary to aid eligible individuals either on an open-ended basis or up to an aggregate cap.

Where a legal entitlement was expressed or implied, lawyers further analyzed the legislation to determine whether the program operated as an individual entitlement or a restricted right to coverage.

¹¹ Federal lawmakers tend to draft detailed authorizing and appropriations statutes. The limited staff and legislative sessions in state capitols frequently can mean that statutory language creating a program is minimal, with some additional language contained in appropriations legislation. The details of a program may be left to state agency regulation and program guidance.

Results

The results are displayed on Tables 1 and 2. Table 1 shows that as of the fall of 2000, thirty-four states elected to establish a separate SCHIP program, either alone or as part of a “hybrid” program that combined both a Medicaid expansion for the poorest children (e.g., increasing Medicaid income eligibility for all children ages 6 to 19 to 100% of the federal poverty level)¹² with a separate SCHIP program for less poor children.¹³ Table 1 shows the basic coverage structure and current status of state SCHIP programs.

Table 2 summarizes the results of the analysis conducted under the 4-pronged typology (express entitlement, implied entitlement, express non-entitlement, implied non-entitlement). Among the 34 states with separate SCHIP programs, thirty-three operated their programs pursuant to separately enacted state legislation (enabling legislation and/or appropriations legislation).¹⁴ An analysis of these 33 state laws revealed the following:

None of the separate program laws appears to create an individual entitlement to coverage for eligible children as a matter of state law. This finding probably is not surprising. Were a state to entitle children to coverage on an open-ended financing basis, one would expect the state to adopt a simple Medicaid expansion. Even if a state wanted to extend to near-poor children a more limited Medicaid benefit package or employ greater cost-sharing requirements, the more practical financing approach might be an expansion of Medicaid and an accompanying proposal to HHS to alter benefit and cost-sharing rules for the expansion population, as several states have done under §1115 of the Social Security Act.¹⁵

Among the 33 states whose separate programs are accompanied by legislation, researchers concluded that nine states laws could be characterized as creating restricted rights to coverage, since the language used to codify the program creates defined eligibility criteria from which mandatory spending up to available funding levels might be inferred. Some of these state laws authorize spending and enrollment up to the level of combined state and federal appropriations.¹⁶ Alternatively, some states express an intent to cover as many children as possible (Maine) or anticipate enrollment up to the level of appropriations (Wyoming). This spending mandate could support a legal interpretation under traditional judicial principles that the legislation creates a restricted right to coverage among eligible children to receive coverage,

¹² Coverage of all children ages 6 to 19 with family incomes at or below 100% of the federal poverty level is not mandatory until 2002. §1902(a)(10)(a)(1)(i) of the Social Security Act, 42 U.S.C. §1396a(a)(10)(A)(i). A number of state hybrid programs combine a “speed-up” of this phase-in date with a separate SCHIP program.

¹³ Sixteen states and the District of Columbia elected to spend their SCHIP allotments entirely through a Medicaid expansion, thereby providing a federal individual entitlement to those individuals covered by the expansion.

¹⁴ Oregon added its program through a modification of its §1115 demonstration and did not enact new legislation.

¹⁵ For example, Massachusetts, Minnesota, Tennessee, and Oregon operate expanded and modified Medicaid programs.

¹⁶ Connecticut, Indiana, Iowa, Kansas, Maine, Michigan, Mississippi, Montana, New Jersey, New York, Wyoming.

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but only as long as specified appropriations are available. Furthermore, none of these nine state laws prohibits an individual action to enforce the right to coverage. Therefore, in these states it might be possible for courts to infer the existence of an individually enforceable right under state law, depending on the judicial policy of a state regarding the ability to privately enforce rights even in the absence of an express right of action.

Several of the nine state entitlement laws are quite explicit in requiring the administrative agencies to project likely enrollment, create enrollment priorities among eligible children, and provide for queuing in the event enrollment approaches the limits of funding to support it.¹⁷ These contingency provisions clearly illustrate the restricted nature of the right created, while reflecting an intent to provide coverage to the limit of available funding. In some of these states, the commitment to mandatory spending on behalf of children is limited through language (common in many state laws enacted pursuant to federal grant in aid programs) providing for the automatic elimination or reduction in the program in the event that federal financial participation declines or ends.¹⁸

Among the remaining 24 states with separate laws, the legislation either expressly or by implication refutes any inference regarding the existence of any individual legal entitlement to coverage. In a number of instances the legislation specifies that the law creates no enforceable right to coverage.

Among the 24 states,¹⁹ sixteen explicitly state that no right to coverage exists, while eight use the type of language that under traditional judicial principles probably would be considered too broad and generalized to sustain an argument of entitlement. For example, certain states use language that vests broad discretion in the administering agency to make expenditures from appropriated amounts, rather than directing the agency to expend funds on eligible children up to authorized levels. Not surprisingly, the legislative language used by state legislatures to create their programs and achieve legislative intent varies significantly, an expected result given the differences in state legislative drafting practices and customs. Three states did not enact specific enabling legislation. Rather, they rely on the appropriations process to provide or authorize appropriations to executive departments whose authority to develop child health insurance programs predates SCHIP. Alternatively, the legislature simply authorized an executive agency to develop and submit a state SCHIP plan to HCFA.

¹⁷ Many of the states that explicitly deny an individual entitlement also include similar contingent provisions that anticipate enrollment up to the level of appropriations. See, e.g. Florida, Georgia, Colorado.

¹⁸ See e.g. Montana and New York.

¹⁹ These states include Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Massachusetts, Nevada, New Hampshire, North Carolina, North Dakota, Pennsylvania, South Dakota, Texas, Utah, Vermont, Virginia, Washington, and West Virginia.

Conclusion

The findings from this study are important in understanding state policy choices and priorities as reflected in permanent state enabling legislation regarding health coverage for low-income children. They suggest that when given the option, states tend to avoid the creation of a right to public pediatric health coverage. Even where, as in the enactment of SCHIP, Congress indicates a willingness to support the continued guaranteed right to coverage among children by giving states an option to use their SCHIP funds to do so, most states opt in whole or in part for an alternative to the traditional Medicaid approach of granting an individual entitlement. Only 16 states elected to use their SCHIP allotments exclusively to fund Medicaid expansions that would extend a federal individual entitlement backed by open-ended federal funding to eligible children. Of the 33 states studied with separate SCHIP programs, none grant an individual entitlement and only nine extend a restricted right to coverage. Most states with separate programs appear to have retained discretionary control over the actual level of expenditures they might be required to undertake during a year, regardless of authorized funding levels or the guarantee of federal allotments. In these states enrollment could be frozen legally, despite the fact that funds remain available for coverage of eligible children.

We assume that states make these types of policy decisions for several important reasons. First, in expressly stating that states could elect between an entitlement and a non-entitlement approach, Congress indicated its willingness to extend federal financial assistance to states in the case of health coverage for near-poor children on a non-entitlement basis, at the election of a state. The fact that so many states elected to avoid an individual entitlement is consistent with Congress' own signals on this matter.

Congress' willingness to permit states to make this election in the case of near-poor children does not mean of course that Congress would not provide additional funding. Were federal SCHIP funds to fall far short of need (i.e., were waiting lists to spring up throughout the country), Congress could respond by increasing state allotments. But the non-entitlement structure of the program allows Congress to make a deliberate choice with respect to children under separate SCHIP programs rather than have spending rise automatically in relation to need. It is inevitable that most states would follow suit in their own legislative adoption of SCHIP. Indeed, the states that established individual entitlements did so only through Medicaid expansions that brought with them the guarantee of open-ended federal matching funds.

Another important dimension of the underlying policy in the case of SCHIP is Congress' rejection of even a restricted right to coverage among near-poor children. Under federal law, states are entitled to an aggregate amount of federal funding, but children are not entitled to coverage up to the cap. Again, it should not be surprising that in the face of Congressional unwillingness to pursue even a restricted right to coverage, so few states appeared to do so. Where Congress expresses its opposition to entitlements in such a strong fashion (i.e., by specifying the absence of entitlement in the statute itself and by capping the amount of money guaranteed to states through SCHIP), it is not unexpected that states would follow suit, even

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though the legislation gives states the option of applying their funds toward a Medicaid expansion. Discussions with state officials and advocates suggest anecdotally that many of the same concerns that were evident in Congress – the financial exposure, ideological concerns, and a real concern over employer crowd out, all played a role in the state deliberative process that went into the creation of SCHIP.

In 1996 Congress seriously debated, and came close to enacting, a Medicaid block grant that would have transformed Medicaid from an individual entitlement program to a program of capped allotments to states, similar to the structure of SCHIP. The results of this study suggest that were Congress to revisit this approach, states could be expected to emulate Congress' choices and implement the resulting program as a non-entitlement. Such a result would mean a repudiation of Medicaid's current guarantee of a right to coverage. During good economic times with full employment and relatively high access to employer coverage,²⁰ offering public health insurance on a non-individual entitlement basis may be feasible and might not leave a large number of eligible children and adults without assistance. Even so, recent studies have shown consistently high levels of under-enrollment of eligible persons.²¹ As the economy begins to slow and signs of worker layoffs increase, the potential for the need for subsidized pediatric health insurance also grows, and state programs may begin to face stronger pressures.

The findings in this analysis might be limited to state policy decision-making in the case of the near-poor children who qualify for coverage under separate SCHIP programs but who are not poor enough to qualify for Medicaid. However, it is likely that states' desire for greater discretionary controls over spending on child health would be even stronger in cases in which the target of aid is not children of the "working poor" but the poorest children, whose claim of a right to assistance might be the least politically strong.

This analysis indicates that if low-income children are to be guaranteed health coverage as a matter of law, such an entitlement necessarily would flow from the existence of a mandatory open-ended federal entitlement rather than from separate state decisions. The findings here suggest that the decision to create a right to health care coverage must flow from a national commitment to do so.

A key area for further study is how a state's decisions regarding entitlements or restricted rights to coverage affect the overall administration of separate SCHIP programs. For example, the

²⁰ How good access to employer-sponsored coverage is for lower income workers even in boom times appears to be in doubt. Among lower income workers earning \$7 per hour or less, only 42% have insurance coverage. A study of low wage workers and employer-sponsored health benefits suggests that the majority of those without coverage work for employers that do not offer any and the remainder cannot afford the plans that they are offered. Ellen O'Brien and Judith Feder, *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers*, Kaiser Commission on Medicaid and the Uninsured, May, 1999.

²¹ Lynda Flowers and Trish Riley, "An Analysis of Policy Issues in S-CHIP and Medicaid Implementation," National Academy for State Health Policy, August 2000; Robert Pear, "Forty States Forfeit Health Care Funds For Poor Children, *The New York Times*, September 24, 2000; *State Health Monitor*, "Majority of States Have Failed to Spend First-Year SCHIP Money, October 1, 2000; and Marilyn R. Ellwood and Leighton Ku, "Welfare and Immigration Reforms: Unintended Side Effects for Medicaid," *Health Affairs*, May/June 1998.

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decision to mandate coverage, even only up to authorized limits, might lead states to offer fewer benefits, impose higher cost sharing, or pay providers at a lower rate as techniques for controlling outlays. The absence of a legal entitlement or a restricted right to coverage might also affect the existence of waiting lists for coverage. The absence of a legal entitlement or restricted right to coverage might affect participation in the program among providers concerned with the cessation or deferral of benefits for eligible children. Finally, the true effects of state decisions regarding the entitlement status of their programs may be visible only when economic conditions cause states to halt or slow spending that they otherwise would make in a full or limited entitlement situation. Thus, fully understanding the effects of state entitlement decisionmaking requires further research and monitoring over time.