

ISSUE BRIEF

SCHIP in the Formative Years: An Update

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A discussion featuring

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SCHIP Update

With great enthusiasm and fanfare, the State Children's Health Insurance Program (SCHIP) was passed in 1997 as part of the Balanced Budget Act (BBA). An amendment (Title XXI) to the Social Security Act, SCHIP was the first major health financing program to be enacted since Medicare and Medicaid more than 30 years before. As was evidenced by the large funding commitment made to the program on enactment—\$24 billion for the first five years and \$40 billion over ten years—there was strong consensus about support for a new program to cover some of the estimated 11 million uninsured children and to reach out to enroll the more than 4 million children estimated to be eligible but not enrolled in Medicaid. But the new program nevertheless brought forth significant differences of opinion about the appropriate way to provide new coverage. Of particular concern was the role of state and federal government and the extent to which authority would be devolved to state and local government. As enacted, SCHIP emerged as a compromise between those who wanted to leave program design and administration entirely to the states in a completely block-granted program, as was done the previous year with welfare reform, and proponents of a program that would be structured more like Medicaid, with federally defined benefits, coverage, and eligibility. The resulting compromise retained some federal oversight of a capped, non-entitlement program but provided states with a large degree of flexibility. Thus, states may opt to implement an entirely private, separate insurance program for children; a Medicaid expansion; or a combination of the two. This compromise has produced very different SCHIP programs in the various states, creating complexity for those who try to understand the status of the new program overall.

It is clear, however, that by many measures, progress has been rapid in the three years since enactment. All 50 states, the District of Columbia, and the territories have begun new children's health insurance programs after submitting state plans to the Health Care Financing Administration (HCFA). As of August 21, 2000, there were 15 stand-alone SCHIP programs, 23 Medicaid expansion programs, and 18 programs that combined elements of separate program structure and Medicaid. Because of the flexibility allowed, many states began with a core strategy, often a limited Medicaid expansion, and many have developed or are still developing program additions and modifications.

HCFA currently has 21 pending plan amendments, indicating that states continue to modify their existing SCHIP programs.

How does this hybrid program look now, several years after enactment? Most state SCHIP programs have been enrolling children for about two years, so some information about the extent of enrollment is available. Some states have drawn down the full funding allotment apportioned to them, while many others have not. Since SCHIP is a capped, non-entitlement program with less funding allocated in future years, these funding and enrollment issues are critical. Almost all states, as required by the law, have submitted their first annual reports and evaluations, but serious concerns remain about measuring and describing what is being accomplished. Some common problems as well as many common successes are being identified—even among states that have made dissimilar choices as to the nature of their SCHIP program design. Choices made by states—creating separate new programs with catchy, clever names; expanding and enhancing access to a current Medicaid program; or some creative combination—reflect the flexibility allowed in the law. SCHIP has presented both an opportunity and a challenge to states as they have sought, with limited funds and time, to design and implement the largest public health expansion program in decades. States have addressed their unique needs and problems in implementing

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SCHIP, and the result is a tremendous variety of program designs.¹

To provide a midcourse review of SCHIP, this Forum session will explore some of the most critical and timely questions facing policymakers seeking to evaluate its progress. Among these questions are the following: What do we know now? How many children are covered? How much money are states spending on SCHIP programs? What kinds of services are children receiving? When will we have more and better data? What is the status of the evaluation efforts under way? Is SCHIP a model for expanding insurance coverage to parents or to additional groups of uninsured people?

NUMBER OF CHILDREN ENROLLED

Counting the number of Medicaid enrollees has always been a challenge fraught with the vagaries of federal reporting requirements and lag times. Under SCHIP, both federal and state officials have tried to develop new and more timely reports.

HCFA currently estimates that over 2 million children have enrolled in SCHIP. This figure reflects information submitted by states to HCFA in quarterly and annual enrollment reports. These statistics indicate that 1,979,450 children were “ever enrolled” during all or part of fiscal year 1999, with about 1.3 million children in separate SCHIP programs and nearly 700,000 in Medicaid expansion programs.² In a recent report, HCFA noted that strong enrollment trends continued through the first quarter of 2000. The agency also reported that the 43 states that had submitted data experienced an average enrollment increase of 80 percent between June 1999 and June 2000, with 19 states reporting a doubling in enrollment and 9 of those states reporting a tripling of enrollment.³

Perhaps the most timely statistics have been compiled by Vernon K. Smith, Ph.D., for the Kaiser Commission on Medicaid and the Uninsured. Smith surveyed states three times to provide “point-in-time” data on the number of children enrolled for the specific months of December 1998, June 1999, and December 1999. (These “point-in-time” data contrast with the HCFA data, which reflect the number of children enrolled at any time and for any length of time during a federal fiscal year or a quarter during the federal fiscal year. Thus, they are likely to be somewhat lower than those reported by HCFA.)

The most recent Smith/Kaiser data, reported in July 2000,⁴ indicate that, between December 1998 and

December 1999, the number of children enrolled in SCHIP programs increased from 833,303 to 1,766,174, a gain of 112 percent. Many differences between states are reflected in these data, however, and the report notes that “these aggregate increases mask considerable variation at the state level.”⁵ The report goes on to indicate that, while enrollment doubled in 20 states during the study period, it moderated in several states, particularly those that had implemented their programs relatively early on. And in at least one state, there was a significant decrease during the study period.⁶

The Smith/Kaiser data reflected enrollment increases in all program types, but enrollment increases in separate SCHIP programs were greater than those in Medicaid expansion programs, both in the number of children enrolled and in the percentage increase. Over two-thirds of the growth in total SCHIP enrollment was in separate programs. The greatest growth rates, however, were in the states with both Medicaid expansion and separate SCHIP programs.⁷ The report concluded that the pace of enrollment continued in almost every state throughout the year studied, reflecting the priority that states place on finding and enrolling eligible children.⁸

Since the overall goal of the BBA was to get more children covered in both SCHIP and Medicaid, determining the number of children being served in Medicaid is clearly important. However, getting these data in a timely fashion has been a perennial problem. (This difficulty relates primarily to the long time allowed states before they must report their data to HCFA.) Measuring increases and decreases in children enrolled in Medicaid since the advent of SCHIP, not to mention ascribing credit for Medicaid increases to SCHIP-generated activities, is an even more difficult task, one that promises to be a thorn in the side of analysts and program administrators for some time to come.

Since the mid-1990s, Medicaid enrollment in general, and for children, actually declined. This decline is usually attributed to changes in the welfare system and the economy. Welfare cash assistance changed under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), adding a strong emphasis on work. At the same time the economy improved and higher employment rates meant fewer people received cash assistance. Many of those who previously received cash assistance—including many children—were still eligible for Medicaid, but for a variety of reasons were not covered. Since Medicaid-eligible children live in families with lower incomes than those of SCHIP families, most would see outreach and enrollment efforts aimed at the former as a high

priority. A recent study of Medicaid enrollment in 21 large states between 1997 and 1999 suggested that the decline in Medicaid may be reversing itself. In addition, the authors noted that SCHIP has contributed to the recent upturn in Medicaid enrollment, with Medicaid-expansion SCHIP programs found to account for 28 percent of the increase in Medicaid enrollment for the period from December 1998 to June 1999.⁹

FUNDING ALLOTMENTS AND EXPENDITURES

A system for dividing block-granted SCHIP funds among the states was established in the BBA. Allocation was based on a formula that considers the proportion of a state's uninsured children living in families with incomes under 200 percent of the federal poverty level based on three years of merged Current Population Survey (CPS) data, with adjustments made to take into account differences in health care costs between states. Higher amounts are authorized for allotment in the early years of the program. The Balanced Budget Refinement Act of 1999 (BBRA) made technical modifications that stabilized allotments over the years to prevent wide annual fluctuations and slightly moderate the effect of the lower future authorizations. States receive a federal matching percentage under SCHIP that is higher than that under Medicaid; the enhanced match is about 30 percent higher and is capped at 85 percent.¹⁰

Each allotment is available to be expended by a state for three years—that is, each state can use its fiscal year (FY) 1998 allocation during FY 1998, FY 1999, and FY 2000. Title XXI requires that funds remaining from states that do not expend their allotments are to be reallocated to states that have fully expended theirs. Therefore, on September 30, 2000, the end of the current federal fiscal year, any state that has not expended its allotment for FY 1998 stands to lose that money and have it reallocated to other states that have expended all of their funds.

An accurate tally of expenditures is not possible until after submission of the final reports, which are due to HCFA at the end of October, 30 days following the end of the fiscal year. However, HCFA, the Congressional Budget Office (CBO), the Urban Institute, and others are in agreement that at least \$1.9 billion of the allocation will not have been expended and will therefore be available for reallocation. Based on current submissions to HCFA and recent calls made by the National Association of Medicaid Directors, it appears that eight to ten states will have expended their entire

allotment and will thus be eligible to receive additional money from the unspent \$1.9 billion.

Why are many states not using their allotments? States cite a variety of reasons, often unique to a particular state, including startup time lags, limitations on administrative expenditures, limitations on coverage of groups like children of state employees, and the poor quality of the CPS data that were used to set the allocations. On the other hand, the CBO projected during the debate that more money would be available than would be necessary to cover eligible children. And in an early projection, the Urban Institute noted that the allocation was sufficient to fund coverage of almost 6 million children but concluded that only about 3.2 million children would actually be eligible for the SCHIP program.¹¹ As one congressional staffer noted privately, "It's politically correct to use big dollar numbers in support of health care for kids; it's politically incorrect to suggest there's no way the states can spend that much money." So the program may well have been overfunded from the beginning.

Regardless, the allocation and reallocation process is fraught with complexity. It became the subject of heated political controversy in the appropriations process both last year and again this year when committee members broached the idea of either taking all or part of the unused portion of the allotment out of the SCHIP program or reserving it for use in later years of the program when the allocations are smaller.

Proponents of rescinding part or all of the unspent allocation suggest that there is no way that the estimated \$1.9 billion can be spent, if reallocated, by the states that would be eligible to receive it. Those supporting rescission argued that the funds should be spent on other important health or social programs. On the other hand, convincing arguments are made that the program is in a startup mode, that some states did not begin full program operations until fiscal 1999, and that rescission would present a dangerous precedent "by eliminating the reallocation system in SCHIP in fiscal year 2001 and introducing great uncertainty into the program's funding structure for years after that."¹²

This problem is not a one-time phenomenon, however, as it appears that an even higher amount of funds allocated for FY 1999 will go unspent and that, possibly, a lower number of states will be eligible to receive reallocated funds as a result of having spent their entire allotment. Congressional staff are considering changes that would moderate the problems being encountered in these early years of the program. The Urban Institute

will release this fall a brief designed to assist policymakers in sorting out the many complexities and interactions related to allocation policy. In the meantime, this controversy represents an interesting lesson about a set of intricacies associated with block-granted programs. Such programs are often seen as less technically complicated than categorical entitlement programs, but in fact the allotment and reallocation of funds is subject to great complexity, too.

EVALUATION REQUIREMENTS AND ACTIVITIES

Expenditures and enrollment totals provide one measure of program progress and success. More formal evaluation efforts, encompassing those features and others, are also under way. The statute requires a series of reports and evaluations by states and the secretary of health and human services, including annual reports by each state to the secretary to assess the operation of the plan and report on progress in covering uninsured children and a formal and extensive evaluation in March 2000. This latter evaluation was made more valuable when, with funding from the David and Lucile Packard Foundation, the National Academy for State Health Policy (NASHP) worked with states, HCFA, the National Governors' Association, and the American Public Human Services Association in 1998 and 1999 to develop a model evaluation framework, so that there would be some consistency in states' submissions. All states that have submitted the evaluation have generally used the framework, resulting in much easier and more standardized presentation and information. All of the submitted evaluations, from a total of 48 states and the District of Columbia, are available on the HCFA Web site for review. In addition, HCFA recently released a report based primarily on these documents, and additional efforts are under way to synthesize the individual state evaluations.

An additional evaluation effort is part of a major HCFA contract with Mathematica Policy Research. This five-year national evaluation will include a comprehensive research review of SCHIP effectiveness, measured by enrollment, broadened coverage of children, access to health care for children, parent satisfaction, quality of children's health care, and improvement of health status of children. In addition to this research review and synthesis, the Mathematica work will monitor the states' own evaluations and undertake independent surveys, site visits, and focus groups.

Also under way is another major evaluation effort in which the Agency for Healthcare Research and Quality,

the Health Resources and Services Administration, and the Packard Foundation are sponsoring nine projects under the Child Health Insurance Research Initiative. This three-year, \$9 million project funds nine studies of public child health insurance programs and health care delivery systems. The goal is to supply federal and state policymakers with additional information to help improve access to and quality of health care for low-income children.

Concerned that further study was needed, Congress mandated an additional extensive evaluation in BBRA, and appropriated \$10 million to carry it out. Within the Department of Health and Human Services, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is responsible for this last evaluation effort, which is to be completed by the end of 2001. To complete this work, ASPE has recently released major statements of work, with awards planned for later this fall.

Perhaps the most important evaluation question is one that no one can, at this point, answer definitively. That question is, once covered, are children getting services? And is service delivery of high quality, promoting enhanced health status for SCHIP-enrolled children? Tracking service provision and quality is part of the major evaluation designs, but certainly no answers are yet available. An early study by Jack Meyer and Nancy Bagby reviewed 19 of the first SCHIP state plans to survey state intentions in the area of tracking quality of health care and connections of children to primary and preventive care.¹³ In their report, they concluded that (a), while states were planning a variety of measures, many of these were process-based and (b) "states are much less engaged in direct follow-up activities conducted after children are enrolled to assure that they get the care they need. With some important exceptions, most of the state plans reviewed were largely silent on the issue."¹⁴

INTERACTION OF MEDICAID AND SCHIP

Healthy competition? Creative tension? Learning from one another? Where you stand on the issue of SCHIP-Medicaid interaction likely depends on where you sit.

SCHIP is currently serving 2 million children. But Medicaid serves ten times as many, 21 million children, with an estimated 4 to 5 million more who are eligible but not enrolled.¹⁵ Do these numbers alone tell one part of this story—the new, private-sector program gets all the glory while the older, public program carries the real load?

Actually, the most intrepid Medicaid supporter will freely admit that SCHIP has been good for Medicaid. It has brought new enthusiasm to the task of providing children with health care coverage and new political and community support for the task. It has put a spotlight on children's health care needs that did not exist before. It has resulted in greatly simplified Medicaid eligibility determination processes and shifted the focus of eligibility determination from minimizing errors to maximizing enrollment. Outreach and enrollment activities, nonexistent for the most part in Medicaid prior to SCHIP, are under way in every state.¹⁶ And certainly not to be discounted, SCHIP has brought new funding with a preferential federal match.

Many innovations and important administrative improvements developed for SCHIP are moving into the Medicaid program. Medicaid and SCHIP directors alike report that, in separate or combination programs, administrative streamlining, new outreach techniques, or simplified application procedures are tried in SCHIP, found efficient, effective, and acceptable and moved into Medicaid. In Georgia, for example, application processing time was 2 days for PeachCare, the SCHIP program, while Medicaid processing generally took 45 days. A recent decision to bring the PeachCare processing agent into the Medicaid program will now bring that program's processing time in line with the much more efficient PeachCare standard. This Medicaid reform probably would not have happened but for SCHIP.

The federal "screen and enroll" requirement, the subject of much controversy among many SCHIP and Medicaid directors, demands coordination between the programs. This process, required in the statute, mandates that states with separate programs must screen all children applying for coverage for Medicaid and enroll children in Medicaid if they are eligible. The controversy centers on the fact that some families reportedly reject the welfare-oriented Medicaid program, wanting instead to have their children enroll in what they perceive as a private-sector SCHIP program. Medicaid supporters counter that the real problem relates to how people are treated by caseworkers and providers and what burdens accompany the Medicaid application and enrollment process.

The stigma associated with Medicaid does seem to be real, and research is beginning to focus in on defining and measuring this phenomenon. One report, for example, has suggested that stigma-related barriers are likely to be the result of how people perceive they are treated in the application process and by health providers.¹⁷ But there is also great reluctance to expand and

encourage an entitlement program in some states where memories of budget-busting Medicaid costs remain strong. Simplification and coordination of SCHIP and Medicaid are more difficult where such views prevail. Finally, the underlying complexity and bureaucratic inertia of a 35-year-old program makes coordination between Medicaid and SCHIP a serious challenge.¹⁸

COMMON PROBLEMS ACROSS MANY STATES

Many problems in SCHIP implementation relate to unique situations, program and policy choices, and the health and political environment of a particular area. However, there are some pervasive problems across the country that challenge many SCHIP administrators, regardless of program design or state idiosyncracies. Three such problems, high on state and federal policy agendas, are discussed below.

Immigration Policy

Immigrants comprise one of the largest groups of uninsured people across the states. Immigrant children are at risk and are generally not receiving coverage under SCHIP, even if they are otherwise eligible.

Provisions in the 1996 welfare reform statute, PRWORA, radically changed eligibility for public programs for persons immigrating to the United States, including legal immigrants. PRWORA limited eligibility for Medicaid, Temporary Assistance to Needy Families, Supplemental Security Income, Food Stamps, and a myriad of other programs, and these rules have been applied to SCHIP. Although somewhat modified in 1997's BBA—especially regarding provision of assistance to children—the 1996 PRWORA changes brought significant fear into the immigrant community. Many observers believe that this widespread alarm has extensively limited SCHIP and Medicaid enrollment among immigrant families, increasing the rolls of the uninsured in this group of vulnerable people and limiting their access to health care. This is a particularly large problem in some of the biggest states in the nation, including California, Texas, Florida, and New York.

In a recent report on the use of public benefits, Michael Fix and Jeffrey Passel documented a decline of more than one-third in noncitizens' use between 1994 and 1997.¹⁹ These statistics are important because one in five children in the United States is an immigrant or a member of an immigrant family, and the number of children in immigrant families is rising at a rate seven times faster than that for children in U.S.-born families.

Finally, these children are more likely to live in poverty, less likely to have health insurance, and less likely to receive medical care.²⁰

The climate of fear created by PRWORA and the immigration policy changes in the statute, mixed with language and cultural barriers, continue to limit the number of target children served in SCHIP. Some states are using their own funds to cover immigrants, with no federal matching, while others are engaged in special outreach and enrollment efforts targeted at children who are legally eligible for the program but not enrolled because of the factors discussed. Legislation to repeal some immigration provisions of PRWORA, including an administration proposal to restore Medicaid eligibility to some immigrants, is pending in both houses of Congress, but action does not seem likely this session. The issues surrounding potential changes to expand immigrants' access to public programs are contentious and complicated by strongly held values and beliefs that will likely not change in the short term.

Covering Families, Not Just Children

Family coverage enhances children's coverage. Studies have shown that children are more likely to use health care when their parents are covered. In addition, the notion that health insurance is a critical component of support services to low-income families, helping them maintain work and stay off of welfare, is becoming widely accepted. On the other hand, concerns have been voiced about covering families when not all low-income children, the clear focus of SCHIP, have been covered. Another counter-argument, that coverage of low-income families is likely to supplant employer coverage, is also significant and may well slow the momentum toward greater family coverage in public programs.

Many states want to cover uninsured families, not just children.²¹ Some, such as Washington, Minnesota, and Rhode Island, already covered the majority of low-income children in their states before SCHIP was enacted, and they are angry that they can not use their SCHIP allotments to cover the parents of those children. Although the SCHIP statute requires a cost-effectiveness test to demonstrate that the cost of covering a family will be less than or equal to child-only coverage, many state officials believe that HCFA has placed roadblocks in the area of family coverage that are not justified under the statute and are far too onerous. HCFA has promised to carefully review the many comments received on this subject when SCHIP regulations were proposed last fall, and there is the potential

for some relief. However, the existing statutory requirements will preclude major change, and other legislation has been introduced to provide relief for states seeking to expand coverage of families.

The president's FY 2001 budget included an initiative to replace SCHIP with a new FamilyCare Program. This program would provide health insurance to parents of children enrolled in Medicaid or SCHIP and would include financial incentives to cover families at higher income levels. While few details have been provided about this proposal, it has been endorsed by the vice president, and bills with similar intent have been introduced this summer. In the House, Rep. John D. Dingell (D-Mich.) introduced H.R. 4927, the Family-Care Act of 2000; the bill was offered in the Senate by Sen. Edward M. Kennedy (D-Mass.) and a bipartisan group. Some observers believe that all or part of these proposals will receive careful consideration this fall in the final days of the 106th Congress, and that some features in the legislation to broaden current SCHIP limitations might be enacted. Regardless of legislative outcomes this year, there is little doubt that the existence of SCHIP has caused the beginning of a serious dialogue about family coverage.

Experimentation under Title XXI

If statutory change is not enacted to enhance states' ability to cover families, another route, and another interest in many state capitals, is additional flexibility to experiment under SCHIP. When SCHIP was enacted, HCFA took the position that the new program should have a chance to be up and running before the agency approved demonstration waivers to states under Section 1115. This position was denounced by many state administrators, particularly those who wanted to expand coverage to families; they also saw it as an inappropriate federal control over states' desires for a more flexible program. Just this summer, on July 31, HCFA made moot the argument by releasing guidance for states that wish to pursue SCHIP waivers under the Section 1115 authority.²² The guidance provides information about the types of demonstrations that will be considered and describes what states will have to provide to HCFA before approval. It stresses that coverage of low income children must be a state's first priority and that a state must "demonstrate that it is successfully reaching and enrolling eligible children."²³ In addition to areas related to enhanced public health ties or supplemental health services, the guidance recognizes state interest in the coverage of low-income parents and does not rule out such demonstrations,

although HCFA indicated that it would support these initiatives “within constraints of the SCHIP law and available funds.”²⁴

HCFA’s Section 1115 advice will allow more flexibility to states and more chance to expand the innovation and creativity that have become the hallmark of SCHIP so far. HCFA staff members report that four states have been discussing draft proposals with them—all around the family coverage issue—but no doubt a myriad other subjects will soon be on this list.

THE FORUM SESSION

This Forum session will provide an overview of SCHIP three years since enactment, including discussion of state successes, problems that are particularly difficult, the status of evaluation efforts, and federal plans and concerns. While to some administrators it seems early in the process to be asking tough questions, the nature of the political process is to expect change to come quickly. In a program with great state flexibility and many program alternatives, this may or may not be a realistic expectation. Key questions will include the following:

- Can enrollment increases continue at a rapid pace? Are states on target to reach most of the children originally thought to be eligible for SCHIP?
- Why have expenditures been slower than expected? Were expectations based on inaccurate data or impossible projections? What steps are being taken at the national or state level to address underlying data questions?
- What is known about service delivery? How many enrolled children have received services? How are different states tracking service delivery, and will different methods be evaluated?
- Is the quality of the service being delivered under SCHIP being measured? If so, how? Are measures consistent from state to state?
- What conclusions can be made about the strengths and weaknesses of Medicaid based on the SCHIP experience? Has Medicaid been weakened or strengthened through SCHIP? Does the administrative expense and resource commitment to SCHIP detract from Medicaid or enhance it?
- What kinds of innovative programs are states likely to undertake under SCHIP Section 1115 demonstration waivers?

Speakers

A group of speakers with strong expertise in both Medicaid and SCHIP will help sort out these difficult subjects. **Trish Riley**, executive director of the National Academy for State Health Policy, will lead off the discussion by commenting on the status of SCHIP as she views it through her extensive work across the country. Her comments will emphasize state evaluation activities. A long-time advocate for and consultant to state health programs, Riley and her staff were responsible for pulling together groups of states just after SCHIP enactment to work out a standard approach to evaluation reporting. This has been a major contribution to SCHIP work to date by assuring at least some consistency across state evaluation efforts. Prior to her work at NASHP, she held several appointive positions under four governors in the state of Maine.

Vernon K. Smith, Ph.D., principal at Health Management Associates (HMA), will discuss enrollment in SCHIP and Medicaid and the interaction of the two programs. In addition to consulting with a number of states on general SCHIP, Medicaid, and health policy issues, Smith currently is involved with several special surveys and studies being undertaken by states to get better data on the extent of their uninsured population. Prior to accepting his position at HMA, he served for many years in Michigan, including five years as director of the Michigan Medicaid program. He was also vice-chair of the National Association of State Medicaid Directors and chaired the governing board of NASHP.

Jana Leigh Key is director of Georgia’s PeachCare program. She also serves as vice chair of the Alliance of SCHIP Directors. She will represent SCHIP directors and provide information about the status of the program from the perspective of those on the firing line administering this new program. Director of PeachCare since a few months before the program was implemented in January 1999, Key previously worked for the Florida Healthy Kids program and served as deputy director of the Healthy Kids Replication Program, a Robert Wood Johnson Foundation–supported effort to assist states in creating health care programs for uninsured children.

Speaking from the federal perspective will be **Cindy Mann**, director of the Family and Children’s Health Program Group, Center for Medicaid and State Operations, HCFA. She will comment on recent HCFA activities and policy concerns and provide a status report on pending HCFA policy, including the status of the final regulations for SCHIP. An expert on eligibility for Medicaid, welfare, SCHIP and related programs,

Mann was director of the State Low-Income Initiatives Project at the Center on Budget and Policy Priorities before joining HCFA last year. Additional federal perspectives will be provided by several congressional staff, schedules permitting.

ENDNOTES

1. For up-to-date information about a whole host of SCHIP activities, see the Health Care Financing Administration Web site (www.hcfa.gov) or the Web site of the National Academy for State Health Policy (www.nashp.org).
2. Health Care Financing Administration, "State Children's Health Insurance Program Annual Report for FY 1999," January 11, 2000; accessed August 4, 2000, at <http://www.hcfa.gov>.
3. Health Care Financing Administration, "The State Children's Health Insurance Program: Preliminary Highlights of Implementation and Expansion," July 2000, 2; accessed August 4, 2000, at <http://www.hcfa.gov>.
4. Vernon K. Smith, "CHIP Program Enrollment: December 1998 to December 1999," Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., July 2000.
5. Smith, "CHIP Program Enrollment," 3. The state with a large decrease is Texas. One explanation is that the initial Texas program was a Medicaid expansion to older children, who have begun to "age out" of the program.
6. Smith, "CHIP Program Enrollment," 3.
7. Smith, "CHIP Program Enrollment," 4.
8. Smith, "CHIP Program Enrollment," 5.
9. Eileen R. Ellis and Vernon K. Smith, "Medicaid Enrollment in 21 States, June 1997 to June 1999," Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., April 2000.
10. See Richard E. Hegner, "The State Children's Health Insurance Program: How Much Latitude Do the States Really Have?" NHPF Issue Brief No. 725, October 1, 1998, for full information about the basic features of the SCHIP program matching rates and other facets of the program.
11. Frank Ullman, Brian Bruen, and John Holahan, "The State Children's Health Insurance Program: A Look at the Numbers," Occasional Paper Number 4, Assessing the New Federalism, Urban Institute, Washington, D.C., March 1998, 2.
12. Jocelyn Guyer, "Senate Appropriations Committee Proposal Poses Threat to SCHIP," Center on Budget and Policy Priorities, Washington, D.C., June 2, 2000, 7.
13. Jack A. Meyer and Nancy S. Bagby, "Beyond Enrollment: Are SCHIP Plans Linking Children to Quality Health Care?" New Directions for Policy, Washington D.C., May 1998.
14. Meyer and Bagby, "Beyond Enrollment," 2.
15. For more information on the subject of low-income uninsured children, see "Enrolling Uninsured Children in Medicaid and CHIP," fact sheet, Kaiser Commission on Medicaid and the Uninsured, January 2000, and "Health Coverage for Low-Income Children," fact sheet, Kaiser Commission on Medicaid and the Uninsured, March 2000; accessed August 1, 2000, at <http://www.kff.org>.
16. See Judith D. Moore, "CHIP and Medicaid Outreach and Enrollment: A Hands-On Look at Marketing and Applications," NHPF Issue Brief No. 748, October 19, 1999.
17. Jennifer Stuber et al., "Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?" Center for Health Services Research and Policy, George Washington University, Washington, D.C., July 2000.
18. For more discussion of SCHIP and Medicaid interaction, see Lynda Flowers and Trish Riley, "An Analysis of Policy Issues in SCHIP and Medicaid Implementation," Meeting #1, Study Group on CHIP and Medicaid, National Academy for State Health Policy, Portland, Maine, July 2000.
19. Michael Fix and Jeffrey Passell, "Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-1997," Urban Institute, Washington D.C., 1999.
20. Ann Morse, "SCHIP and Access for Children in Immigrant Families," National Conference of State Legislatures, Denver, Colorado, January 2000, vii.
21. For a discussion of one strategy for covering families, see Karl Polzer, "Using SCHIP to Subsidize Employment-Based Coverage: How Far Can This Strategy Go?" NHPF Background Paper, June 2000.
22. Timothy M. Westmoreland, director, Center for Medicaid and State Operations, Health Care Financing Administration, letter to state health officials, July 31, 2000; accessed August 4, 2000, at <http://www.hcfa.gov>.
23. Westmoreland, letter, 2.
24. Westmoreland, letter, 2.