Has the Jury Reached a Verdict? States' Early Experiences with Crowd Out under SCHIP

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State Children's Health Insurance Program Evaluation

Assessing the New Federalism
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About the Series

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site (http://www.urban.org). This paper is one in a series of occasional papers analyzing information from these and other sources.

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Executive Summary

In the months leading up to the enactment of the State Children's Health Insurance Program (SCHIP), policymakers, government officials, researchers, and advocates debated policy options for extending health insurance to the estimated 10.7 million children who had none (Current Population Survey 1997). Given that a significant expansion in publicly sponsored children's health insurance would require considerable federal, state, and local resource commitments, policymakers weighed concerns regarding the efficiency of public funding and the need to safeguard the private market from "crowd out"—broadly defined as the substitution of public health insurance coverage for private health insurance coverage.

Crowd out emerged as one of the most contentiously debated issues during the development of the SCHIP legislation. Based on research suggesting that Medicaid expansions for pregnant women and children in the late 1980s and early 1990s may have crowded out some private health insurance coverage, policymakers theorized that further expansions might create additional opportunities for employers and employees to pass on their health insurance costs to the government. These concerns persuaded the Title XXI drafters to include provisions in the law requiring that states implement strategies to prevent SCHIP from substituting for private insurance. States were instructed, via a letter from the Health Care Financing Administration (HCFA), "to describe procedures in their State SCHIP plans that reduce the potential for substitution," and were told that greater scrutiny would be applied to programs that expanded to higher levels of income eligibility. In response, but without specific federal regulations or guidelines from the research community on effective crowd-out prevention policies, states adopted a range of strategies.

This qualitative study examines how 18 states are addressing crowd out, the degree to which state officials perceive crowd out to be occurring, and the implications of crowd-out prevention strategies on enrollment.* The study is based on site visit and in-depth telephone interviews with a broad range of key informants in the 18 states.

Findings

Mirroring deliberations at the federal level, state-level debates over the potential for SCHIP to crowd out private insurance were often contentious. Policymakers were commonly divided between the belief that aggressive policies (such as waiting periods) were needed to prevent crowd out, and the belief that such policies were unnecessary and could potentially deter enrollment. For some states, a hard-line approach to crowd out was a critical means of building broad-based political support for a children's health insurance program. In contrast, other states were reluctant to address crowd out at all. For example, the three states that were grandfathered into SCHIP because of their prior experience administering children's health insurance programs

* The study states are Alabama, California, Colorado, Connecticut, Florida, Massachusetts, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, Washington, and Wisconsin.

were required to meet new federal crowd-out requirements despite their belief that crowd out had not occurred in their pre-SCHIP initiatives. Nevertheless, 17 of the 18 states in our study adopted policies to address crowd out. Although specific approaches varied considerably, seven types of crowd-out strategies were identified:

Waiting periods: Imposing waiting periods, whereby families must be uninsured for a specified period of time before being permitted to enroll in SCHIP, emerged as the most common strategy used by the study states for controlling crowd out. Although waiting periods were often criticized for excluding from SCHIP children whose private coverage might be limited or unaffordable, they were still widely viewed as the most direct approach to preventing crowd out. Most states include exceptions to their waiting period policies, however. Each of the 11 states in our study with waiting periods has exception policies relating to families losing insurance through no fault of their own—6 of these 11 states have additional exceptions for families with access to health coverage deemed unaffordable. Of special note, one state in our study extends an exception to children with special health care needs (CSHCN)[7]—a subgroup of children who are often described as being underinsured for the treatment of their chronic illnesses and disabilities—so that they may enroll in SCHIP if the program offers a more comprehensive and affordable alternative to current private insurance.

Monitoring/application questions regarding children's health insurance status: Monitoring crowd out and using application questions about health insurance status was another approach commonly used by the study states to address crowd out concerns. In contrast to waiting periods, monitoring crowd out occurrence was described as the least stringent approach available to states, a strategy that essentially accepts that some degree of crowd out will occur. Typically, monitoring is accomplished through application form questions regarding applicants' insurance status. However, some state officials believe that including insurance status questions on the SCHIP application can, in itself, serve to deter families from dropping private coverage or as an avenue for following up with families to determine if their existing coverage is adequate.

Verifying insurance status against databases of private coverage: Rather than relying on self-declaration of insurance status, some states are verifying whether an applicant is without insurance before granting eligibility. Of the study states, Alabama, Michigan, Mississippi, Missouri, and Wisconsin indicated in their state plans that they are verifying the insurance status of applicants as a means to prevent crowd out.

Cost sharing: Cost sharing, in the form of premiums, enrollment fees, and copayments, may allow SCHIP programs to more closely resemble private insurance and, consequently, create the appropriate economic incentives to deter families from substituting SCHIP for private insurance. Although cost-sharing policies can be implemented to accomplish numerous goals, and all the non-Medicaid SCHIP programs in our study require some form of cost sharing, only three states—Alabama, New York, and Washington—explicitly identified in their state plans that cost sharing was one of their strategies to deter crowd out. Since state

plan submission, California and North Carolina have come to consider their cost-sharing provisions as part of their overall crowd-out prevention strategy.

Subsidizing employer-based coverage: States have also shown considerable interest in designing policies to subsidize employer-sponsored insurance (ESI), in order to achieve the broader goals of capitalizing on private sector resources already supporting the provision of health insurance and strengthening the foundation of employer-sponsored insurance in the states. State officials also believe the initiatives can effectively deter crowd out by helping employers maintain employee health benefits and by helping employees afford those benefits. Interestingly, federal officials fear that subsidizing ESI actually holds significant potential to promote crowd out—that families who might otherwise contribute to their health care costs without a subsidy will be likely to seek premium assistance, and that employers with low-wage workers might be inclined to reduce or eliminate their dependent coverage if SCHIP was subsidizing premium costs. As a result of this concern, HCFA has issued detailed guidelines for how an employer-subsidy program under Title XXI must be structured—guidelines that many state officials described as overly rigid and burdensome. Indeed, four states in our study designed employer subsidy programs, but only two have been able to implement them.

Imposing obligations on employers or insurers: A final strategy to limit crowd out was identified by one of our study states: California has imposed legal obligations on employers and insurers to not alter their coverage policies in response to SCHIP.

As the debate continues over whether SCHIP poses a threat to private market insurance, crowd-out concerns appear to be diminishing at the state and local levels. Among the 18 study states, SCHIP and Medicaid officials, as well as other key informants, consistently reported little to no concern over crowd out; many believed it was a non-issue. Shedding further light on the issue, a handful of states have conducted preliminary quantitative assessments of crowd out as part of their annual evaluations for HCFA. Studies in California, Colorado, and Texas have found that a small proportion of program applicants have been denied eligibility because they possessed private insurance at the time of application (or within the state's waiting period). Specifically, California found that only 3.7 percent of applicants had coverage through an employer within 90 days prior to their application; Colorado found that 3 percent of applicants were denied for having private insurance coverage; and Texas found that 3.4 percent of applicants were denied coverage because of current insurance. Other states have monitored the percentage of enrollees that dropped employer-sponsored insurance to enroll in SCHIP, which may provide a better estimate of actual crowd out: Missouri estimated that the rate of crowd out is between 1.6 and 3.2 percent of the population of its SCHIP expansion members; New York found 4.87 percent crowd out based on application questions about health insurance status; and North Carolina reported an 8.3 percent crowd-out rate of enrollees based on data from a survey of a sample of SCHIP enrollees.

Combined, these assessments neither refute nor support the belief that SCHIP will lead to significant levels of crowd out. However, based on information gathered

from the 18 study states, it is apparent that pressures to increase enrollment have begun to outweigh concerns about crowd out at the state and local levels. As energy has shifted to enrolling every last eligible child in SCHIP, some states have reordered their priorities and considered or enacted policies aimed at boosting enrollment even at the expense of potentially more crowd out. For example, New Jersey lawmakers actually reduced their 12-month waiting period to 6 months for children enrolled in employer-sponsored plans, and entirely eliminated the waiting period for families earning less than 200 percent of the federal poverty level (FPL) with individual plans or Consolidated Omnibus Reconciliation Act (COBRA) coverage. In 2000, the Mississippi legislature passed a bill eliminating the state's six-month waiting period altogether. Furthermore, an increasing number of states have initiated outreach efforts directly targeted at employers and small businesses.

As with many public policy issues, crowd out is ultimately about trade-offs. Although some degree of crowd out seems inevitable under a large expansion of public coverage, policymakers need to determine which is the greater priority—limiting the displacement of private health insurance coverage, or making significant strides in reducing uninsurance. A number of individuals interviewed for this study believe that it is still too early to modify federal or state policies relating to crowd out and that more needs to be learned about whether substitution occurs as public coverage is extended to higher income families. Many others maintain, however, that the disadvantages of crowd-out prevention mechanisms tip the scale in favor of less stringent approaches, noting SCHIP's horizontal inequity of treating children in the same economic circumstances differently from one another. Child advocates believe that SCHIP's crowd-out policies are particularly unfair to low-income families that had valued insurance in the past, purchased it, and that may now find themselves struggling to make premium contributions for coverage that is possibly both more expensive and more limited in scope than that offered by SCHIP. This issue becomes particularly striking for some families with children with special health care needs who may qualify for SCHIP based on income, but who are locked into costly and perhaps substandard private insurance plans. These views may prompt more states to include children with special health care needs in their waiting period exception policies, or cause federal policymakers to consider allowing SCHIP coverage to wrap around less comprehensive private coverage—as Medicaid has wrapped around private coverage throughout its history. Moreover, despite widely divergent views as to whether ESI subsidies fuel or restrict crowd out, many states believe that the related federal rules should be loosened to permit more state experimentation. Although it is difficult to predict the direction that SCHIP will take, it is clear that issues surrounding crowd out will continue to influence the discussion, particularly as the program reaches higher income families.

Has the Jury Reached a Verdict? States' Early Experiences with Crowd Out under SCHIP

Introduction

In the months leading to the enactment of the State Children's Health Insurance Program (SCHIP), policymakers, government officials, researchers, and advocates debated policy options to address the problem of an estimated 10.7 million uninsured children (Current Population Survey 1997). Given that a significant expansion in publicly sponsored children's health insurance would require considerable federal, state, and local resource commitments, policymakers weighed concerns regarding the efficiency of public funding and the need to safeguard the private market. "Crowd out," broadly defined as the substitution of public program coverage for private health insurance coverage, was one of the most contentious and hotly debated issues surrounding proposals for expanding children's health insurance coverage.

Based on research suggesting that Medicaid expansions for pregnant women and children in the late 1980s and early 1990s may have crowded out some private health insurance coverage, policymakers theorized that further expansions might create additional opportunities for employers and employees to pass on their health insurance costs to the government. There was also the question of whether new child health insurance programs would crowd out Medicaid—some were concerned that welfare stigma might tempt families to try to enroll their Medicaid-eligible children in new non-Medicaid programs, thereby reducing the efficiency of public funding targeted to children without access to insurance.

These crowd-out concerns persuaded the drafters of Title XXI of the Social Security Act to include in the law provisions requiring that states target uninsured children ineligible for Medicaid and implement strategies to prevent the substitution of SCHIP for both Medicaid and private coverage.[1] With regard to deterring the substitution of SCHIP for private coverage, states were instructed, via a letter from the Health Care Financing Administration (HCFA), "to describe procedures in their State SCHIP plans that reduce the potential for substitution," and were told that greater scrutiny would be applied to programs that expanded to higher levels of income eligibility. Despite the reluctance of some states' policymakers, who believed either that crowd-out concerns were unfounded or that increasing access and improving quality of care through public programs outweighed the negative potential for crowding out sometimes costly and limited private coverage, all states were required to identify and implement crowd-out prevention policies. Without specific

federal regulations or guidelines from the research community on effective crowd-out prevention policies, states adopted a range of strategies, including:

- Waiting periods—during which a child must remain uninsured before being permitted to enroll in SCHIP;
- Monitoring/application questions—to inquire about applicants' health insurance status and measure in some manner the degree to which crowd out is occurring;
- Verifying applicants' insurance status—through cross-checks against existing insurance databases;
- Imposing cost-sharing—to make SCHIP coverage resemble private-sector coverage and to attach a cost to the decision to enroll;
- Subsidizing employer-sponsored insurance—to help maintain the existing base of employer-based coverage in a state; and
- Imposing obligations on employers or insurers—to ensure that they would not change their coverage policies in an attempt to persuade families to drop private plans in favor of SCHIP.

In the aftermath of SCHIP implementation, it is the more stringent of these crowd-out prevention strategies—such as waiting periods and high cost sharing—that have been criticized as potentially creating barriers to enrollment or placing a disproportionate burden on certain subgroups of the uninsured, such as children with special health care needs. Some analysts oppose all crowd-out policies and believe that SCHIP's objective to target only uninsured children creates horizontal inequities by providing low-cost comprehensive coverage to uninsured children while denying such coverage to children in similar income groups who may be underinsured in less comprehensive or more costly private plans. Conversely, others believe it is important to maintain crowd-out prevention policies at least until there is sufficient evidence that disputes crowd-out fears, or until SCHIP objectives are modified.

Although it is still too soon to accurately assess the degree to which SCHIP may be crowding out private and public coverage, this study uses qualitative information and preliminary quantitative data to describe states' early impressions of and experiences with crowd out. Specifically, this study examines how 18 states are addressing crowd out, the degree to which officials perceive crowd out to be occurring, and the implications of crowd-out prevention strategies on enrollment. The study focuses on private-market crowd out, reserving an examination of Medicaid crowd out for a forthcoming Urban Institute publication.

Study Methods and Paper Organization

This study was conducted as part of the Urban Institute's *Assessing the New Federalism* project and, more specifically, of its evaluation of the impact and implementation of SCHIP. The qualitative component of the Institute's SCHIP evaluation involved

site visits (four to five days in length) to 15 states and in-depth telephone interviews with 3 states, selected based on their diversity in size, population characteristics, geographic location, and SCHIP policies. The study states follow:

SCHIP Study States

Alabama	Michigan	North Carolina
California	Minnesota	Ohio
Colorado	Mississippi	Pennsylvania
Connecticut	Missouri	Texas
Florida	New Jersey	Washington
Massachusetts	New York	Wisconsin

During the site visits, we conducted numerous interviews with a broad range of key informants. At the state level, we interviewed SCHIP, Medicaid, and Title V/Maternal and Child Health officials, governors' health policy staff, state legislators involved with child health policy, representatives of provider groups (such as the American Academy of Pediatrics and the primary care association), and leading child advocacy organizations. At the local level, we interviewed clinic- and office-based pediatric providers, managed care organizations, social services departments responsible for SCHIP or Medicaid eligibility determination, and community-based organizations involved with outreach. To ensure consistent gathering of information across sites, we used a set of detailed interview protocols that explored a broad range of SCHIP implementation issues, including those related to crowd out.

This paper is based on qualitative data collected during site visit interviews, some preliminary quantitative assessments of crowd out, and existing literature on the subject. The report is organized as follows:

- "Why the Concern over Crowd-Out?" provides the reader with background information on the phenomenon of crowd out, the lessons and limitations of prior research on the subject, and proposed federal regulations on prevention strategies that suggest varying levels of concern based on states' eligibility levels.
- "State Efforts to Prevent Crowd Out under SCHIP" summarizes states' efforts to prevent crowd out under SCHIP and, specifically, addresses the policy debates that surrounded crowd out during the program design phase, mechanisms instituted to deter crowd out, and the implications of these mechanisms for enrollment.
- "Conclusions and Policy Implications" closes the paper with a summary of findings and their policy implications.

Why the Concern over Crowd Out?

Private-market crowd out results from the behavior of either consumers, employers, or a combination of the two. Specifically, public insurance "crowds out" private coverage when individuals choose a government-subsidized program instead of selecting available employer-sponsored coverage. This may occur either when a family actively drops private dependent coverage to enroll their child in subsidized health coverage, or when a previously uninsured family whose child is enrolled in SCHIP chooses to maintain that coverage and refuse an offer of employer-sponsored insurance. Crowd out may also occur when an employer deliberately reduces or eliminates health insurance coverage for workers and their dependents with the expectation that available public programs will instead provide needed coverage. Finally, crowd out may occur as a result of a combination of employer and individual actions—if an employer covers only a small portion of the cost of insurance, the remainder is then transmitted to families through premiums and cost sharing, which families may perceive as unaffordable and decide not to purchase.

Crowd out is an important issue for those concerned that new public health insurance initiatives target children with the greatest need—those who are uninsured and who do not qualify for other public programs. To the extent that new public coverage simply substitutes for private coverage already in place, uninsurance rate decreases will be smaller and fewer improvements in access to care and health status may result. Such substitution may also lead to greater-than-expected increases in program expenditures (Blumberg, Dubay, and Norton 2000). Nevertheless, it is important to remember that concerns about SCHIP leading to crowd out are largely based on the perception that the Medicaid expansions of the 1980s had a significant crowd-out effect. Flaws in this perception have been the topic of previous research. The following section provides a brief discussion of the lessons and limitations of relating Medicaid crowd-out research to SCHIP.

Relating Medicaid Crowd-Out Research to SCHIP–Lessons and Limitations

Following the Medicaid expansions for pregnant women and children in the late 1980s, a body of literature emerged on the degree to which Medicaid displaced private coverage.[2] Initial policy research on the impact of Medicaid expansions yielded seemingly high crowd-out estimates that were often misinterpreted. For example, one study found that for children, 31 to 41 percent of increases in Medicaid coverage that occurred as a result of the Medicaid expansions were offset by declines in private coverage (Cutler and Gruber 1996 a, b).[3] Subsequent research found that between 17 and 21 percent of enrollment over the expansion period was due to crowd out (Dubay and Kenney 1996; 1997). Given that children eligible for SCHIP would likely have higher rates of private coverage than children eligible for Medicaid expansions, policymakers feared that SCHIP would produce even higher levels of crowd out measured in terms of new SCHIP enrollees who had dropped private cov-

erage. Consequently, the SCHIP legislation was designed to target uninsured children and requires states to establish policies to limit crowd out.

More recent studies have yielded crowd-out estimates ranging between 1 and 23 percent (Blumberg et al. 2000; Thorpe and Florence 1998; Yazici and Kaestner 2000). However, it is important to note that all of the crowd-out studies measure crowd out differently, varying by data and statistical method and perhaps most importantly by research question, and are therefore not directly comparable. Nevertheless, consistent conclusions are that expanding children's health insurance for the poorest households may result in little crowd out because this population has limited access to insurance coverage, while expanding coverage to those in higher income brackets may produce a greater degree of crowd out.

Although findings from Medicaid crowd-out research are compelling, this research has limited applicability to SCHIP for several reasons. First, it is important to note that these studies focused on the share of new entrants attributable to crowd out, rather than the share of those with private coverage who dropped their coverage to enroll in a public program. Thus, policymakers attempting to predict the extent of crowd out that would occur with an expansion of coverage to certain groups of children with higher incomes and more private coverage were not aided by the previous literature. In addition, research based on the Medicaid expansions may not be relevant to SCHIP because of several programmatic differences such as SCHIP's higher eligibility levels, and potentially different benefit packages, cost-sharing requirements, and simplified enrollment processes. Moreover, as will be discussed further below, states are required by federal regulations to implement policies aimed at deterring crowd out. It is also worth noting that of the Medicaid crowd-out literature, or of any other literature, none examined the effectiveness of crowd-out prevention polices, thereby leaving states to experiment with different approaches to limiting crowd out under SCHIP.

Proposed Federal Regulations on SCHIP Crowd-Out Policies[4]

The SCHIP legislation, specifically Section 2102(b)(3)(C) of Title XXI, requires that state plans include descriptions of procedures that demonstrate how they will address the potential for SCHIP to crowd out private health insurance coverage. HCFA reviewed each state's SCHIP plan to determine whether it sufficiently addressed the issue of crowd out, particularly scrutinizing those states that opted to design non-Medicaid programs. Those states choosing to expand Medicaid under SCHIP were not permitted to adopt policies to limit crowd out (e.g., waiting periods, cost-sharing, verifying insurance status). Medicaid SCHIP programs that have implemented such policies are those with Medicaid waivers.

In the absence of crowd-out policy regulations, states individually negotiated appropriate policies with HCFA. However, in the November 8, 1999 edition of the *Federal Register*, HCFA presented proposed rules that speak to its position in determining whether state crowd-out policies are reasonable. The proposed rules include the following major points:

- HCFA acknowledges that there is little evidence of crowd out below 150 percent of FPL; however, the agency reiterates that states providing coverage to children in families at or below 150 percent of FPL should at least monitor the extent of substitution.
- Because there is an increased risk of crowd out within higher income eligibility levels, HCFA says that states providing coverage to children in families between 150 and 200 percent of FPL should at least have procedures to study the extent of substitution, and if it occurs at unacceptable levels, identify steps they will take for its reduction and prevention. The proposed rules also stipulate that stricter standards for the degree of "permissible" substitution will apply to states expanding coverage at higher income levels.
- Finally, HCFA's proposed rules require states providing coverage to children in families above 200 percent of FPL to implement specific procedures or strategies to limit substitution (Federal Register 1999).[5]

Importantly, the proposed rules do not suggest or require that states use particular crowd-out prevention strategies, but rather allow states the flexibility to select their own approaches. This flexibility grows from the Title XXI statute, which authorizes states, not the federal government, to design approaches to prevent crowd out. Moreover, as mentioned earlier, at the time of the passage of the Balanced Budget Act (BBA), there was no evidence assessing which strategies were most effective.

Although states are afforded considerable flexibility in the overall design of their SCHIP programs, more specific rules are laid out for states considering expansions of children's coverage through subsidies of employer-sponsored insurance (ESI). HCFA is applying particular scrutiny to these programs, regardless of their income eligibility levels, because federal officials believe there is greater potential for crowd out to occur in this type of arrangement—either as a result of employers reducing or eliminating their premium contributions for dependent coverage, or as a result of families dropping their purchase of dependent coverage through ESI and obtaining that same coverage through SCHIP. In order to limit such potential for promoting crowd out, HCFA has required that states choosing to use SCHIP funds to subsidize employer-sponsored group health plans meet the following four provisions:

- To ensure that coverage is targeted to children in families otherwise unable to afford dependent coverage, children who had employer-sponsored insurance within the previous six months are ineligible unless their coverage was involuntarily terminated.
- To discourage employers from reducing their existing contributions, states are permitted to subsidize ESI only in cases in which the employer contributes at least 60 percent toward the cost of family coverage.
- To ensure that subsidizing ESI is cost-effective, a state's subsidy for employer-sponsored family coverage can be no greater than the payment that the state would make had the child been enrolled in a separate SCHIP plan (or in Medicaid, if appropriate).

- The state is also required to monitor the amount of crowd out that occurs under the program and the effect of these provisions on access to the program. HCFA advises states to collect information on applications to evaluate the prevalence of substitution (Federal Register 1999).

Thus, states designed and implemented policies to address crowd out without the benefit of knowing what percentage of private coverage SCHIP was likely to crowd out and without evidence of which policies would be most effective. Moreover, crowd-out policy design was often a highly politicized process, as will be discussed in the next section.

State Efforts to Prevent Crowd Out under SCHIP

In response to the considerable attention and concern directed at the issue during SCHIP's design phase, states have instituted a number of varied strategies to deter crowd out. These strategies, along with a summary of the state-level policy debates that preceded them, are described below.

The Policy Debate

During the design phase of the SCHIP programs, crowd out was a controversial issue. Policymakers weighed the merits of researchers' Medicaid crowd-out estimates against the experiences of pre-SCHIP children's health insurance programs that reported little qualitative or quantitative evidence that it had occurred. For example, Florida's *Healthy Kids* Program, the precursor to the state's current *KidCare* program, reported that only 2 percent of a sample of enrolled families indicated that they had had private, employer-based coverage at some time during the year prior to enrolling in *Healthy Kids* (Shenkman et al. 1997). Similarly, Minnesota reported little evidence of crowd out in *MinnesotaCare*. Nor were Pennsylvania and New York concerned with crowd out based on their experiences with state-funded children's health insurance programs prior to SCHIP.

Despite reports of low crowd-out concern among experienced states, many policymakers still saw a significant potential for SCHIP to crowd out private health insurance. Some believed that *MinnesotaCare's* low estimate was a result of its relatively stringent crowd-out policy, which required an 18-month waiting period for families with access to employer-sponsored coverage in which the employer contributes 50 percent or more of the premium.[6] Consequently, those concerned about crowd out adopted aggressive approaches, typically waiting periods, to deter families from dropping private coverage.

Without conclusive evidence, the issue of crowd out was a sticking point for many states, one which protracted SCHIP policy debates and program design. Policymakers were often divided between the belief that aggressive policies (such as waiting periods) were needed to prevent crowd out, and the belief that aggressive crowd-out policies were unnecessary and could potentially deter enrollment. For some

states, an aggressive approach to crowd out was a critical means of building broad-based political support for a children's health insurance program. In Missouri, the exclusion of policies to deter crowd out became a "deal breaker" for many state legislators—if the program did not include an aggressive approach to limiting crowd out (e.g., a waiting period, cost sharing, and a state legislative requirement to conduct a crowd-out study) then the bill would not have passed the state legislature. Similarly, there was very strong gubernatorial support for a six-month waiting period in Mississippi and for a one-year waiting period in New Jersey.[7] In Alabama, work-group participants drafting the state's SCHIP plan felt that some waiting period was necessary, but that six months was too long. Hence, they decided on a three-month waiting period.

In contrast, other states were reluctant to address crowd out at all. For example, the three states that were grandfathered into SCHIP because of their prior experience administering children's health insurance programs were required to meet new federal crowd-out requirements despite their grandfathered status. Yet policymakers from these states—Florida, New York, and Pennsylvania—believed that crowd out did not occur in their previously state-funded initiatives nor that it posed much of a threat under Title XXI. Thus, each opted to implement less aggressive approaches such as monitoring crowd out or screening out those children with private coverage through application questions. Ohio took an alternative approach, simultaneously enacting a regular Title XIX eligibility expansion along with its Medicaid expansion under Title XXI. Today, therefore, with both programs with upper income eligibility thresholds of 200 percent of FPL, Ohio can enroll children without any form of insurance into SCHIP (and receive enhanced federal match on their behalf), and enroll those with other insurance into Medicaid/Title XIX (and receive regular Medicaid matching funds). Through this strategy, the state was able to both avoid time-consuming debates over crowd out and extend Title XIX "wraparound" coverage to underinsured Medicaid-eligible children.

Policies to Deter Private Market Crowd Out

Among the 18 study states, all except Ohio and Minnesota adopted crowd-out deterrence policies as indicated in their SCHIP plans submitted to HCFA—with Ohio later deciding to monitor its occurrence. Although specific approaches varied considerably, seven types of crowd-out deterrence strategies were identified:

- Waiting periods
- Monitoring
- Application questions regarding children's insurance status
- Verifying insurance status against private coverage databases
- Imposing cost sharing (to model programs after private insurance)
- Providing premium assistance to subsidize employer-based coverage
- Imposing obligations on employers or insurers

Table 1. *Policies Identified to Deter Crowd Out in 18 States*

State	Waiting Period (months)	Monitoring	Application Question(s)	Verifying Insurance Status against Database of Private Coverage	Cost Sharing	Subsidizing Employer-Sponsored Insurance	Obligations Imposed on Employers or Insurers
Alabama	3			X	X		
California	3		X		X		X
Colorado	3		X				
Connecticut	6						
Florida			X				
Massachusetts						X	
Michigan	6		X	X			
Minnesota							
Mississippi				X			
Missouri	6	X	X	X			
New Jersey	6						
New York		X	X		X		
North Carolina	2	X	X		X		
Ohio*		X					
Pennsylvania		X	X				
Texas	3						
Washington	4	X	X		X		
Wisconsin	3	X		X		X	
Total	11	7	9	5	5	2	1

Shaded area = Not applicable to this Medicaid expansion.
*Although federal crowd out requirements are not applicable to Ohio's Medicaid SCHIP expansion, the state has decided to monitor its occurrence.

This section describes these strategies and state experiences with their implementation. (For information on policies in all 50 states and the District of Columbia, please see the appendix.)

Waiting Periods

Imposing waiting periods, whereby families must be uninsured for a period of time before being permitted to enroll in SCHIP, emerged as the most common strategy used by the study states for controlling crowd out. As seen in table 1, 11 of the 18 states impose waiting periods ranging from two months to six months (Alabama, California, Colorado, Connecticut, Michigan, Missouri, New Jersey, North Carolina, Texas, Washington, and Wisconsin); seven of these states' waiting periods are less than six months. The proportion of our study states that adopted this strategy is roughly consistent with the national trend, as slightly over two-thirds of all SCHIP programs have implemented waiting periods as a strategy to deter crowd out. Simi-

larly, roughly half of all states with waiting periods have elected time periods of less than six months.

For the most part, states obtain information about prior insurance status from application questions related to applicants' current and previous health coverage. Therefore, they typically rely on applicants' self-reported information. However, several states—Alabama, Michigan, Pennsylvania, and Wisconsin—are verifying applicants' declared insurance status against other databases. For example, Pennsylvania is employing a records match with private insurance files. Alabama, Michigan, and Wisconsin's practices are discussed further in the section on verifying insurance status, below.

Waiting periods may also be imposed if a state determines that a family has access to health insurance (through an employer, for example), as opposed to actually possessing that insurance. For example, in addition to its three-month waiting period for children already covered by insurance, Wisconsin imposes an 18-month waiting period upon families who have access to, but have not elected, employer-sponsored coverage under the following circumstances: there is a family member who is currently employed and is eligible to sign up for employer-provided dependent coverage; the employer pays 80 percent or more of the cost of the family premium; and the employer-provided health care plan meets the standards of the federal Health Insurance Portability and Accountability Act. (Wisconsin is verifying families' access to employer-sponsored coverage by sending a questionnaire to employers of *BadgerCare* applicants at enrollment and again at re-determination.) Although Wisconsin is trying to enroll these applicants into their employer coverage subsidy program, the Health Insurance Premium Payment (HIPP) program, few have qualified. This is primarily because employers fail to meet federal requirements under SCHIP for subsidizing ESI—federal law requires that employers contribute at least 60 percent of premium costs and provide a comprehensive benefit package. Barring families from enrolling in SCHIP because they have such access has been controversial in several states because some policymakers and advocates believe that private coverage, despite high employer contributions, often imposes high deductibles and other cost sharing, making the coverage unaffordable.

Although waiting periods have been criticized for their stringency, it is important to note that most states include exceptions to their waiting-period policies. Each of the 11 states with waiting periods in our study has exception policies and uses application questions to evaluate an applicant's reasons for dropping private insurance coverage. For example, Alabama's form asks applicants, "Has any health insurance ended within the last 3 months," and then "Please explain why this insurance ended or will end and who it affects." Exceptions to waiting periods vary somewhat in comprehensiveness, but generally relate to families losing coverage within the specified waiting period through no fault of their own. For example, most states allow exceptions in cases in which an employer stopped offering dependent coverage, or an applicant lost his or her job (and thus his or her insurance), moved, changed jobs, or had COBRA benefits expire.

In seven of our study states, however, additional exceptions are permitted if existing private coverage is deemed excessively expensive for families. Specifically:

- Colorado waives its three-month waiting period for families whose employers contribute less than 50 percent toward the cost of coverage;
- Connecticut waives its six-month waiting period for families that can demonstrate that they are spending more than five percent of their gross income on health insurance;
- Texas's three-month waiting period is waived for families paying more than 10 percent of their income on family coverage;
- Washington waives its four-month waiting period for families paying more than $50 per month, out-of-pocket, for health care coverage;
- California, New Jersey, and Michigan waive their waiting periods in cases in which a child's existing coverage is under an individual policy, because of the typically high costs of individual health insurance coverage; and
- Michigan also waives its waiting period if a child has employer-sponsored coverage through a noncustodial parent and lives outside of the health plans' providers' area, thereby having no reasonable or geographic access to the coverage.

Taken together, these exception policies appear to reflect state officials' attempts to narrow their view of what kinds of crowd out are problematic and worth preventing. Moreover, these policies mitigate the potential for waiting periods to create excessive horizontal inequities among families that are income-eligible for SCHIP. That is, officials in these states did not desire to "punish" (by excluding from SCHIP) those families that valued health insurance for their children. These policies, therefore, appear to be designed to help those families who might be judged "underinsured" because of the cost of their existing coverage.

Of special note, only one state in our study—North Carolina—has attempted in its exception policies to assist children who are "underinsured" by virtue of the breadth or quality of their existing coverage—that is, children whose existing coverage either excludes, or does not sufficiently cover, the services they need. Specifically, North Carolina received approval in October 2000 of an amendment that will permit children with special health care needs—a subgroup of children who are often described as being underinsured for the treatment of their chronic illnesses and disabilities—to be exempt from the state's two-month waiting period if "health insurance benefits available to the family of a special needs child have been terminated due to a long-term disability or a substantial reduction in or limitation of lifetime medical benefits or benefit category." According to state officials, this language will essentially permit a blanket exclusion from the state's waiting period for children who are identified by their doctor as having a special health care need.

Monitoring and Application Questions

Monitoring crowd out and posing application questions about health insurance status are the second-most common strategies employed by the study states to address crowd-out concerns. According to SCHIP plans approved by HCFA, five of the study states—New York, Pennsylvania, Missouri, Washington and Wisconsin—identified monitoring as an explicit strategy for addressing the potential problem. In

addition, North Carolina and Ohio have since added monitoring as part of their crowd-out prevention strategy. In contrast to waiting periods, monitoring crowd-out occurrence is among the least stringent approaches available to states, a strategy that essentially accepts the inevitability of some degree of crowd out.

Typically, monitoring is accomplished through evaluation of information gleaned from application form questions on insurance status. For example, Pennsylvania monitors by examining the number of applications that indicate current access to insurance. North Carolina uses its application questions in a similar fashion, asking,

> "Is anyone covered by other health or medical insurance? Has any child's health coverage been discontinued?"

New York is also monitoring crowd out through its application, asking a number of questions related to an applicant's current and previous health coverage and collecting information in the following areas:

- The number who answered "yes" to having health insurance in the past 6 months;
- Of those with prior insurance, the number who were insured through an employer; and
- The number who indicated the following reasons as to why the enrollee's prior employer-based insurance was discontinued:

  a) Employer discontinued offering the benefit or is no longer contributing towards premium for the enrollee but continued benefits for the working parent;

  b) The premium was increased beyond what was affordable;

  c) Child Health Plus is a less expensive insurance alternative;

  d) Child Health Plus insurance benefits are better;

  e) No longer working for the employer who offered the insurance.

New York sums the totals for a, c, and d to determine a statewide crowd-out percentage of the total Child Health Plus enrollees; the state has negotiated an agreement with HCFA whereby if measurable crowd out exceeds 8 percent over any 9-month period, then the state will implement a waiting period.

Interestingly, three states in our study—California, Florida and Michigan—also use insurance status questions on their applications, but not explicitly for monitoring. For example, Florida officials hypothesize that simply asking a family if their children already have insurance acts as a deterrent against families dropping coverage. In Michigan, state officials are interested in whether applicants' existing coverage is adequate, in terms of comprehensiveness and access to providers, and so uses application questions to investigate these issues with families and their employers.

Combined, 16 of 18 study states either monitor crowd out or use application questions in isolation. Nationally, 29 of 51 states plus the District of Columbia are employing monitoring or application questions to address crowd out.

Verifying Insurance Status against Private Coverage Database

Rather than relying on self-declaration of insurance status, some states are verifying whether an applicant is without insurance before granting eligibility. Of the study states, Alabama, Michigan, Mississippi, Missouri, and Wisconsin indicated in their state plans that they are verifying applicants' insurance status as a means to prevent crowd out. For example, Wisconsin is sending letters to all employers of SCHIP applicants inquiring about their access to employer-sponsored insurance and is verifying insurance status by matching *BadgerCare* cases with private insurance monthly tape submissions. Alabama is developing the AL Health Care Information Network, which will have a patient index of current private coverage of Alabama citizens. Michigan is conducting a similar process whereby Blue Cross/Blue Shield checks its databases to see if applicants are already covered in their system. (As of November 1999, Michigan had only identified 10 children already enrolled in a private Blue Cross/Blue Shield plan.) Checking Blue Cross/Blue Shield databases may be problematic, though, as policyholder identification numbers are typically attached only to the employed adult rather than to each individual family member. Nationally, a total 8 of 51 states plus the District of Columbia are verifying applicants' insurance status in this manner.

Cost Sharing

Cost sharing, in the form of premiums, enrollment fees, and copayments, may allow SCHIP programs to more closely resemble private insurance and, consequently, create both an image and the appropriate economic incentives to deter families from substituting SCHIP for private insurance. Although cost-sharing policies can be implemented to accomplish numerous goals, and all of the non-Medicaid SCHIP programs in our study require some form of cost-sharing, only three states—Alabama, New York, and Washington—explicitly identified in their state plans that cost sharing was one of their strategies to deter crowd out. Since state plan submission, California and North Carolina also have come to consider their cost-sharing provisions as part of their overall crowd-out prevention strategy.

Interestingly, many key informants interviewed in the course of the study questioned whether cost-sharing amounts in SCHIP programs were large enough to deter crowd out—the $50-per-child annual fee in Alabama and the $9-to-$13-per-child-per-month premiums in New York, for example, were considered quite low in comparison with the cost sharing found in typical private plans, which often also include, in addition to premiums, significant annual deductibles and 80/20 coinsurance for utilized services. Similarly, others speculated that the imposition of cost sharing, however nominal, might serve to reduce the stigma often associated with public programs and, as a result, actually attract rather than deter participation in SCHIP—although there is no empirical evidence to suggest that this is true.

Subsidizing Employer-Sponsored Insurance

States have also shown considerable interest in designing policies to subsidize employer-sponsored insurance (ESI) on behalf of children. These efforts have been

initiated to achieve the broader goals of capitalizing on private sector resources already supporting the provision of health insurance and strengthening the foundation of employer-sponsored insurance in the states. But state SCHIP and Medicaid officials have also described the initiatives as strategies that can effectively deter crowd out by helping employers to maintain and employees to afford health benefits: Massachusetts considers its ESI program as part of its official strategy to prevent crowd out.

Federal officials fear, however, that these very efforts hold significant potential to promote crowd out because families who might otherwise contribute to their health care costs without a subsidy will be likely to seek premium assistance, and because employers with low-wage workers might be inclined to reduce or eliminate their dependent coverage if SCHIP is subsidizing premium costs. As a result of this concern, HCFA has issued detailed guidelines for how an employer-subsidy program under Title XXI must be structured if it is to receive federal approval, guidelines that most state officials described as untenable. Thus, although Florida, Massachusetts, Mississippi, and Wisconsin pursued ESI programs, only Wisconsin and Massachusetts have succeeded in gaining federal approval and establishing programs that subsidize the purchase of employer-sponsored coverage for children under SCHIP. Their experiences provide an interesting case study of the potential of, as well as the challenges associated with administering, such initiatives—experiences that will be detailed in a forthcoming Urban Institute report.

Obligations Imposed on Employers and/or Insurers

A final strategy to limit crowd out was identified by one of our study states: California has imposed legal obligations on employers and insurers to not alter their coverage policies in response to SCHIP.[8] Specifically, the state's *Healthy Families* program addressed crowd out, in part, by amending its existing labor practices act to prohibit employers from changing the employee-employer cost ratio based upon the employee's wage base or job classification. It is believed that this will discourage employers from increasing premium costs as a means of forcing families to "opt out" of private coverage and enroll in SCHIP. In addition, the new labor practices act prohibits employers from making any modification (i.e., reductions) to benefits coverage for employees and their dependents in an attempt to induce them to enroll in SCHIP. Finally, the California law prohibits employers from directly encouraging employees to enroll in *Healthy Families* (for example, by including program marketing materials in its human resources benefits packets).

States' Experiences with Crowd Out under SCHIP

With approximately two years of implementation experience to reflect on, state and local officials have begun to observe the effects of crowd-out prevention efforts and are in a stronger position to answer the question of whether, or to what degree, private-market crowd out may be occurring under SCHIP. This section provides a brief analysis of the perceived impact of crowd-out-prevention policies based on information gathered during the site visits and on data from state evaluations.

The Policy Debate Continues, but Concerns Diminish

Although the debate continues over whether SCHIP poses a threat to private-market insurance, crowd-out concerns appear to be diminishing at the state and local levels. Among the 18 states in our study, SCHIP and Medicaid officials, as well as other key informants, consistently reported little or no concern over crowd out; many saw it as a non-issue. In some state states where there had initially been a high degree of concern about crowd out, the issue was being reexamined. For example:

- In California, Governors Wilson and Davis expressed concern about crowd out during SCHIP design and early implementation phases, respectively. Now that SCHIP has been implemented, however, state officials do not consider crowd out to be a major issue. Administrators of *Healthy Families*, California's SCHIP program, believe that the vast majority of children have been uninsured at the time of application. Looking back, these officials believed the crowd-out debate might have been much ado about nothing, noting that employers who hire mostly low-income workers do not offer insurance to their employees, much less dependent coverage.

Very similar sentiments were shared with Urban Institute researchers by officials in other states during site visit interviews. For example:

- In Alabama, key informants believed that the problem of uninsurance across the state is so large that it is unlikely that crowd out has been or will be an issue.
- In Colorado, officials reported that concerns over crowd out have been replaced by the more pressing concerns of finding uninsured children and getting them enrolled.
- New York and Pennsylvania officials, with the benefit of hindsight, reported that they did not believe they had experienced crowd out during the pre-Title XXI history of their *Child Health Plus* and *PACHIP* programs, respectively, and thus wondered why they should be concerned today.
- Michigan and North Carolina officials called crowd out "a non-issue," and expressed their belief that people are more likely to be uninsured than poorly insured.

Quantitative Evaluations Indicate the Jury Is Still Out

Shedding further light on the issue, a handful of states have conducted preliminary quantitative assessments of crowd out as part of their annual evaluations for HCFA. California, Colorado, and Texas have measured the percentage of applicants denied eligibility because they possessed insurance within the specified waiting period. Specifically:

- California found that only 3.7 percent of applicants had coverage through an employer within 90 days prior to their application;

- Colorado found that between July 1, 1998 and September 30, 2000, 3 percent of applicants were denied for having private insurance coverage; and
- Texas found that as of October 12, 2000, 11,838 children of a total of 331,745 applicants were denied coverage because of current insurance, yielding a crowd-out rate of 3.4 percent.

Other states have monitored the percentage of enrollees who dropped employer-sponsored insurance to enroll in SCHIP, which may provide a better estimate of actual crowd out. Specifically:

- Based on data from mailed and telephone surveys, Missouri estimated that the rate of crowd out is between 1.6 to 3.2 percent of the population of MC+ expansion members;
- Between January 1, 1999 and September 30, 1999, New York found 4.87 percent crowd out based on data from application questions about health insurance status[9]; and
- North Carolina reported an 8.3 percent crowd-out rate of enrollees based on data from a survey of a sample of SCHIP enrollees.[10]

Florida has taken a different approach to monitoring crowd out by determining the share of new enrollees who have had access to employer-sponsored coverage. The Institute for Child Health Policy conducted more than 1,500 phone interviews with "new enrollees," defined as children enrolled in *KidCare* for less than 3 months.[11] Researchers found that, overall, 11 percent of these children had access to employer-based coverage within the previous 12 months.[12] The telephone survey also asked families whether they currently had access to employer-sponsored coverage (i.e., an offer of employer coverage at the time of the interview). The extent to which enrollees had such access varied considerably depending on the *KidCare* component to which their families belonged, but averaged 13.3 percent.[13] Families were asked why they elected not to take their employer-based coverage and the primary response was that such coverage was too expensive—on average, employer-based offerings equaled 9 percent of family income (Institute for Child Health Policy 2000).

It is important to note that these quantitative evaluations measured different concepts of crowd out, over different time periods, and are consequently not comparable.

Pressures to Increase Enrollment Outweigh Crowd-Out Concerns

Thus far, quantitative assessments of crowd-out potential neither refute nor support the threat of SCHIP to substitute for private coverage. However, based on information gathered from the 18 states in this study, it is apparent that pressures to increase enrollment have begun to outweigh concerns about crowd out at the state and local level. Although SCHIP enrollment has accelerated in the past year, the program was widely perceived as having gotten off to a slow start and was frequently criticized for enrolling low percentages of the target population—at the annual meeting of the National Governor's Association in August 1999, President Clinton

announced his disappointment that only 1 million of an estimated 10 million eligible children had been enrolled in SCHIP since 1997 (American Health Line 1999). The fact that a large majority of states will return significant amounts of unspent SCHIP dollars to the federal government underscores that SCHIP enrollment is not where most would like it to be—at the end of FY 2000, over three-quarters of the states will have unexpended funds from their FY 1998 allotment, totaling $1.95 billion (Kenney, Ullman, and Weil 2000). Consequently, policymakers, researchers, and advocates have focused considerable attention on outreach and enrollment practices, encouraging states to substantially increase their enrollment numbers. As energy has shifted to enrolling every last eligible child in SCHIP, a small number of states have revisited the issue of crowd out and considered or enacted policies aimed at boosting enrollment even at the risk of more crowd out. For example:

- New Jersey lawmakers actually reduced their 12-month waiting period to 6 months for children enrolled in employer-sponsored plans, and entirely eliminated the waiting period for families earning less than 200 percent of FPL with individual plans or COBRA coverage.
- In Missouri, diminished crowd-out concerns resulted in support for a bill to eliminate the six-month waiting period. However, although the bill passed the House of Representatives, it died in the Senate as policymakers were still uncertain about the potential for SCHIP to substitute for private coverage.
- In Mississippi, although there was initially strong gubernatorial support for the six-month waiting period, a bill passed in the 2000 legislative session eliminating the waiting period altogether. HCFA subsequently approved Mississippi's request to eliminate the waiting period.

In some states, pressures to increase enrollment, coupled with a lack of concern over crowd out, have influenced the development of outreach strategies. Despite initial apprehension that SCHIP would cause employers to drop or reduce contributions toward dependent coverage or influence their decision to provide dependent coverage in the future, some states and localities are now targeting small businesses as part of their outreach plan. For example, local outreach initiatives in New Jersey have targeted small businesses that don't provide dependent coverage, particularly retail merchants. Similarly, in Ohio, a local Cleveland outreach initiative is developing SCHIP materials to be included with paycheck stubs at businesses not likely to offer health insurance. New York's health plans, which are responsible for enrollment, have reported success in giving Child Health Plus presentations at business establishments that don't offer health insurance. Colorado's SCHIP outreach and enrollment vendor—Child Health Advocates—targets businesses not likely to provide dependent coverage, through staff training at the community level. In Missouri, a state partner agency to Medicaid that focuses on economic development efforts, is marketing SCHIP to business community members unlikely to offer dependent coverage. Together, these examples illustrate a trend toward diminishing concern over crowd out as well as an acknowledgement that employers not likely to offer health insurance to their employees (or dependents) are a natural target for ongoing outreach.

Conclusions and Policy Implications

In sum, 17 of the 18 states included in the Urban Institute's evaluation have implemented numerous and varied strategies to limit crowd out in response to the high degree of initial concern over its potential and federal requirements to address the issue in state SCHIP plans. These strategies include:

- Waiting periods
- Monitoring
- Application questions regarding children's insurance status
- Verifying insurance status against databases of private coverage
- Imposing cost sharing so as to model their programs after private insurance
- Providing premium assistance to subsidize employer-based coverage
- Imposing obligations on employers and/or insurers

With previous research from earlier Medicaid expansions indicating that crowd out may be as high as 23 percent, most states (12 of 18) elected to take a fairly aggressive approach to crowd out and implemented waiting periods ranging between two and six months. Other states, notably those with previous experience administering subsidized children's health insurance programs—Florida, New York, and Pennsylvania—did not view crowd out as a significant threat and implemented less aggressive policies, primarily monitoring, cost sharing, and asking about private health insurance on SCHIP applications.

Over time, states' concerns about crowd out appear to have diminished—with a large majority of key informants expressing little concern over the possibility that SCHIP would cause large numbers of families to drop employer-based coverage or large numbers of employers to reduce or eliminate contributions to health benefits. Indeed, these officials believe that such crowd out has not materialized, citing anecdotal and some preliminary quantitative evidence. Indeed, some states have even reduced or considered reducing or eliminating their waiting period policies for fear that waiting periods may be creating an unnecessary barrier to enrollment. Moreover, as fears of employer-based crowd out have lessened, some states and localities are explicitly targeting outreach to local chambers of commerce and employers who don't offer dependent coverage.

Crowd out also emerges as an important issue in the implementation of state programs to subsidize employer sponsored insurance (ESI). Federal concern that such programs may fuel crowd out have thus far outweighed states' beliefs that ESI subsidies can capitalize on private sector resources already supporting the provision of health insurance coverage and strengthen the foundation of employer-sponsored insurance. To date, only two states—Massachusetts and Wisconsin—have implemented such programs due to federal regulations that state informants criticized as overly rigid and burdensome. The new SCHIP regulations, released January 2001, removed the requirement for a 60 percent minimum contribution, as it takes a sub-

stantial employer contribution to make coverage subsidized through employer plans cost-effective. The new regulations are intended to provide more flexibility for states aiming to adopt premium assistance programs in SCHIP. At this writing, it is unclear whether these new regulations will result in greater experimentation with subsidizing ESI.

Overall, this study's findings provide an intriguing first look at crowd out under SCHIP—which early qualitative experiences in the states suggest is not occurring to a significant degree. Clearly, however, further quantitative analysis is needed to build more solid evidence of the magnitude of SCHIP-related crowd out. In the meantime, federal and state policies related to crowd out have implications for SCHIP's ability to reach uninsured children, and raise questions about whether SCHIP should also be addressing underinsured children.

As with many public policy issues, crowd out is ultimately about trade-offs. Although some degree of crowd out seems inevitable under a large expansion of public coverage, policymakers need to determine the greater priority—limiting the displacement of private health insurance coverage, or making significant strides in reducing uninsurance. A number of individuals interviewed for this study believe that it is still too early to modify federal or state policies relating to crowd out and that more needs to be learned about whether substitution occurs as coverage is extended to higher income families. Many others maintain that the disadvantages of crowd-out prevention mechanisms tip the scale in favor of less stringent approaches, noting SCHIP's horizontal inequity of treating children who are in the same economic circumstances differently. Child advocates believe that SCHIP's crowd-out policies are particularly unfair to low-income families that had valued insurance in the past, purchased it, and that may now find themselves struggling to make premium contributions for limited coverage. This issue becomes particularly striking for some families with children with special health care needs who may qualify for SCHIP based on income, but who are locked into costly and perhaps substandard private insurance plans.

The initial reasons for crowd out becoming such an important issue— the desire to safeguard the private market and concern over the efficiency of public funding—may be diminishing in light of a robust economy, large numbers of uninsured, and billions of dollars in unspent federal SCHIP funds. Even in the absence of conclusive data, it is possible that policymakers will have to grapple with implications of crowd-out policies and address proposals to allow waiting period exceptions for CSHCN. Policymakers may also have to consider proposals to allow SCHIP coverage to wrap-around less comprehensive private coverage—as Medicaid has wrapped around private coverage throughout its history. It is also likely that policymakers will be weighing the advantages and disadvantages of extending SCHIP to parents and considering whether a broader SCHIP mandate will further promote substitution. Although it is difficult to predict the direction that SCHIP will take, it is clear that issues surrounding crowd out will continue to shape the discussion, particularly as the program reaches higher income families.

Appendix A

Table 1A. *Policies Identified to Deter Crowd Out in 50 States and the District of Columbia.*

State	Application Questions[a]	Cost Sharing	Subsidizing Employer-Sponsored Coverage	Monitoring	Obligations Imposed on Employers or Insurers	Waiting Period < 6 Months	Waiting Period ≥ 6 Months	Verifying Insurance Status against Private Coverage Database	Pursue Insurance Availability of Absentee Parent
Alabama		X				X		X	
Alaska							X		
Arizona							X		
Arkansas									
California					X	X			
Colorado	X					X			
Connecticut							X		
Delaware							X		
District of Columbia				X					
Florida	X								
Georgia	X					X		X	
Hawaii				X		X			
Idaho									
Illinois			X			X			
Indiana	X					X			
Iowa							X		
Kansas				X			X		
Kentucky				X			X		
Louisiana	X					X			X
Maine								X	
Maryland	X				X		X	X	
Massachusetts			X						
Michigan	X						X	X	
Minnesota									
Mississippi								X	
Missouri							X		
Montana						X			
Nebraska				X					
Nevada							X		
New Hampshire							X		
New Jersey							X		
New Mexico							X		
New York	X	X		X					
North Carolina	X	X		X		X			
North Dakota	X						X		
Ohio*				X					
Oklahoma				X					
Oregon							X		
Pennsylvania	X			X					
Rhode Island						X			
South Carolina				X					
South Dakota	X								
Tennessee									
Texas						X			
Utah						X		X	
Vermont						X			
Virginia	X								
Washington	X	X		X		X			
West Virginia							X		
Wisconsin				X		X		X	
Wyoming				X		X			
Total	14	4	2	14	2	17	17	8	1

Shaded area = Not applicable to this Medicaid expansion.
*Although federal crowd-out requirements are not applicable to Ohio's Medicaid SCHIP expansion, the state has decided to monitor its occurrence.
a. The state plan specifically mentioned applicant question(s) as a crowd-out deterrence.

Appendix B

Key SCHIP and Medicaid Contacts in the Study States

Alabama — Gayle Sandlin and Mike Murphy

California — Sandra Shewry and Doug Porter

Colorado — Barbara Ladon and Dean Woodward

Connecticut — David Parella

Florida — Rose Naff and Bob Sharpe

Massachusetts — Mark Reynolds and Pat Canney

Michigan — Denise Holmes and Bob Stampfly

Minnesota — Mary Kennedy

Mississippi — Theresa Hanna and Maria Morris

Missouri — Greg Vadner

New Jersey — Michelle Walsky

New York — Judy Arnold

North Carolina — June Milby

Ohio — Sukie Barnum

Pennsylvania — Patricia Stromberg

Texas — Jason Cooke

Washington — Steven Wish and David Hanig

Wisconsin — Peggy Bartels

Notes

1. With regard to Medicaid, the BBA contained three provisions aimed at preventing SCHIP/Medicaid substitution: States were required to coordinate SCHIP with other public and private programs, including Medicaid; "Maintenance of effort" provisions required that states not adopt more restrictive resource and income methodologies to determine a child's eligibility for Medicaid than those in place as of March 31, 1997 or June 1, 1997; and states were required to screen any child applying for SCHIP to first determine if he or she might be eligible for Medicaid—the so-called "screen and enroll" provision. So-called "Medicaid crowd out," however, is beyond the scope of this paper and is not addressed here.

2. For a more in-depth review of the crowd-out literature see Dubay, Lisa C. 2000. Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says. In: *Options for Expanding Health Insurance Coverage: What Difference Do Different Approaches Make?* Washington, D.C.: Henry J. Kaiser Family Foundation Project on Incremental Health Reform. Background Papers.

3. These estimates include individuals who dropped their private coverage when other members of their family became eligible, but who did not enroll in the program because they were not eligible. Cutler and Gruber's (a) work estimates that only 20 percent of those made eligible by the expansions dropped their private coverage solely to enroll in the program.

4. The final rules for SCHIP were published in the *Federal Register* in January 2001. Discussion of these new rules is beyond the scope of this paper as they are not relevant to the information we collected during our 1999–2000 site visits.

5. Despite these proposed regulations, HCFA is not requiring states to apply eligibility-related substitution provisions, such as periods of uninsurance, to the Medicaid eligibility group for "optionally targeted low income children" that was added to section 1902(a)(10)(A)(ii)(XIV) because of HCFA's belief that such conditions are inconsistent with the entitlement nature of Medicaid. HCFA recognizes that states expanding Medicaid to higher income levels may be concerned about the potential for crowd out, and will review section 1115 demonstration requests for substitution provisions. States with approved Medicaid demonstration projects under section 1115(a)(2) that currently apply substitution provisions may continue to do so.

6. All children under 150 percent of FPL are exempt from this requirement, and children in families earning more than 150 percent are exempt if a parent becomes unemployed and loses access to employer-sponsored coverage.

7. In the 2000 legislative session, Mississippi passed a bill to eliminate its waiting period.

8. Nationally, Maryland is the only other state to adopt this strategy to limit crowd out. Specifically, *Maryland's Children and Families First Health Care Act of 1998* prevents an agent, broker, or insurer with an economic interest in the arrangement from referring an individual employee or employee's dependent to SCHIP.

9. New York's crowd-out estimate is based on application questions regarding whether children who had insurance in the last six months dropped private coverage for the following reasons: the employer discontinued offering health insurance or is no longer contributing towards the premium, Child Health Plus is a less expensive alternative, or Child Health Plus insurance benefits are better.

10. North Carolina's state evaluation to HCFA notes that the data from this sample did not allow for control of multiple Healthy Children enrollees in one family; it is assumed that each child's coverage decision is made independently.

11. Florida KidCare consists of Medicaid, MediKids (a Medicaid "look-alike" program for children ages 0–5 years in families earning between 133–200 percent of FPL), Healthy Kids (a non-Medicaid program for children ages 5 to 6 in families earning between 133–200 percent FPL and children ages 6 to 19 in families earning between 100 and 200 percent of FPL), and the Children's Medical Services (CMS) Network (a program for children ages 0 to 19 who have special health care needs, in families earning below 200 percent of FPL.)

12. The percentages break down as follows: 9 percent in MediKids, 10.27 percent in CMS, 11.03 percent in Healthy Kids, and 17 percent in Medicaid.

13. Much higher percentages of children enrolled in MediKids and Healthy Kids had access to employer-based coverage (21 percent and 24 percent), than Medicaid and CMS (5 percent and 3 percent).

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