

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: AN ADMINISTRATIVE EXPERIMENT IN FEDERALISM

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The authors describe Title XXI of the Social Security Act as a funding scheme for children's health insurance that represents an "experiment in federalism," a new cooperative model under which state and federal governments interact on an equal basis. Under this scheme, the federal government provides funding and the states remain free to establish administrative details. The authors compare the advantages and disadvantages of this new approach with older approaches, such as Medicare and Medicaid. The authors argue that Title XXI has proven successful in allowing state governments without fiscal or administrative capacity the flexibility to aid children in need of medical care. Finally, the authors urge continued study of Title XXI to determine the extent to which cooperative federalism can serve as a model for national health care.

As part of the Balanced Budget Act of 1997 (B.B.A.), Congress enacted Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP). SCHIP is a federally funded block grant program that gives the states more policy-making and administrative authority than ever before in a joint state-federal health care program. Congress created this new program to "significantly increase the opportunities for the states to provide meaningful health benefit coverage for targeted low income children."¹ The federal government allocated forty

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1. Ctrs. for Medicare & Medicaid Servs., Title XXI State Child Health Plan Approval Process: A Guide for States and Public/Private Partners, at <http://www.cms.gov/schip/chguide.asp> (last modified Nov. 20, 2003).

billion dollars in federal block grant funds, over ten years, to support state efforts to provide health insurance to children in low-income households.² This program represents an expansion in health insurance for children who are not already eligible for Medicaid.³ This program does not represent an entitlement to individuals, but is rather a grant to the states. The legislation specifies that the block grants are designed to provide “child health assistance to uninsured children in low-income families in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.”⁴

The Title XXI block grant program represents a new and different kind of relationship in health care policy-making and implementation between the federal and state levels of government. This program may be viewed as an administrative experiment⁵ in federalism as it relates to providing health insurance to a needy, target population. It should be noted, however, that there is no evidence that the legislation’s authors intended it to be an experiment per se. SCHIP represents an ideal administrative experiment in federalism on two levels. First, it provides the states the choice between three administrative structures for providing health insurance to low-income, needy children: Medicaid expansion, a new “stand-alone” or separate program, and a combination of Medicaid expansion and the stand-alone option.⁶ The experiment also allows for variation in eligibility standards, the design of benefits packages, and the state financial contribution to the program. Secondly, SCHIP creates a new, cooperative, and more equal relationship between federal and state governments.⁷ The federal government provides the basic policy framework and the primary source of financing and allows the states to make the administrative decisions. In addition, the new and powerful role assigned to the states has been expanded and/or reinforced during the course of program implementation over the past five years. The federal-state relationship embodied in this new experiment has distinct opportunities and risks that can be informative in formulating an effective model for federalism in the health care arena.

Part I of this article lays out how federalism, as it relates to health care, evolved to the point where this experiment was possible. Part II

2. Lisa Dubay et al., *Five Things Everyone Should Know About SCHIP*, NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES (Urban Inst., Wash., D.C.), Oct. 2002, at 1, <http://www.urban.org/url.cfm?ID=310570> (last visited Feb. 6, 2004).

3. See Thomas M. Selden et al., *Waiting in the Wings: Eligibility and Enrollment in the State Children’s Health Insurance Program*, 18 HEALTH AFF. 126, 126 (1999), available at <http://content.healthaffairs.org/cgi/reprint/18/2/126.pdf> (last visited Feb. 6, 2004).

4. State Children’s Health Insurance Program, 42 U.S.C. § 1397aa(a) (2002).

5. See generally Donald T. Campell, *Administrative Experimentation, Institutional Records, and Nonreactive Measures*, in ORGANIZATIONAL EXPERIMENTS: LABORATORY AND FIELD RESEARCH 169 (William M. Evan ed., 1971) (advocating “administrative experimentation”).

6. See Dubay et al., *supra* note 2, at 1.

7. See Frank Ullman et al., *The State Children’s Health Insurance Program: A Look at the Numbers*, ASSESSING THE NEW FEDERALISM (Urban Inst., Wash., D.C.), Mar. 1998, at 3, available at <http://www.urban.org/urgl.cfm?ID=307470> (last visited Feb. 6, 2004).

describes the SCHIP program as an administrative experiment. Part III analyzes the advantages and disadvantages of the basic choice for a state in implementing the administrative experiment (i.e., the stand-alone program, the Medicaid expansion option, and the "combination" option). Part IV describes the roles of the federal and state governments in the area of healthcare prior to the enactment of Title XXI. Part V addresses the issues states have faced in implementing SCHIP up to this point. It also shows how the states have gained more administrative discretion and flexibility over time through amendments to SCHIP and through their increased use of Medicaid 1115 waivers. The article concludes with part VI, which discusses the future of federalism in health care and the extent to which Title XXI can serve as a model for other programs and other policy areas.

I. THE EVOLUTION OF HEALTH CARE AND FEDERALISM PRIOR TO THE NEW ADMINISTRATIVE EXPERIMENT

Since World War II, federalism in health care has been dominated by a traditional senior-junior partner model, where the federal government sets policy, mandates state action, and provides the primary funding for program operations; the states (the junior partners) administer/implement these policies while providing some of the required funding.⁸ Medicaid is the primary example of this type of "partnership." In other cases (e.g., Medicare, ERISA), the federal government sets and administers the policy or develops and enforces a regulatory framework in which state governments are not financially, administratively, or politically involved.⁹

Unlike these other models of federalism, SCHIP represents a new form of cooperative federalism where the federal government provides the primary financing, formulates the basic framework for the program, and sets a minimum set of performance standards (a floor) that the states must meet. State governments, in turn, have the flexibility and discretion to tailor a program that best meets their needs and to respond to the target group (i.e., uninsured children). State government is a full partner in this intergovernmental relationship and possesses policy-making, not just administrative or implementation, authority.

This new form of cooperation is distinguished from traditional "cooperative federalism" (the junior-senior partnership model) in which the federal government employs fiscal tools in the form of state grants-in-aid and block grants to help ensure that federal policies and goals can be im-

8. Robert F. Rich & William D. White, *Health Policy, Federalism, and the American States*, in *HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES* 3, 11 (Robert F. Rich & William D. White eds., 1996).

9. *Id.*

plemented by the states.¹⁰ In the traditional era of cooperative federalism, which was at its height between 1954 and 1978,¹¹ state governments applied for financing from the federal government on a “voluntary” basis and accepted the “strings” attached to these grants because of the superior fiscal and administrative position of the federal government. States were willing partners because of their inability to finance the programs and services citizens demanded.¹²

Within the health care arena, Medicaid, enacted in 1965, represents the prime example of the old, traditional model of cooperation. Congress envisioned this program as a federal-state partnership providing medical services to low-income individuals who meet the eligibility criteria. The program provided a core minimum set of services all states must provide and a second set of services states had the option to provide.¹³ Medicaid represents an “entitlement” to individuals who qualify on the basis of specific eligibility criteria. The national government finances between 50% and 80% of program operations and each state provides between 20% and 50%, depending upon its size and wealth.¹⁴

In the transitional period between the traditional junior-senior federalism and this new model of cooperation with a more equal balance of power, Congress did, intentionally, experiment with giving state governments more power. These experiments took the form of Medicaid 1115 waivers.¹⁵ Medicaid 1115 waivers allowed states to design their own approaches to providing health care to their impoverished citizens, without the restrictions of the federal Medicaid requirements. These waivers acknowledged that the best way to provide publicly funded health coverage to target populations was not known, and allowed states to experiment with different forms of demonstration projects. As we will address later in this article,¹⁶ 1115 waivers are still being used with SCHIP programs to further experiment with and change publicly funded health coverage programs.

In the transformed cooperative federalism of the late 1990s and early twenty-first century, federal and state levels of government are equal and interdependent partners.¹⁷ Integral to this model, from the

10. See John Kincaid, *From Cooperative to Coercive Federalism*, 509 ANNALS AM. ACAD. POL. & SOC. SCI. 139 (1990).

11. *Id.* at 139.

12. See MICHAEL D. REAGAN & JOHN G. SANZONE, *THE NEW FEDERALISM* 35–45 (2d ed. 1981) (describing the financial implications of federalism).

13. Dayna Bowen Matthew, “*The New Federalism*” Approach to Medicaid: Empirical Evidence That Ceding Inherently Federal Authority to the States Harms Public Health, 90 KY. L.J. 973, 980 (2001–2002).

14. *Id.* at 979.

15. *Id.* at 982.

16. See *infra* notes 89–96 and accompanying text.

17. See Robert F. Rich & William D. White, *Transformed Federalism and the American Health Care System*, Seminar Presentation to the University of Illinois College of Law (Mar. 13, 2003), and to the George Mason University School of Public Affairs (Apr. 23, 2003) (manuscript at 10–11, on file with University of Illinois Law Review).

state perspective, is choice, discretion, flexibility, and variation. State government takes the lead in formulating what the operating policy and program will be; it is a full partner in setting accountability and performance standards, and the federal government is dictating less than it has in the past with respect to what the policy or program will be. The federal government continues, however, to provide the primary source of funding.

This new approach to cooperative federalism suggests that the federal and state levels of government both bring important resources and capacity to intergovernmental programs. They may have different areas of strength, but the two levels of government agree to work together on a given problem or issue. There is recognition and respect for the statutory authority and resources that each level of government can bring to a mutual problem-solving process. The federal and state levels of government each have distinct competencies, and within a given policy framework, each level has its responsibilities and duties.

The basis for this new cooperation is not preemption or mandates, nor is it the product of superior economic or political resources. Incentives or negotiated programmatic rules and procedures serve as the basis for effective interactions. In this model, the federal and state governments share legal, economic, and political responsibility for a particular program. This does not necessarily imply equal sharing across all programs and policy initiatives, but it does mean that a program cannot be cooperative unless both levels of government are actually contributing to the financing, administration, and policy direction of the program. SCHIP is a prime example of this new form of cooperative federalism.

II. SCHIP AS AN ADMINISTRATIVE EXPERIMENT

Congress adopted SCHIP as part of the B.B.A.¹⁸ Incorporating this new program into the same piece of legislation created to limit federal spending and balance the federal budget, at a time when the public was pressuring the federal government to substantially reduce the deficit, meant that it had to respond to a variety of issues and tensions debated in Congress. The legislation provides assistance to states, not children, and sets lower state financial obligation levels than Medicaid.¹⁹ While children's access to adequate health care concerned governors, uncontrolled spending also posed a grave concern and governors strongly opposed any new entitlements where spending could not be tightly controlled.²⁰ In contrast to Medicare and Medicaid, which function as legal

18. SCHIP was further refined through the Balanced Budget Refinement Act of 1999. Pub. L. No. 106-113, 113 Stat. 1501.

19. 42 U.S.C. § 1397ee (2000).

20. See Sara Rosenbaum et al., *The Children's Hour: The State Children's Health Insurance Program*, 17 HEALTH AFF. 75, 77 (1998).

entitlements, federal spending for Title XXI is capped and can, therefore, be controlled.

Policymakers, experts, and advocates were also concerned that states might use new funds to supplant Medicaid expenditures and previous state initiatives designed to serve low-income children.²¹ The new law, therefore, precludes coverage of Medicaid-eligible children and includes “maintenance of effort” requirements.²² In other words, states cannot replace already existing programs with SCHIP; they have to use SCHIP to cover only the children that are not eligible for the existing programs.²³ The new program a state develops through SCHIP should ensure improvement, rather than simple maintenance of the status quo. Critics of SCHIP focused on the flexible administrative structure and states’ discretion in determining how to spend program funds, including decisions on the benefit packages to be provided to children. “The program’s lack of strict federal standards for qualifying benefit packages creates controversy over whether the federal funds will actually reduce the number of uninsured children. Concern also exists regarding whether states will offer plans that contain important benefits that may be integral to children’s health”²⁴

SCHIP “enables states to insure children from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance” themselves or through an employer.²⁵ States can implement SCHIP by choosing one of three options: creating their own separate programs (the stand-alone option), expansion of their existing Medicaid programs, or a combination of Medicaid and creation of a separate program.²⁶ The same federal regulations that apply to Medicaid programs do not apply to stand-alone programs.²⁷ States, therefore, have more flexibility in comparison to Medicaid in terms of tailoring these public health insurance programs to meet their needs. For example, stand-alone programs can include cost-sharing requirements, which are not permitted under Medicaid.

Each state with a plan approved by the U.S. Secretary of Health and Human Services receives enhanced (beyond the level previously allocated through Medicaid) federal matching funds for its SCHIP expen-

21. *Id.*

22. *Id.*; see also 42 U.S.C. § 1397ee(d).

23. See Rosenbaum et al., *supra* note 20, at 77.

24. Allison Cendali, *Implementation of the Children’s Health Insurance Program: HHS, States and Lessons for National Health Reform*, 50 ADMIN. L. REV. 659, 667 (1998); see also Robert Pear, *\$24 Billion Would Be Set Aside for Medical Care for Children*, N.Y. TIMES, July 19, 1997, at A17. There are, however, some strict federal guidelines requiring all programs to provide preventative care at no cost to families of eligible children. See, e.g., 42 U.S.C.A. § 1397cc (West 2003).

25. See CTRS. FOR MEDICARE & MEDICAID SERVS., THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM: PRELIMINARY HIGHLIGHTS OF IMPLEMENTATION AND EXPANSION (2000), available at <http://www.cms.hhs.gov/schip/wh0700.pdf> (last visited Feb. 6, 2004).

26. *Id.*

27. See Ullman et al., *supra* note 7.

ditures up to a fixed state allotment.²⁸ The formula determining a state's allotment is based primarily on each state's share of the total number of low-income children—specified as those who reside in families with incomes below 200% of the federal poverty line (FPL)—in the United States, as well as each state's share of the total number of uninsured children in the country.²⁹ SCHIP also requires that states provide some matching funds to receive the federal dollars. The state's "match" is equal to 70% of its Medicaid rate.³⁰ For example, a state, such as Illinois, that currently pays 50% of its Medicaid costs would be responsible for 35% of the new program's costs.³¹ The minimum state matching rate for SCHIP is 15%.³² The federal government pays between 65% and 85% of the cost of covering a child through SCHIP.³³ This is known as the "enhanced" federal contribution. Policymakers designed the enhanced federal contribution to encourage states to cover the health insurance needs of low-income children.³⁴

The legislation also anticipated that it would take the states some time to fully implement this new program.³⁵ Consequently, a state can use its SCHIP allotment for a given year for a period of up to three years.³⁶ Thus, for example, a state can use its 1999 SCHIP allotment during fiscal years 1999, 2000, and 2001. If the funds have not been used within this three-year period, then the Secretary of Health and Human Services must reallocate the unused money to states that have fully spent their allotments for a given fiscal year.³⁷ This provision was designed to be responsive to variations in funding needs by the states.

As already indicated, Congress authorized and funded this program for ten years. In the first year of program implementation, which was fiscal year 1998, states were allocated \$4.3 billion in federal SCHIP funds.³⁸ Congress provided that the funding was to remain level at more than \$4 billion a year through fiscal year 2001. Then, in fiscal year 2002, the legislation provided that federal funding was scheduled to decrease by twenty-six percent to \$3.1 billion. The funding level is to remain at slightly more than \$3 billion through fiscal year 2004, after which it is scheduled to return to more than \$4 billion.³⁹ The legislative history does

28. *Id.* at 3.

29. *Id.* at 1.

30. *Id.* at 3.

31. *Id.* at 3, 7 tbl.1.

32. *Id.* at 3.

33. *See id.* at 8.

34. *Id.*

35. *Id.* at 3.

36. *Id.*

37. *See* JOCELYN GUYER, CTR. ON BUDGET & POLICY PRIORITIES, SENATE APPROPRIATIONS COMMITTEE PROPOSAL POSES THREAT TO SCHIP (2000), <http://www.cbpp.org/6-2-00health.htm> (last revised June 22, 2000).

38. *Id.*

39. *Id.*

not indicate a particular reason why Congress adopted this funding pattern.

States have flexibility and discretion in setting eligibility and beneficiary cost-sharing requirements, designing enrollment strategies and benefits packages, and measuring program performance. Enrollment eligibility standards are related to geographic areas served, age, income and assets, residency, disability status, access to or coverage under other health plans, and duration of eligibility.⁴⁰ At least twenty-five different states require cost-sharing in the form of premiums and copayments.⁴¹ States may also require a three to six month waiting period of “uninsurance” before a client is eligible for SCHIP.⁴² Although states have broad flexibility in devising their own children’s health insurance programs, they must meet one of several “benchmarks” as a “floor,” or minimum set of benefits for the program: a) the standard Blue Cross and Blue Shield preferred provider option available to federal employees; b) the health insurance benefits package available to state employees; or, c) the benefits package available through the health maintenance organization (HMO) with the highest commercial enrollment (excluding Medicaid enrollment) in the state.⁴³ A state may also provide “benchmark equivalent” coverage through a plan that has an “aggregate actuarial value equal to or greater than the actuarial value of the benchmark plan.”⁴⁴ Unlike Medicare and Medicaid, Title XXI has no consumer protections written into federal legislation. While the B.B.A. amended Medicare and Medicaid to contain safeguards against misleading or fraudulent enrollment, protections for enrollees, and other individual safety procedures, states are entirely on their own to create safeguards in their Title XXI programs.⁴⁵ No state has opted to make SCHIP coverage an enti-

40. See Ullman et al., *supra* note 7, at 3.

41. See MARY JO O'BRIEN ET AL., THE COMMONWEALTH FUND, STATE EXPERIENCES WITH COST-SHARING MECHANISMS IN CHILDREN'S HEALTH INSURANCE EXPANSIONS v (2000), available at http://www.cmf.org/programs/insurance/lewin_cost_fr_385.pdf (last visited Feb. 6, 2004). For those children in families with incomes below 150% of the FPL, premiums may not exceed those allowed by Medicaid for medically needy individuals. Copayments and other cost sharing must be in accordance with similar Medicaid provisions. For those children in families living above 150% of the FPL, cost sharing may be implemented on a sliding scale as it relates to income, so long as it does not exceed 5% of a family's annual income. *Id.* at 2 (providing overview).

42. See Selden et al., *supra* note 3, at 126.

43. Social Security Act § 2103, 42 U.S.C. § 1397cc (2000). Florida, New York, and Pennsylvania are exempt from these benchmark requirements and are permitted to continue offering their pre-existing (i.e., pre-SCHIP) state-designed health insurance plan. Social Security Act § 2103(d)(1), 42 U.S.C. § 1397cc(d)(1).

44. Social Security Act § 2103(a)(2), 42 U.S.C. § 1397cc(a)(2). See also Ullman et al., *supra* note 7, at 4. The benchmark-equivalent plan must also have certain basic services and substantial cultural value for additional services included in the benchmark package. *Id.*

45. See ALINA SALGIANICOFF ET AL., THE KAISER COMM'N ON THE FUTURE OF MEDICAID, CHILD HEALTH FACTS: NATIONAL AND STATE PROFILES OF COVERAGE 5-7 (1998), available at <http://www.kff.org/medicaid/loader.ctm?url=/commonsspot/security/getfile.cfm&PageID=14899> (last visited Feb. 6, 2004).

tlement to eligible children under state regulations.⁴⁶ By not explicitly requiring that these safeguards exist in Title XXI programs, the federal government demonstrated the unique hands-off role it assumed in the design of the SCHIP plans.

There are, however, some federal requirements associated with this program. For example, Congress authorized states to spend only ten percent of their total SCHIP allotments for noncoverage activities, including administrative costs associated with the operation of the program and outreach activities.⁴⁷ In addition, the federal government will not provide Title XXI funds to states that lower their Medicaid child eligibility standards below their June 1, 1997 levels.⁴⁸ This means that states cannot create stand-alone programs with eligibility levels lower than those allowed under Medicaid (the maintenance of effort requirement). States may not create programs that favor higher income children over lower income children and they may not use Title XXI as a substitute for Medicaid.⁴⁹ The new money can only be spent on low-income, uninsured children who are not eligible for Medicaid.⁵⁰

Under Title XXI, the Secretary of the U.S. Department of Health and Human Services is granted "broad authority to issue rules and regulations, to require data reporting, and generally to assure that the standards and requirements established by the new law assure that comprehensive and affordable coverage is provided to uninsured children."⁵¹ Congress seemed to be most concerned with exerting control as it relates to preserving the entitlement aspect of Medicaid and preventing states from using Title XXI as a means to cut back on health care benefits to children. There are also yearly audits of the program and specific reporting requirements (modified by the Medicaid, Medicare, and SCHIP Bal-

46. Sara Rosenbaum & Barbara Smith, *Policy Brief #1: State SCHIP Design and the Right to Coverage*, SCHIP POL'Y STUD. PROJECT (George Washington Ctr. for Health Servs. Research & Policy, Wash., D.C.), Mar. 2001, at 7, available at http://www.gwhealthpolicy.org/downloads/SCHIP_brief1.pdf (last visited Feb. 7, 2004).

47. 42 U.S.C.A. § 1397ee(c)(2)(A) (West 2003); see also JOCELYN GUYER, CTR. ON BUDGET & POLICY PRIORITIES, MAXIMIZING CHILD HEALTH COVERAGE DEPENDS ON ESTABLISHING AN EFFECTIVE SYSTEM FOR REALLOCATING UNSPENT SCHIP FUNDS (2000), available at <http://www.cbpp.org/10-18-00health.htm> (last visited Feb. 7, 2004). However, there has been some financial relief for those states who have been less successful in enrollment to use an additional ten percent of their retained funds from previous years on outreach and administrative activities due to changes made by the Medicare, Medicaid, and SCHIP in the Balanced Budget Refinement Act of 1999. 42 U.S.C.A. § 1397dd(g)(2)(C).

48. 42 U.S.C.A. § 1397ee(d)(1).

49. "Crowding out" of private insurers, who are providing health insurance to children through employers, also concerned the critics of Title XXI. See *infra* notes 127-36 and accompanying text.

50. See Peter P. Budetti, Editorial, *Health Insurance for Children—A Model for Incremental Health Reform?*, 338 NEW ENG. J. MED. 541 (1998).

51. CINDY MANN, CTR. ON BUDGET & POLICY PRIORITIES, WHY NOT MEDICAID? USING CHILD HEALTH FUNDS TO EXPAND COVERAGE THROUGH THE MEDICAID PROGRAM (1997), <http://www.cbpp.org/1119mcaid.htm> (last visited Feb. 7, 2004).

anced Budget Reconciliation Act of 1999).⁵² These provide for federal oversight and accountability for these programs.

III. THE STATES' BASIC CHOICE IN THE ADMINISTRATIVE EXPERIMENT

From the states' perspective, the most basic choice in designing this cooperative program with the federal government is whether to create a stand-alone program, a Medicaid expansion program, or some combination of both. States experience many advantages in choosing to create a separate non-Medicaid, stand-alone children's health insurance program. The most important of these advantages may be in the mere fact that the program would not be operated as an entitlement, such as the Medicaid program, where income transfers are made to individuals and the states' most important function is to administer the program. Under a block grant program, such as SCHIP, a state maximizes its flexibility, especially as compared to an entitlement program. The state has the authority to cap enrollment numbers, as well as control how much it will spend on the program. States can create waiting lists for enrollment in the program, limit coverage to children residing in certain parts of a state and impose a time limit on the coverage provided.⁵³ The stand-alone programs also allow for cost sharing through beneficiary copayments or deductibles. Furthermore, with Title XXI funds, states can create their own insurance programs or purchase insurance for children from private insurers. In fact, the federal government has no authority over which agency in the state administers the program at all; states may contract with private firms or foundations to administer their SCHIP programs. Finally, states have full discretion in deciding which providers may participate in the program, what delivery system will be used to provide health care benefits, and what procedures to use for monitoring quality of care.⁵⁴

Although it may seem that every state would naturally strive to create a stand-alone Title XXI program, there are a number of issues for states to consider that may lead states to choose the Medicaid expansion option, at least in the beginning. For example, every state already has an established Medicaid infrastructure,⁵⁵ through which an expanded SCHIP program could be administered. Creating a new stand-alone program may require the design and creation of a new administrative structure.

52. 42 U.S.C.A. § 1397hh.

53. *See* MANN, *supra* note 51. States may also prefer a stand-alone program because of the stigma associated with a "welfare or public aid program." In the past, Medicaid-eligible individuals became enrolled at the same time they were enrolled in Aid to Families with Dependent Children (AFDC). The welfare reform legislation of 1996, however, de-coupled this process, and individuals have been enrolling in Medicaid independent of cash assistance. Title XXI can further unlink health and welfare programs because, under the SCHIP program, states can expand benefits to children from families with higher incomes. In addition, because states can impose cost-sharing requirements, stand-alone programs may look more like private insurance. *See id.*

54. *See id.*

55. *See id.*

For this reason, it is faster and easier to create SCHIP Medicaid expansion program to obtain federal funds during the first year and add a stand-alone program later.

Social workers and child advocates have underscored another advantage for Medicaid expansion: it generally offers more comprehensive benefits than benchmark plans that most states would pursue under the stand-alone option.⁵⁶ Expansion will most likely give a state leverage when negotiating with providers, due to larger market share.⁵⁷ States may also find Medicaid's uniform eligibility process attractive.⁵⁸ Additionally, the Medicaid expansion option may provide more financial security to state government, unless Medicaid were to lose its entitlement. For states, this becomes a significant consideration in light of the funding plan for Title XXI, which could cause hardships to states with stand-alone programs due to the cap on federal funds for SCHIP.

In light of the increasing expenditures by states on Medicaid and the fact that Medicaid alone accounts for one-fifth of all state expenditures,⁵⁹ some states may find the combination option particularly attractive. With this third option, a state can take advantage of the Medicaid infrastructure, yet still obtain the benefits associated with the stand-alone option.

Clearly, all of these options present advantages and disadvantages to states. Given the states' long desire to have greater control and flexibility in running their Medicaid programs, it seems reasonable that a state might be enthusiastic about gaining the flexibility Title XXI offers. While there may be some administrative and financial advantages associated with choosing Medicaid expansion, these considerations may be offset by the greater financial control states enjoy under a stand-alone program. In the same vein, Medicaid expansion offers basic security to states with a strong commitment to maintaining the entitlement aspect of their health insurance policies for low-income individuals.

The implications of the choices and options for the states cannot be fully understood without considering the role of the states in expanding health care for children before the Title XXI block grant. SCHIP is not the first occasion states have had to address children's health care. The extent to which states have developed initiatives to provide health insur-

56. See Sharon M. Keigher, *The Medicaid Sweater, Children's Health, and the Tiny Hole*, 22 HEALTH & SOC. WORK 306, 306-11 (1997).

57. See MANN, *supra* note 51.

58. See, e.g., ANNE K. GAUTHIER & STEPHEN P. SCHRODEL, EXPANDING CHILDREN'S COVERAGE: LESSONS FROM STATE INITIATIVES IN HEALTH CARE REFORM 7 (1997) ("One advantage of Medicaid expansions is that there is an existing administrative apparatus, facilitating implementation.").

59. NASBO Analysis: *Medicaid to Stress State Budgets Severely into Fiscal 2003* (Nat'l Ass'n of State Budget Officers, Wash., D.C.), Mar. 15, 2002, at 1, available at <http://www.nasbo.org/Publications/PDFs/medicaid2003.pdf> (last visited Feb. 7, 2004).

ance for their uninsured children in the past has important implications for their overall reception to the federal block grant legislation.

IV. THE ROLE OF THE FEDERAL AND STATE LEVELS OF GOVERNMENT PRE-SCHIP

Congress enacted Title XXI in the political and economic context of a resurgence in state government power and influence generally and in the area of health care in particular.⁶⁰ In the mid nineties, State governments enjoyed significantly increased revenue and professional staff, demonstrating fiscal strength. States' increased political influence is represented by the adoption of the Unfunded Mandate Act of 1995 and the granting of federal "waivers" from federal regulations in the areas of education and health.⁶¹

The B.B.A.,⁶² which created SCHIP, contains provisions that "represent the most significant set of structural changes in Medicaid since 1981 [and] greatly expand the substantial discretion that states already enjoyed in administering their Medicaid programs."⁶³ Although B.B.A. made many Medicaid changes that had been advocated for years, three of these changes represent the most significant increases in state autonomy over Medicaid. These changes include the states' expanded authority to enroll Medicaid beneficiaries in managed care organizations (MCOs), the repeal of the Boren Amendment, and allowing states to use presumptive eligibility to enroll children in Medicaid.⁶⁴ States particularly disliked the Boren Amendment because it gave the federal government jurisdiction over provider reimbursement rates for states, thereby determining how high a state's Medicaid bill might be.⁶⁵ As a result of this repeal, states can negotiate reimbursement rates for nursing homes and other health care providers, rather than being federally mandated to reimburse at specific levels. The National Governors Association (NGA) was a particularly strong advocate for repeal of the Boren

60. See William T. Gormley, Jr., *An Evolutionary Approach to Federalism in the U.S.*, remarks delivered at the Annual Meeting of the American Political Science Association (Aug. 30 to Sept. 2, 2001) (on file with the University of Illinois Law Review); Richard C. Kearney & Ann O.M. Bowman, *Resurgence Redux: An Assessment of the States*, remarks delivered at Annual Meeting of the American Political Science Ass'n (Aug. 30 to Sept. 2, 2001) (on file with the University of Illinois Law Review); see also Robert F. Rich & William D. White, *supra* note 17.

61. See Gormley, *supra* note 60, at 5.

62. See Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251.

63. See ANDY SCHNEIDER, *CTR. ON BUDGET & POLICY PRIORITIES, OVERVIEW OF MEDICAID PROVISIONS IN THE BALANCED BUDGET ACT OF 1997*, P.L. 105-33 (1997), available at <http://www.cbpp.org/908mcaid.htm> (last revised Sept. 8, 1997).

64. This provision allows states the flexibility to enroll clients in Medicaid that it feels meet the eligibility standards before a formal determination of eligibility is made. This is very attractive to state government because it can result in an increase in federal Medicaid spending. Under B.B.A., determinations of presumptive eligibility can be made by agencies designated by the state, such as children's hospitals, Federally Qualified Health Centers (FQHCs), Head Start programs, and other child care agencies. Before B.B.A., states only had this option with respect to pregnant women. *Id.*

65. *Id.*

Amendment because without it states could negotiate provider reimbursement levels that more accurately reflect market pressures.⁶⁶

The summer of 1997 was not the first time these proposed changes in Medicaid had been debated in Congress. The 1995 Republican proposals to restructure Medicaid into a block grant contained many of them, including the repeal of the Boren Amendment.⁶⁷ Their adoption in 1997 reflects Congress's increased willingness to satisfy the strong state desire for increased flexibility and discretion.

Before Congress enacted Title XXI, the federal government required that states provide coverage to indigent children through Medicaid. The federal government mandated that the states provide coverage to children ages zero through five in families with incomes up to 133% of the FPL.⁶⁸ Federal legislation further required states to cover children between the ages of six and thirteen in families with incomes up to 100% of the FPL.⁶⁹ Each year, states would be required to phase in another cohort of children one year older, until eventually all children under nineteen living below the FPL could be covered by Medicaid.⁷⁰

Before Congress enacted SCHIP in 1997, states already had substantial flexibility to expand health insurance to children from low-income families through waiver provisions, options that existed in the Medicaid statute. Through non-SCHIP stand-alone programs, forty-one states had expanded Medicaid-eligibility levels to increase coverage for more children and pregnant women.⁷¹ Of this group, eight states used federal waivers to increase coverage and eligibility for children.⁷²

66. CTR. ON BUDGET & POLICY PRIORITIES, MEDICAID AND CHILD HEALTH PROVISIONS OF THE BIPARTISAN BUDGET AGREEMENT (1997), <http://www.cbpp.org/mcaidbud.htm> (last visited Feb. 7, 2004).

67. See generally ARLEEN LEIBOWITZ & HELEN DUPLESSIS, RESTRUCTURING THE MEDICAID PROGRAM, <http://www.rand.org/publications/CF/CF123/leibowitz> (last visited Feb. 7, 2004).

68. MARGO ROSENBACH ET AL., MATHEMATICA POLICY RESEARCH, INC., IMPLEMENTATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: MOMENTUM IS INCREASING AFTER A MODEST START 14 n.3 (2001), available at <http://www.mathematica-mpr.com/PDFs/schip1.pdf> (last visited Feb. 7, 2004).

69. *Id.*

70. Press Release, Children's Defense Fund, All Children Living Below the Poverty Line Are Finally Eligible for Health Coverage Through Medicaid (Sept. 27, 2002), available at <http://www.childrensdefense.org/release020927.php> (last visited Feb. 7, 2004). Even with this federal mandate, however, the needs of uninsured children were not fully met. Many uninsured children did not meet these relatively low income guidelines to be eligible for Medicaid. In addition, states failed to enroll all children eligible to receive benefits under these guidelines. As a result, initiatives pursued at the federal and state levels in recent years have focused on providing health insurance for children in low-income families who did not meet official poverty guidelines, and enrolling children already eligible for Medicaid or other public assistance programs.

71. Eugene M. Lewit, *The State Children's Health Insurance Program (CHIP)*, 8 FUTURE CHILD, No. 2, Summer/Fall 1998, at 152-58.

72. The use of 1115 waivers or 1915(b) waivers made Maryland's "Kids Count" program, Minnesota's "MinnesotaCare," Rhode Island's "RIteCare," and Washington State's "Basic Health Plan Plus" possible. See Ctrs. for Medicare & Medicaid Servs., Section 1115 Health Care Reform Demonstrations (8/28/03), at <http://www.cms.gov/medicaid/1115/statesum.pdf> (last visited Feb. 4, 2004).

In addition, eight states⁷³ established other non-Medicaid stand-alone programs to provide health insurance to children in low-income families. Many of these stand-alone initiatives had been highly successful, as measured by the number of children enrolled in the program. Pennsylvania's program proved so successful that it served as the model for the development of Title XXI.⁷⁴ By 1995, fourteen states and upward of twenty-four private sector organizations financed some form of health insurance for children in low-income families. The number of children enrolled in these programs, on average, was between 5,000 and more than 100,000, depending on the state.⁷⁵ Among the most prolific of these programs are the "Caring Programs" for children administered by state Blue Cross/Blue Shield plans.⁷⁶

Only six states⁷⁷ neither expanded Medicaid nor used a public or private program to provide some form of subsidized health insurance to low-income children.⁷⁸ Instead, low-income uninsured children had to meet minimal federal Medicaid income eligibility guidelines in order to receive public assistance in these states.

In sum, variety in terms of both design and scope seemed to dominate state efforts. Enrollment in state children's health insurance programs ranged from 1,000 to over 100,000. In four states—Hawaii, Vermont, Washington, and Minnesota—the penetration rate⁷⁹ exceeded forty percent.⁸⁰ In many cases, however, these pre-Title XXI state efforts to expand health insurance resulted in coverage for a relatively small proportion of each state's uninsured children.⁸¹

The fact that states took significant steps to address the problem of uninsured children prior to SCHIP indicates that Title XXI is not a program forced upon the states that had no interest in children's health care. Rather, SCHIP came as a boost, in the case of many states, to children's health insurance programs already initiated by the states. Although for some states, Title XXI put them in a position to expand children's health

73. Colorado, Connecticut, Florida, Hawaii, Massachusetts, New Jersey, New York, and Pennsylvania. ROSENBAUGH ET AL., *supra* note 68, at 11.

74. Ctrs. for Medicare & Medicaid Servs., Evaluation of Pennsylvania's Children's Health Insurance Plans Under Title XXI of the Social Security Act, <http://www.cms.hhs.gov/schip/evaluations/1998/paeval98.pdf> (last visited Feb. 7, 2004).

75. See U.S. Gen. Accounting Office, Report to the Ranking Minority Member Subcomm. on Children & Families, Comm. on Labor & Human Res., U.S. Sen., Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children, at 2, <http://www.gao.gov/archive/1996/he96035.pdf> (last visited Feb. 7, 2004).

76. See GAUTHIER & SCHRODEL, *supra* note 58, at 10.

77. *Id.* at 5. Alaska, Illinois, Indiana, Nebraska, Nevada, and South Carolina. See U.S. Gen. Accounting Office, *supra* note 75, at 30–31.

78. See GAUTHIER & SCHRODEL, *supra* note 58, at 5.

79. As measured by the percent of children covered of the total group of low-income uninsured children in the state.

80. See GAUTHIER & SCHRODEL, *supra* note 58, at 25.

81. The range of penetration rates: 52% in Hawaii, 45% in Washington, 44% in Vermont, 43% in Minnesota, 20% in Massachusetts, 16% in New York, 15% in Pennsylvania, 5% in Florida and Montana, 4% in Colorado, and 2% in New Jersey. *Id.* at 27.

insurance for the first time, for many states Title XXI merely put them in a better position to do what they were hoping to do all along.

V. IMPLEMENTATION OF THE SCHIP EXPERIMENT: ISSUES FACED BY THE STATES

Despite this relatively high level of state activity in providing children's health insurance in the pre-Title XXI period, the SCHIP program was attractive to the states for several major reasons: the enhanced match rate reduced the state share of the cost by thirty percent, as compared with what the state would be obliged to contribute under the regular Medicaid program; the flexibility and discretion given to the states, which is even greater than it would be with a federal Medicaid 1115 waiver; and SCHIP's emphasis on providing children's health insurance to the working poor and not just to those who were previously Medicaid-eligible.⁸²

Implementation of the SCHIP administrative experiment can be looked at from at least four different perspectives: Did the states take advantage of the flexibility and discretion offered to them? Have the federal and state roles in administering and guiding this program changed in the four years since its inception? What have been the impacts of the SCHIP administrative experiment? What impact has Title XXI had in reducing the number of uninsured children?

A. State Flexibility and Discretion

As of July 2000, fifty states, five territories, and the District of Columbia had approved SCHIP plans covering over two million previously uninsured children.⁸³ State plans differ so extensively that there are essentially fifty-one different SCHIP programs.⁸⁴ Only eight states began enrollment of children under SCHIP in 1997; thirty-three states began enrollment in 1998; and nine began enrollment in 1999.⁸⁵

Of the approved plans, eighteen states have created stand-alone children's health insurance programs, nineteen states have expanded Medicaid, and nineteen have implemented a combination of Medicaid expansion and a stand-alone program.⁸⁶ These state plans are dynamic and evolving in nature; states and territories have received approval for

82. See Lewit, *supra* note 71, at 153.

83. See MARGO EDMUNDS ET AL., HEALTH DIV., CHILDREN'S DEF. FUND, ALL OVER THE MAP: A PROGRESS REPORT ON THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) 2 (2000), available at http://www.childrensdefense.org/pdf/cdfchip_report_sum.pdf (last visited Feb. 7, 2004).

84. *Id.* at 73.

85. See ROSENBACH ET AL., *supra* note 68, at 5.

86. See CTRS. FOR MEDICARE & MEDICAID SERVS., STATE CHILDREN'S HEALTH INSURANCE PROGRAM PLAN ACTIVITY AS OF DECEMBER 3, 2003, <http://www.cms.hhs.gov/schip/chip-map.pdf> (last visited Feb. 7, 2004).

176 program amendments to their original plans.⁸⁷ As of December 3, 2003, twenty-one states have amendments pending with the Department of Health and Human Services.⁸⁸ States can also propose demonstration projects (e.g., to use unspent SCHIP funds to cover parents) under SCHIP through Medicaid 1115 waivers. As of February 2003, ten states have been granted waivers,⁸⁹ and another four states have waiver applications under review.⁹⁰

The 1115 SCHIP waivers,⁹¹ which are very much like the original Medicaid 1115 waivers, have allowed states real flexibility to experiment with delivery of health care services to low-income children and their families, which were not allowed in the original legislation. Administrative guidelines require that 1115 Demonstration Proposals are “budget neutral,” meaning that the states’ demonstration spending cannot exceed the unused amount of the states’ annual SCHIP allotments.⁹² Beginning in August 2001, the Health Insurance Flexibility and Accountability initiative (HIFA),⁹³ made these 1115 waivers easier to get by encouraging states to extend health coverage to new uninsured populations (people below 200% FPL) and by providing a simple application process with a ninety-day expedited review for waiver applications that meet the criteria.

Critics fear that states will reduce benefits and increase copayments for those already covered to “cover” more people through Medicaid and SCHIP under the same budget.⁹⁴ The twelve SCHIP waivers, which have all been approved after an initial period of program implementation, allow states to: a) claim Title XXI funding for parents and/or legal guardians and/or “relative caretakers” of SCHIP and Medicaid children; (b) extend coverage to pregnant women; (c) extend coverage to indigent adults with no dependant children; (d) implement cost-sharing, annual enrollment fees, and twelve-month-continuous eligibility for low-income families; and (e) implement a six-month period of uninsurance prior to en-

87. *Id.*

88. *See id.*

89. Arizona, California, Colorado, Maryland, Minnesota, New Jersey, New Mexico (x2), Ohio, Rhode Island, and Wisconsin. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP) APPROVED SECTION 1115 DEMONSTRATION PROJECTS (July 25, 2003), <http://www.cms.hhs.gov/schip/1115waiv.pdf>.

90. *See id.* Those states with waivers currently under review are California, Maryland, New Jersey, and Rhode Island. *Id.* (current as of Jan. 22, 2004).

91. These are formally known as SCHIP Section 1115 Demonstration Projects. *See infra* notes 146–50 and accompanying text.

92. *See* Jeanne Lambrew, Policy Brief, *Section 1115 Waivers in Medicaid and the State Children’s Health Insurance Program: An Overview*, KAISER COMMISSION ON MEDICAID & UNINSURED (Henry J. Kaiser Family Found., Wash., D.C.), July 20, 2001, available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13881> (last visited Feb. 7, 2004).

93. *See* Ctrs. for Medicare & Medicaid Servs., Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative, at <http://cms.hhs.gov/hifa/default.asp> (last modified Aug. 11, 2003).

94. *See* Nat’l Conference of State Legislatures, *Dawn of a New Day: States Given More Flexibility in Crafting Medicaid Waivers*, 23 ST. HEALTH NOTES 368, available at <http://www.ncsl.org/programs/health/shnlt.htm> (last visited Feb. 7, 2004).

rollment in SCHIP.⁹⁵ The five states with waivers under review have submitted proposals to use Title XXI funds to address the unmet health care needs of low-income children and adults.⁹⁶

Title XXI authorizes states to expand Medicaid coverage for children in families with incomes up to 200% of the FPL, which is 50% above the Medicaid eligibility level.⁹⁷ In terms of income eligibility to qualify for SCHIP coverage, as of June 2000, twenty states had implemented eligibility at 200% of the FPL, thirteen states at a level above 200%, fourteen states in the range between 150% and 199% of the FPL, and four states set eligibility below 150% of the FPL.⁹⁸ Eligibility standards in the states ranged from 133% to 350% of the FPL.⁹⁹ States raised income eligibility thresholds for children's health insurance between June 1997 and June 2000; the "average state" raised its eligibility standard from 121% to 206% of the FPL.¹⁰⁰ In addition, eighteen states have twelve-month-continuous eligibility¹⁰¹ for SCHIP and thirteen states have this same provision for Medicaid.¹⁰²

Since the beginning of SCHIP, controversy has raged about both the size of the overall allotment and the formula used to allocate funds across states.¹⁰³ States spent only 24% of the federal SCHIP dollars allocated to them between the fiscal years of 1998 and 2000.¹⁰⁴ Twelve states spent less than one-quarter of their allotments.¹⁰⁵ Sixteen states spent between 2% and 49% of their allotments, and twelve spent between 50% and 74%.¹⁰⁶ At the end of fiscal year 2000, there was approximately \$2 billion in unspent fiscal year 1998 funds.¹⁰⁷ As already indicated,¹⁰⁸ the law stipulates that states have up to three years to spend the allotment

95. See *supra* note 89.

96. See Ctrs. for Medicare & Medicaid Servs., *supra* note 93.

97. This authorization was set as of March 31, 1997. See Am. Acad. of Pediatrics, The State Children's Health Insurance (SCHIP) Summary, at <http://www.aap.org/advocacy/schipsum.htm> (last visited Feb. 8, 2004).

98. See *id.*

99. See ROSENBACH ET AL., *supra* note 68, at 14–18.

100. See John Holahan et al., *Health Policy for Low-Income People: States' Responses to New Challenges*, HEALTH AFF. WEB EXCLUSIVE (May 22, 2002), at W198, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.187v1.pdf> (last visited Feb. 8, 2004).

101. See Donna Cohen Ross & Laura Cox, Ctr. on Budget & Policy Priorities, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey*, KAISER COMMISSION ON MEDICAID & THE UNINSURED (Henry J. Kaiser Family Found., Wash., D.C.), Oct. 2000, at 8–9, available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13443> (last visited Feb. 8, 2004). This means that once children are determined to be eligible, they remain enrolled in the program regardless of fluctuations in family income.

102. *Id.*

103. See Dubay et al., *supra* note 2, at 3.

104. See Holahan et al., *supra* note 100, at W198.

105. See ROSENBACH ET AL., *supra* note 68, at 8.

106. *Id.*

107. See *SCHIP Funds Are Redistributed*, ST. BUDGET & TAX NEWS (Nat'l Conference of State Legislatures, Wash., D.C.), Apr. 1, 2001, <http://www.ncsl.org/programs/fiscal/sbfn010401b.htm> (last visited Feb. 9, 2004).

108. See *supra* notes 36–37 and accompanying text.

provided in a given year. At the end of this period, the Department of Health and Human Services reallocates the unexpended funds to states that completely use their allotments. Thirty-nine states (including the District of Columbia) reported that they required significantly more time than Congress anticipated to fully implement their SCHIP programs and, consequently, to spend the dollars included in their allotments.¹⁰⁹ Partially in response to these concerns, Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).¹¹⁰ BIPA extends the availability of a portion of unused fiscal year 1998 and 1999 SCHIP funds until the end of 2002.¹¹¹ This legislation offers a compromise between those states eligible to receive reallocated funds and those with unexpended allotments: the twelve states eligible to receive reallocated funds would receive some share of the unexpended funds (\$700 million or 35% of the funds legally available for reallocation) and the other thirty-nine states would be able to retain some of the unexpended funds (\$1.3 billion or 65% of the available funds).¹¹² This may be a recurring problem in the short-run because states are required to use all of their retained funds before they can spend their regular SCHIP allotments.

BIPA also created a new 10% outreach option for unspent first-year SCHIP funds. Up to 10% of the unused funds would not count against the noncoverage requirements of the law.¹¹³ This responded to the argument that the noncoverage constraint served as a disincentive to undertake publicity and other outreach required to enroll needy children.¹¹⁴ The development of effective outreach efforts is a very important issue for the states in terms of trying to increase enrollment¹¹⁵ and, hence, spend the allotment provided to a particular state. Outreach strategies employed by the states have included: “family friendly websites” with consumer friendly enrollment information (thirty-nine states),¹¹⁶ “eligibility workers,” who are “out-stationed” with broad geographic distribution (forty-seven states), the use of fax or mail applications (forty-six states), shortening of the application form so that it is four pages or less (forty-eight states), the use of a toll-free hotline (fifty states), involving schools and health care providers (fifty-one states), in-

109. See EDWIN PARK & MATTHEW BROADDUS, CTR. ON BUDGET & POLICY PRIORITIES, OMB ESTIMATES INDICATE 400,000 CHILDREN WILL LOSE HEALTH INSURANCE DUE TO REDUCTIONS IN SCHIP FUNDING (2001), <http://www.cbpp.org/11-8-01health.htm> (last visited Feb. 9, 2004).

110. See MATTHEW BROADDUS ET AL., CTR. ON BUDGET & POLICY PRIORITIES, SELECTED STATES HAVE A NEW OPPORTUNITY TO USE MORE OF THEIR SCHIP FUNDS FOR OUTREACH (2001), <http://www.cbpp.org/4-27-01health.htm> (last visited Feb. 9, 2004).

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. See EDMUNDS ET AL., *supra* note 83, at 22. Only eight states post total enrollment figures on their websites.

volving the business community (thirty-two states), and funding community-based organizations to conduct effective outreach activities (ten states).¹¹⁷

During implementation, the states have also designed a variety of benefits packages to be delivered to eligible children. The non-Medicaid SCHIP plans (i.e., the stand-alone and combination options) seem to be distinguishable from the Medicaid expansion option in terms of the benefits package. All of these non-Medicaid plans include prescription drug coverage, inpatient and outpatient mental health services, and outpatient substance abuse services.¹¹⁸ All of the non-Medicaid plans, except for one, cover durable medical equipment and physical and occupational therapy.¹¹⁹ At least eighteen of the non-Medicaid plans cover case management services, which are particularly important for children with special health needs.

The Medicaid expansion states have provided a variety of “child appropriate” benefits packages with some limitations, which vary from state to state.¹²⁰ A nationwide analysis of SCHIP managed care contracts revealed that separate SCHIP programs contracting with managed care organizations offer benefits that are narrower than under Medicaid for preventive and chronic care services. Without the extensive requirements of Medicaid, states draft their freestanding contracts to parallel those written for the commercial market. Benefits are more limited and the instrument gives more discretion to the contractor in the areas of access, continuity of care, and networks.¹²¹

Twenty-five states and the District of Columbia have introduced some form of cost-sharing—contributions to premiums or copayments for services received—as part of their SCHIP programs.¹²² These requirements are limited to the stand-alone and combination Title XXI states because of limitations Medicaid places on such a requirement, with the exception of states receiving new Medicaid 1115 waivers allowing cost-sharing.¹²³ The cost-sharing requirement offsets program costs, en-

117. *See id.*

118. *Id.* at 25.

119. *Id.*

120. *See id.* at 8, 22.

121. *See* Sara Rosenbaum et al., Policy Brief, *Managed Care Purchasing Under SCHIP: A Nationwide Analysis of Freestanding SCHIP Contracts*, SCHIP POL'Y STUD. PROJECT (George Washington Ctr. for Health Servs. Research & Policy, Wash., D.C.), Dec. 2001, at 5 & n.20, available at http://www.gwhealthpolicy.org/downloads/SCHIP_brief3.pdf (last visited Feb. 9, 2004).

122. *See* O'BRIEN ET AL., *supra* note 41, at 2.

123. *See id.* at 45–52. Under a regular 1115 application approved on February 9th, 2002, Utah will become the first state in the nation allowed to limit Medicaid services to some recipients to provide limited primary and preventive services to others (adults nineteen years of age and older who fall under 150% of the FPL). To fund the expansion, Utah will trim benefits from medically needy and adult welfare populations and will impose more substantial cost sharing for some optional and mandatory Medicaid populations. *Medicaid: HHS Approves Utah's First-in-Kind Medicaid Waiver Proposal to Extend Coverage to 25,000 While Reducing Other Benefits*, DAILY HEALTH POL'Y REP. (Henry J. Kaiser Family Found., Menlo Park, Cal.), Feb. 11, 2002, available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=9405 (last visited Feb. 9, 2004).

courages greater personal responsibility for the enrollees, decreases the use of unnecessary or inappropriate medical services, and makes SCHIP more like a product that could be purchased in the private insurance market.¹²⁴ The federal government, however, placed a cap of 2.5% of family income (of costs) on cost-sharing for families with incomes below 150% of the FPL¹²⁵ and a 5% cap on cost-sharing for families above 150% of the FPL.¹²⁶

One concern of critics of the enactment of Title XXI was “substitution”¹²⁷ of private insurance by the SCHIP program. These effects, critics theorized, might take the form of federal funding for children’s insurance increasing (i.e., increasing the federal share of payments for children eligible for Medicaid), while private coverage decreases.¹²⁸ This could result in fewer improvements to access and quality of care for children than had been hoped for with the introduction of SCHIP.¹²⁹ The Congressional Budget Office believed that families and employers would not drop private coverage entirely, but private coverage would capture a smaller share of the market with implementation of the new public program.¹³⁰ Similarly, the enhanced federal matching rate might “encourage states to find creative ways to use the funds for children currently eligible for Medicaid.”¹³¹

There is little empirical evidence available on the real effects of substitution and crowd-out. One study of the Florida Healthy Kids Program suggests that some degree of crowd-out can be documented and that some “degree of substitution may need to be tolerated to ensure that children receive needed health insurance.”¹³² States used at least six different types of strategies to address crowd-out effects in their SCHIP programs. The strategies include waiting periods during which families must be uninsured before enrolling, monitoring or application questions regarding insurance status, verifying insurance status against private coverage databases, cost-sharing (to avoid economic incentives to replace private insurance with SCHIP), subsidizing employer-based coverage, and imposing legal obligations on employers or insurers not to alter their

124. See O'BRIEN ET AL., *supra* note 41, at 3.

125. See Letter from Families USA et al., to Tommy Thompson, Secretary, Department of Health & Human Services (July 25, 2001), available at http://www.familiesusa.org/site/PageServer?pagename=media_alerts_chip_letter (last visited Feb. 9, 2004).

126. Ctrs. for Medicare & Medicaid Servs., Welcome to the State's Children Health Insurance Program, at <http://www.cms.hhs.gov/schip/about-SCHIP.asp> (last visited Feb. 9, 2004).

127. See JOHN HOLAHAN, EXPANDING INSURANCE COVERAGE FOR CHILDREN (1997); David M. Cutler & Jonathan Gruber, *Medicaid and Private Insurance: Evidence and Implications*, 16 HEALTH AFF. 194, 198 (1997); see also Budetti, *supra* note 50, at 541–42.

128. Budetti, *supra* note 50, at 542.

129. See Elizabeth Schenkman et al., *Crowd out: Evidence from the Florida Healthy Kids Program*, 104 PEDIATRICS 507, 507 (1999).

130. Budetti, *supra* note 50, at 542.

131. *Id.*

132. See Schenkman et al., *supra* note 129, at 507.

coverage policies in response to SCHIP.¹³³ Individual state studies have found between 1% and 8% crowd-out rates among SCHIP enrollees.¹³⁴ In June 2001, however, pressures to increase enrollment outweighed concerns about crowd-out at state and local levels.¹³⁵ In comparison, 1% to 8% crowd-out is not very high if you consider studies that associated 50% of Medicaid coverage increase between 1987 and 1992 with a reduction in private insurance coverage.¹³⁶

“States’ performance under [S]CHIP has been, quite literally, all over the map on any dimension that can be measured: eligibility levels, types of programs, implementation timetables, scope of benefits, relationship between [S]CHIP and Medicaid, approaches to outreach, and progress in identifying and enrolling eligible children.”¹³⁷ Due to all of this variation, SCHIP is a true experiment in the use of different administrative arrangements and approaches to provide health insurance and health care benefits to eligible low-income and/or uninsured children.

B. Changing Federal and State Roles in the Implementation Period

It seems clear that states have taken full advantage of the flexibility and discretion offered to them as part of SCHIP. Indeed, the states have continued to influence the development of this program over time. In the adoption of BIPA,¹³⁸ the state perspectives were instrumental in the formulation of the ultimate compromise enacted. The original law stipulated that unspent funds not used by the states after three years and not reallocated would be returned to the U.S. Treasury.¹³⁹ Data from the Centers for Medicare and Medicaid Services (CMS) show that the Treasury expects to receive \$700 million in returned funds at the end of fiscal year 2002 and another \$2.3 billion at the end of fiscal year 2003.¹⁴⁰ Based on the BIPA, the states appear to be successful in amending this law so that SCHIP can continue to evolve. State officials convinced Congress that they had legitimate reasons for not spending their SCHIP allotments and should, therefore, not be penalized by having to return these funds to the Treasury. The states successfully made the case that there would be several “deleterious consequences” of having to return unspent funds

133. See Amy Westpfahl Lutzky & Ian Hill, *Has the Jury Reached a Verdict? States’ Early Experiences with Crowd out Under SCHIP*, ASSESSING THE NEW FEDERALISM (Urban Inst., Wash., D.C.), June 2001, at viii–ix, available at http://www.urban.org/UploadedPDF/310218_occa47.pdf (last visited Feb. 9, 2004).

134. *Id.* at 4.

135. *Id.* at ix.

136. See David M. Cutler & Jonathan Gruber, *Does Public Insurance Crowd out Private Insurance?*, 111 Q.J. ECON. 391, 391 (1996).

137. See EDMUNDS ET AL., *supra* note 83, at 8.

138. Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554, 114 Stat. 2763A-463.

139. 42 U.S.C. § 1397dd (2002).

140. Redistribution and Continued Availability of Unexpended SCHIP Funds from the Appropriation for FY 1999, 67 Fed. Reg. 20,794 (Apr. 26, 2002).

to the Treasury.¹⁴¹ In addition, in July of 2000, CMS issued new guidelines making it easier for states to use unspent funds to insure people other than children, including parents.¹⁴² This, once again, reflects the influence of the states seeking flexibility and discretion.

The Department of Health and Human Services announced new regulations for the implementation of SCHIP in June of 2001.¹⁴³ The new implementation rules are consistent with state government preferences: eliminating the 2.5% cap on the cost-sharing obligations of families with incomes below 150% of the FPL; permitting states to require families to spend more than 5% of their incomes meeting cost-sharing requirements; eliminating minimum standards for review procedures.¹⁴⁴ The modifications also allow states to design and use their own processes; defining a broad array of benefit packages as “automatically qualified for Secretary approved coverage” and, thereby, reducing the role of the CMS to review on a state specific basis benefits provided to children.¹⁴⁵ These regulations reflect the strong state role in continued development of the Title XXI program.

In addition, President Bush launched the Health Insurance Flexibility and Accountability (HIFA)¹⁴⁶ initiative in August of 2001. HIFA intends to enable states to increase the number of people covered by Medicaid and SCHIP within the limits of existing resources.¹⁴⁷ The initiative features a new policy regarding federal waivers for expanded enrollment of Medicaid and SCHIP. Through these new waivers, state governments will have increased discretion to limit benefits for so-called “optional groups” and expand coverage to new groups—the so-called “expansion groups” (e.g., parents of eligible children in SCHIP).¹⁴⁸ As part of this initiative, the U. S. Department of Health and Human Services “strongly encourages” waiver proposals using Medicaid and SCHIP funds to purchase either individual or employer-sponsored coverage for

141. See GUYER, *supra* note 47.

142. California was the first state to have a waiver of this type approved in January of 2002. *State Watch: HHS Approves California Waiver to Expand Coverage to 300,000 Uninsured*, DAILY HEALTH POL’Y REP. (Henry J. Kaiser Family Found., Menlo Park, Cal.), Jan. 25, 2002 [hereinafter *Children’s Health*], available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=9146 (last visited Feb. 9, 2004).

143. *Children’s Health: HHS Issues Revised CHIP Regulation Regarding Enrollment Procedures*, DAILY HEALTH POL’Y REP. (Henry J. Kaiser Family Found., Menlo Park, Cal.), June 22, 2001, available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=5412 (last visited Feb. 9, 2004).

144. The previous standard included review procedures such as external appeals for eligibility denial or denial of a reimbursement claim, timeliness, and notice requirements. Revisions to the Regulations Implementing the State Children’s Health Insurance Program, 66 Fed. Reg. 33,810, 33,815 (June 25, 2001).

145. *Id.* at 33,814.

146. See Ctrs. for Medicare & Medicaid Servs., *supra* note 93.

147. *Id.*

148. Ctrs. for Medicare & Medicaid Servs., Guidelines for States Interested in Applying for a HIFA Demonstration, at <http://www.cms.hhs.gov/hifa/hifagde.asp> (last modified May 23, 2002).

eligible people.¹⁴⁹ The initiative eliminates previous requirements providing a minimum package of benefits and defining a maximum cost-sharing requirement. A state cannot use this new initiative, however, to receive federal funds for a health services program currently funded exclusively by a state. Consequently, states such as Minnesota, New Jersey, Rhode Island, and Washington, which provide coverage to adults without using any federal funds, may not apply for a waiver.¹⁵⁰

The definition of the federal and state government roles originally envisioned in the creation of the SCHIP program has been reinforced and strengthened in the last four years of implementation. The federal role continues to be one of financing, providing a general framework for implementation, which includes setting minimum standards, and approving state plans and proposed changes to these plans. State governments have flexibility, discretion, and control over the specifics of program design and operations, and this discretion has only increased over time.

C. *Impact of the Administrative Experiment*¹⁵¹

As of March 2000, only twenty-one states selected the Medicaid expansion option as their vehicle for implementing SCHIP.¹⁵² Thirty-two states either had stand-alone programs or combination programs, which included a stand-alone component.¹⁵³ Since this is the most basic element of the administrative experiment, a critical question to be addressed is: As far we can tell in this relatively short implementation period, what difference has this choice made?

There appears to be a correlation between this basic choice and the income eligibility criteria that have been implemented for Title XXI programs. Twelve of the nineteen Medicaid expansion programs set their eligibility standards below 200% of the FPL, while only five out of fifteen stand-alone programs and six out of seventeen combination programs set the eligibility standard at this level.¹⁵⁴ The range of eligibility standards (100%–300%¹⁵⁵ of the FPL) is the same for all administrative options; however, ten of the fifteen stand-alone states have set a standard of 200% of the FPL or higher for eligibility, and the combination programs have a narrow, low range of eligibility for the Medicaid expansion com-

149. *Id.*

150. These states, however, have successfully obtained SCHIP waivers for low-income parents. Embry M. Howell et al., *Early Experience with Covering Uninsured Parents Under SCHIP*, NEW FEDERALISM: ISSUES & OPTIONS FOR STATES (Urban Inst., Wash., D.C.), May 31, 2002, <http://www.urban.org/url.cfm?ID=310498> (last visited Feb. 9, 2004).

151. The data reported in this section are drawn from the first official annual evaluation of SCHIP sponsored by the Health Care Financing Administration (HCFA). See ROSENBACH ET AL., *supra* note 68.

152. *See id.* at 2.

153. *See id.*

154. *See id.*

155. Vermont is the one exception to this rule, with a 350% of FPL eligibility standard. *Id.* at tbl.3.

ponent of their plan (sixteen out of seventeen plans have an eligibility standard below 200% of the FPL) and a broader range for the stand-alone component (twelve out of seventeen have set the standard at 200% or above).¹⁵⁶ The ranges of eligibility may reflect the variation in pre-SCHIP state child health programs and the SCHIP regulations that require maintenance of effort.¹⁵⁷

As already indicated, the issue of unspent allotments is a salient one in the implementation of SCHIP. All but one of the eight states that spent 100% of their allotments in fiscal year 1998 were combination or stand-alone.¹⁵⁸ Most of these states also received approval for their Title XXI plans in 1997 or the first half of 1998. SCHIP enrollment grew by 29.1% from the fourth quarter of fiscal year 1999 to the end of the second quarter of fiscal year 2000.¹⁵⁹ Eight of the thirty-seven states (reporting enrollment data in SCHIP plans) exceeded a 50% growth rate during the first six months of fiscal year 2000.¹⁶⁰ The three states with pre-existing comprehensive child health programs—Florida, New York, and Pennsylvania—accounted for close to 40% of the total SCHIP enrollment in fiscal year 1999.¹⁶¹

Another way of examining the implementation data is to focus on the states that developed non-Medicaid children's health programs prior to the enactment of SCHIP.¹⁶² These states were among the most active prior to 1997. With one exception,¹⁶³ these eight states are among the thirty-two with current stand-alone or combination Title XXI programs and were among the first to receive approval for their plans.¹⁶⁴ Moreover, they are among the states with the highest levels of SCHIP enrollment.

As implementation continues, it will be important to document the extent to which the basic choice in type of SCHIP plan adopted continues to make a difference in the number of children enrolled, the funds expended, and the outcomes for clients of the program. Lowering the number of uninsured children is, of course, the ultimate objective of this program.

156. Some states with narrower child eligibility criteria, e.g., Arkansas, Maryland, Minnesota, and Tennessee, had previously expanded Medicaid eligibility through Medicaid 1115 waivers to nonchild populations. *See id.* at 19; *see also* 42 U.S.C. § 1315(a) (2000).

157. *See generally* ROSENBACH ET AL., *supra* note 68 (providing statistical analysis).

158. *See id.* at 3–5.

159. *See id.* at 30, 32.

160. *See id.* at 30–31.

161. *See id.* at 8. Nineteen percent of those enrolled in the beginning of 1999 were still enrolled at the end of 1999. *Id.* There is a real need for analysis of turnover rates.

162. Colorado, Connecticut, Florida, Hawaii, Massachusetts, New Jersey, New York, and Pennsylvania. *See supra* notes 73–74.

163. Hawaii. *See* ROSENBACH ET AL., *supra* note 68, at 3.

164. *See id.* at 3–4, 83–85.

D. Impact on Reducing the Number of Uninsured Children

The Congressional Budget Office originally estimated that SCHIP would cover approximately 2.8 million children who were not previously eligible for Medicaid;¹⁶⁵ this would succeed in extending coverage to 25% of the 10.7 million uninsured children in the United States.¹⁶⁶ Up to this point in time, SCHIP has served approximately two million children; the unmet need is still, therefore, very high.

In terms of SCHIP implementation, there have not been statistically significant changes in the number of uninsured children from 1987 to 1999.¹⁶⁷ About 86% of children have been insured steadily between 1987 and 1999, with fluctuations between private and government sources of insurance.¹⁶⁸ Declines in Medicaid enrollment offset the impact of SCHIP in 1998.¹⁶⁹ SCHIP enrollment in 1999 was approximately 1.9 million.¹⁷⁰ The number of children ever enrolled in SCHIP increased from 3.3 million in fiscal year 2000 to 4.6 million in fiscal year 2001 and again to 5.3 million children by 2002.¹⁷¹ In addition, over 349,000 adults were enrolled in SCHIP through 1115 waivers in 2002.¹⁷² These increases are due to state coverage expansions, program maturity, and streamlined enrollment procedures. In 1997, 27.8% of children in families with incomes in the range of 100% to 150% of the FPL were uninsured.¹⁷³ This was the highest rate of uninsurance for any subgroup of the population.¹⁷⁴ These children were not eligible for Medicaid or any other type of insurance coverage that they could afford. SCHIP was designed for this group and for others with family incomes up to 200% of the FPL. It extended coverage to this group and to other uninsured low-income children.

The preliminary evaluation results for the SCHIP program nationally show that the steady increase in the number of uninsured children in groups with incomes between 100% and 150% of the FPL has been re-

165. See HEALTH POLICY STUDIES DIV., NAT'L GOVERNORS ASS'N CTR. FOR BEST PRACTICES, ISSUE BRIEF: STATE TOOLS TO PROVIDE FAMILY HEALTH INSURANCE COVERAGE (1999), available at http://www.nga.org/center/divisions/1,1188,C_Issue_Brief^D_629,00.html (last visited Feb. 9, 2004).

166. See FED. INTERAGENCY FORUM ON CHILD & FAMILY STATISTICS, AMERICA'S CHILDREN: KEY NATIONAL INDICATORS OF WELL-BEING (2001), available at <http://childstats.gov/ac2001/pdf/econ.pdf> (last visited Feb. 9, 2004).

167. Data are currently available for these years. *Id.*

168. *Id.*

169. See JOCELYN GUYER ET AL., CTR. ON BUDGET & POLICY PRIORITIES, MISSED OPPORTUNITIES: DECLINING MEDICAID ENROLLMENT UNDERMINES THE NATION'S PROGRESS IN INSURING LOW-INCOME CHILDREN (1999), <http://www.cbpp.org/10-20-99health.htm> (last revised Oct. 21, 1999).

170. See Ctrs. for Medicare & Medicaid Servs., State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999, <http://cms.hhs.gov/schip/enrollment/fy99-00.pdf> (last visited Feb. 9, 2004).

171. *Id.*; see also *infra* note 172.

172. See Ctrs. for Medicare & Medicaid Servs., Fiscal Year 2002 Number of Children Ever Enrolled in SCHIP—Preliminary Data Summary, <http://www.cms.hhs.gov/schip/enrollment/schip02.pdf> (last modified Jan. 30, 2003).

173. ROSENBACH ET AL., *supra* note 68, at 43 tbl.8.

174. *Id.*

versed.¹⁷⁵ In the next income group (150% to 200% of the FPL), the upward trend appears to have “flattened out” and is no longer rising.¹⁷⁶ “In sum, our findings in the trend in the uninsured rate by poverty level are at least suggestive of an early influence of SCHIP, before we can draw valid influences about the direction and magnitude of change.”¹⁷⁷

As states are still in the early stages of implementing their Title XXI programs, it is a bit early to collect meaningful outcome data that would allow for a full assessment of the program’s effectiveness. Instead, it is only possible to examine preliminary data and trends.

VI. CONCLUSIONS

The administrative experiment in federalism represented by SCHIP has been successful. State government has taken advantage of the flexibility and discretion provided in the statute creating this innovative program. The differences between state Title XXI plans are striking. Thirty-two states have developed stand-alone programs or a stand-alone component of their combination plans.¹⁷⁸ Within these plans, there is great variety regarding the use of available funds—in terms of benefit packages, eligibility standards, outreach programs, cost-sharing requirements, and the use of the private insurance market. It is also clear that variation in the administrative mechanism used to implement the program (i.e., stand-alone, Medicaid expansion, combination) correlates with differences in program operations and performance (e.g., eligibility standards, expenditure levels). The value placed on the vast interstate variations evident in the implementation of SCHIP is central to the question of whether this experience should serve as a model for federalism in health care and other policy areas.

The critics of this program have maintained, from the beginning, that the wide discretion assigned to the states will probably not lead to the most effective outcomes for American children.¹⁷⁹ Through Title XXI, Congress formed a social contract with children by providing “funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.”¹⁸⁰ The real question then becomes which model for dividing up the job between the federal and state levels of government is most effective in fulfilling this contract. (But that question isn’t really answered by this administrative experiment, is it? We would

175. *See id.* at 43 tbl.8, 45.

176. *Id.*

177. *Id.* at 45.

178. *See supra* note 153 and accompanying text.

179. *See Cendali, supra* note 24.

180. *See State Children’s Health Insurance Program*, 42 U.S.C. § 1397aa(a) (2003).

need to try cooperative federalism in some states, and more imbalanced power models with other states to see which is most effective.)

The new model of cooperative federalism represented by SCHIP¹⁸¹ envisions that the federal government will provide the primary financing for a program, develop the basic framework for the program in the form of rules and regulations, set minimum standards of enforcement, and seek compliance through its financing and plan approval role. States have the lead responsibility for program design, implementation, and enforcement, while accepting a secondary role in financing. The recent experience in the formulation of revised implementation rules by the Bush administration suggests that even the minimum federal standards are being relaxed (e.g., cost-sharing requirements).¹⁸² Those that favor devolving policy-making authority to the states for reasons associated with their political will and past track record in providing services need to recognize that if this is linked to devolution of fiscal responsibilities, the effects could be crippling. The new wave of waivers announced by the Bush administration in late 2001, as part of the HIFA initiative, suggest that we have not learned this lesson; the budget neutrality provisions of this initiative place the financial responsibility for new innovations on state government. No new funds are forthcoming from the federal government to implement SCHIP waivers. The Bush administration initiative also illustrates how state autonomy may limit the ability or desire of the national government to impose national standards leading to uniformity. Will the effect of this budget neutrality principle, along with the relaxing of federal standards, lead to fewer services for low-income children and their families or to eligibility thresholds that leave more children uninsured? To what extent will the health disparities between the "haves" and "have-nots" increase nationally as a consequence of substantial state variation?

The extent to which SCHIP may serve as a model for federalism in health care for the future may rest on the critical differences between block grants and entitlements. Entitlements represent legal obligations of government to individuals based on fairly uniform eligibility criteria (e.g., Medicaid). Entitlements tend to redistribute funds on a national basis and do not work effectively with great variation. Block grants, on the other hand, are given to state or local governments based on a formula and allow for substantial variation in implementation, including eligibility and enrollment (e.g., SCHIP).

Title XXI is popular with states because it granted them increased flexibility they did not have under Medicaid and because it provided

181. The Health Insurance Portability and Accountability Act (HIPPA) of 1996 may represent another example of how this new form of cooperation operates. *See, e.g.*, Robert F. Rich & Christopher T. Erb, *The Two Faces of Managed Care Regulation*, at 9 (Nov. 10, 2003) (unpublished manuscript, on file with the University of Illinois Law Review).

182. *See Children's Health, supra* note 143.

them with enhanced federal matching rates. SCHIP has helped both states that have been active reformers and states that have made little effort to reform their Medicaid programs or address children's health insurance needs to reduce the number of uninsured children in their states. But, it is unclear whether the SCHIP programs have succeeded in reducing the number of uninsured children or whether health care outcomes are being improved for children in the Title XXI programs. We do have some evidence to suggest that some new children (roughly two million) are now insured under SCHIP.

If states continue to rise to the challenge of implementing innovative health care reforms as a result of Title XXI, then the federal government may be even more inclined to make increased concessions to states in Medicaid, and the federal government may seriously reconsider Medicaid block grant proposals mirroring SCHIP. While these proposals may prove beneficial to the health of relationships between the federal and state governments, it may also mean the end of a health care entitlement for indigent Americans. This could result in the provision of less generous health service delivery programs than currently exist.

Ultimately, the federal and state levels of government need to decide on the value of entitlements and uniformity based on some level of centralization and variation and some level of decentralization based on a matching grant system. Perhaps, the combination programs available as part of SCHIP offer a system that maximizes the interests of all major constituencies. States can maintain their Medicaid entitlements and extend coverage to other uninsured children while not risking financial security; and the federal government can assist states in reducing the number of uninsured children, while maintaining the ability to ensure state accountability and limit federal spending.

There is little doubt that state governments simply do not have the fiscal or administrative capacity to carry out large redistributive programs like Medicare based on an age-based entitlement.¹⁸³ Congress has also demonstrated little willingness to amend ERISA, which would be required to give states a sustained role in health care policy more generally.

Consequently, as we look toward the future of federalism in health care, this new cooperative model has great promise. It redefines federal and state roles to form a true partnership where one level does not dominate over the other. In creating this new reconfigured or transformed partnership, the model also offers substantial risks. The greatest risk is in devolving primary fiscal and enforcement responsibilities to the states that do not have the capacity to carry them out. This can result in a reduction of service to the target population, a narrowing of the band

183. See Robert F. Rich & William D. White, *The American States, Federalism, and the Future of Health Care Policy*, in *HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES*, *supra* note 8, at 293, 303-04.

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of eligibility, and an increase in health disparities within the population as a whole.

The new cooperative federalism will be an important dimension of federalism in the health care policy arena of the future. Under Title XXI, states and the federal government are partners not only in financing and administration (the traditional model of cooperative federalism), but also in determining policy that is central to the new model. Administrative experiments like SCHIP provide a wealth of information and lessons for future cooperation. It cannot solely provide the basis for dividing up the job of government at the federal and state levels.

