

# Coping With SCHIP Enrollment Caps: Lessons From Seven States' Experiences

Although capping enrollment was necessary, the states that did tried to mitigate the impact on families until enrollment could resume.

by Ian Hill, Brigitte Courtot, and Jennifer Sullivan

**ABSTRACT:** Seven states with separate (as opposed to Medicaid expansion) State Children's Health Insurance Programs (SCHIP) implemented enrollment caps during the 2001–2003 recession. Interviews with SCHIP officials and Covering Kids and Families grantees in these states examined implementation policies and their effects on enrollment, outreach, and public support. Enrollment caps were generally maintained for less than a year and resulted in large spending reductions, but enrollment declined steeply. Most key informants indicated that caps were preferable to reversals of simplified enrollment, comprehensive benefits, and low cost sharing and thus offered policymakers an important tool for controlling costs. [*Health Affairs* 26, no. 1 (2007): 258–268; 10.1377/hlthaff.26.1.258]

**A** NATIONAL RECESSION, STRUGGLING STATE and local economies, and increased public spending demands have made it difficult for states to maintain balanced budgets in recent years. Most have attempted to contain costs by trimming a broad range of programs, including Medicaid and the State Children's Health Insurance Program (SCHIP).<sup>1</sup> Although SCHIP, noteworthy for its popularity among policymakers, providers, and the public, was relatively well protected during the early years of budget tension, the length of the recession prompted a number of states to cut SCHIP costs.<sup>2</sup> Most often, states stopped doing outreach, reversed enrollment simplifications, and increased cost sharing.<sup>3</sup> Seven states took a more dramatic step by capping SCHIP enrollment. This paper examines the experiences of these seven states.

## Background

In 1997, when SCHIP was passed, states were given considerable latitude to either expand Medicaid, create new “separate” child health programs, or combine these two strategies. More than three-quarters of states adopted separate pro-

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grams, either alone or in combination with smaller Medicaid expansions.

The thirty-nine states that created separate programs did so to take advantage of the flexibility that was permitted by the statute, setting out to test new models of public coverage that were “more like private insurance.”<sup>4</sup> Typically, these programs are characterized by benefit packages that, although broad, do not offer the full protection of Medicaid and entail nominal cost sharing in the form of monthly premiums or copayments, or both. Most importantly, unlike Medicaid, these programs can be closed to control state spending.

All SCHIP programs—Medicaid expansion and separate programs alike—invested unprecedented resources in efforts to promote child enrollment during the early years of implementation. States launched public awareness campaigns to inform families of the availability of new coverage and dramatically simplified enrollment procedures.<sup>5</sup> State-funded outreach was augmented by private-sector efforts, most notably the Robert Wood Johnson Foundation’s (RWJF’s) Covering Kids and Families (CKF) initiative. CKF grants supported outreach, simplification, and coordination activities in more than 140 community-based projects in forty-five states and the District of Columbia.

These public- and private-sector initiatives spurred steady enrollment gains. Between 1997 and 2004, total SCHIP enrollment grew to nearly 3.95 million children, and rates of uninsurance among low-income children dropped from more than 22 percent to approximately 15 percent.<sup>6</sup> Unfortunately, when the economy began to slow in 2001 and worsen in 2002 and 2003, many states felt that they could not sustain growth in their programs. Between 2001 and 2003, seven states—Alabama, Colorado, Florida, Maryland, Montana, North Carolina, and Utah—took the dramatic step of capping enrollment.

## **Study Data And Methods**

In October and November 2004 we conducted telephone interviews with SCHIP and CKF grant directors in each of the seven states that enacted enrollment caps.<sup>7</sup> We asked informants to discuss the factors that led to both the imposition and the lifting of caps, policies that were adopted to manage implementation, caps’ impact on SCHIP enrollment and other aspects of the program, and state and local officials’ strategies to mitigate the caps’ negative effects. Administrative data were obtained to document enrollment trends. To prepare for our interviews, we reviewed existing literature on enrollment caps.<sup>8</sup> Following commonly accepted qualitative research methods, interview notes were independently reviewed, and responses were categorized using data collection forms that mirrored the interview protocols. The analysis entailed comparing and contrasting the responses within each category, noting and discussing dominant themes and divergent opinions, and summarizing findings by topic area. This study was conducted as part of an evaluation of CKF, begun in 2002 and designed to assess grantees’ outreach, simplification, and coordination strategies.

## Study Results

Worsening economic conditions and tight state budgets were the primary factors that spurred state policymakers to impose enrollment caps in the study states. Rapidly growing SCHIP enrollment contributed to budget pressures, and enrollment caps were viewed as a way to immediately control program growth and, in turn, spending. Federal regulations, however, did not specify how states should implement caps. Thus, each state introduced its own cap, identified areas where policies were needed to guide implementation, and developed its own rules.

■ **Policies for cap implementation.** Our study found that no two states operated their enrollment caps in precisely the same way. Rather, states adopted a variety of policies pertaining to wait lists, exemptions, and other key areas (Exhibit 1).

*Waiting lists.* State administrators in four states chose to maintain waiting lists of children who would have qualified for SCHIP while enrollment was capped. Directors in these states reported that the lists served many purposes, including reducing parental confusion, helping enrollment “rebound” when caps were lifted, and keeping policymakers and the public aware of the demand for coverage among children. The programs choosing not to keep waiting lists indicated that they wanted to avoid the administrative burden of creating and maintaining one, and one administrator acknowledged policymakers’ desire to avoid negative publicity.

*Exemptions.* State officials also had to decide whether any children should be exempted from the cap. Two states chose not to exempt any children. Five others identified an array of exempt groups, including (1) children who “age out” of Medicaid (that is, become eligible for SCHIP when their age exceeds the eligibility threshold of Medicaid); (2) children who lose Medicaid eligibility as a result of increases in family income (that is, children whose lost eligibility would have made

**EXHIBIT 1**  
**State Children’s Health Insurance Program (SCHIP) Enrollment Cap Policies In Seven States, 2004**

	AL	CO	FL	MD	MT	NC	UT
Waiting list	●		●	●	●	●	
Modified premium payment policies			●	●			
Modified renewal policies	●	●	●	●	●	●	●
Groups exempt from cap <sup>a</sup>							
Children “aging out” of Medicaid		●			_b		●
“New” children in existing SCHIP families		●			●		●
Children with special health care needs			● <sup>c</sup>				
Families in/out of active-duty military					●		●
Families with income increases				●	●		

**SOURCE:** Telephone interviews with SCHIP officials, fall 2004.

<sup>a</sup> Florida began allowing exemptions for Medicaid age-outs and families with income increases when the state put time limits on enrollment periods.

<sup>b</sup> Montana stopped exempting this group in May 2004.

<sup>c</sup> Florida uses a set of screener questions on the KidCare application to identify children with special health care needs.

them eligible for SCHIP, but for the cap); (3) “new” children in existing SCHIP families (that is, children born or adopted into families that already had children in SCHIP); (4) children with special health care needs (that is, children with chronic illnesses or disabilities for which state officials sought to extend extra protection); and (5) children in military families (that is, children who lose health coverage provided by the U.S. Defense Department when their parents’ active duty ends).

*Premium nonpayment.* SCHIP rules allow states with separate programs to impose premiums on participating families; those that do must then decide how to treat families who fall behind in their payments (offering a “grace period” or extending extra time to pay), and when to permit children who are disenrolled because of nonpayment to reenroll (often after a “lockout” period). After implementing enrollment caps, some states modified their cost-sharing policies. For example, Maryland eliminated its lockout period so that children who were disenrolled for premium nonpayment could immediately reenroll once the cap was lifted.

*Renewal.* In each of the states with caps, children facing eligibility renewal were not subject to the enrollment cap as long as they complied with the program’s renewal procedures. The presence of a cap underscored for families the importance of maintaining coverage, and many states simplified renewal procedures while caps were in place. Some intensified outreach to inform families about the importance of renewing on time during the freeze; others introduced preprinted renewal forms that were simple for families to review and submit.

■ **Impacts on enrollment.** Three states—Montana, North Carolina, and Utah—enacted enrollment caps in 2001 at the outset of the recession, in response to rapidly growing program enrollment and concerns about state budget deficits (Exhibit 2). The remaining four states—Alabama, Colorado, Florida, and Maryland—capped enrollment between July and November 2003 at the height of the national recession. Enrollment caps were short-lived in six states; every state except Montana lifted its cap on SCHIP enrollment within one year of enactment. Alabama, Colorado, Maryland, and North Carolina returned to full-year open enrollment after lifting their caps, while Florida and Utah switched to systems where enrollment was allowed only at certain times of year. During spring 2005, however, both states returned to full year-round open enrollment. As of this writing, Montana has continued its cap, permitting children from its waiting list to enroll each month as attrition allows.

Although news that enrollment caps were relatively short-lived in most states is positive, this is offset by the fact that the caps took a serious toll on children’s coverage. While caps were in place, total enrollment dropped by an aggregate 61,133 children (15 percent) in the six states that capped and then reopened enrollment. Rates of attrition ranged from 6 percent in Florida and Maryland to 29 percent in North Carolina (Exhibit 2). The summaries below and Exhibits 3 and 4 provide more detail on each state’s experience.

**EXHIBIT 2**  
**Program Characteristics And Enrollment Cap Overview, States With State Children’s Health Insurance Program (SCHIP) Enrollment Caps, 2004**

Program name (state)	Program type	Cap in place	Summary of enrollment trends			Resolution
			Enrollment at start of cap	Enrollment at end of cap	Percent change	
ALLKids (AL)	Separate	9/03–3/04	62,449	54,932	–12	Full-year open enrollment
Child Health Plan Plus (CO)	Separate	11/03–7/04	50,822	37,165	–27	Full-year open enrollment
Healthy Kids (FL)	Combination	7/03–3/04	326,755	308,648	–6	Time-limited enrollment periods <sup>a</sup>
MCHP Premium (MD) <sup>b</sup>	Combination	7/03–6/04	6,501	6,111	–6	Full-year open enrollment
Children’s Health Insurance Program (MT)	Separate	1/01–present	9,503	– <sup>c</sup>	– <sup>c</sup>	Rolling cap
NC Health Choice (NC)	Separate	1/01–10/01	72,024	51,294	–29	Full-year open enrollment
Children’s Health Insurance Program (UT)	Separate	12/01–6/02	26,427	21,931	–17	Time-limited enrollment periods <sup>a</sup>

**SOURCE:** Telephone interviews with SCHIP officials, fall 2004.

<sup>a</sup> As of this writing, Florida and Utah had passed legislation that returned the programs to full, year-round open enrollment for state fiscal year 2005. Therefore, Florida adopted time-limited open enrollment from January through June 2005. Utah adopted time-limited open enrollment from June 2002 through June 2005.

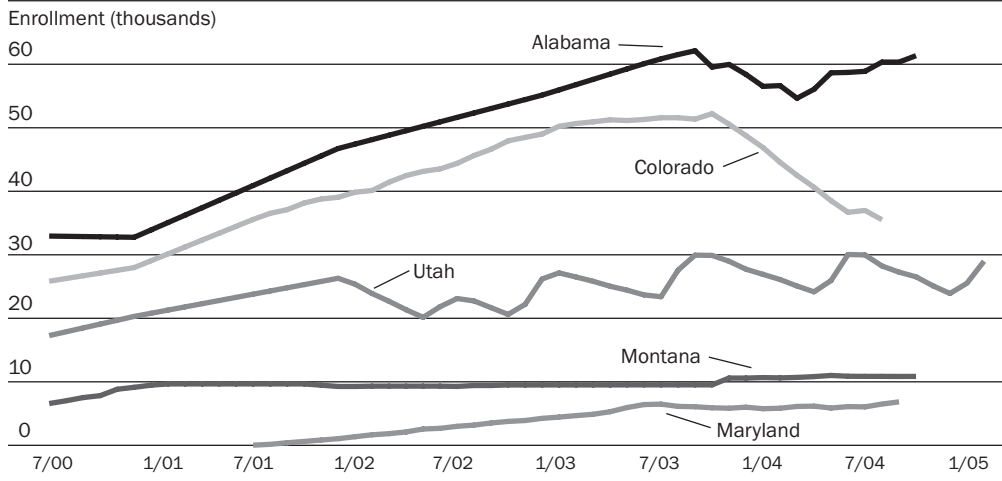
<sup>b</sup> Maryland’s cap applied only to those new applicant children in families earning 200–300 percent of the federal poverty level.

<sup>c</sup> Not applicable.

Alabama’s enrollment cap was officially in place from October 2003 to August 2004. However, in November 2003 and January and February 2004, roughly 2,000 children were allowed to enroll from the waiting list. In March 2004, because of negative publicity, the state legislature fully funded SCHIP for fiscal year 2005, effectively ending the cap. During the six-month period when enrollment was restricted, total enrollment fell by approximately 7,500 children (12 percent), from 62,499 to 54,932. In the six months following the lifting of the cap, Alabama’s SCHIP enrollment rebounded to near its previous peak, reaching approximately 62,000 children by October 2004.

Colorado’s enrollment cap was in place from November 2003 until July 2004. SCHIP officials chose not to maintain a waiting list, believing that it would be administratively burdensome, and thus could not gauge the level of unmet demand during the year. Policymakers entered 2004 aiming to lift the cap, and the governor’s budget included full funding for SCHIP. The provision passed easily, and enrollment was reinstated at the beginning of the new fiscal year. During the eight-month cap, however, program enrollment dropped by nearly 27 percent, from 50,822 to 37,165.

**EXHIBIT 3**  
**State Children’s Health Insurance Program (SCHIP) Enrollment Trends In Five States, July 2000–February 2005**

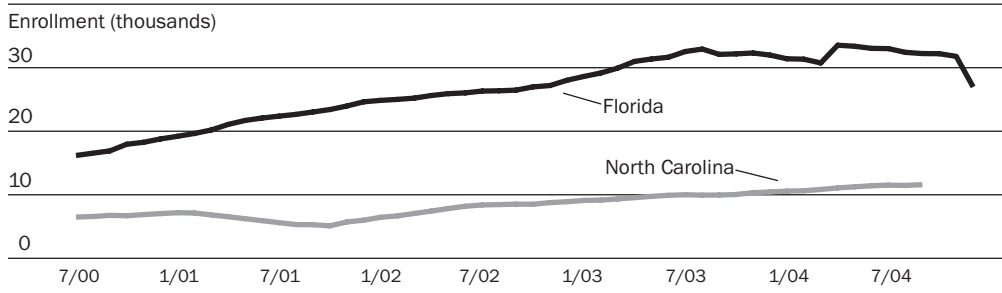


**SOURCE:** Telephone interviews with SCHIP officials, fall 2004.

**NOTES:** Maryland’s cap applied only to new applicant children in families earning 200–300 percent of the federal poverty level.

Florida’s enrollment cap was implemented in July 2003 and stayed in place until March 2004, during which time a waiting list grew to nearly 91,000 children.<sup>9</sup> Because of the state’s “passive” renewal system, Florida had less attrition during its cap, losing roughly 18,000 children (6 percent).<sup>10</sup> Considerable political pressure to lift the cap existed at the beginning of 2004, and the state legislature quickly did so, fully funding coverage of children on the waiting list; this led to an enrollment jump of more than 28,000 children in March 2004. However, in return for full funding, the legislature removed many of the state’s simplified enrollment and renewal policies, replacing them with new rules that would suppress future enrollment. Specifically, the state moved to periodic, rather than year-round, enrollment; stopped allowing families to “self-declare” income at application; and

**EXHIBIT 4**  
**State Children’s Health Insurance Program (SCHIP) Enrollment Trends In Two States, July 2000–December 2004**



**SOURCE:** Telephone interviews with SCHIP officials, fall 2004.

moved from a “passive” renewal process to a more traditional “active” process whereby families must update their information and submit new income verification to continue coverage.<sup>11</sup> By December 2004, with these policies in place, Healthy Kids enrollment dropped by nearly 66,000 children, or 20 percent. Amid renewed pressure to restore children’s coverage, new legislation was passed in June 2005 allowing children to be enrolled in Healthy Kids throughout the year.

Maryland capped SCHIP enrollment in July 2003 under legislation that required the cap to “sunset” in one year unless action was taken to extend it. No such action was taken, as the cap garnered considerable negative publicity for the governor and legislature. Maryland’s cap affected only new applicants from families earning 200–300 percent of poverty, and so it had relatively limited effects on enrollment and costs.<sup>12</sup> Maryland’s enrollment in the 200–300 percent band fell 6 percent, from 6,501 to 6,111, during the year.<sup>13</sup> Enrollment rebounded quickly after the cap was lifted, surpassing its previous zenith in just two months.

Montana policymakers, despite having set a low upper eligibility threshold of 150 percent of poverty, determined that funds were insufficient to permit open-ended enrollment and implemented a cap at the start of 2001. Montana has continuously kept a waiting list of eligible children and enrolls children from that list each month, based on attrition. As a result, SCHIP enrollment remained virtually level between January 2001 and November 2003. In fall 2003, policymakers diverted the state’s federal fiscal relief funds to SCHIP to clear the list, which had grown to 1,300 children. Since that time, enrollment has remained constant at slightly below 11,000 children.

North Carolina garnered much national attention when it became the first state to cap enrollment in January 2001. The state confronted this decision when it became clear that escalating enrollment would exceed expectations (based on Current Population Survey data) and the state’s appropriation for SCHIP. Enrollment stood at 72,024 in January 2001 and plunged 29 percent, to 51,294, by October of that year. State officials described imposing the cap as very painful, especially when the waiting list peaked at more than 34,000 children. Despite the forecast for an overall state budget deficit in state FY 2002, legislators worked to reverse the cap by November 2001. In the ensuing six months, enrollment rebounded steadily until it exceeded the level witnessed at the start of the cap. The specter of an enrollment freeze has loomed over every legislative session since 2001, but policymakers have managed to avoid repeating what everyone agrees was a challenging period in North Carolina’s SCHIP history.

From the outset, Utah policymakers created SCHIP in the image of private insurance. Thus, when enrollment began exceeding the state SCHIP appropriation, the notion of shifting to a system of periodic enrollment was consistent with a private insurance model. In December 2001, when the state first froze enrollment, it also reduced the scope of its dental benefit and raised premiums for eligible families, bringing the program even closer in line with typical private products.<sup>14</sup> After

that, Utah held five “open” enrollment periods—in June 2002, November 2002, July 2003, May 2004, and January 2005—during which enrollment rebounded to 23,000–31,000 children. During each of the ensuing “closed” months, attrition rates ranged from 11 percent to 23 percent. This see-sawing enrollment ended in May 2005 with the passage of a bill extending full funding to Utah’s SCHIP program, thereby permitting the state to enroll children throughout the year.

■ **Attrition and rebound.** Exhibit 5 displays the average monthly rates of enrollment attrition recovery that occurred while caps were in place and after caps were lifted. Coupling this information with that included in Exhibit 1, one can observe whether or not various state policies surrounding cap implementation were correlated with differing rates of attrition or rebound. Our analysis, while based on limited data, suggests the following.

*Passive renewal may moderate attrition.* Florida’s average monthly rate of attrition while it had “passive renewal” was 0.69 percent; this rate rose to 2.44 percent when it did away with passive renewal. Three other states with active renewal (Alabama, Colorado, and North Carolina) experienced similar monthly attrition of 2.0–3.36 percent; Maryland imposed its cap on a small subset of its enrollees. Utah, however, also adopted passive renewal, and its monthly attrition was 3.2 percent, a rate in line with other active-renewal states.

*Waiting lists might not improve enrollment recovery.* Our data suggest that states without waiting lists (Maryland, Utah) have stronger enrollment recovery than those with lists (Alabama, Florida, North Carolina). But pent-up demand and well-advertised open enrollment periods could explain why Utah experienced average monthly recovery of 10.65 percent. At the same time, Alabama’s enrollment of 6,000 children from its waiting list while its cap was in place likely attenuated both the demand and the enrollment recovery rate.

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**EXHIBIT 5**  
**Average Monthly State Children’s Health Insurance Program (SCHIP) Enrollment Attrition (During Enrollment Caps) And Average Monthly Enrollment Recovery (After Enrollment Caps)**

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	Average monthly attrition (%)	Average monthly recovery (%)
Alabama	-2.01	1.75
Colorado	-3.36	— <sup>a</sup>
Florida	-0.69, -2.44 <sup>b</sup>	9.09
Maryland	-0.55	4.07
Montana	— <sup>c</sup>	— <sup>c</sup>
North Carolina	-2.99	7.60
Utah	-3.20	10.65

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**SOURCE:** Telephone interviews with SCHIP officials, fall 2004.

<sup>a</sup> Not available.

<sup>b</sup> Florida experienced an average 0.69% decline while the state had a passive renewal process, and an average 2.44% decline in enrollment after the state adopted an active renewal process.

<sup>c</sup> Not applicable.

*Exemption could offset attrition.* One might hypothesize that exempting certain children from caps could offset rates of attrition, while more generous premium nonpayment policies might slow attrition and improve recovery. With the limited data available for this study, however, we were unable to observe such effects.

■ **Impacts on other aspects of SCHIP.** In addition to highly visible impacts on program enrollment, SCHIP and CKF officials told us of the “ripple effect” that caps had on outreach, public trust in SCHIP, and retention, as summarized below.

*Outreach.* Enrollment caps appear to have a chilling effect on outreach, at least temporarily. CKF grantees described their reluctance to conduct outreach while programs were capped. Staff in North Carolina told how the cap dampened the enthusiasm of community volunteers. Colorado officials said that some workers were reluctant to do outreach even after the state’s cap was lifted for fear of driving up enrollment too quickly and necessitating another cap. After the initial shock, however, outreach agencies adjusted their messages and strategies to emphasize renewal or applications for Medicaid. Eventually, states and CKF partners were eager to promote coverage once caps were lifted.

*Public trust.* Key informants told us that enrollment caps caused much confusion for parents. Fear that SCHIP programs had been entirely closed was widespread. Alabama officials interpreted a “precipitous” drop in application volume after instituting its cap as families believing that the program was “over.” Florida officials said that parents were “frustrated and angry” when national Back to School campaigns advertised SCHIP at a time when the program was closed. Still, the rapid enrollment recovery in most states after caps were lifted (as well as the strong spikes in enrollment during “open” periods in Florida and Utah) suggest that SCHIP still represents a needed and desirable product to parents.

*Retention.* There was consensus among key informants that rates of retention among SCHIP enrollees improved during and after caps. Few data were shared, but Montana estimated that its retention rate rose from 70 percent before the cap to 90 percent while the cap was in place. “People really pay attention to renewal when the threat of a waiting list is there,” said the SCHIP director in North Carolina.

## **Conclusions And Policy Implications**

SCHIP faced its greatest challenges during 2001–2003. Most states experienced three straight years of budget deficits, and a combined deficit topping \$78 billion existed for FY 2004.<sup>15</sup> To balance their ledgers, states cut deeply into health programs, including SCHIP. Seven of the thirty-nine states with separate SCHIP programs took the most dramatic step available by capping program enrollment. Our interviews with officials in these states revealed that although it was painful, the decision to cap enrollment was consistent with policymakers’ decisions in 1997 to adopt separate program models under SCHIP, which provide greater flexibility to control program growth and costs. Indeed, enrollment caps resulted in quick cost

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savings and, largely because of this, were lifted by the states relatively quickly.

Unfortunately, these savings came as a result of steep declines in enrollment, when thousands of children did not renew in time to retain coverage and untold uninsured-but-eligible children were not permitted to enroll. Undoubtedly, this loss of access to coverage caused hardships for children and their families. Caps were also painful for policymakers, who reportedly paid a high political price as media and advocacy attention focused on children’s growing unmet needs. Invariably, this pressure, too, contributed to the quick reversal of caps.

Our interviews with SCHIP and CKF officials also shed light on a number of other lessons, many of which hold implications for policymakers in other states. First, caps were seen as the lesser of two evils. Most SCHIP and CKF officials we interviewed believed that enrollment caps, while painful, were preferable to cuts in other program areas. As controversial as this sounds, these respondents reasoned that it was more important to maintain the features that made SCHIP successful—including simplified enrollment, rich benefits, low cost sharing, and adequate provider reimbursement—even if it meant having to adopt temporary enrollment caps. They also pointed out that in contrast to caps, policy cuts in benefits, cost sharing, and reimbursement would have been more difficult to reverse in state legislatures once adopted. Unfortunately, testing this hypothesis by studying the relative impacts of alternative cost containment policies on enrollment was beyond the scope of this study.

Second, it was necessary to mitigate the negative effects of enrollment caps on families. State and CKF officials believed that a range of policy strategies helped accomplish this. These included (1) maintaining a waiting list (an important and useful tool for gauging the demand for coverage, serving families on a first-come, first-served basis as slots in the programs opened up, helping the programs rebound quickly once caps were lifted, and endorsing ongoing outreach); (2) simplifying renewal procedures (by preprinting forms, reducing verification, and adopting passive approaches that require families to respond only if their circumstances have changed so that eligible children do not unnecessarily lose coverage); and (3) modifying cost-sharing policies (such as extending grace periods for families that fall behind in their payments and eliminating lockout periods for families who are disenrolled because of premium nonpayment). Our analysis, however, found that only simplified renewal seemed to reduce rates of attrition; the other two practices could not be observed as having an effect on either enrollment attrition or recovery.

CAPPING ENROLLMENT UNDER SCHIP is a drastic step that can lead to large drops in children's coverage. SCHIP and CKF officials expressed the hope that budget circumstances would never require them to take such a drastic step again. But with health care costs rising, state economies in flux, and the federal reauthorization of SCHIP pending for 2007, states may indeed be confronted by the need to consider enrollment caps again. Perhaps the lessons learned by the states studied here can help others design policies that minimize the negative impacts on vulnerable children.

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*The authors acknowledge the Robert Wood Johnson Foundation, which funded the study, as well as the state and Covering Kids and Families officials who so generously shared their time and data with us.*

#### NOTES

1. J. Holahan et al., *State Responses to Budget Crisis in 2004: An Overview of Ten States—Overview and Case Studies*, 2004, <http://www.kff.org/medicaid/7002.cfm> (accessed 6 December 2005); and T.A. Coughlin and S. Zuckerman, "Three Years of State Fiscal Struggles: How Did Medicaid and SCHIP Fare?" *Health Affairs* 24 (2005): w385–w398 (published online 16 August 2005; 10.1377/hlthaff.w5.385).
2. E. Howell, I. Hill, and H. Kaputska, *SCHIP Dodges the First Budget Ax*, Assessing the New Federalism, Policy Brief no. A-56 (Washington: Urban Institute, 2002); and I. Hill, B. Courtot, and J. Sullivan, *Ebbing and Flowing: Some Gains, Some Losses as SCHIP Responds to Third Year of Budget Pressure*, Assessing the New Federalism, Policy Brief no. A-68 (Washington: Urban Institute, 2005).
3. I. Hill, H. Stockdale, and B. Courtot, *Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis*, Assessing the New Federalism, Policy Brief no. A-65 (Washington: Urban Institute, 2004).
4. J. Wooldridge et al., *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress* (Princeton, N.J.: Mathematica Policy Research Inc., 2005).
5. D.C. Ross and I.T. Hill, "Enrolling Eligible Children and Keeping Them Enrolled," *Future of Children* 13, no. 1 (2003): 81–97.
6. V.K. Smith and D.M. Rousseau, *SCHIP Program Enrollment in Fifty States: December 2004 Data Update* (Washington: Kaiser Commission on Medicaid and the Uninsured, 2005); and R.A. Cohen and Z. Coriaty-Nelson, *Health Insurance Coverage: Estimates from the National Health Interview Survey, 2003* (Hyattsville, Md.: National Center for Health Statistics, 2004).
7. All key informants were administering their programs when their state's cap was enacted.
8. C. Pernice and D. Bergman, "State Experience with Enrollment Caps in Separate SCHIP Programs," February 2004, [http://www.nashp.org/Files/Enrollment\\_Cap\\_policy\\_brief\\_final.pdf](http://www.nashp.org/Files/Enrollment_Cap_policy_brief_final.pdf) (accessed 6 December 2005); and P. Silberman et al., *The North Carolina Health Choice Enrollment Freeze of 2001* (Washington: Kaiser Commission on Medicaid and the Uninsured, 2003).
9. An additional 25,000 undocumented children were also on a separate waiting list for the state-only funded portion of Healthy Kids.
10. Under Florida's system, children's enrollment was automatically renewed if premium payments were up to date and no changes to family circumstances were reported on preprinted renewal forms.
11. To offset potential negative effects of renewal policy changes, Florida increased children's continuous coverage period from six to twelve months and launched a renewal assistance program, Pathfinder.
12. The state exempted children in families whose income increased above Medicaid and M-SCHIP levels, thus making them eligible for SCHIP.
13. Maryland officials believe that up to one-third of these children might have left the program as a result of other policy changes that occurred at the same time as the cap, including the state's discontinuance of its subsidized employer-based coverage program that served approximately 200 children.
14. Utah also adopted passive renewal after it adopted time-limited enrollment periods.
15. National Conference of State Legislatures, *State Budget Update: February 2004* (Denver: NCSL, 2004).