Georgetown University Health Policy Institute
Center for Children and Families

Program Design Snapshot: Public Coverage Waiting Periods for Children

Description

"Waiting period" refers to the length of time a child is required to be uninsured prior to enrolling in a public health coverage program. The restriction generally applies to separate Children's Health Insurance Program (CHIP) programs only, as waiting periods are not permitted in Medicaid without a waiver. Waiting periods are primarily designed to deter crowd out (when private coverage is dropped when better, more affordable public options are available). However, because waiting periods essentially require children to go without coverage for reasons beyond their control and their effectiveness in deterring crowd out has not been proven, many states have sought to target waiting periods by limiting their length and/or establishing targeted exceptions.

Legislative Background

In the name of minimizing substitution of private coverage, many states with a separate CHIP program require that children be uninsured for a specified period of time before they can be enrolled in coverage. The CHIP law enacted in 1997 requires states to describe in their state plans the procedures that they will use to ensure that CHIP coverage does not substitute for group-based coverage.[1] It, however, does not specify exactly which procedures a state must use, instead providing states the flexibility to decide which strategies are most effective given their particular economic conditions, health insurance system, and demographics. Waiting periods are not permitted in Medicaid without a waiver.

Where States Stand

In their initial CHIP plans[2], there was considerable variation across states regarding their use of waiting periods. Five states had 12-month waiting periods; 17 states had six-month waiting periods; 18 states had waiting periods of four months or less; and 11 states had no waiting period at all.[3]

Over time, several states dropped or shortened their waiting periods, in part because of minimal evidence of a crowd out problem. As of January 2009, 10 states do not have a waiting period in their SCHIP programs and 38 states have waiting periods of 6 months or less. Only three states, Alaska, Louisiana, and West Virginia, have waiting periods of 12 months, and only above certain income levels.[4]

(View http://ccf.georgetown.edu/index/medicaid-and-schip-programs for up-to-date waiting periods for children in Medicaid/SCHIP by state.)

Issues to Consider

Any policy that leaves children uninsured for a period of time should be considered in the context of the health consequences and financial costs associated with limited access to health care. As such, when setting waiting periods, there are several issues that states should consider.

The Price of Waiting Periods can be High

Waiting periods clearly can harm children by requiring them to go without coverage for longer than necessary. Research has shown that uninsured children generally have less access to medical care, especially primary care, and as a result may receive more costly care in emergency rooms or may altogether delay or forgo care necessary for their healthy development.[5] Delayed or forgone care of uninsured children can have adverse effects on their health and can make treatments more costly when a child is able to obtain coverage or secure medical services.

In addition, a state should consider the administrative costs that could accompany the imposition of a waiting period. Any modification to eligibility standards is likely to require a change to the application form, especially if a state implements more than one standard (i.e. a longer waiting period for children with higher incomes). Changes to the technical systems that process applications and determine eligibility might also be necessary.[6]

The Effectiveness of Waiting Periods is Under Debate

It is not clear how effective waiting periods are in minimizing crowd out. For instance, one study found little evidence that waiting periods reduce crowd out,[7] but another study found an inverse relationship between waiting periods and crowd out, (specifically, they estimate a 50 percent substitution rate with no waiting period and no substitution with a six-month waiting period).[8] In combination with minimal state-based evidence of a crowd out problem, many states have reduced or eliminated the waiting period since SCHIP was first implemented.[9]

On April 9, 2008, Peter Orszag, Director of the Congressional Budget, citing the studies above, testified that it is not clear that waiting periods will help reduce crowd out. To the contrary, a long waiting period may have as much of a negative effect on the enrollment of uninsured children, as it does on children who might have had private coverage. In fact, several studies have shown that mandatory waiting periods reduce SCHIP enrollment, which may suggest that waiting periods not only restrict the number of eligible kids, but also create the impression of a less available program, discouraging even those who are in fact eligible from applying.[10]

(For more on addressing crowd out in SCHIP, see the Center for Children and Families website: http://ccf.georgetown.edu/index/strategy-center.)

States Have Flexibility in Targeting the Waiting Period

The purpose of establishing a waiting period in SCHIP is to deter families from substituting public coverage for affordable private options. Because waiting periods can only be applied to separate SCHIP programs, there is a lower income level at which waiting periods will not be applicable. In addition, states may further limit the income level at which the waiting period is in effect (for example, West Virginia has a six-month waiting period for children with incomes less than 200 percent of the FPL and a 12-month waiting period for those with incomes between 200 percent and 220 percent of the FPL). States also may institute a waiting period only for certain ages; such as in Pennsylvania where children under age two are exempt so no important immunizations or screenings are missed.

States should also consider the waiting period in relation to affordable and quality coverage. For example, in Wisconsin, the plan must meet Health Insurance Portability and Accountability Act (HIPPA) standards and an employer must contribute 80 percent of the premium in order for the coverage to be deemed "affordable." States could also decide to require that certain benefits be included in the private coverage, such as those covered by Early Periodic Screening, Diagnosis and Treatment (EPSDT).

- **States Often Have Exceptions to Waiting Periods**
  States routinely allow exceptions to the waiting period for children who lost private coverage for reasons that may be out of their control. Some states consider general exemptions, such as when families lose coverage through "no fault" of their own or who drop private coverage for "good cause." Many states have specific exemptions, such as:

  - A **change in family structure**, due to the death of a parent or a divorce;
  - The **loss of or change in employment**, such as a parent being laid off or accepting a new job or position in which health care benefits are not offered;
  - A **loss or change in benefits**, for example an employer no longer offers coverage, an employer does not offer dependent benefits, COBRA coverage is expired, or coverage is terminated because lifetime maximums have been reached;
  - **Cost sharing** requirements (including premiums) that are not affordable, often defined as a percentage of income;
  - **Special health care needs**, such as a disability, or a pre-existing condition that makes private coverage options unavailable.[11]
  - **Other less common exceptions** include exemptions for survivors of domestic violence or the self-employed. The lack of access to local medical services, or the loss of coverage when a parent leaves work to serve as the primary caretaker for a young child are also considered good cause exceptions.

  (For examples of legislative or regulatory language from states with broad exemption policies see: California, Pennsylvania, New Hampshire, and Rhode Island on the Center for Children and Families website at: http://ccf.georgetown.edu/index/strategy-center.)

State Experiences

Pennsylvania: When Pennsylvania implemented its SCHIP expansion to 300 percent of the FPL in early 2007, it imposed a requirement that children be uninsured for six months before enrolling in coverage (with exemptions for good cause reasons). In response to the concerns of pediatricians and child health advocates that young children might therefore miss vital screenings and immunizations, the state opted to exempt children under the age of two from the six-month uninsured waiting period.

New Jersey: New Jersey's original SCHIP state plan covered children up to 200 percent of the FPL and included a 12-month waiting period. In 1999, the state sought to reduce the waiting period from 12 months to six months because program experience and a review of demographic data indicated that by doing so the state could cover more uninsured children without crowding out private coverage.[12] Since 2000, New Jersey has added exceptions to its waiting period and further reduced it to 3 months.

Other States: Since originally implementing their SCHIP programs, a number of states have reduced their waiting periods, usually in response to their crowd out experience. For example, since they implemented their SCHIP programs, Arizona, Connecticut, Montana, New Jersey, New Mexico, and Virginia have reduced the length of their waiting period; and Iowa, Kansas, Louisiana, Mississippi, North Carolina, and Rhode Island have completely eliminated their waiting period.[13]

For More Information

- Addressing Crowd Out
  Center for Children and Families, 2008
  This strategy brief defines crowd out and provides a legislative history and detailed discussion of the available data used to measure crowd out in SCHIP. It also discusses state strategies and the issues to consider when addressing crowd out.

- The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs
  J. McInerney, M. Hensley-Quinn, & C. Hess, National Academy for State Health Policy, 2008
  This report examines the requirements within the August 17th directive that are of the greatest concern to states, including the 12-month minimum waiting period. It provides background on current state policy and practice, as well as discussing the implications of the directive.

- SCHIP Approved State Plan Information
  Centers for Medicare and Medicaid Services (CMS)
  CMS posts the currently approved SCHIP State Plans, all state plan amendments (SPAs), and press releases on this web site. Most states discuss the details of their waiting periods, if applicable, in section 4.4.4 of their state plan amendment.

Endnotes

[1] Section 2102(b)(3)(C) of the Social Security Act.
[2] SCHIP was created through the Balanced Budget Act of 1997. By September 30, 1999, SCHIP plans had been approved for all 56 states, territories, and the District of Columbia; the majority (53) had implemented their programs as of October 1999.
[3] D. Cohen Ross, A. Horn & C. Marks, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," Kaiser Commission on Medicaid and the Uninsured (January 2008), Table 2.
[4] Illinois has a 12-month waiting period for the state-funded coverage of some children; Wisconsin has a 12-month waiting period that is applicable in certain circumstances where a family currently has access to employer-sponsored insurance; *op. cit.* (5); updated by Center for Children and Families.
[5] For example, see C. Hoffman, K. Schwartz, & J. Tolbert, "The Uninsured: A Primer," Kaiser Family Foundation (October 2007); and W. Johnson & M. Rimsza, "The Effects of Access to Pediatric Care and Insurance Coverage on Emergency Department Utilization," *Pediatrics*, 113: 483-487 (2004).
[6] J. McInerney, M. Hensley-Quinn, and C. Hess, "The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs," National Academy for State Health Policy (April 2008).
[7] J. Gruber & K. Simon, "Crowd-out 10 Years Later: Have Recent Public Expansions Crowded Out Private Health Insurance," *Journal of Health Economics*, in press (2008); also available as NBER Working Paper #12858 (January 2007).
[8] A. Lo Sasso & T. Buchmueller, "The Effect of State Children's Health Insurance Program on Health Insurance Coverage," *Journal of Health Economics,* 23: 1059-1082 (September 2004).
[9] *op. cit.* (5).
[10] K. Kronebusch & B. Elbel, "Simplifying Children's Medicaid and SCHIP: What Helps? What Hurts? What's Next for States?" *Health Affairs*, 23(3) (May/June 2004); B. Wolfe & S. Scrivner, "The Devil May Be in the Details: How the Characteristics of SCHIP Programs Affect Take-Up," *Journal of Policy Analysis and Management*, 24(3) (Summer 2005); and C. Bansak & S. Raphael, "The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children's Health Insurance Program," *Journal of Policy Analysis and Management*, 26(1) (Winter 2007);
[11] M. Rosenbach, *et al.,* "Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations," Mathematica Policy Research (2003); and N. Kaye, C. Pernice, & A. Cullen, "Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs," National Academy for State Health Policy (September 2006).

[12] New Jersey State Plan Amendment 1, (Approved May 7, 1999).
[13] *op. cit.* (5).

The report was prepared by Martha Heberlein, the Center for Children and Families, with support from the Robert Wood Johnson Foundation.

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