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SCHIP

State Children's
Health Insurance
Program Evaluation

During their first year facing severe budget stringency, SCHIP administrators in the ANF states reported very few actual cutbacks, especially in eligibility or benefits.

SCHIP Dodges the First Budget Ax

Embry Howell, Ian Hill, and Heidi Kapustka

The five-year-old State Children's Health Insurance Program (SCHIP), which currently benefits 3.8 million low-income children, is facing its first real fiscal challenge, as states contend with deficits surpassing \$36 billion in fiscal 2002.

What are the prospects for retrenchment of this joint federal-state endeavor? To answer that question, Urban Institute health policy researchers interviewed SCHIP administrators and other officials in 13 states during summer 2002. The study, part of the Urban Institute's multiyear SCHIP evaluation being conducted by its *Assessing the New Federalism* (ANF) project, looked at how SCHIP is faring in Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.

SCHIP budgets in almost all these states, which together account for 64 percent of SCHIP enrollment, are under exceptional pressure because of deteriorating budget conditions, swift growth in SCHIP enrollment, and, in some cases, a lack of SCHIP funds carried over from earlier years. Yet SCHIP directors reported very few cutbacks in eligibility or benefits for fiscal year (FY) 2002. Only New Jersey, a state with rapidly increasing enrollment and a large forecasted deficit, restricted eligibility—but even there the limitations applied to parents and not children.

None of the ANF states cut its benefit package in FY 2002. In fact, Colorado,

Florida, Mississippi, and New York continued plans made before the budget squeeze to enhance their benefits, primarily for dental care. And while many ANF states have reduced their outreach efforts, this contraction largely reflects the perception that a mature program like SCHIP requires less advertising.

Premiums did start to rise in New Jersey in FY 2002, and Texas imposed additional copayments on some services. However, only one state, Minnesota, has cut reimbursement rates to health plans (by 0.5 percent).

Interview results show that many factors explain why SCHIP is largely immune to significant cuts—including SCHIP's relatively small size (compared with Medicaid), the fact that it is not an entitlement program, its high federal match rates, and its success at insuring a high number of previously uninsured children. But this resilience could change if state budget difficulties persist, enrollments continue rising, or congressional funding falters.

SCHIP after the Boom

The State Children's Health Insurance Program was initiated in a time of unprecedented economic expansion. As a result, states were able to readily institute SCHIP requirements using the funding flexibility granted by the Title XXI statute. Specifically, all 50 states and the District of Columbia took only two years to adopt

SCHIP programs; all but 11 states established upper income eligibility limits at 200 percent of the federal poverty level (FPL) or higher; and many states invested unprecedented resources in outreach and enrollment simplification, adopted fairly comprehensive benefit packages, and imposed relatively low levels of cost sharing (Dubay, Hill, and Kenney 2002).

However, for the first time in the life of SCHIP, states are facing severe economic difficulties. Forty-six states confronted budget deficits in FY 2002, leading to a combined deficit by June 30 of \$36.1 billion across all states. State fiscal situations are expected to deteriorate even further in FY 2003, with combined deficits predicted to increase to \$57.4 billion (National Conference of State Legislatures 2002). To close these budget gaps, states have been forced to use special “rainy day” funds, spend tobacco settlement funds in unplanned ways, raise taxes, or make program cuts.

During 2002, state budgets were particularly burdened owing to continued growth in Medicaid spending, a program claiming more than 20 percent of all state budgets. According to the National Association of State Budget Officers (2002), Medicaid spending increased by 13.3 percent in FY 2002 and 10.6 percent in FY 2001. In contrast, total state revenue grew only 5 percent between FY 2000 and FY 2002.

SCHIP is a much smaller program than Medicaid. At the federal level, total SCHIP expenditures were only \$2.7 billion in FY 2001, compared with \$130.4 billion for Medicaid (Congressional Budget Office 2002). However, SCHIP spending continues to grow rapidly

because of enrollment increases. SCHIP expenditures increased by almost 46 percent from FY 2000 to FY 2001 (Kaiser Commission on Medicaid and the Uninsured 2002) and are forecast to grow by 74 percent from FY 2001 to FY 2005, a rate substantially exceeding the 38 percent growth forecasted for Medicaid (Congressional Budget Office 2002). Consequently, although small in scale relative to some other state programs, growth in SCHIP also puts increasing pressure on state budgets.

SCHIP Programs in the ANF States

The ANF states include the four largest states in terms of SCHIP enrollment—California, Florida, New York, and Texas—which together account for over half the nation’s SCHIP population. The 13 states account for 64 percent of total SCHIP enrollment. It is important to note that SCHIP programs in the 13 ANF states differ in several distinct ways from SCHIP programs in other states. First, while roughly two-thirds of all states created separate programs (either alone or in combination with Medicaid expansions), 11 of the 13 ANF states started such programs. Second, the ANF states have higher than average eligibility thresholds. While in 2002 the national average income threshold for SCHIP was 213 percent of FPL, the ANF state average was 227 percent of FPL.¹ Very few states cover parents under SCHIP, but three ANF states do (New Jersey, Minnesota, and Wisconsin). In addition, the ANF sample includes two of the nation’s three programs that were “grandfathered” into SCHIP by virtue of their history as state-funded child health programs (Florida and New York). In most

other ways, however, the ANF states offer a representative cross-section of the nation’s SCHIP programs. Similar to other states across the nation, each ANF state has aggressively conducted outreach, simplified enrollment, adopted generous benefits coverage, imposed cost sharing, and implemented various policies to prevent crowd out.

Almost all the ANF states face pressure on their SCHIP budgets, either through rapid enrollment growth or a lack of carryover SCHIP funds from previous years (see table 1). Some characteristics of the 13 SCHIP programs in the ANF states are critical to understanding how state officials assessed their SCHIP budget situations:

- Eleven of the ANF states have separate programs.² This distinction matters for state budgeting, since a separate program can be “capped” (for example, applicants can be put on a waiting list), while a Medicaid SCHIP program cannot.
- Most ANF states have sources of funding for the state match that are outside the state general funding process. For example, 9 of the 13 states use tobacco settlement funds for some portion of the state match, and 5 use some other non-general-revenue source. Three states protect their SCHIP funds by placing them in special accounts. These additional sources of financing provide some protection from the competition for general revenue funds.
- All but three ANF states have experienced growth in SCHIP enrollment between FY 2001 and

TABLE 1. Characteristics of SCHIP Programs and Financing in ANF States

State	Type of SCHIP program	Number of children enrolled FY 2002 (Q2) ^a	Percent increase in enrollment FY 2001 to 2002 ^a	Sources of SCHIP financing	Reallocated SCHIP funds received	Forecast of FY 2003 budget gap as percent of general fund budget
Alabama	Combination	47,779	43	General revenue and tobacco settlement funds	No	0.4
California	Combination	616,370	33	General revenue and tobacco settlement funds	No	28.0
Colorado	Separate	43,609	43	Designated fund; funded by general revenue and tobacco settlement funds	No	7.0
Florida	Combination	273,952	28	General revenue, tobacco settlement funds, and local matching funds	No	0.0
Massachusetts	Combination	69,978	-4	Designated fund; funded by general revenue and cigarette taxes	Yes	15.0
Michigan	Combination	47,240	-2	General revenue	No	4.1
Minnesota	Medicaid	23 ^b	109	Provider taxes	No	11.5
Mississippi	Combination	53,547	44	General revenue and tobacco settlement funds	No	0.0
New Jersey	Combination	100,629	22	General revenue and tobacco settlement funds	Yes	25.6
New York	Combination	594,521	0	Provider taxes	Yes	13.0
Texas	Combination	560,588	95	General revenue and tobacco settlement funds	No	0.0
Washington	Separate	7,621	68	Designated fund; funded by provider, liquor, and tobacco taxes, as well as tobacco settlement funds	No	8.0
Wisconsin	Medicaid	36,671	10	General revenue and tobacco settlement funds	Yes	5.0
Total	Combination: 9 Medicaid: 2 Separate: 2	2,452,528	22^c	General revenue: 10 Tobacco settlement funds: 9 Other sources: 5	Yes: 4 No: 9	Not available

Source: Data are from Centers for Medicare and Medicaid Services (2002a) ("Type of SCHIP Program"); Centers for Medicare and Medicaid Services (2002b) ("Number of Children Enrolled" and "Percent Increase in Enrollment"); Campaign for Tobacco-Free Kids (2002) ("Sources of SCHIP Funding"); Federal Register (2002) ("Reallocated SCHIP Funds Received"); and National Conference of State Legislatures (2002) ("Forecast of FY 2003 State Budget Gap").

a. Data represent children ever enrolled in the second quarter.

b. Minnesota covered children up to 275 percent of the federal poverty level under its MinnesotaCare program at the time SCHIP legislation was passed, so few children are covered by SCHIP. Minnesota received an SCHIP waiver in June 2001 that allows use of SCHIP funds to cover parents of children on MinnesotaCare.

c. Total for the percent increase in enrollment represents the nationwide total.

2002, often very substantial growth.³ The inclusion of parent coverage puts additional pressure on some programs.

■ Four of the ANF states (Massachusetts, New Jersey, New

York, and Wisconsin) met or exceeded expected enrollment growth early in the program and spent their full federal allocation. (As a result, they received reallocated federal matching funds from other states.) These states,

with enrollment continuing to grow in three of the four, cannot count on rollover funds from unused federal SCHIP money to cushion any funding setbacks.

We explored whether the ANF states have adopted any cost-cutting strategies for their SCHIP programs to address their budget difficulties through interviews with SCHIP administrators in each state.

We interviewed both the directors of SCHIP programs and others that the directors chose to participate. Since we did not interview the Medicaid directors (unless they also direct the SCHIP program), we could not get a complete or detailed picture of proposed and enacted Medicaid changes.⁴

How Did State SCHIP Programs Change during 2002?

During our interviews with SCHIP officials, we explored the extent to which states were either enacting, or considering enacting, restrictions in the areas of eligibility and enrollment, outreach, benefits coverage, cost sharing, and provider reimbursement. We also asked whether states had forgone or postponed planned expansions of coverage or services.

During their first year facing severe budget stringency, SCHIP administrators in the ANF states reported very few actual cutbacks, especially in eligibility or benefits. In interviews, officials voiced a reluctance to cut this popular program and emphasized that the need for SCHIP (and Medicaid) was heightened during the economic downturn. While states report that they are continuing to simplify their enrollment processes, many of them have reduced spending on outreach for the program; these reductions in part

reflect the perception that there is less need to advertise a mature program.

No state cut its SCHIP benefit package. In fact, counter to what one might expect during a period of tight budgets, some states reported a recent increase in program benefits. Looking to the future, more states are considering cuts to SCHIP than are considering expansions.

Table 2 shows the program areas in which ANF states enacted major SCHIP changes in 2002, as reported by program staff in the 13 ANF states. The following sections summarize the findings in more detail.

Eligibility

One aspect of SCHIP welcomed by some state policymakers is that the program is not an entitlement. In a separate SCHIP program, in contrast to Medicaid, a state has the flexibility to control program growth through a limit on the number of people enrolled. When states began facing budget hardships, some advocates for the program were concerned that states might restrict SCHIP eligibility to help control their SCHIP budget.

The only ANF state that restricted SCHIP eligibility in FY 2002 is New Jersey, which capped enrollment for parents but not children. The restriction applies only to parents who are new applicants, and does not affect eligibility for parents who are already enrolled. None of the ANF states enacted such restrictive measures for children. Two states—Alabama and Washington—are discussing the possibility of enrollment caps for children, though no firm proposals are yet in place. Washington has considered capping enrollment at its budgeted level of 7,000 children and forming a waiting list for new applicants. Two states have slightly expanded the number

of parents and children who are eligible for SCHIP. Colorado received approval of its waiver to cover pregnant women with income between 133 and 185 percent of FPL, and Wisconsin has expanded its premium assistance program. However, California, which received federal approval of a waiver to cover some of the parents of SCHIP enrollees, decided to forgo this planned expansion owing to its budget shortfall.

Enrollment Process

We also found that states are not interested in making their enrollment processes more difficult, and several states continue to simplify them. For example, California officials are considering allowing uninsured children who are screened by the state's Child Health and Disability Program to be "pre-enrolled" in SCHIP while a formal application is submitted. In New York, several measures are being considered, including eliminating the requirement for a face-to-face interview at enrollment renewal, adding a grace period for renewal application submission, and creating a simpler joint application form. Colorado plans to implement presumptive eligibility for the pregnant women it will cover. Florida has recently taken an array of steps to streamline the enrollment process, such as adding an online application. None of the states we interviewed is considering changing its waiting period for enrollment. Only one state has modified its enrollment process in a way that could possibly deter enrollment: Massachusetts no longer sends a reminder notice at renewal.

Outreach

While eligibility and the enrollment process remain largely unchanged, the majority of ANF states are reduc-

ing, or considering reducing, outreach spending. States reported several types of reduced SCHIP outreach efforts. California has eliminated funding for mass media campaigns and its outreach grants to community organizations. (Funding was retained, however, for the state's toll-free hotline and the Certified Application Assistance program.) In Florida, Minnesota, Mississippi, New Jersey, Texas, and Washington, outreach efforts are also being curtailed to varying degrees. Examples include reductions in the budgets for mass media (New Jersey), printing of brochures and other materials (Minnesota), and community outreach grants (Washington). State officials in Alabama and Massachusetts anticipate reductions in outreach spending in the near future. At the same time, New York has increased outreach spending this year in anticipation of its new (non-SCHIP) family coverage expansion.

Some states—such as Florida, Alabama, and Texas—do not view reductions in outreach as a budget strategy, saying instead that intensive outreach for a mature program is no longer necessary. In Texas, the long-term plan has always been to reduce state-funded outreach and emphasize community-funded outreach once the state reached its enrollment target of 485,000 children (which occurred in 2001).

Benefits

None of the 13 states has eliminated benefits, and four states expanded program benefits during 2002. Colorado and Florida substantially enhanced their SCHIP programs by adding dental benefits, and Mississippi improved its existing dental coverage. New York added emergency transportation and hos-

TABLE 2. Major Changes Enacted or Under Consideration in SCHIP Programs in ANF States

State	Eligibility	Enrollment process	Outreach	Benefits	Cost sharing	Reimbursement rates
Alabama			(-)		(-)	
California		(+)				
Colorado	(+)	+		+		
Florida		(-)	-	+		
Massachusetts			(-)			
Michigan						
Minnesota			-			-
Mississippi			-	+		
New Jersey	-		-	(-)		
New York		+	+	+		
Texas			-			
Washington	(-)		-		(-)	
Wisconsin	+					

Source: Urban Institute telephone interviews with state SCHIP administrators.

Key: - = Restrictions enacted + = Expansions enacted
 (-) = Restrictions considered (+) = Expansions considered

price benefits. Separate SCHIP programs may or may not offer such benefits, because these services are often not in the benchmark plans the states must use to set their benefit policies. Significantly, the movement toward covering dental care began in these states some time ago, so implementing the benefits in FY 2002 was the result of a long process initiated before the states' budget difficulties began. For example, Colorado and Florida were the only states not offering dental coverage in an earlier 18-state study of SCHIP dental benefits,

and Mississippi's benefits were more restrictive than most states (Almeida, Hill, and Kenney 2001).

Two states (Wisconsin and New Jersey) reported that they might consider reducing SCHIP benefits. Wisconsin may do so if the state's budget situation continues to deteriorate; however, there are no specific proposals under consideration. New Jersey has proposed changing the benefit package for parents to one with more limited benefits, similar to private coverage.

Cost Sharing

Cost sharing under SCHIP can come in the form of annual enrollment fees, monthly premiums, or copayments at the time of service delivery. Five states are either considering or have imposed increased cost sharing, which can affect program costs either through deterred enrollment (in the case of enrollment fees or premiums) or reduced use of services (in the case of copayments). In March 2002, Texas began imposing copayments on some services. Reportedly, however, Texas did not make these changes to raise additional revenues, but rather to reduce unnecessary service use. New Jersey has proposed raising premiums annually according to the growth in inflation. Program staff said that this decision was made with the view that SCHIP is based on a private-sector model, under which premiums rise annually.

Three states—Alabama, Massachusetts, and Washington—are considering increasing cost sharing as a cost-containment strategy. For example, Massachusetts proposes to increase premiums for families between 150 and 200 percent of FPL, although the level of the increase has not been determined. Washington is proposing to impose a premium for all families above 100 percent of FPL. The premium for families above 200 percent of FPL would increase from \$10 to \$20 per child per month. Washington would also increase drug copayments and add an emergency room copayment.⁵

Reimbursement Rates

Only one state reduced provider rates. Minnesota reported that it had cut reimbursements to health plans by 0.5 percent. Each year states must consider whether to increase or

reduce provider fees. If rates are not raised for inflation or kept on par with private sector rates, there is a risk that access to care will deteriorate. It is too early to tell whether the more subtle cost-containment strategy of a slow erosion in provider fees will characterize some SCHIP programs, as has been the case for many Medicaid programs over the years.

Why Is SCHIP Resilient?

Among the 13 ANF states, SCHIP programs were largely protected from the budget ax, even though these states were generally facing the toughest economic conditions and largest deficits they had seen in over a decade. The reasons given for this resilience include the following:

- SCHIP is widely viewed as addressing a vital need. As the number of uninsured children falls in many states, it is perceived as working well to achieve its primary goal.
- SCHIP programs in most states are small in relation to Medicaid. Therefore, they are not seen as overly costly.
- The fact that SCHIP is not an entitlement (in states with separate programs) reinforces governors' and state legislators' sense that they have some control over the program. This sense has led to a more positive program image but not, so far, to a significant use of capped program enrollment.
- A high federal match rate makes it extremely difficult to justify significant program cuts, especially as the increased cost of caring for uninsured children is like-

ly to lead to increased state-only expenditures.

- No governor or legislator wants to cut a program that explicitly serves children, especially during an election year.

We also found that many of the points outlined above apply to the Medicaid programs in the ANF states, at least to their coverage of children. However, because of its large size, Medicaid has not been ignored in the budget process to the degree that SCHIP has been to date.

Conclusion

As states enter FY 2003, they face continuing budgetary constraints and worsening deficits. Notably, in FY 2002, the ANF states did not make significant cuts in their SCHIP programs to save money. This finding is consistent with earlier research for a larger group of states (Fox, Reichman, and McManus 2002). It is important to emphasize, however, that the ANF experience may not be entirely representative of the national pattern. Indeed, several smaller non-ANF states have taken more stringent approaches (Ornstein 2002).

If state budget difficulties continue into another fiscal year, SCHIP (and its parallel program, Medicaid, which covers the lowest-income children) could fall under the budget ax. Already, more states say they are considering program restrictions as opposed to expansions. This is due to several factors, including continued program enrollment growth and an uncertain picture regarding future federal funding. (See Dubay, Hill, and Kenney 2002 regarding the impact of the "SCHIP Dip" on available federal funds.) Emerging patterns in some of the more mature and generous programs may signal how

other states respond to budget pressure. States with parent coverage may first consider cutting adult coverage before cutting benefits for children. States that modify their SCHIP programs for children are likely to begin with minor modifications, in an effort to safeguard recent gains in health care access among low-income children.

Notes

1. Data are current as of September 2002. A state's average income eligibility threshold for children was calculated by determining the income eligibility thresholds for children of each age up to age 19, summing the thresholds, then dividing by 19.
2. In nine of the ANF states, the separate program is combined with a Medicaid expansion, although the Medicaid expansion portion of the combined programs is declining in size in most of the states.
3. From FY 2001 to 2002, older children in combination programs began to be covered by Medicaid rather than SCHIP, because of the phasing in of mandatory Medicaid eligibility levels. This change explains the leveling off or decrease in SCHIP enrollment in some states.
4. Urban Institute researchers are currently studying Medicaid changes in 7 of the 13 ANF states.
5. The state has also applied for a waiver to impose the same copayments for Medicaid in order to retain consistency between the two programs.

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