

**SCHIP Family Coverage in Three States:**  
A Report on the Early Experiences of New Jersey, Rhode Island,  
and Wisconsin

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## EXECUTIVE SUMMARY

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As part of the Balanced Budget Act of 1997, Congress created the State Children's Health Insurance Program (SCHIP) by adding Title XXI to the Social Security Act. SCHIP gives states the option to provide coverage to certain low-income children who do not qualify for Medicaid. Although created to provide health coverage to children, SCHIP has also been viewed by some states as a possible vehicle for extending coverage to the parents of eligible children. These states have argued that providing coverage to both children and their parents offers a more effective—and ultimately a more successful—way to cover children.

In July 2000, The Centers for Medicare and Medicaid Services (CMS) announced that it would consider §1115 demonstration projects designed to use SCHIP funding to cover families (not just children). Several states submitted waiver applications, and on January 18, 2001, CMS authorized three states to extend SCHIP coverage to parents: New Jersey, Rhode Island, and Wisconsin. As part of its Congressionally mandated SCHIP evaluation, the Office of the Assistant Secretary for Planning and Evaluation contracted with George Washington University, which subcontracted with the National Academy for State Health Policy, to conduct site visits to the three approved states and to examine family coverage in their SCHIP programs: NJ Family Care, RIte Care, and BadgerCare (Wisconsin).

The early experience in the site visit states indicates that:

- family coverage is an effective way to cover children;
- employers, parents, health plans, and providers strongly support family coverage; and
- these programs do not appear to have had an impact on the private market.

### Findings: Program Design

New Jersey, Rhode Island, and Wisconsin all have a long history of covering families, first under Medicaid, and more recently under SCHIP. All three of these states pursued family coverage because they felt it was the most effective way to cover children. They believed, based on evidence from the literature and their own experience, that under family coverage:

- more children would enroll in Medicaid and SCHIP; and
- children would receive more primary and preventive health care.

In addition, each of these three states viewed family coverage as an important component of their efforts to achieve larger policy goals. New Jersey and Rhode Island wanted to reduce the number of uninsured in their states. New Jersey and Wisconsin saw SCHIP family coverage as a way to support families in their transition from welfare to work.

As a result of their interest in family coverage, all three states began covering adults before their SCHIP family coverage waivers were approved. Both New Jersey and Rhode Island did so under §1931 of the Social Security Act, while Wisconsin did so under a §1115 Medicaid waiver. The programs were not changed when the SCHIP waivers were approved so this study considers family coverage to have begun when each state first began covering parents of Medicaid and SCHIP enrolled children. Figure A summarizes basic SCHIP eligibility and premium requirements for families and children-only groups in the three states.<sup>1</sup>

**Figure A SCHIP income eligibility requirements and monthly premiums in the site-visit states**

FPL	New Jersey	Rhode Island	Wisconsin
400%			
350%	\$100		
300%	\$60		
250%	\$30		
200%	\$25 to \$50	\$3 to \$8	
185%			--- \$30 to \$75
150%			
133%	No premium	No premium	No premium
100%			

Children-only eligible
  Families (children and parents) eligible

## Findings: Program Impact

### Family coverage is an effective way to cover children

The three states found that family coverage increased children’s enrollment, and some evidence exists to suggest that family coverage has a positive impact on enrolled children’s utilization.

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<sup>1</sup> In addition to premiums, all enrollees in New Jersey pay small co-pays for each service provided. Those in Rhode Island can choose co-pays instead of premiums, and those in Wisconsin who are not children or enrolled in an HMO pay co-pays. The federal poverty level (FPL) for a family of four in 2001 was \$17,650 in the 48 contiguous states and the District.

Unfortunately, this study was unable to examine SCHIP family coverage's effect on children's retention because the programs had not operated long enough to produce sufficient data.

Two facts best indicate the effect of family coverage on children's enrollment.

1. All three states experienced rapid increases in enrollment when they expanded their programs to include parents of Medicaid and SCHIP eligible children.
2. All three states reported that the greatest growth was among children from lower-income families. In many of these families the children (but not the parents) could have been eligible for Medicaid before family coverage was implemented. In other words, even though some children in many of these families were eligible for Medicaid the families did not apply for coverage for their children until the parents could also be covered.

Although this early experience indicates that family coverage increases children's enrollment, it is not possible to identify how much of the increase in enrollment was due to family coverage and how much was due to other causes such as increased outreach efforts, streamlined enrollment, or erosion of the private insurance market.

The evidence for family coverage's effect on children's utilization in the site visit states is still anecdotal. Some health plans reported that parents understood the system better and were more "on top of things" when they were enrolled in the same health plan as their children. Providers also presented anecdotal evidence. As one provider noted: "Children are much more likely to become enrolled in programs and be taken in for preventive and primary care services if all family members can receive services at one medical home."

### **Employers, parents, health plans, and providers strongly support family coverage**

All stakeholder's interviewed in all three states were strongly supportive of family coverage.

- Employers supported the programs as a way to provide coverage to low-income families who may not work enough hours at a single job to qualify for employer-sponsored coverage and/or help families transition from welfare to work.
- Parents were overwhelmingly positive about family coverage and advocates' responses were almost as positive as families.'
- Health plans:
  - believed that treating the parent would ultimately benefit the child's health;
  - had been concerned about crowd-out during program start-up, but none except two plans in Rhode Island reported experiencing any crowd-out; and
  - were concerned that the cost of serving SCHIP parents was higher than the cost of serving Medicaid parents. They reported that SCHIP parents tended to be older than Medicaid parents and were more likely to have chronic conditions such as

diabetes. Rhode Island and Wisconsin raised capitation rates and instituted risk-sharing to address these concerns. (New Jersey already had risk-sharing in place at the time of the expansion.)

- Providers felt that providing coverage to the entire family not only increased the number of children enrolled in the program; it also improved the parents' health, enabling them to better care for their children.

### **SCHIP family coverage does not have an impact on the private market, but the private market does have an effect on these programs**

SCHIP enrollees in Wisconsin and New Jersey do not appear to have substituted private coverage with public coverage (i.e., these states did not experience crowd-out). In Rhode Island, people switched from private coverage to public coverage because of changes in the private market. Families dropped private coverage due to rapidly increasing premiums and the withdrawal of two of the four commercially licensed HMOs from the state's commercial market. Private coverage was no longer accessible or affordable. These stakeholders believed that those who dropped their private coverage would have done so even if RIteCare had not existed. Without RIteCare, however, they would have become uninsured.

One study of Rhode Island's SCHIP eligibles supports the stakeholders' opinions about crowd-out. It found that only nine percent of enrollees with incomes between 100 percent and 185 percent of FPL had access to private coverage at the time of application, an indication that people joined RIteCare because they lost access to private coverage. On the other hand, one health plan conducted a study that found that some people were switching from the plan's private product to its RIteCare product. However, the study did not address whether they were switching because they could no longer afford the private product.

All three SCHIP programs used waiting periods and cost-sharing to prevent crowd-out. However, most stakeholders felt that other factors—such as a strong economy, employer commitment to covering their employees, and the private insurance market—played a greater role in preventing crowd-out.

In all three states the private market and small group insurance laws had an effect on the SCHIP program. In New Jersey small group insurance laws helped prevent crowd-out by encouraging employers to keep coverage available *and* affordable; if 75 percent of qualified employees did not participate in the employer's plan the employer could not offer coverage to any employee. These laws have also created a firewall between private and public coverage: employees who work less than 25 hours each week do not qualify for employer coverage but do qualify for NJ FamilyCare if they are low-income. In Rhode Island the increasing premiums and decreasing choice of health plans in the private market contributed to rapid increase in RIteCare enrollment. Finally, in Wisconsin a healthy private market and high levels of employer coverage prevented crowd-out.

## INTRODUCTION

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Congress created the State Children's Health Insurance Program (SCHIP) in 1997 by adding Title XXI to the Social Security Act. SCHIP gives states the option to provide coverage to certain children.<sup>2</sup> A few states have recently been allowed, under an SCHIP §1115 waiver,<sup>3</sup> to use SCHIP funding to cover the *parents* of children enrolled in Medicaid and SCHIP.<sup>4</sup> This study examines family coverage efforts in the first three states to receive authorization to expand SCHIP coverage to parents: New Jersey, Rhode Island, and Wisconsin. The report is based on a literature review and site visits to those states.

### Why Cover Families, Not Only Children

The income levels of families in which both children and parents are covered by Medicaid are much lower than those of families whose children alone are covered by Medicaid or whose children qualify for SCHIP. However, some states have chosen to expand family coverage beyond federal requirements and to include more parents of eligible children in Medicaid and SCHIP. States have done so because they believe that covering parents has the potential to increase children's enrollment and boost children's use of primary and preventive care. States have also chosen to proceed with family coverage at higher income levels as part of a strategy to support a parent's transition from welfare to work and as a response to high rates of uninsurance among adults.<sup>5</sup>

### Covering families increases children's enrollment

The evidence that enrolling parents will promote children's coverage comes from experiences in several states and from the literature. One study looked at the changes in children's coverage that occurred in states that extended coverage to parents compared to states that did not. In three states that expanded Medicaid coverage to parents in the early 1990s (Hawaii, Oregon, and

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<sup>2</sup> Specifically, states may choose to serve children who (1) would not have been eligible for Medicaid in the state under the income limits in effect as of March 31, 1997; (2) are from families that earn less than a state-established limit (which may not exceed 200 percent of the federal poverty level or 50 percentage points above the state's income limits in effect as of March 31, 1997, whichever is higher); and (3) are uninsured.

<sup>3</sup> Under a §1115 waiver the Secretary can waive any Medicaid or SCHIP requirement if the request meets certain criteria.

<sup>4</sup> SCHIP family coverage is defined as using SCHIP (Title XXI) funding to cover parents of children eligible for Medicaid (Title XIX) and SCHIP as well as children eligible for SCHIP.

<sup>5</sup> See Appendix B.

Tennessee), children's enrollment increased from 51 percent to 67 percent of eligible children between 1990 and 1998. By contrast, in 41 states that did not expand coverage to parents, children's coverage increased from 51 percent to only 54 percent during the same time period. (Six states that implemented expansions later or that implemented expansions outside of Medicaid were excluded from the comparison.)<sup>6</sup>

Another recent study reported that the Medicaid participation rate for children was 57 percent in states without any type of family coverage, while it was 81 percent in states with Medicaid family coverage expansions.<sup>7</sup> The study concludes that covering parents can increase the extent to which uninsured children are enrolled in Medicaid and SCHIP.

An earlier study of policies initiated by the Omnibus Budget Reconciliation Act of 1989 found that when parents and older children in some families were ineligible for coverage, the situation discouraged participation by eligible children. The authors of this study also noted that including parents and children in the same package allowed for the use of a common health insurance package and network of providers, thus improving continuity of care and ease of administration.<sup>8</sup> The authors estimated that child-only expansions would enroll about 45 percent of those potentially eligible, while family-based expansions would enroll 75 percent of program eligibles.

More recently, Ohio experienced a significant rise in children's enrollment following an increase (from 80 to 100 percent of the Federal Poverty Level or FPL) in Medicaid eligibility for parents. In the six months before the parents' eligibility expansion, children's enrollment increased from 45,100 to 47,300 children, and in the six months after the expansion went into effect (on July 1, 2000), children's enrollment jumped to 66,600.<sup>9</sup>

### **Enrolling parents boosts children's use of health services**

A related benefit for children whose parents become enrolled is the positive effect on children's utilization of health services. Insured parents are more likely to access the health care system on

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<sup>6</sup> Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Coverages: New Research Findings about State Health Reforms* (Washington, DC: Center on Budget and Policy Priorities, September 2000).

<sup>7</sup> Lisa Dubay and Genevieve Kenney, *Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, October 2001).

<sup>8</sup> Kenneth E. Thorpe and Curtis S. Florence, *Covering Uninsured Children and Their Parents: Estimated Costs and Number of Newly Insured*, (New York, NY: Commonwealth Fund, July 1998).

<sup>9</sup> Vernon K. Smith, *CHIP Program Enrollment: December 2000* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, September 2001).

behalf of their children. Children of insured parents receive more preventive care and a more appropriate level of health services in general.<sup>10</sup>

For example, researchers in New York found that parents' use of services is a strong determinant of children's use of services, particularly among the insured. Parents with insurance are more likely to obtain health care services, and children are two to three times more likely to receive services if their parents use services. The authors state that even if all children were insured, parents' use of services would remain a key determinant of the children's use of services. They conclude that policies that integrate financing and delivery systems for all family members can foster better access for children.<sup>11</sup>

## **Federal Policies Addressing SCHIP Family Coverage**

Since 1965, the U.S. Department of Health and Human Services (DHHS) has had the authority to grant §1115 research and demonstration waivers to states for Medicaid. Under these waivers, the Secretary can waive any federal requirement if the project meets certain criteria such as budget neutrality. In the past, several states have used Medicaid §1115 waivers to use Medicaid funding to cover higher-income families. In July 2000, The Centers for Medicare and Medicaid Services (CMS, then the Health Care Financing Administration or HCFA) issued a Letter to State Health Officials with a Q & A section that specified that it would consider §1115 demonstration projects conducted with SCHIP funding that met specific guidelines. The letter indicated that SCHIP funds were intended to cover children, but demonstrations would be considered if:

- the SCHIP program had operated for at least one year;
- the state had submitted all evaluation and enrollment reports to CMS (HCFA);
- the demonstration had identified objectives and included an evaluation; and
- the state had already expanded coverage to low-income children up to 200 percent FPL.

CMS further specified three criteria it planned to use to assess whether a state sufficiently promoted enrollment of the target population of children in families with incomes below 200 percent FPL.

1. The state must show that children under 200 percent FPL are eligible for SCHIP statewide and that no waiting lists exist.
2. Low-income members of the eligible population must be targeted before higher-income potential enrollees.

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<sup>10</sup> See Note 7.

<sup>11</sup> Karla L. Hanson, "Is insurance for children enough? The link between parent's and children's health care use revisited," *Inquiry* 35, no. 3, (Fall 1998): 294-302.

3. The state's enrollment and renewal process must be streamlined, which CMS defined as the state having adopted at least three of the following five policies:
  - a. use of a joint mail-in application and a common application procedure for SCHIP and Medicaid;
  - b. elimination of assets tests;
  - c. use of 12-month continuous eligibility;
  - d. use of procedures that simplify the renewal process by allowing families to mail in forms and, in states with separate SCHIP programs, by establishing simple and effective transfer procedures between Medicaid and SCHIP; and/or
  - e. use of presumptive eligibility for children.

In addition to SCHIP §1115 waivers, states have three other options for covering parents of Medicaid and SCHIP eligible children. These are not examined in this report except as they relate to the site-visit states' family coverage under the SCHIP §1115 waiver.

1. Delaware, Hawaii, Massachusetts, Minnesota, Missouri, New York, Oregon, Tennessee, Vermont, and Wisconsin use §1115 Medicaid waivers to cover parents and, in some cases, adults without children with incomes ranging from 100 percent FPL to 400 percent FPL.<sup>12</sup>
2. California, Connecticut, the District of Columbia, New York, and Rhode Island make use of comparatively high income eligibility levels under §1931 of the Act to cover parents with incomes ranging from 100 percent FPL to 200 percent FPL.<sup>13</sup>
3. States may also implement premium assistance programs under which they may purchase employer-sponsored family coverage from private insurance companies by paying the family's share of the premium, if the family and the coverage meet certain criteria. All three study states operate premium assistance programs in the Medicaid and/or SCHIP programs.

Finally, the Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA)<sup>14</sup> released August 10, 2001, simplifies the approval process for §1115 waivers. Under HIFA, a state can submit electronically a §1115 waiver request to make certain changes to its Medicaid

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<sup>12</sup> Melora Krebs-Carter and John Holahan, *State Strategies for Covering Uninsured Adults* (Washington, DC: The Urban Institute, *Assessing the New Federalism Discussion Paper 00-02*, February 2000). And Jeanne Lambrew, *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, July 2001) [www.gwhealthpolicy.org](http://www.gwhealthpolicy.org).

<sup>13</sup> New Jersey also covered parents under §1931 prior to approval of its SCHIP §1115 waiver.

<sup>14</sup> More information on HIFA is available at: <http://www.hcfa.gov/medicaid/hifademo.htm>

and/or SCHIP program (including covering the parents of children who are SCHIP enrollees). When doing so, states must use a standard template to make budget neutral changes to their state programs. (HIFA is also not examined in this report because none of the site-visit states had any experience with this new initiative at the time of the site visits.)

## **First SCHIP family coverage waivers**

The first family coverage waivers under SCHIP were granted on January 18, 2001, to New Jersey, Rhode Island, and Wisconsin. New Jersey and Rhode Island also cover pregnant women under their waivers. Since then, family coverage waivers have been granted to New York (in May 2001) and Minnesota (in June 2001). California submitted a waiver to cover parents which has since been delayed for two years due to severe budget shortfalls in that state.<sup>15</sup>

## **Study Purpose**

A Congressional mandate requires the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to evaluate SCHIP. In June 2001, ASPE contracted with George Washington University, which subcontracted with the National Academy for State Health Policy (NASHP), to conduct the study upon which this report is based. The study was designed to inform ASPE's report to Congress and examines the early efforts of New Jersey, Wisconsin, and Rhode Island to expand coverage to parents of children eligible for Medicaid and SCHIP. The study focused on program design, enrollment, effect on the private market, and impact on children's health coverage.

## **Study Method**

NASHP staff conducted a literature review and site visits to three states: Rhode Island (July 30-31, 2001), New Jersey (August 2-3, 2001), and Wisconsin (September 19-21, 2001). The site-visit states were selected by ASPE and were chosen because they were the first states to begin enrolling parents into their SCHIP programs. Other states have covered parents of SCHIP and Medicaid eligible children under §1931 or a Medicaid §1115 waiver, but those programs are not discussed here except as they relate to family coverage in the three site-visit states. In each of the three states, NASHP staff interviewed representatives of a range of stakeholder groups, including SCHIP staff, the staff of managed care organizations (MCOs), advocates and parents, employers, state insurance agency staff, legislators, and Governors' health policy advisors.

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<sup>15</sup> Andrew LaMar, "Davis goes after \$2.2 billion in cuts to budget," *Contra Costa Times*, November 15, 2001.

NASHP staff prepared separate but similar protocols for each group of stakeholders. (See Appendix D.) These site-visit protocols were derived from the eight research questions the study was to address:

1. What factors motivated the states to expand coverage to parents of Medicaid and SCHIP-eligible children?
2. How are the states implementing family coverage expansions and what issues are they currently facing?
3. How has implementation of family coverage affected enrollment of children into Medicaid and SCHIP and disenrollment from these programs? What barriers remain for eligible, but not enrolled, parents and children?
4. What interaction has occurred with this expansion and the private market, particularly in the area of substitution of coverage?
5. What has been the reaction among employers, insurers, parents, health plans, and providers?
6. How are the states addressing unanticipated consequences of their family coverage expansions?
7. What are the states' policies regarding cost sharing? What factors went into the states' decisions regarding the cost-sharing limits?
8. What are the costs associated with these programs?

Based on the literature review, NASHP staff also prepared a matrix (Appendix A) outlining pertinent aspects of the family coverage and SCHIP program in each state. State program staff reviewed the matrix and the draft of this report to ensure accuracy.

## **Study Limitations**

As they consider this report, readers should bear in mind the following:

- The report presents information that was available during the site visits, as reported by stakeholders and documented in state policies. The authors wish to caution readers that policies may have changed and that the views of informants may not always reflect the opinions of the constituencies they represent.
- This report reflects these states' early experiences with SCHIP family coverage. Findings regarding family coverage may change as these programs mature.

- Stakeholders in all three states viewed SCHIP family coverage as part of a larger comprehensive program. This viewpoint made it difficult for stakeholders to separate their experience and opinions about covering parents in SCHIP from covering children or others, such as childless adults, who were enrolled into the program. (Some of these groups were enrolled solely with state funding.)



## SITE VISIT FINDINGS: PROGRAM DESIGN

Before discussing the effect of family coverage in New Jersey, Rhode Island, and Wisconsin, it is important to understand the design of each state's program (Table 1), including the reasons why the state pursued the expansion and a brief history of family coverage in each state.

It is also important to remember that many families will have a mix of Medicaid and SCHIP eligibility:

- The children (but not the parents) may be eligible for traditional Medicaid as poverty level children while the parents are covered by the SCHIP family coverage waiver.
- The younger children in the family may be eligible for traditional Medicaid as poverty level children while the older children are enrolled in SCHIP and the parents are covered by the SCHIP family coverage waiver.

**Table 1 Summary of basic program information for the three site-visit states**

State	New Jersey	Rhode Island	Wisconsin
<b>Program name</b>	NJ FamilyCare (adults) NJ KidCare (children)	RlteCare	BadgerCare
<b>SCHIP program type</b>	<ul style="list-style-type: none"> <li>• Medicaid expansion</li> <li>• Separate</li> </ul>	Medicaid expansion	Medicaid expansion
<b>SCHIP waiver submitted</b>	September 26, 2000	November 2, 2000 January 2001, revised	March 10, 2000
<b>SCHIP waiver approved</b>	January 18, 2001	January 18, 2001	January 18, 2001
<b>SCHIP waiver program enrollment started</b>	<ul style="list-style-type: none"> <li>• October 1, 2000, SCHIP parent enrollment began under §1931.</li> <li>• January 18, 2001 enrollment of parents did not change but the cost of serving parents with family incomes over 133% FPL shifted to SCHIP</li> </ul>	<ul style="list-style-type: none"> <li>• November 1998, SCHIP parent enrollment began under §1931 with Medicaid funding</li> <li>• January 18, 2001 enrollment of parents did not change but the cost of serving parents with family incomes from 100-185% FPL and pregnant women from 185-250% FPL shifted to SCHIP</li> </ul>	<ul style="list-style-type: none"> <li>• July 1999, SCHIP parent enrollment began under a Medicaid §1115 waiver with Medicaid funding</li> <li>• January 18, 2001 enrollment of parents did not change but the cost of serving parents with family incomes over 100% FPL shifted to SCHIP</li> </ul>
<b>SCHIP family income limit</b>	Medicaid expansion: 133% FPL  Separate: 200% FPL	185% FPL	Applicants may earn up to 185% FPL but once enrolled may earn up to 200% FPL w/out losing eligibility
<b>SCHIP children income limit</b>	Medicaid expansion: 133% FPL  Separate: 350% FPL (through disregards)	Children up to 250% FPL, up to age 19	Same as family

## Eligibility, Including Waiting Periods

All three states use SCHIP funding to cover parents and children—New Jersey and Rhode Island also cover pregnant women (Table 2). Both New Jersey and Wisconsin cover families (parents and children) up to 200 percent FPL, while Rhode Island covers them up to 185 percent FPL. Also, among the three programs, both New Jersey and Rhode Island have a higher income limit for children than for families (parents and children), while Wisconsin uses the same limit for all enrollees. Finally, New Jersey and Rhode Island exceed the 200 percent of FPL for children’s coverage that CMS requires for states applying for SCHIP §1115 waivers.

**Table 2 Groups covered by SCHIP funding in the site-visit states**

State	People covered by SCHIP funding
<b>New Jersey</b> <sup>16</sup>	<ul style="list-style-type: none"> <li>• Parents with incomes from 133-200% FPL (parents with incomes below 133% FPL are served with Medicaid funding);</li> <li>• Pregnant women with incomes from 185-200% FPL; and</li> <li>• Children up to age 19 from families with incomes below 350% FPL, who did not qualify for Medicaid under the policies in effect on March 31, 1997.<sup>17</sup></li> </ul>
<b>Rhode Island</b>	<ul style="list-style-type: none"> <li>• Families (parents and children) with incomes from 100-185% FPL (families with incomes below 100% FPL are served with Medicaid funding);</li> <li>• Pregnant women from 185-200% FPL; and</li> <li>• Children up to age 19 from families with incomes from 185-250% FPL.</li> </ul>
<b>Wisconsin</b>	<ul style="list-style-type: none"> <li>• Families (parents and children) with incomes from 100-185/200% FPL<sup>18</sup> (families with incomes below 100% FPL are served with Medicaid funding).</li> </ul>

In addition to limiting family income all three states also limit eligibility by imposing waiting periods. In New Jersey those with incomes above 133 percent FPL must wait six months since their last health insurance coverage to enroll. In Rhode Island those over 185 percent FPL must wait four months,<sup>19</sup> and in Wisconsin all enrollees must wait three months. These states have exceptions to this general rule. New Jersey, for example, provides that a child whose gross

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<sup>16</sup> In addition to those covered with SCHIP funding, New Jersey uses state funding to cover: (1) couples without dependent children who earn less than 100 percent FPL; (2) single adults who earn less than 100 percent FPL; and (3) legal aliens entering the U.S. for permanent residence within the last five years, including children, up to 350 percent FPL.

<sup>17</sup> New Jersey disregards all income between 200 and 350 percent of FPL to achieve a maximum income limit of 350 percent FPL.

<sup>18</sup> Wisconsin covers applicants (children and parents) up to 185 percent FPL, but once a family is enrolled the state allows the family income to increase to 200 percent FPL without loss of eligibility.

<sup>19</sup> Since Rhode Island does not cover parents with incomes over 185 percent FPL the waiting period applies only to children from families with incomes over 185 percent FPL.

family income does not exceed 200 percent of FPL will be exempted from the six-month waiting period if the child was covered under an individual health benefits plan or COBRA plan prior to application for NJ KidCare.

## **Service Delivery**

New Jersey, Rhode Island, and Wisconsin enroll parents into SCHIP programs that are expansions of their Medicaid program. Parents enrolled in the Medicaid expansion programs receive the full Medicaid benefit package. New Jersey also enrolls parents into the component of their separate program that covers from 133 percent FPL to 200 percent FPL. Parents enrolled in the separate program receive a comprehensive benefit package that mirrors the most widely sold commercial HMO in New Jersey.

All three states operate Medicaid managed care programs and deliver care to SCHIP enrolled families through that delivery system. (Wisconsin also serves enrollees through the Medicaid fee-for-service program in a few areas of the state.) Both Medicaid beneficiaries and SCHIP families are enrolled in the same health plans and their plans deliver the same benefit package to both groups. All members of the same family are enrolled in the same plan, regardless of whether individual family members are funded by Medicaid or SCHIP. In other words all members of enrolled families are subject to the same policies regarding delivery of care; whether a family member's care is funded by Medicaid or SCHIP is transparent to families and providers.

Families, advocates, health plans, and providers feel that this transparency is important to making the program work for families because it facilitates the establishment of a single medical home for the family. Plans and providers also reported that this transparency reduces the administrative burden on the plans and providers who do not have to treat the parents differently from their children, except when their needs for care differ. The MCOs are aware of the source of funding for services provided to each family member so that they can track the cost and utilization of the waiver groups separately from other Medicaid enrollees. This has been particularly useful for comparing the cost and utilization of SCHIP parents with that of other Medicaid adults.

All three states also operate premium assistance programs,<sup>20</sup> although few people were enrolled in these programs at the time of the site visits. Families participating in a premium support program receive their employer's package of benefits and may also receive some wrap-around services to bring the employer coverage in line with that of the Medicaid/SCHIP program. Stakeholders in these states felt that premium assistance programs are important because they support the private market and keep employer dollars in the system. RIteCare staff, in particular,

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<sup>20</sup> Under a premium assistance program the Medicaid/SCHIP program buys into an employer's coverage for an enrollee by paying the employee's share of cost.

felt strongly about this due to the turmoil it is experiencing in the private market and its effect on SCHIP and Medicaid.

## Cost Sharing

All three states require some SCHIP enrollees to pay a portion of their costs in the form of monthly premiums and/or co-pays for some services (Table 3). These states limit their cost-sharing requirements to enrollees who have higher incomes:

- New Jersey and Wisconsin both apply cost sharing to enrollees with family incomes above 150 percent FPL.<sup>21</sup> In addition:
  - New Jersey does not charge co-pays for prenatal or preventive services;
  - Wisconsin does not require children or HMO enrollees to pay co-payments, although all families have to pay premiums;<sup>22</sup> and
  - Wisconsin prorates the premiums paid by American Indian families to exclude the children.<sup>23</sup>
- Rhode Island's cost-sharing requirements only apply to enrollees with family incomes of 185 percent FPL or above. Since the upper-income limit for families is 185 percent FPL, the cost-sharing requirements currently apply only to children and pregnant women.

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<sup>21</sup> Under federal law, no state may apply cost sharing to enrollees with family incomes below 150 percent FPL without a §1115 waiver.

<sup>22</sup> These two exclusions effectively eliminate co-payment requirements for most families enrolled in Medicaid and SCHIP.

<sup>23</sup> The tribes object to this practice because they believe the government has an obligation to provide health care to American Indians, an obligation made, in treaty, in exchange for land.

**Table 3 Enrollee cost-sharing policies in the three states**

	<b>New Jersey</b>	<b>Rhode Island</b>	<b>Wisconsin</b>
<b>Monthly Premium Amounts</b>	<ul style="list-style-type: none"> <li>• Up to 150%: no premium</li> <li>• 151-200%: \$25 for first adult, plus \$10 for second adult, plus \$15 for children</li> <li>• 201-250%: \$30 for all children in the family (no adult coverage above 200%)</li> <li>• 251-300%: \$60/family</li> <li>• 301-350%: \$100/family</li> </ul>	<ul style="list-style-type: none"> <li>• Up to 185%: no cost sharing</li> <li>• 185-300%: choice of either sliding scale premiums or co-payments (premiums range from \$3 to \$8)</li> </ul>	<ul style="list-style-type: none"> <li>• Up to 150%: no premium</li> <li>• Above 150%: no more than 3% of income               <ul style="list-style-type: none"> <li>– \$25,050-\$30,894: \$30/family</li> <li>– \$30,895-\$33,400: \$75/family</li> </ul> </li> <li>• Premiums paid by American Indian families are pro-rated to exclude children</li> </ul>
<b>Co-Payments</b>	<ul style="list-style-type: none"> <li>• No co-pays for prenatal and preventive services</li> <li>• Start at 151% FPL for families and at 185% FPL for pregnant women:               <ul style="list-style-type: none"> <li>– \$5 office visit</li> <li>– \$5 outpatient surgery</li> <li>– \$5 lab and x-ray</li> <li>– \$5 prescription drugs</li> <li>– \$25 mental health outpatient</li> <li>– \$25 psychological services</li> <li>– \$35 ER visit</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Start at 185% FPL</li> <li>• Apply only if select co-pay as alternate to premium:               <ul style="list-style-type: none"> <li>– \$2 prescription drugs</li> <li>– \$5 office visit</li> <li>– \$15 outpatient surgery</li> <li>– \$25 inpatient stays, ER</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• No co-pays for children or HMO enrollees</li> <li>• All others:               <ul style="list-style-type: none"> <li>– \$1-\$3 physician visits</li> <li>– \$1 prescription drugs</li> <li>– \$3 inpatient day</li> <li>– \$3 eyeglasses</li> <li>– \$0.50-\$3 dental</li> <li>– \$0.50-\$3 mental health</li> <li>– \$0.50-\$3 physical therapy</li> </ul> </li> </ul>
<b>Ways to pay premium</b>	<ul style="list-style-type: none"> <li>• Mail-in check</li> <li>• Credit card</li> </ul>	Check	<ul style="list-style-type: none"> <li>• Electronic funds transfer</li> <li>• Wage withholding</li> <li>• Check, with mailed coupons</li> </ul>
<b>Third party premium payment</b>	Not promoted, but not prohibited	Not promoted, but not prohibited	Anyone may pay premiums
<b>Maximum out-of-pocket limit</b>	5% of family income	5% of family income, families notify state	5% of family income

Program staff in all three states believed that cost sharing is important because it: deters substitution of private coverage by public coverage, reduces the “welfare stigma” associated with public health insurance programs, encourages awareness of health care costs, and encourages appropriate use of health care services. Most other stakeholders agreed with this assessment and felt that cost-sharing levels were reasonable.

Among all the stakeholders interviewed only two concerns about cost sharing surfaced. The first concern was expressed by advocates in Rhode Island. They felt that current cost-sharing requirements were reasonable but they expressed concern about the possibility of lowering the cost-sharing threshold to 150 percent FPL. One advocate reported that she had calculated that a family with an income of 150 percent FPL had \$26 left over every month after paying for necessities and that the state was contemplating a co-pay of \$43. The second concern was expressed by an advocate in Wisconsin. This advocate was concerned that families who do not

pay their premiums without good cause are disenrolled from the program for six months and required to pay any amount owed before they are re-enrolled. The advocate felt these provisions were too difficult for poor families to meet.

## **Reasons for Expansion**

All stakeholders interviewed in the three site visit states reported that the state had expanded their SCHIP programs to include parents because they (program staff and all other stakeholders) believed that doing so was an effective way to cover children. Some reported that they held this belief because they had seen literature supporting it, but most reported it simply made sense that:

- parents are more likely to enroll their children and keep them enrolled when the entire family can be covered; and
- parents are more likely to seek primary and preventive care for their children when:
  - they themselves are healthy enough to do so; and
  - they, through their own experience, understand the importance of preventive care and how to access the health care system on behalf of their children.

During the site visits program staff and other stakeholders consistently articulated two reasons for their pursuit of family coverage in addition to improving children's coverage.

1. Family coverage helped these states meet other policy goals.
2. Covering families in SCHIP enabled them to maximize federal funding (up to the limit of the state's SCHIP allotment).

The first additional reason may help explain why these states were the first three states to pursue family coverage waivers—they were pursuing family coverage before the waivers became available. Maximizing federal funding may also have been more of a factor for these three states than it would be for other states interested in pursuing family coverage; few other states are already funding groups of parents with Medicaid funding whose costs could be shifted to SCHIP funding (and its higher percentage of federal funding) under a family coverage waiver.

## **Family coverage helped site visit states meet other policy goals**

New Jersey, Rhode Island, and Wisconsin viewed SCHIP family coverage as a means to reach a larger objective. In other words, all three states had already been pursuing the idea of offering health insurance to families before the SCHIP waiver became available; they did not decide to

pursue family coverage because the waiver became available. The two reasons cited by the three states for seeking to cover families were to:

1. ensure that all residents had access to affordable coverage (New Jersey and Rhode Island); and
2. support families as they moved from welfare to work by making affordable coverage available to families who left welfare for low-paying jobs that might not offer such coverage (New Jersey and Wisconsin).

### **Increased federal funding**

The federal government pays a higher percentage of the cost of caring for SCHIP enrollees than it does for Medicaid beneficiaries. This ability to maximize federal funding (up to the limit of the state's SCHIP allotment) was a factor in these states' decisions to pursue family coverage under SCHIP. It is possible to cover the parents of SCHIP enrollees under either §1931 or a §1115 Medicaid waiver as all three states did before implementing SCHIP family coverage. (New Jersey and Rhode Island covered parents under §1931 and Wisconsin did so under a §1115 Medicaid waiver.) Program staff in all three states mentioned this as a reason for seeking the family coverage waiver. It is, however, important to note that the higher federal financial participation (FFP) under SCHIP enabled these states to leverage federal dollars to enable their state dollars to go further in covering the uninsured, but they incurred higher Medicaid costs to do so. In fact:

- All three states increased the income limit for families to qualify for regular (pre-SCHIP expansion) Medicaid as part of their SCHIP family coverage expansions. Before family coverage, families were only covered with Medicaid funding up to the old AFDC limits, which are much less than 100 percent FPL. Now Rhode Island and Wisconsin use Medicaid funding (at the Medicaid FFP) to cover families up to 100 percent of the FPL, and New Jersey uses Medicaid funding to cover families up to 133 percent of the FPL.
- All three states reported that the greatest increase in enrollment was at the lower income levels, including many children who would have been eligible for Medicaid if their parents (who would not have been eligible for Medicaid) had applied to Medicaid before SCHIP family coverage was implemented. In order to obtain the enhanced FFP for paying for services provided to SCHIP parents these states incurred increased Medicaid costs for children.

### **History of Family Coverage**

Each of the three site visit states had a demonstrated long-term interest in family coverage as a way to decrease the number of uninsured and/or support families as they moved from welfare to work. In these three states the commitment to family coverage was so strong that they had

already implemented family coverage, under existing Medicaid authority, before the SCHIP family coverage waivers became available.

**Table 4 History of family coverage in the site-visit states**

State	History
<b>New Jersey</b>	<ul style="list-style-type: none"> <li>• New Jersey implemented NJ KidCare (the state's SCHIP program) on February 1, 1998, as a Medicaid expansion program serving SCHIP eligible children from families with incomes below 133% FPL. On March 1, 1998, NJ KidCare became a combination program with the implementation of a separate program for children with incomes from 133-200% FPL.</li> <li>• On April 30, 1999, New Jersey added a second component to the separate program to provide children from families with incomes from 201-350% FPL with a commercial benefit package.</li> <li>• New Jersey then implemented NJ FamilyCare which serves parents of Medicaid and SCHIP children from families with incomes up to 200% FPL and other adults (October 1, 2000). At first, parents were covered under a §1931 state plan amendment, but their coverage switched to SCHIP upon approval of the SCHIP §1115 waiver on January 18, 2001. The other adults are covered with state funding.</li> </ul>
<b>Rhode Island</b>	<ul style="list-style-type: none"> <li>• Rhode Island implemented RItCare as a Medicaid §1115 waiver program in August 1994, which began an incremental strategy to provide health insurance coverage to low-income, uninsured families through a series of expansions in eligibility.</li> <li>• In October 1997, Rhode Island implemented children's coverage under SCHIP as part of RItCare.</li> <li>• RItCare then expanded to include the parents of Medicaid and SCHIP children from families up to 185% FPL on November 1, 1998. At first parents were covered under a §1931 state plan amendment, but their coverage switched to SCHIP upon approval of the SCHIP §1115 waiver on January 18, 2001.</li> </ul>
<b>Wisconsin</b>	<ul style="list-style-type: none"> <li>• Wisconsin implemented a SCHIP program in April 1999 by expanding its Medicaid program to include children ages 15 through 18 in families with incomes below 100% FPL.</li> <li>• In July 1999, Wisconsin implemented BadgerCare which covers families up to 200% FPL. (The income limit at application is 185% FPL, but once enrolled a family's income may increase to 200% FPL without loss of eligibility.) At first parents were covered under a Medicaid §1115 waiver, but their coverage switched to SCHIP upon approval of the SCHIP §1115 waiver on January 18, 2001.</li> </ul>

## **SITE VISIT FINDINGS: PROGRAM IMPACT**

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The early experiences in New Jersey, Rhode Island, and Wisconsin shed light on a number of issues related to family coverage in SCHIP. In particular, their experience indicates that more children will enroll if the entire family is covered and shows some preliminary indications that children's utilization improves when their parents are also covered. In these three states, family coverage has proved a popular concept and has had little or no effect on the private insurance market.

### **Family Coverage's Effect on Children's Coverage**

One of the reasons site-visit states pursued family coverage was that they believed that covering families was an effective way to cover children. Early experience in the site-visit states indicates that family coverage has increased children's enrollment, although some barriers to enrollment remain. Some evidence also suggests that family coverage has a positive impact on enrolled children's utilization. Unfortunately, SCHIP family coverage was so new at the time of the site visits that not enough data exists to examine SCHIP family coverage's effect on children's retention.<sup>24</sup> All three states plan to study this issue once they have accumulated enough data.

#### **Effect on children's enrollment**

New Jersey, Rhode Island, and Wisconsin all experienced rapid increases in enrollment when they expanded their programs to include parents of Medicaid and SCHIP eligible children (Table 3). All three states reported that the greatest growth was among children from lower-income families. In many of these families the children (but not the parents) could have been eligible for Medicaid before family coverage was implemented. This is perhaps the strongest evidence of family coverage's importance to children's enrollment; even though some children in many of these families were eligible for Medicaid, the families did not apply for Medicaid for their children until the parents could also be covered.

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<sup>24</sup> At the time of the site visits, no SCHIP waiver had been approved for more than nine months. Even including the states' pre-SCHIP waiver experience covering parents of SCHIP children, New Jersey had been covering families for only 10 months; Wisconsin had been doing so for 26 months; and Rhode Island had been doing so for 33 months. Although Rhode Island had been covering families for a sufficient time to accumulate data, it did not track parents with their children under the §1931 expansion.

**Table 5 Number of SCHIP enrollees in the three site-visit states**

State	Enrollment
<b>New Jersey</b>	<ul style="list-style-type: none"> <li>• NJ KidCare had enrolled an estimated 60% to 70% of children eligible for SCHIP when NJ FamilyCare began in October 2000.</li> <li>• In July 2000, there were no adults enrolled in NJ FamilyCare and there were 68,446 children enrolled in NJ KidCare.</li> <li>• In July 2001 about 120,567 adults and 77,598 children (a 13% increase in one year) were enrolled in NJ FamilyCare/KidCare. About 81,546 of these adults (all newly enrolled) were parents. The remaining 39,021 were childless adults. (Federal funding is not used to pay for childless adults.)</li> </ul>
<b>Rhode Island</b>	<ul style="list-style-type: none"> <li>• Rhode Island reported that the number of children and adults enrolled in RItCare had been stagnant for several years prior to November 1998, when this state began enrolling parents of children enrolled in SCHIP (at that time Medicaid funded the parents' coverage).</li> <li>• In November 1998, about 22,000 adults and 51,000 children were enrolled in RItCare</li> <li>• As of June 2001, these numbers had increased to about 39,000 adults and 73,000 children, an increase of 77% for adults and 43% for children.</li> </ul>
<b>Wisconsin</b>	<ul style="list-style-type: none"> <li>• Wisconsin reported that the number of children and adults enrolled in Medicaid was stagnant for several years prior to July 1999, when the state implemented BadgerCare (the state's SCHIP program). At that time Medicaid funding covered the cost of serving BadgerCare parents.</li> <li>• As of July 2001, the state credited BadgerCare with adding a total of 131,829 people to the Medicaid/BadgerCare program: 26,726 BadgerCare children, 57,986 BadgerCare parents, and about 47,117 new children to the traditional Medicaid program. This is an increase of 61% over the 215,474 parents and children receiving Medicaid family coverage in June 1999—the month before BadgerCare's implementation.</li> <li>• From June 30, 1999 to September 2001, Wisconsin has seen a 45.7% increase in the enrollment of children in Family Medicaid.</li> </ul>

Wisconsin's results clearly demonstrate the increase in the number of children enrolled in Medicaid that can result from offering SCHIP coverage to their parents. In this state most of the growth in the number of children enrolled in BadgerCare/Medicaid occurred among traditional Medicaid eligibility groups, not SCHIP children. Similarly, in New Jersey, the one subset of children whose enrollment has lagged behind projections are those children from families with incomes from 200-350 percent FPL, families in which the children, but not the parents, can be covered by SCHIP.

Enrolling families, instead of just children, almost certainly increased children's enrollment. There were, however, other causes, and it is difficult to determine the contribution each made to the rapid increase. Two of these additional causes were common to all three states. At the same time they implemented family coverage, they also:

1. conducted intensive outreach campaigns including both media advertisements and community based outreach; and
2. simplified their enrollment and application processes by such efforts as reducing the length of the application and allowing applicants to mail in their applications instead of requiring a face-to-face interview as part of application.

In addition Rhode Island's health care market changed; two of the four plans with commercial operations in the state withdrew from the market, and the cost of health insurance, particularly for small employers, increased steeply between 1999 and 2000.

Some stakeholders in each of the three states also offered anecdotal evidence that enrolling the family increased children's enrollment. For example,

- County eligibility staff in New Jersey reported that some parents did not apply for NJ KidCare for their children because the parents had the more immediate need, and covering the children would not help the adults. County staff also reported that they saw more children come in when the program began covering parents.
- Before NJ FamilyCare became available to parents, the state insurance department representative reported that she would often get callers seeking health insurance. She would tell them about NJ KidCare with a response of "That's great! I have three kids. What about me?" or "If you're not taking the whole family I don't want any part of it."
- All MCO representatives interviewed in Wisconsin reported that they felt that covering parents increased children's coverage. One multi-state MCO compared their Wisconsin experience to experience in other states and found that "dramatically more children were enrolled in Wisconsin," a result the MCO attributed to family coverage.
- The provider representative in Wisconsin reported that "children are much more likely to become enrolled in programs if all family members can receive services at one medical home." Such is the case with BadgerCare.

Among the stakeholders in the site-visit states, there was general agreement that family coverage increased children's enrollment but that additional effort was still needed to reach all eligible children. Most frequently, stakeholders in the three states reported that the application and application process needed to be even simpler. Even though all three states use shortened application forms many stakeholders reported that some applicants still were not able to complete the application without assistance. Advocates in the three states also reported that immigrants faced additional barriers to enrollment. For example, in Rhode Island an advocate expressed concern over applicants' understanding of whether or not enrollment in RItCare will count against a family when applying for U.S. citizenship. She felt that the issue has been resolved at the federal level, but immigrant populations still do not understand that enrollment in Medicaid or SCHIP will not adversely affect citizenship.

## **Effect on children's utilization**

Program staff in all three states reported that they believed that enrolling parents would have a positive impact on children's use of services. Some of the preliminary experience of plans and providers in New Jersey and Wisconsin supports this belief. For example,

- In New Jersey, one health plan reported that it was now hearing “we get care” instead of “make sure my kids are getting care.” This health plan felt this new attitude encouraged the parents to be more proactive for all members of the family.
- In Wisconsin, some plans reported that involving the whole family gave the family a better understanding of the system.
- In Wisconsin, the community health center representative reported that health center experience was that “children are much more likely to become enrolled in programs and be taken in for preventive and primary care services if all family members can receive services at one medical home.”

## **Interaction with the Private Market**

Substitution of SCHIP for private health insurance or “crowd out” has been of concern to policy makers since SCHIP was established in 1997. This concern is not directly related to family coverage except that offering coverage to the whole family might make switching from private insurance to SCHIP more attractive than it had been in the past when only the children were covered.

Wisconsin and New Jersey do not appear to have experienced crowd-out. In Rhode Island, people switched from private coverage to public coverage, but almost all stakeholders believed that the switch was not due to the existence of RItCare. Instead, as will be explained shortly, many stakeholders felt that families dropped private coverage because it was no longer accessible or affordable. Stakeholders believed that those who moved from private to public coverage would simply have become uninsured if the public coverage had not been available.

## **Policies to prevent crowd-out**

In each of the three site-visit states, two state agencies play a potentially major role in preventing substitution of coverage: the SCHIP program and the state agency responsible for licensing and oversight of insurers.

1. The SCHIP program can establish policies that discourage those who have private health insurance from voluntarily switching to publicly funded health care.

2. The state insurance agency can establish policies that support the commercial market and that discourage employers from considering publicly funded health insurance as a viable alternative to employer-sponsored insurance.

New Jersey, Rhode Island, and Wisconsin have established policies for enrollment in SCHIP that are designed to prevent crowd-out (Table 6). All three states have established waiting periods, a specified period of time during which the applicant must be without health insurance in order to qualify for SCHIP. New Jersey and Rhode Island apply this requirement only to the higher income enrollees. (In Rhode Island the waiting period only applies to those over 185 percent FPL which would be just children as parents are only covered up to 185 percent.) Wisconsin applies them to all applicants.

The three states all allow exceptions to the crowd-out provisions. New Jersey, for example, may waive the six-month waiting period if prior coverage was lost because an employer went out of business or the employee was laid off or changed jobs (if the insured does not have access to affordable coverage in the new job).

**Table 6 SCHIP policies to prevent substitution of coverage in the site-visit states**

State	Policies
<b>New Jersey</b>	<ul style="list-style-type: none"> <li>• Enrollees with incomes above 133% FPL must be without health insurance for at least six months or qualify for an exception, such as dropping individual or COBRA coverage in families under 200% FPL.</li> <li>• Premium assistance program implemented 6/1/01. Served 12 enrollees in 8/01.</li> </ul>
<b>Rhode Island</b>	<ul style="list-style-type: none"> <li>• Enrollees with incomes between 185% and 250% FPL must be without health insurance for at least four months.</li> <li>• Premium assistance program implemented 4/1/01, became mandatory 5/1/01. Served 100 enrollees in 8/01.</li> </ul>
<b>Wisconsin</b>	<ul style="list-style-type: none"> <li>• Enrollees must be without health insurance for at least three months.</li> <li>• Enrollees must not have access to employer coverage where employer pays at least 80% of family premium.</li> <li>• Existing Medicaid premium assistance program expanded to include SCHIP at program implementation. Employer must pay 60-80% of premiums. Served about 45 families in 9/01.</li> </ul>

In addition to using waiting periods, all three states operate premium assistance programs. These programs deter crowd-out by keeping families who have access to employer sponsored insurance in that system. They also discourage employers from encouraging employees to take public coverage rather than join the employer sponsored plan because even if the employee joins the public program he/she will still be enrolled in the employer's plan and the employer will need to continue to pay the share of the premium. In New Jersey and Rhode Island these programs are still relatively new and have few participants. But both states expect enrollment to grow to more significant levels. Wisconsin has submitted a state plan amendment to include enrollees in this

program whose employer pays 40 percent or more of the premium (instead of the current 60 percent or more). This state feels this change will increase program enrollment and effectiveness.

**Table 7 Insurance laws that have an effect on crowd-out**

State	Regulation
<b>New Jersey</b>	<ul style="list-style-type: none"> <li>• Employers may not offer health insurance to employees who work fewer than 25 hours/week. (Those who work 25 or more hours/week are referred to as qualified employees.)</li> <li>• 75% of an employer's qualified employees have to enroll in coverage in order for the employer to offer health coverage.</li> </ul>
<b>Rhode Island</b>	<ul style="list-style-type: none"> <li>• If an employer offers insurance to one employee the employer must offer it to all others who qualify for benefits.<sup>25</sup></li> </ul>
<b>Wisconsin</b>	<ul style="list-style-type: none"> <li>• If an employer offers insurance to one employee the employer must offer it to all others who qualify for benefits.</li> </ul>

In Rhode Island and Wisconsin, the insurance agency, program staff, and employers reported that they believe that requiring employers to offer health insurance to all employees who qualify for benefits is a key detriment to crowd-out. This provision prevents employers from deciding not to offer health coverage to low-income employees (who would qualify for SCHIP) while continuing to offer coverage to higher-income employees (who would have no alternative coverage). New Jersey's requirement that an employer may not offer health insurance to any employee unless 75 percent or more of qualified employees<sup>26</sup> join the program produces a similar outcome. New Jersey's requirement, however, also establishes an incentive for an employer to make sure the company's coverage is affordable for lower-income employees.

New Jersey prohibits employers from offering coverage to any employee who works less than 25 hours per week. As a result, a large segment of low-income workers (many of whom work more than one part-time job) are ineligible for employer coverage, and individual policies are considered unaffordable for low-income families. In general, the employers and representatives of the state agency responsible for insurer oversight felt that NJ FamilyCare was filling a need for those who did not qualify for employer-sponsored insurance, rather than crowding out that type of coverage.

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<sup>25</sup> Federal insurance law requires states to have this provision or a more stringent one in place. (New Jersey's provisions are more stringent.)

<sup>26</sup> A qualified employee is one who works 25 or more hours/week. (New Jersey insurance law prohibits employers from offering coverage to employees who work less than 25 hours/week.)

## Little or no evidence of crowd-out

Among the site-visit states only Rhode Island may have more mixed experience with crowd-out. Stakeholders in New Jersey and Wisconsin generally felt that the crowd-out provisions of the SCHIP program played a role in preventing crowd-out. Stakeholders in all three states felt that insurance laws were also contributing to the prevention of crowd-out. New Jersey in particular felt that their small group insurance laws prevented crowd-out. Many stakeholders also felt that employers simply do not consider SCHIP family coverage in their decisions to offer coverage. Factors such as a good economy, low unemployment, and tradition within a state were felt to be more influential on employer's decisions than state policies to prevent crowd-out.

### *New Jersey*

In New Jersey, program staff, employers, and state insurance department staff reported that they felt that crowd-out was not occurring because New Jersey's small group insurance laws keep small groups in the private market. The insurance department representative reported that little crowd-out was occurring in the small group market. The representative had noticed a decline in the individual market of about 5,000 lives per quarter that began before NJ FamilyCare was implemented. Data was not available to determine if those dropping insurance did so to enroll in NJ FamilyCare or chose to go without health coverage. The representative, however, felt that the decline was strictly due to increased premiums. She said she had not heard anyone say, "I'm dropping my insurance and in six months I'll get NJ FamilyCare." She had heard many say, "I'm dropping my coverage and I'll go without health insurance." Health plan representatives confirmed that they have seen little change in the individual or small group market since NJ FamilyCare's implementation.

### *Rhode Island*

Although people switched from private to public coverage in Rhode Island most stakeholders felt that the movement was not caused by the existence of RIteCare.

In the past few years, it has become increasingly evident that access to affordable commercial coverage in Rhode Island is rapidly eroding, primarily due to two factors.

1. High increases in premiums during 1999 and 2000 affected both employees and employers. Small employers and low-wage workers in particular suffered from these increases; many were unable to afford higher premium contributions and were driven out of the commercial market.
2. The sudden, unexpected departure of both Harvard Pilgrim Health Care of New England and Tufts Health Plan of New England from the Rhode Island market (and most of New England, except Massachusetts)<sup>27</sup> in January 2000 left many employers and employees

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<sup>27</sup> It should be noted that in 2000 in Maine, Tufts Health Plan also left the commercial market and Harvard Pilgrim of New England no longer takes new business, but only renews existing policies.

with limited options for health care coverage; only two commercial plans remained to serve the state. Also, 150,000 Rhode Islanders were members of the departing plans; they were immediately at risk of becoming uninsured.

Rhode Islander's concerns about the state of private coverage was so great that in January 2000 the Governor convened a group of administration staff, legislative leaders, and consumer and business representatives to find solutions to Rhode Island's deteriorating health insurance market. This group focused on methods of stabilizing the employer-based health insurance market primarily by stabilizing premiums. It also directed RIteCare staff to establish a premium assistance program and request CMS to allow them to establish a six-month waiting period for certain populations below 185 percent FPL.<sup>28</sup>

Most stakeholders reported that without RIteCare many of the people who enrolled in RIteCare would have left private coverage to become uninsured. They felt that RIteCare acted as a safety net for those unable to afford or obtain private insurance not as a factor in the creation of the market turmoil. In general program staff and most stakeholder's characterized the interaction between RIteCare and the private market in this way: the private market affected RIteCare, but RIteCare (much less family coverage in RIteCare) did not affect the private market.

One health plan was an exception among stakeholders. This plan studied its membership and found evidence that families who are not subject to cost-sharing or waiting periods (families earning less than 185 percent of the FPL) are more likely to drop employer coverage than are families with higher incomes or who are subject to waiting periods and cost sharing. During calendar year 1999, the first year following the §1931 expansion to parents, data provided by United Healthcare indicated that a small number of RIteCare enrollees migrated to their RIteCare plan from their commercial products. Further analysis by United Healthcare revealed that the movement from employer coverage into RIteCare was occurring at a much greater rate in eligible families with incomes below 185 percent of the FPL. United reported that employers were continuing to buy their commercial products but that families were dropping their employer coverage. It is unclear if the families' decisions were due to RIteCare's availability or their inability to afford the commercial product.

In addition to the health plan study there is some anecdotal evidence that crowd-out may have occurred. Other stakeholders recounted stories, which were confirmed by program staff, of some employers encouraging their employees to join RIteCare, but the extent to which this occurred is unknown.

Contradicting the health plan's study, evidence from the state indicates that few enrollees had access to employer coverage at the time of application to RIteCare. A detailed review of RIteCare eligibility files from October 1997 to May 2001 indicates that only nine percent of eight- to nineteen-year-old enrollees between 100 percent and 185 percent of the FPL had

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<sup>28</sup> This amendment has been approved but program staff have not implemented it because RIteCare enrollment appears to be leveling off and it may not be necessary to do so.

employer-sponsored coverage at the time of application, despite no rules preventing their enrollment. (The study did not examine how many of these children were long-time uninsured vs. how many had recently lost access to private coverage because their parent's employer had stopped offering family coverage.)

### ***Wisconsin***

All stakeholders in Wisconsin agreed that there is no evidence that BadgerCare is crowding-out employer sponsored coverage. Three reports are particularly telling.

1. The association representing small businesses had surveyed its members and found that while most were aware of BadgerCare, few had any employees enrolled in the program.
2. The three health plans interviewed have not noticed any crowd-out. One even reported that the number of small group quotes had risen since BadgerCare's implementation.
3. The community health center organization reported that members were seeing an increase in Medicaid coverage, but no decrease in employer coverage.

Most stakeholders cited several reasons for the lack of crowd-out. Many cited the BadgerCare crowd-out provisions. Most stakeholders, however, felt that two other factors were more influential.

1. Employers viewed offering health insurance coverage as a way of attracting and retaining employees in a state with low unemployment and a strong economy.
2. Employers simply don't consider BadgerCare as an alternative to employer-sponsored coverage.

Some, primarily the employer associations, felt that although no crowd-out was occurring, the changing environment (double-digit increases in health insurance premiums, potential for recession, and increasing unemployment) might, in the future, more severely test employers' commitment to providing health insurance and BadgerCare's crowd-out provisions.

## **Feedback From Employers, Parents, Health Plans, and Providers**

All stakeholders interviewed in the three states were strongly supportive of family coverage. Some stakeholders, especially employers, did express concern about the future direction of these programs, but at the time of the site visit all felt that family coverage was a good idea and was producing results.

### **Employers**

Among the employers and employer representatives interviewed during the site visits those in New Jersey were the most positive. They reported that many retailers were pleased because many of their largely part-time workforce, who do not, under New Jersey law, qualify for employer coverage have benefitted from enrollment in NJ FamilyCare. Employer representatives in Wisconsin were least positive. They reported that they supported the concept of family coverage but were concerned that BadgerCare not supplant private coverage.

## **Parents and Advocates**

Parents described family coverage as “a godsend” and “great for the self-employed.” Advocate responses were generally as positive. Both groups did express concerns, such as the need to continue working to eliminate remaining barriers to enrollment, but these concerns were not associated with family coverage. Some advocates in Wisconsin were the only group to report that at first they had been concerned that SCHIP funding should be used as it was intended: to cover children. However, these advocates reported that they had since changed their minds and now strongly supported family coverage.

## **Health Plans**

All health plans interviewed felt that treating the parent would ultimately benefit the child’s health. Not only would the parent be better able to care for the child, but the parent would also better understand how to access care for the whole family.

The sole concern raised by all plans focused on the higher than anticipated cost of providing care to the newly enrolled parents. These plans had found that the cost of serving SCHIP parents was higher than the cost of serving Medicaid parents. They reported that part of the difference was due to pent-up demand among SCHIP parents but that much of it was due to differences in demographics; SCHIP parents tended to be older and were more likely to have chronic conditions, such as diabetes. Plans in Rhode Island and Wisconsin reported that these states had increased capitation payments or instituted risk-sharing with the plans in response to this concern, and these plans were satisfied with that response. (New Jersey had risk-sharing in place at the time of the expansion.)

Except in Rhode Island, plans reported that although some had been concerned that crowd-out might occur, their experience showed that it had not. One plan in Wisconsin even reported that its commercial business had grown during BadgerCare’s implementation. In Rhode Island, however, two plans were concerned that some families might be dropping their private coverage to enroll in RItCare.

## Providers

Providers in all three states felt that providing coverage to the entire family not only increased the number of children enrolled in the program but also improved the health of the parent, enabling them to better care for their children.

## Unanticipated Consequences

Most of the unanticipated consequences that the site visit states have encountered since implementing family coverage seem related to SCHIP as a whole and not to family coverage. However, all three have encountered two issues that most likely relate to family coverage.

First, enrollment in the family coverage programs in all three states has been much more rapid than expected, especially when compared with the much slower enrollment New Jersey and Rhode Island experienced when implementing their child-only programs. This unanticipated pace of enrollment has required program staff in all three states to obtain additional funding from their legislatures in order to pay for services during the initial year(s) of the program. (New Jersey's and Wisconsin's projections of maximum enrollment appear to be on-target, but they reached their projections more quickly than expected because of the rapid enrollment.) In addition:

- When New Jersey reached its enrollment goal of 125,000 earlier than expected, the state stopped enrolling new childless adults, except for general assistance. (Federal funding was not used to serve childless adults and general assistance enrollees.) This move allowed the state to reserve the remaining slots for the waiver populations (parents and pregnant women).
- New Jersey found itself struggling to process applications in a timely manner because of the unexpectedly high volume of applications and possibly because the state switched to a new vendor (for processing the applications) just as NJ FamilyCare was being implemented. In response, the administrative contractor hired more staff to process the applications and respond to questions (staff has tripled since implementation of NJ FamilyCare). Medicaid staff also cut back on outreach to families and now concentrate on outreach to children.
- In Rhode Island, in response to both the rapid increase in RItCare enrollment and the turmoil in the commercial market, the state passed the Health Reform Rhode Island Act in June 2000. In addition to small group reform, the Act directed the Department of Human Services to implement a premium assistance program. RItCare also cut back on outreach, which probably contributed to the slowing enrollment.

Second, as noted above, all MCOs reported that, especially initially, the cost of serving the newly-enrolled adult family members was higher than expected (based on the cost of serving

families that qualify for traditional Medicaid). All MCOs interviewed reported that part of the increase was due to pent-up demand from people who had not previously had a source of payment for their health care costs. But all but one MCO also reported that even after pent-up demand was met, differences in demographics meant that differences in cost between traditional Medicaid and SCHIP adults continued. In general, MCOs reported that compared to the lower-income adults who were enrolled under Medicaid family coverage, those enrolled under SCHIP family coverage:

- were older;
- were more likely to be male;
- were more likely to have a chronic disease, such as heart disease or diabetes;
- used more prescriptions (one MCO reported that pharmacy costs for SCHIP enrollees were about double those for other Medicaid enrollees); and
- had lower in-patient utilization.<sup>29</sup>

Both Rhode Island and Wisconsin raised MCO capitation rates and implemented cost-sharing to compensate for this unexpected cost difference.

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<sup>29</sup> New Jersey began enrolling single adults (including those who were enrolled in the states general assistance program which had an income limit of 23 percent FPL) with state-only funding at the same time it began enrolling families with SCHIP funding. MCOs reported that the general assistance population had many unmet and chronic needs, many more than SCHIP or Medicaid families.

## LESSONS LEARNED

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The most important lesson learned from these site visits may be that family coverage does appear to improve children's coverage.

The site visit states' early experiences also provide helpful information both to other states contemplating family coverage and to all policy makers interested in the effect of SCHIP family coverage.

### Advice to Others

Based on the experiences of New Jersey, Rhode Island, and Wisconsin, other states could anticipate that:

- Family enrollment may occur more rapidly than child-only enrollment, and states may need to be ready to accommodate rapid enrollment, including higher than expected service costs during program start-up. New Jersey, for example, recommends making sure that enough flexibility exists in administrative contracts to respond to the unexpected.
- SCHIP family enrollment may result in increased Medicaid enrollment as families with children who already qualify for Medicaid may enroll these children in Medicaid once coverage for the whole family is available through a combination of Medicaid and SCHIP.
- SCHIP parents tended to be older than parents receiving traditional Medicaid and more likely to have chronic conditions. States and health plans may need to consider this in developing their networks, in anticipating the needs of the new enrollees for health care services, and in determining reimbursement rates. Both Rhode Island and Wisconsin increased capitation and used risk-sharing to respond to the unexpectedly high costs. (New Jersey had risk-sharing in place at the time of the expansion.)
- The state of the private health insurance market and small group insurance laws may need to be considered in program planning.
  - In Rhode Island the erosion of the private market contributed to rapid RItCare enrollment because private insurance became less available and too expensive for low-income residents. Rhode Island is modifying its small group insurance laws and has implemented a premium assistance program to support the private market and would advise others to consider these actions earlier when implementing family coverage. Wisconsin believes that premium assistance programs might be more effective if federal law enabled states to allow Medicaid/SCHIP enrollees

- whose employer paid less than 60 percent of the premium into the support program.
- New Jersey’s small group laws have created a firewall between private and public coverage. Employers reported being pleased with NJ FamilyCare because it provides coverage to employees who do not qualify for employer-sponsored coverage under state law.

## Effect of Family Coverage

The early experience in the three site-visit states suggest several important findings about family coverage in SCHIP that are of general interest.

- Family coverage is an extremely popular policy choice. No stakeholder expressed current concern about using SCHIP funding, which was intended for children, to cover the parents of eligible children. All seemed firmly convinced that family coverage was the most effective way to provide children’s coverage.
- Concerns about crowd-out may be unfounded. Little or no evidence of crowd-out exists in the three states. Neither New Jersey nor Wisconsin experienced crowd-out. Most stakeholders in Rhode Island saw that residents were switching from private insurance to RItCare but felt they were switching because they were driven from the commercial market, not because RItCare became available. These stakeholders felt that RItCare did not cause crowd-out but instead acted as a safety net for those who could no longer find affordable coverage in the commercial market.
- Enrolling the family as a whole increases and speeds children’s enrollment in SCHIP, as demonstrated by: (1) the rapid enrollment in all three states; (2) data from a multi-state MCO comparing its experience in Wisconsin to that in other states that do not cover families; and (3) anecdotal reports from numerous stakeholders about the increased interest in enrollment when these states began to cover families.
- Covering the whole family is a more effective way to serve children. Family coverage allows the family to establish and understand the importance of a medical home and enables MCOs and providers to treat parents’ health issues, increasing parents’ ability to attend to the primary and preventive care needs of their children.
- SCHIP parents may have greater medical needs than traditional Medicaid families. MCOs in all three states reported that compared to parents who are traditional Medicaid enrollees, the SCHIP parents are more likely to be older, have chronic conditions that require ongoing medical treatment, use more prescription drugs, and use fewer inpatient services. As a result, the cost of serving SCHIP parents remains higher than the cost of serving traditional Medicaid parents even after pent-up demand for services is met.

## APPENDICES

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- A. State Comparative Matrix
- B. Literature Review Findings on Family Coverage's Effect on Parents
- C. Stakeholders Interviewed by State
- D. Interview Protocols

Appendix A  
**State Comparative Matrix**

**Matrix Comparing Basic Elements of SCHIP Family Coverage in  
New Jersey, Rhode Island, and Wisconsin**

<b>State</b>	<b>New Jersey</b>	<b>Rhode Island</b>	<b>Wisconsin</b>
<b>Name</b>	NJ FamilyCare	RIte Care	BadgerCare
<b>Program type</b>	Combination	Medicaid expansion only	Medicaid expansion only
<b>State agency</b>	NJ Department of Human Services Division of Medical Assistance and Health Services	Rhode Island Department of Human Services	Department of Health and Family Services
<b>SCHIP waiver submitted to HCFA</b>	September 26, 2000	November 2, 2000 January 2001, revised	March 10, 2000
<b>Waiver approved</b>	January 18, 2001	January 18, 2001	January 18, 2001
<b>Enrollment started</b>	October 1, 2000	<ul style="list-style-type: none"> <li>• November 1998 under Medicaid §1931 with Medicaid funding</li> <li>• January 18, 2001 funding shifted to SCHIP</li> </ul>	<ul style="list-style-type: none"> <li>• July 1999 under Medicaid 1115 waiver with Medicaid funding</li> <li>• January 18, 2001 funding shifted to SCHIP</li> </ul>

State	New Jersey	Rhode Island	Wisconsin
<b>Eligibility</b>			
<b>Family income limit</b>	Families up to 200%	Families up to 185% FPL	Applying Families up to 185% FPL, but up to 200% FPL once enrolled
<b>Children income limit</b>	Children up to 350%, through disregards	Children up to 250% FPL, up to age 19 through 1115 waiver	Applying Families up to 185% FPL, but up to 200% FPL once enrolled
<b>Other groups</b>	Single adults – 100% FPL Couples without children – 100% FPL Pregnant women – 200% FPL Children up to 21 leaving foster care, regardless of income	Pregnant women – 250% FPL Foster children	None
<b>State-funded groups</b>	Legal aliens living in the U.S. less than five years, including children up to 350% FPL.	Non-citizen children Pregnant women 250% to 350% FPL Ineligible alien pregnant women up to 250% FPL Licensed family child-care providers and their children under 18 Pay-your-own-way: conversion policies, uninsured children under 8 with incomes above 250%, pregnant women with incomes above 350%.	None
<b>Presumptive eligibility</b>	Time limited presumptive eligibility. Hospitals and FQHCs could make initial determination. Ended on April 2, 2001.	None	None for children
<b>Waiting period</b>	Enrollees with incomes above 133% FPL must be without health insurance for at least <b>six</b> months.	Enrollees with incomes between 185% and 250% FPL must be without health insurance for at least <b>four</b> months. <sup>1</sup>	Enrollees have to be without health insurance for at least <b>three</b> months. Enrollees must not have access to employer coverage, where employer pays at least 80% of family premium.
<b>Redetermination</b>	Every 12 months, with preprinted form	Every 12 months	Every 12 months

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<sup>1</sup> Rhode Island has requested permission from CMS to extend the waiting period down to 150% FPL. If approved will implement only if necessary to control enrollment.

State	New Jersey	Rhode Island	Wisconsin
<b>Cost Sharing</b>			
<b>Premiums</b>	Start at 150% FPL	Start at 185% FPL (premiums for 150% FPL and above pending CMS Approval)	Start at 150% FPL; Premiums paid by American Indian families are pro-rated to exclude children
<b>Premium for family of four</b>	Up to \$26,475 (150%)– no premium \$26,476 - \$35,300 - \$25/adult, plus \$10 for second adult, plus \$15 for children \$35,301 - \$44,125 - \$30/family \$44,126 – 52,950 - \$60/family \$52,951 - \$61,775 - \$100/family	Up to 185 % - no cost sharing (cost sharing for 150 to 185% FPL pending CMS approval) 185% to 300% - choice of either sliding scale premiums or co-payments, premiums range from \$3 to \$8.	Up to 150% - no premium Above 150% - no more than 3% of income  \$25,050 - \$30,894: \$30/family \$30,895 - \$33,400: \$75/family
<b>Co-payments</b>	Start at 150% FPL for families and at 185% FPL for pregnant women. \$5 office visit, \$5 outpatient surgery, \$5 lab and x-ray, \$5 prescription drugs, \$25 mental health outpatient, \$25 psychological services, \$35 ER visit.	Co-pays: \$2/prescription drugs, \$5 office visit, \$15 outpatient surgery, \$25 inpatient stays, ER. (Pending CMS approval for cost sharing under 185% of the FPL)	No co-pays for children or for HMO enrollees. All others: Physician visits: \$1 - \$3 Prescription: \$1 Inpatient day: \$3 Eyeglasses: \$3 Dental: \$0.50 - \$3 Mental health visit: \$0.50 - \$3 Physical therapy: \$0.50 - \$3
<b>Ways to pay premium</b>	Check	Check	Electronic funds transfer Wage withholding Check, with mailed coupons
<b>Third party payment of premium</b>	Not promoted, but not prohibited.	Not promoted, but not prohibited.	Yes, premiums may be paid by anyone, including relatives, public assistance programs, community-based organization, or charity.
<b>Maximum out-of-pocket limit</b>	5% of family income	5% of family income, families notify state	5% of family income

State	New Jersey	Rhode Island	Wisconsin
<b>Service Delivery</b>			
<b>Benefits</b>	Two benefit packages: Lower income enrollees get Medicaid benefits package. Higher income receive a commercial-type package.	Medicaid Benefit Package Physician visits, immunizations, prescriptions, lab, prenatal care, mental health, drug or alcohol treatment, hospital, emergency, home health, skilled nursing, family planning, nutrition, interpreter, childbirth education, parenting classes, smoking cessation, transportation.  Plus a Medical Assistance card for out-of-plan benefits, such as dental and services for children with special health needs.	Same as Medicaid.  Physician visits, immunizations, prescriptions, lab, X-ray, prenatal care, mental health, drug or alcohol treatment, hospital, emergency, family planning, eye care, glasses, speech therapy, medical equipment, health services, hearing aids, dental, transportation
<b>Health plans</b>	Americaid Community Care Horizon/Mercy AmeriChoice PHS health plans UHP	Neighborhood Health Plan of RI United HealthCare of NE Blue Cross Blue Shield of RI/Blue ChiP	Atrium Health Plan Dean Health Plan Group Health Cooperative - Eau Claire MercyCare Security Health Plan Touchpoint Health Plan United HealthCare Unity Health Plan Valley Health Plan  Plans must contract for both Medicaid and BadgerCare in order to participate in either program

State	New Jersey	Rhode Island	Wisconsin
<b>Employer-sponsored programs</b>	Premium Assistance Program, assists enrollee in paying monthly premium. 12 enrollees at time of site visit, agency is preparing for expansion and will review employer plan eligibility at redetermination..	Rlte Share RI Premium Assistance Program operational. April 1, 2001, voluntary enrollment of employees, switched to mandatory enrollment of employees on May 1, 2001. RI is using an incremental strategy to enroll eligible members in premium assistance program. August 2001 enrollment approximately 100 enrollees.	Health Insurance Premium Payment program will purchase employer insurance plan, if cost effective. BadgerCare will pay premium, coinsurance and deductible, plus offer a wrap-around benefit package. Employer must pay 60% to 80% of premiums. 7 parents and 7 children were enrolled in HIPP in 2000. 11 parents and 15 children were enrolled in SCHIP ESI in 2000.

State	New Jersey	Rhode Island	Wisconsin
<b>Enrollment</b>			
<b>How to apply</b>	Mail-In, About 1/3 of enrollment. In person at Boards of Social Services, about 2/3 of enrollment to date.	Mail In person at local DHS office	In person at human services departments; at community based outstations, via mail or phone
<b>Marketing approaches targeting parents</b>	Media plan with TV, radio, newspaper, public service announcements. Media campaign halted after three months. Enroll parents at NJ KidCare enrollment sites. Community-based organizations, especially for immigrants and other hard-to-reach groups. Direct mail to Medicaid and NJ KidCare parents.	Primarily community-based approach. Also targeted mailings, distribution of materials to every school-age child, print media, Internet, piggy back mailings, public service announcements, TV and radio interviews, press conference.	Public information campaigns. Television ad featuring the Governor in Milwaukee. Additional eligibility workers in Milwaukee County. Co-locate eligibility workers in other counties with other programs such as WIC. Community-Based Outstations, including at Tribal facilities
<b>Enrollment</b>	July 2001	June 2001	July 2001 (two years after start-up under Medicaid 1115 waiver)
<b>To date</b>	Adults: 81,546 <sup>2</sup> Children: 77,598	Adults: 38,925 <sup>3</sup> Children: 72,817	Adults: 57,986 Children: 26,726 Additional Medicaid children due to BadgerCare implementation: 47,117 (337,002 total in Medicaid family Coverage)
<b>Projected</b>	Projected 80,000 adults at end of current fiscal year.	Projected 130,000 total by 2003 RIte Care plus RIte Share	Adults: 56,759 Children: 24,762

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<sup>2</sup> About 39,021 childless adults were also enrolled in New Jersey's program, but not under the waiver. Their costs were paid for entirely with state funding.

<sup>3</sup> Rhode Island's enrollment numbers are for the entire RIteCare program, not just those enrolled under the SCHIP waiver.

State	New Jersey	Rhode Island	Wisconsin
<b>Other</b>			
<b>Funding</b>	FY 2001: Federal allotment: \$98,939,802 Costs: \$77,159,860 State share: \$27,005,951 Federal share: \$50,153,909 Enhanced match: 65%  \$25 million in state funds just added to bring enrollment from 120,000 to 135,000 – 140,000.	FY 2000: \$9,570,566 federal Costs: \$12,535,507 State share: \$4,055,236 Federal share: \$8,480,270 Enhanced match: 67.64%	Estimated SFY 2002-03: \$158,252,300 State Share: \$52,234,300 Federal Share: \$102,724,600 Premiums: \$3,293,400  Enhanced Match: 71.5% for SCHIP children and parents in families with incomes over 100% FPL; Regular Medicaid match: 59% for BadgerCare parents with family incomes less than 100% FPL
<b>State demographics</b>	State median income: \$50,234 (ranks 3) Percent children uninsured: 13% Percent of low-income children uninsured: 6.2% Percent of children in Medicaid: 13% Percent of children with private coverage: 73%	State median income: \$40,213 (ranks 20) Percent children uninsured: 8% Percent of low-income (under 200% FPL) children uninsured: 4.8% Percent of children in Medicaid: about 30% Percent of children with private coverage: 75% Almost 60% of uninsured kids live in 4 cities: Providence, Pawtucket, Central Falls, and Woonsocket.	State median income: \$43,055 (ranks 15) Percent children uninsured: 9% Percent of low-income children uninsured: 4.4% Percent of children in Medicaid: 14% Percent of children with private coverage: 77% 2000 state survey estimates 5% of children are uninsured, 6% of population uninsured

Appendix B  
**Literature Review Findings on Family Coverage's Effect on Parent  
Coverage**

# Literature Review Findings on Family Coverage's Effect on Parent Coverage

## Parent-age Adults Are Likely to Be Uninsured

The age group encompassing adults of parent age is the least likely age group in the United States to have health insurance. For example, over one-fourth (27 percent) of 18- to 24-year-olds are uninsured and over one-fifth (21 percent) of 25- to 34-year-olds are uninsured nationwide, compared to one-seventh (14 percent) of the overall population.<sup>4</sup>

Parent-age adults who are poor (with incomes less than 100 percent FPL) are even less likely to have health insurance, almost half (46 percent) of poor, young adults from ages 18 to 34 are uninsured. Specific subgroups, such as Hispanic, foreign-born, and those working for small businesses, are especially unlikely to have health insurance.<sup>5</sup>

In a general sense, SCHIP targets uninsured children in families with incomes under 200 percent FPL, although there is variation from state to state. Taking a closer look at the corresponding uninsured population with incomes under 200 percent FPL; in 1999, there were an estimated 42 million U.S. residents uninsured, and of these, 27 million had incomes below 200 percent FPL.

One-fourth of the 27 million low-income uninsured were parents (6.2 million) and one-fourth were children (7.1 million), the remainder were childless adults. Almost three-fourths of the low-income parents (73 percent) work either full- or part-time.

Uninsured rates for low-income parents vary widely by state. Hawaii has the lowest rate of uninsurance at 11 percent, and Arizona and New Mexico have the highest rates at 47 percent.<sup>6</sup>

The direct benefit to parents, and other adults, of having health insurance is improved health status of the adults involved. An indirect benefit is explored in more detail below, which is the effect of parents'

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<sup>4</sup> U.S. Census Bureau, *Health Insurance Coverage: 2000, Current Population Reports*, (Washington, D.C.: U.S. Census Bureau, September 2001), [www.census.gov/hhes/www/hlthin00.html](http://www.census.gov/hhes/www/hlthin00.html).

<sup>5</sup> Ibid.

<sup>6</sup> Jeanne Lambrew, *Health Insurance: A Family Affair*, (New York, NY: The Commonwealth Fund, May 2001). And Jocelyn Guyer and Cindy Mann, *Employed but Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance*, (Washington, DC: Center on Budget and Policy Priorities, 1999). And Lisa Dubay, Genevieve Kenney, and Stephen Zuckerman, *Extending Medicaid to Parents: An Incremental Strategy for Reducing the Number of Uninsured*, (Washington, D.C.: The Urban Institute, Assessing the New Federalism, June 2000).

health insurance on children's health care utilization. Insured adults are less likely to die in the hospital than are those without health insurance.<sup>7</sup> Low-income uninsured adults are more likely to be in fair or poor health than their insured counterparts. They are much more likely (41 percent) to report having no usual source of care, compared to low-income insured adults (18 percent). They are twice as likely to have an unmet medical need (15 percent versus 8 percent). Finally, uninsured, low-income adults are less likely to have seen a physician in the last year (50 percent compared to 73 percent).<sup>8</sup>

When previously uninsured adults obtain health care coverage, their use of preventive services goes up and their unmet need goes down even within the first months of coverage. In Tennessee, new TennCare female enrollees were more likely to get Pap smears in their first year of coverage than uninsured Tennessee women (73 percent versus 51 percent), and many fewer TennCare enrollees (34 percent) said they needed to see a doctor but did not than did uninsured adults (64 percent).<sup>9</sup>

## **Subsidized Health Insurance as a Transition from Welfare to Work**

During the late 1990s as the economy grew, against expectation so too did the number of uninsured. Much of the growth in the number of uninsured was explained as an unintended consequence of welfare reform, which lowered both welfare and Medicaid caseloads.<sup>10</sup> Coming off welfare, many former participants obtained jobs without health benefits. Surveys show that working parents with incomes below 100 percent FPL are twice as likely to be uninsured as non-working parents with the same incomes.<sup>11</sup>

Researchers found that as with their parents, the children in these low-income, working families were more likely to be uninsured than were children in either higher income or non-working families. The rate of uninsured children was twice as high (32 percent) among working low-income families compared to those in non-working, low-income (16 percent) and higher income families (10 percent).

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<sup>7</sup> Jack Hadley, E.P. Steinberg, and Judy Feder, "Comparison of uninsured and privately insured hospital patients. Condition on admission, resource use, and outcome." *JAMA* 1991, Jan 16;265(3):374-9.

<sup>8</sup> John Holahan and Niall Brennan, *Who are the adult uninsured?*, (Washington, D.C.: The Urban Institute, Assessing the New Federalism, March 2000), Series B, No. B-14.

<sup>9</sup> Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Coverages: New Research Findings about State Health Reforms*, (Washington, DC: Center on Budget and Policy Priorities, September 2000).

<sup>10</sup> John Holahan and Johnny Kim, "Why does the number of uninsured Americans continue to grow?" *Health Affairs*, 19(4) (July/August 2000): 188-194.

<sup>11</sup> See Guyer and Mann's report in Note 9.

The rationale for offering subsidized health insurance to low-income parents as a bridge from welfare to work, and as an efficient way to reach uninsured children was used by states that implemented family coverage.<sup>12</sup> As Wisconsin administrators succinctly put it, “Our goal is to assure that a family that moves from welfare to work will not join the ranks of the uninsured.”<sup>13</sup>

## Summary of Lessons Learned from the Literature

The literature reveals that there are relatively high rates of uninsurance among parent-age adults. Young adults are among the demographic groups in the United States with the lowest levels of health insurance coverage. These uninsured adults are more likely than their insured counterparts to have unmet medical needs and they make lower use of preventive services.

Second, providing subsidized health insurance to parents has eased, and in some cases enabled, a successful transition from welfare to work for many low-income families. Family coverage has been an integral component of the transition from welfare to work in several states.

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<sup>12</sup> Jeremy Alberga, *Wisconsin’s BadgerCare Program Offers Innovative Approach for Family Coverage*, (Washington, D.C.: State Coverage Initiatives, January 2001), 2.

<sup>13</sup> Peggy L. Bartels and Pris Boroniec, “BadgerCare: A Case Study of the Elusive New Federalism,” *Health Affairs*, 17(6), November/December 1998, 165-169.

Appendix C  
**Stakeholders Interviewed by State**

## New Jersey

### **Program staff:**

Deborah Bradley, Acting Director, Division of Medical Assistance and Health Services,  
Department of Human Services

Kathryn Plant, Deputy Director, Division of Medical Assistance and Health Services

Michelle Walsky, Chief of Operations, Division of Medical Assistance and Health Services

Matt D’Oria, Chief of Staff, Division of Medical Assistance and Health Services

Sandy Kelman, Chief, Bureau of Statistical Analysis & Managed Care, Division of Medical  
Assistance and Health Services

Terry Vanderheiden, Director of Marketing and Vendor Management, Office of Managed Health  
Care, Division of Medical Assistance and Health Services

John Guhl, Chief Financial Officer, Division of Medical Assistance and Health Services

Mike Keevey, Chief, Bureau of Budget and Accounting, Division of Medical Assistance and  
Health Services

Heidi Smith, Executive Director, NJ FamilyCare

Dennis Doderer, Manager, Premium Support Program, Division of Medical Assistance and  
Health Services

### **Governor’s staff:**

John Pierro, Deputy Chief, Office of Management & Policy

### **County Boards of Social Services (local enrollment):**

Sue Murray, Administrative Supervisor, Middlesex County

Ernie Sanders, Assistant Administrative Supervisor, Passaic County

Frank Ambrose, Assistant Administrative Supervisor, Camden County

Kathleen Abbott, Supervisor, Camden County

### **Administrative Contractor staff:**

Deborah Sorden, Project Manager, NJ Health Benefits Coordinator Program

Maureen Mulligan, Deputy Project Manager, NJ Health Benefits Coordinator Program

Jaime M. Weber, Quality Assurance Manager, NJ Health Benefits Coordinator Program

Phyllis Nappier-Melendez, Community Relations Manager, NJ Health Benefits Coordinator Program

### **Employers:**

Melanie Willoughby, President, NJ Retail Merchants Association

Bryan Markowitz, Vice President, NJ Business & Industry Association

### **Health plans:**

Norine Yukon, CEO/President, Amerigroup

Sonya Henderson, Vice President of Regulatory Affairs and Compliance, Horizon/Mercy

**Advocates and Parents**

Judy Donlen, Southern NJ Perinatal Cooperative, Inc.

Linda Garibaldi, Legal Services of NJ

Cliffon Johnson, parent

Marlene Lao-Collins, NJ Catholic Conference

Gina Lucas, Association for Children of NJ

Barbara Perry, parent

Helene Tobin, NJ Immigration Policy Network

Deborah Tufts, parent

**Department of Banking and Insurance:**

Ellen DeRosa, Deputy Executive Director, Individual Health Coverage Programs and Small Employer Health Benefits Coverage

**Provider:**

Katherine Grant-Davis, NJ Primary Care Association

## Rhode Island

### Program Staff:

Christine Ferguson, Director, Department of Human Services

Tricia Leddy, Administrator, Center for Child and Family Health

Joan Obara, RItCare Chief, Family Health Systems, Center for Child and Family Health

Murray Brown, Principal and Senior Project Manager, ACS Health Services

Bill White, Senior Vice President, ACS Health Services

Jane Griffin, Research and Evaluation Coordinator, Center for Child and Family Health and  
President, MCH Evaluation

Lissa DiMauro, Rite Share Chief, Family Health Systems, Center for Child and Family Health

John Young, Associate Director, Division of Health Care Quality Financing and Purchasing

Ed Sneesby, Administrator, Field Operations, Department of Human Services

### Legislators:

Senator Catherine E. Graziano, Chair, Senate Health, Education and Welfare Committee

Representative Nancy Hetherington, (also interviewed as an advocate)

Representative Gerald Martineau, Majority Leader

Representative Antonio Pires, Chair, House Finance Committee

### Health Plans:

Luisa Valencia, Program Manager, Blue Cross Blue Shield of RI/Blue CHiP

Chris Koller, Chief Executive Officer and Beth Ann Marootian; Neighborhood Health Plan of Rhode  
Island

Sandi Feretti, Manager, Medicaid Programs and Nancy Trudeau, United HealthCare of New England

### Parents and Advocates:

Lilia Abbatemmatteo, parent

Shondra Bechtold, Ocean State Action Fund

Elizabeth Burke Bryant, Rhode Island KIDS COUNT

Juana Conteras, parent

Melba Depena, Covering Kids

Kerrie Gauthier, parent

Nancy Hetherington, Dorcas Place (also a legislator)

Patricia Martinez, Providence School Department

Luisa Murillo, CHISPA

Beth O'Reilly, Rhode Island Department of Human Services

Trish Pritchard, Rhode Island Hospital

Marti Rosenberg, Ocean State Action Fund

Gisella Ubillus, parent

Claudia Villa, Family Support Center  
Catherine Walsh, Rhode Island KIDS COUNT

**Employer:**

Sidney Goldman, owner operator of Greylawn Foods and Riteshare Business Advisory Group member

**Providers:**

Linda Katz, Rhode Island Health Center Association  
Deb Silvia, Rhode Island Health Center Association

## Wisconsin

### **Program staff:**

Angela Dombrowicki, Director, Bureau of Managed Health Care Programs, Medicaid  
John Haine, Chief, Implementation and Operations Section, Bureau of Health Care Eligibility, Medicaid  
Gregory DiMiceli, Analyst, Medicaid

### **Insurance agency:**

Eileen Mallow, Assistant Deputy Commissioner, Office of the Commissioner of Insurance

### **TANF agency:**

Gary Denis, Acting Director, Bureau of Performance Outcomes, Department of Workforce Development  
Nancy Buckwalter, Bureau Director, BPS, Department of Workforce Development

### **Legislator:**

Senator Peggy Rosenzweig, Committee on Finance, Joint Committee on Finance, and Committee on Health, Utilities, Veterans and Military Affairs

### **Health Plans:**

Mary Anderson, Director of Government Programs, Dean Health Plan, Madison  
Julie Litza, United Healthcare of Wisconsin  
Sandra Tunis, Senior Vice President Program Performance & Regulatory Affairs, Managed Health Services, Milwaukee

### **Parents and Advocates:**

Robert Peterson, Director, ABC for Health, Madison  
Ken Germanson, Community Advocates, Milwaukee  
Shirin Cabraal, Legal Action of Wisconsin, Milwaukee  
Sandra Zabro, Medline, Milwaukee

### **Provider:**

Sarah Lewis, Executive Director, Wisconsin Primary Healthcare Association

### **Employers:**

Eric Borgerding, Lobbyist, Wisconsin Manufacturers and Commerce  
Bill Smith, Executive Director, National Federation of Independent Business, Wisconsin Chapter  
Janice Prior, Oakbrook Corporation, Madison  
Candice Stiebe, Direct Supply, Milwaukee

Appendix D  
**Interview Protocols**

# **Study of Family Coverage Under the State Children's Health Insurance Program**

## **SCHIP (Medicaid agency) Site Visit Protocol**

### **Purpose**

Thank you for agreeing to be one of three states the National Academy for State Health Policy (NASHP) will visit to conduct a study of family coverage under the State Children's Health Insurance Program (SCHIP). The Assistant Secretary for Planning and Evaluation (ASPE) has contracted with The George Washington University Center for Health Services Research and Policy (GWU) for this study to be conducted by NASHP. NASHP will conduct detailed site visits in three states (New Jersey, Rhode Island, and Wisconsin) to look at their experience in providing family coverage in SCHIP under a § 1115 waiver. We will produce a report from these visits that identifies and describes state efforts to provide coverage to the parents of children enrolled in SCHIP. In particular the report will examine the areas of program design, enrollment, effect on the private market, program costs, and impact on children's health coverage rates. (The SCHIP agencies in the three site visit states will receive a copy of the draft report for review prior to its release.) We wish to emphasize that our purpose is not to review state compliance with federal rules or evaluate your program, but rather to prepare a report to:

- inform ASPE's SCHIP evaluation report due to Congress in December 2001; and
- help other states learn from your experience about how to implement family coverage programs in SCHIP and what to expect when doing so.

### **Potential Site Visit Participants**

To gain a complete picture of your state's activities, we hope to spend the first morning of the site visit with SCHIP staff, then spend the balance of our time meeting with other key stakeholders. This outline gives you a sense of our proposed approach. These are meant as loose guidelines, the actual time and participants will vary by state and will be determined in consultation with the selected site visit states.

- SCHIP staff, since different staff are involved in different aspects of the program it might be advisable for the agency to schedule staff to participate at different times during the up to 4 hours we anticipate spending with SCHIP staff. If you use an enrollment broker, staff from these entities should participate in the appropriate parts of the discussion.
- Insurers/MCO staff (Meet individually with three insurers/MCOs for 1 hour each. If possible one of the three will not be participating in the SCHIP program.)

- Advocates and Parents – joint meeting (1.5 hours)
- Employers – joint meeting (1 hour)
- Other stakeholders – will vary by state and may include:
  - S State Insurance agency (1 hour)
  - S Key groups or individuals, other than SCHIP staff, actively involved in moving the family coverage proposal through state political process or federal waiver process. For example, a member of the Governor’s staff or someone from legislative staff (1 hour)
  - S County staff, if counties involved in enrollment of parents (1 hour)

The NASHP site visit team will meet as a team with: SCHIP staff and the advocates and consumers. If necessary, the site visit team will split up for meetings with other interviewees so that up to two simultaneous meetings may be held with the remaining interviewees.

## Requested Materials

- Waiver request for family coverage
- HCFA’s approval letter and terms and conditions
- Marketing material—especially any that was changed to support expansion
- Any state legislation authorizing the expansion
- Any data you have showing the effect of family coverage, such as trends in children’s enrollment pre and post family coverage or trends in employer coverage pre and post enrollment

## Questions

Please review the attached matrix—it includes the basic information about your program that we were able to glean from other sources—is it accurate? Also, please note: We don’t expect you to be able to answer all the question listed here, but want to make sure we don’t miss anything because we didn’t ask!

1. Why did you expand coverage to parents of SCHIP-eligible children?
2. What factors motivated you?
  - a. Who supported it and why?
  - b. Who opposed it and why?
  - c. What/who was key to obtaining funding and authority to expand your program to parents?
  - d. Are there unique circumstances in your state that made it easy/hard to implement family

coverage?

3. How are you implementing family coverage expansions?
  - a. Are you marketing the program differently now that you cover parents?
  - b. How does enrollment work from the families' perspective?
  - c. How did you revise your insurer contracts (if you have them) to accommodate parents?
  - d. What benchmark benefit package did you choose? Why?
  - e. How do benefits compare between parents and children?
  - f. Please describe your delivery system. Are all benefits delivered through managed care to all program participants? Are some benefits delivered on fee-for-service? Are some program participants on fee-for-service?
4. Are there instances in which parents are enrolled in different plans from their children? If so, how does this work? Is this a barrier to enrollment? Why or why not? If it is a barrier, what have you done to mitigate its effect?
5. What issues did you (are you) facing? How did/will you address these?
6. How has implementation of family coverage affected enrollment of children into Medicaid and SCHIP and disenrollment from these programs? What barriers remain for eligible, but not enrolled, parents and children? Have you tracked enrollment trends before and after implementing family coverage? If so, are children's enrollment rates increasing? Are they staying enrolled for longer periods of time?
7. What interaction has occurred with this expansion and the private market, particularly in the area of substitution of coverage? Have employers dropped coverage since the expansion? Have employees dropped coverage? If they have, do you think the change is related to the implementation of family coverage? Why or why not?
8. What substitution prevention mechanism did you implement in your family coverage program? Why? How are you monitoring substitution? What has been your substitution rate to date?
9. What has been the reaction among employers? Among insurers? Among parents? Health plans and providers? Why do you think each reacted that way?
10. Were there any unintended consequences of the family coverage expansion? If so, what were they and how are you addressing them?
11. What are your policies regarding cost sharing? What factors went into your decisions regarding the cost-sharing limits?

12. What are the costs (for providing medical services and administration) associated with family coverage? How much for your overall SCHIP program?
13. Do you anticipate funding problems such as running out of allotment? What will you do if you run out of allotment? Are you considering capping enrollment? Why or why not?
14. Has there been any fall-out from the family coverage expansion? If so, what was it? Has there been any weakening or strengthening of support from the Governor, legislature or business community?
15. How well do you think your family coverage expansion is working? Why?
16. What are the lessons learned? What advice would you give to other states considering adding family coverage to their SCHIP program?
17. Is there anything else we should know about your program?

# **Study of Family Coverage Under the State Children's Health Insurance Program**

## **Site Visit Protocol**

Employers

### **Purpose**

Thank you for agreeing to meet with us to discuss family coverage under the State Children's Health Insurance Program (SCHIP). (Family coverage means enrolling parents into the SCHIP program in addition to their children—so that the whole family may be enrolled into the same program.) The Assistant Secretary for Planning and Evaluation (ASPE) has contracted with The George Washington University Center for Health Services Research and Policy (GWU) for this study to be conducted by the National Academy for State Health Policy (NASHP). NASHP is conducting detailed site visits in three states (New Jersey, Rhode Island, and Wisconsin). We will produce a report from these visits that identifies and describes state efforts to provide family coverage in SCHIP. We wish to emphasize that our purpose is not to review state compliance with federal rules or evaluate the program, but rather to prepare a report to:

- inform ASPE's SCHIP evaluation report due to Congress in December 2001; and
- help other states learn from your experience about how to implement family coverage programs in SCHIP and what to expect when doing so.

We have already met with state staff to gain an understanding of how the program works and their perspective on how they were able to implement it and how well it's working. You are one of a range of stakeholders (consumers, plans, employers, etc.) we are now meeting with to develop a more complete picture of the family coverage in your state. SCHIP agency staff will review a draft of the report and you will receive a copy of the final report.

### **Requested Materials**

- Any documents (brochures, letters, policy statements, etc.) information you developed to support (or oppose) the family coverage expansion
- Any information you gave to the state to help them evaluate whether they would cover your employees

### **Questions**

Note: We don't expect you to be able to answer all the question listed here, but want to make sure we don't miss anything because we didn't ask!

1. Did you/do you support or oppose the family coverage expansion? Why? Has your position changed since the program's implementation? If so, why?
2. What was your role, if any, in the family coverage expansion?
3. Do you know if any of your employees are enrolled in the family coverage program? Do you know if any are in the employer buy-in program (Employer buy-in is when the state pays some or all of your employees' portion of the cost of participating in your health insurance program)? Do you encourage them to enroll in those programs? Why or why not? If you encourage them, how do you encourage them?
4. Do you offer health insurance to your employees? Why or why not? Has the family coverage expansion made it more or less difficult for you to offer health insurance to your employees? If so, how?
5. Do you think the family coverage expansion affected your employees' willingness to enroll in your health insurance program? If so, how?
6. If you don't offer health insurance now did you do so in the past? Why did you stop offering it?
7. Do you have a preference for whether your employees get their health insurance from the family coverage program, the state pays the employee's share of participating in your health insurance program, or the employee pays their share of participating in your health insurance program? Why or why not?
8. Do you think adding family coverage to SCHIP encouraged more families to apply? Why or why not? What else could be done to encourage enrollment?
9. Do you know how much in premiums and co-pays SCHIP enrollees are paying? How do they compare with the health insurance you offer? What should the state consider when deciding those amounts?
10. How well do you think the family coverage expansion is working? Why? What could the state do to improve the family coverage expansion? Why would that be an improvement?
11. What are the lessons learned? What advice would you give to policymakers considering adding family coverage to their SCHIP program?
12. Is there anything else we should know about the family coverage program?

# **Study of Family Coverage Under the State Children's Health Insurance Program**

## **Site Visit Protocol**

Insurers

### **Purpose**

Thank you for agreeing to meet with us to discuss family coverage under the State Children's Health Insurance Program (SCHIP). (Family coverage means enrolling parents into the SCHIP program in addition to their children—so that the whole family may be enrolled into the same program.) The Assistant Secretary for Planning and Evaluation (ASPE) has contracted with The George Washington University Center for Health Services Research and Policy (GWU) for this study to be conducted by the National Academy for State Health Policy (NASHP). NASHP is conducting detailed site visits in three states (New Jersey, Rhode Island, and Wisconsin). We will produce a report from these visits that identifies and describes state efforts to provide family coverage in SCHIP. We wish to emphasize that our purpose is not to review state compliance with federal rules or evaluate the program, but rather to prepare a report to:

- inform ASPE's SCHIP evaluation report due to Congress in December 2001; and
- help other states learn from your experience about how to implement family coverage programs in SCHIP and what to expect when doing so.

We have already met with state staff to gain an understanding of how the program works and their perspective on how they were able to implement it and how well it's working. You are one of a range of stakeholders (consumers, plans, employers, etc.) we are now meeting with to develop a more complete picture of the family coverage in your state. SCHIP agency staff will review a draft of the report and you will receive a copy of the final report.

### **Requested Materials (if readily available and you are willing to share them)**

- Any documents (brochures, letters, policy statements, etc.) information you developed to support (or oppose) the family coverage expansion
- Any information you give to families enrolled in SCHIP that is different from families where the parents are not enrolled.
- Any data you have showing the effect of family coverage on the public or private market.
- Anything else you feel is pertinent to our discussion.

### **Questions**

Note: We don't expect you to be able to answer all the question listed here, but want to make sure we don't miss anything because we didn't ask!

1. Do you participate in the SCHIP program? Why or why not? Do you participate in the Medicaid program? If you don't participate in both why do you participate in one and not the other?
2. How does your enrollment break down? Is it mostly private? Mostly public?
3. Did you/do you support or oppose the family coverage expansion? Why? Has your position changed since the program's implementation? If so, why?
4. What was your role in the family coverage expansion?
5. Has adding family coverage to SCHIP encouraged more families to apply? Why or why not? What else could be done to encourage enrollment? Have you found that more children are enrolling or they're staying in longer since the expansion was implemented?
6. What is your role in program enrollment? How well does enrollment work? How would you improve it?
7. Has the family coverage expansion affected employer's ability or willingness to provide insurance to employees? If so, how? Do you think the family coverage expansion affected employee's ability or willingness to join their employer's health insurance program? Why or why not?
8. Has the family coverage expansion affected your participation in the private or public market? If so, what was the effect? Why did that effect occur? If there was no effect—why not?
9. What is your assessment of any premiums and co-pays SCHIP enrollees need to make? Are they too high or low? Why? How do they compare to your commercial business? What should the state consider when deciding those amounts?
10. Do you have a role in collecting premiums or co-payments? If so, is there any difference in families willingness to pay when the whole family (not just the children) are enrolled? If so, what is the difference? Why do you think there is a difference?
11. What do you have to do differently because parents are enrolled? What are the costs to you of enrolling parents? Is there anything the state could do to lessen any increase in administrative burden caused by enrolling parents? If so, what? How long did you need to prepare to enroll

and serve parents?

12. What has been your reaction to the family coverage expansion? How well do you think it's working? Why? How well do you think SCHIP serves parents?
13. What could the state do to improve the family coverage expansion? Why would that be an improvement?
14. What are the lessons learned? What advice would you give to anyone considering adding family coverage to their SCHIP program?
15. Is there anything else we should know about the family coverage program?

# **Study of Family Coverage Under the State Children's Health Insurance Program**

## **Site Visit Protocol**

Consumers and Advocates

### **Purpose**

Thank you for agreeing to meet with us to discuss family coverage under the State Children's Health Insurance Program (SCHIP). (Family coverage means enrolling parents into the SCHIP program in addition to their children—so that the whole family may be enrolled into the same program.) The Assistant Secretary for Planning and Evaluation (ASPE) has contracted with The George Washington University Center for Health Services Research and Policy (GWU) for this study to be conducted by the National Academy for State Health Policy (NASHP). NASHP is conducting detailed site visits in three states (New Jersey, Rhode Island, and Wisconsin). We will produce a report from these visits that identifies and describes state efforts to provide family coverage in SCHIP. We wish to emphasize that our purpose is not to review state compliance with federal rules or evaluate the program, but rather to prepare a report to:

- inform ASPE's SCHIP evaluation report due to Congress in December 2001; and
- help other states learn from your experience about how to implement family coverage programs in SCHIP and what to expect when doing so.

We have already met with state staff to gain an understanding of how the program works and their perspective on how they were able to implement it and how well it's working. You are one of a range of stakeholders (consumers, plans, employers, etc.) we are now meeting with to develop a more complete picture of the family coverage in your state. SCHIP agency staff will review a draft of the report and you will receive a copy of the final report.

### **Requested Materials (if readily available)**

- Any document you felt was very useful in helping you decide to apply to the SCHIP program.
- Any documents (brochures, letters, policy statements, etc.) information you developed to support (or oppose) the family coverage expansion
- Any documents you've developed identifying how family coverage could be improved
- Any information you have that shows the effect of the family coverage expansion.
- Anything else you feel is pertinent to our visit.

### **Questions**

Note: We don't expect you to be able to answer all the question listed here, but want to make sure we

don't miss anything because we didn't ask!

1. What was your role in the family coverage expansion?
2. If you knew about the family coverage expansion before it began did you think it was a good idea? Why or why not?
3. What do you think about the family coverage expansion now? Why?
4. Did adding family coverage to SCHIP encourage you to apply to the program? To stay in the program? Did it encourage others to join or stay? Why or why not? What else could be done to encourage more families to join and stay in the program?
5. Did adding family coverage encourage you to enroll your children in the program? Does it make it more likely that you will maintain your child's enrollment when your need to re-enroll? Do you think it makes it more likely that other families will join or continue in the program?
6. Have you applied to the program? If so, how did you apply? What information did you need to provide and who did you have to provide it to? Do you feel you were asked for too much information?
7. Were you enrolled in the same plan as your children? If you were enrolled in a different plan, how did that effect you?
8. How well do you think the whole application process works? What could the state do to make it better?
9. Does your employer offer health insurance to you? If so, why didn't you take your employer's insurance?
10. Did your employer recently stop offering health insurance coverage to you? If so, did your employer offer any explanation as to why the coverage was dropped? Did your employer raise premiums, deductibles or copays?
11. Do you think SCHIP family coverage has made it harder for your employer to offer health insurance to you? Do you think your employer is less willing to offer health insurance to you? Why or why not?
12. What about the amount of any premiums or co-pays you need to make? Are they too high or low? Why? What should the state consider when deciding those amounts? Are you more

willing to pay them now that your whole family is enrolled? Why or why not?

13. How well do you think the family coverage expansion is working? Why? What would you do to improve the family coverage expansion? Why would that make it better?
14. If you are enrolled in the family coverage program how well does it work for you? What could be improved? If you are not enrolled, why not? How well does the program work for others?
15. What advice would you give to anyone considering adding family coverage to their SCHIP program?
16. Is there anything else we should know about the family coverage program?

# **Study of Family Coverage Under the State Children's Health Insurance Program**

## **Site Visit Protocol**

State Insurance Agency

### **Purpose**

Thank you for agreeing to meet with us to discuss family coverage under the State Children's Health Insurance Program (SCHIP). (Family coverage means enrolling parents into the SCHIP program in addition to their children—so that the whole family may be enrolled into the same program.) The Assistant Secretary for Planning and Evaluation (ASPE) has contracted with The George Washington University Center for Health Services Research and Policy (GWU) for this study to be conducted by the National Academy for State Health Policy (NASHP). NASHP is conducting detailed site visits in three states (New Jersey, Rhode Island, and Wisconsin). We will produce a report from these visits that identifies and describes state efforts to provide family coverage in SCHIP. We wish to emphasize that our purpose is not to review state compliance with federal rules or evaluate the program, but rather to prepare a report to:

- inform ASPE's SCHIP evaluation report due to Congress in December 2001; and
- help other states learn from your experience about how to implement family coverage programs in SCHIP and what to expect when doing so.

We have already met with state staff to gain an understanding of how the program works and their perspective on how they were able to implement it and how well it's working. You are one of a range of stakeholders (consumers, plans, employers, etc.) we are now meeting with to develop a more complete picture of the family coverage in your state. SCHIP agency staff will review a draft of the report and you will receive a copy of the final report.

### **Requested Materials**

- Any documents (brochures, letters, policy statements, etc.) information you developed to support (or oppose) the family coverage expansion
- Any document that shows the impact of the family coverage expansion on the private market or your duties as an insurance regulator.
- Anything else you feel is pertinent to our discussion.

### **Questions**

Note: We don't expect you to be able to answer all the question listed here, but want to make sure we don't miss anything because we didn't ask!

1. Did you/do you support or oppose the family coverage expansion? Why? Has your position changed since the program was implemented? Why or why not?
2. What was your role in the family coverage expansion?
3. Has adding family coverage to SCHIP encouraged more families to apply? Why or why not? What else could be done to encourage enrollment? Do you have any role in program enrollment? If so, what is your role? How well does enrollment work?
4. Has the family coverage expansion affected the private insurance market? Why or why not? If it affected the market, what has been the effect? Are employers less likely to offer insurance? Are employees less likely to take employer sponsored insurance? Are families less likely to buy individual coverage from insurers? Are you concerned about possible future affects? If so, what affects are you concerned about and why?
5. Do you know the amount of any premiums and co-pays SCHIP enrollees need to make? If so, what is your assessment of them? Are they too high or low? Why? How do they compare to the private market? What should the SCHIP program consider when deciding those amounts?
6. Do you have any concerns about family coverage from a licensing point of view? If so, what are they? Why are you concerned about them?
7. How well do you think the family coverage expansion is working? Why? How well do you think SCHIP serves parents?
8. What could the SCHIP agency do to improve the family coverage expansion? Why would that be an improvement?
9. What are the lessons learned? What advice would you give to other states considering adding family coverage to their SCHIP program?
10. Is there anything else we should know about the family coverage program?

# **Study of Family Coverage Under the State Children's Health Insurance Program**

## **Site Visit Protocol**

Local Enrollment Staff (County or Others)

### **Purpose**

Thank you for agreeing to meet with us to discuss family coverage under the State Children's Health Insurance Program (SCHIP). (Family coverage means enrolling parents into the SCHIP program in addition to their children—so that the whole family may be enrolled into the same program.) The Assistant Secretary for Planning and Evaluation (ASPE) has contracted with The George Washington University Center for Health Services Research and Policy (GWU) for this study to be conducted by the National Academy for State Health Policy (NASHP). NASHP is conducting detailed site visits in three states (New Jersey, Rhode Island, and Wisconsin). We will produce a report from these visits that identifies and describes state efforts to provide family coverage in SCHIP. We wish to emphasize that our purpose is not to review state compliance with federal rules or evaluate the program, but rather to prepare a report to:

- inform ASPE's SCHIP evaluation report due to Congress in December 2001; and
- help other states learn from your experience about how to implement family coverage programs in SCHIP and what to expect when doing so.

We have already met with state staff to gain an understanding of how the program works and their perspective on how they were able to implement it and how well it's working. You are one of a range of stakeholders (consumers, plans, employers, etc.) we are now meeting with to develop a more complete picture of the family coverage in your state. SCHIP agency staff will review a draft of the report and you will receive a copy of the final report.

### **Requested Materials**

- Any documents (brochures, letters, policy statements, etc.) information you developed to support (or oppose) the family coverage expansion.
- Any documents you have explaining your role in enrolling families into SCHIP
- Any documents that you find particularly helpful in carrying out your responsibility for enrollment.

### **Questions**

Note: We don't expect you to be able to answer all the question listed here, but want to make sure we don't miss anything because we didn't ask!

1. Did you/do you support or oppose the family coverage expansion? Why? Has your position changed now that you have some experience with it?
2. What was your role in the family coverage expansion?
3. What is your role in the enrollment process? How well does the process work? How would you improve the process? Is the process different now that you enroll parents? How so?
4. Has adding family coverage to SCHIP encouraged more families to apply? Why or why not? What else could be done to encourage enrollment?
5. Do you think the family coverage expansion made private insurance more or less difficult to get? Has it effected employer's ability or willingness to provide insurance to employees? If so, how?
6. Do you think families prefer SCHIP over their employer's health insurance or insurance they could buy directly from insurers as an individual family? Why or why not?
7. Do you collect premiums or co-pays from enrolled families? If so have you noticed any difference in willingness to pay those now that parents are enrolled? If so, what are the differences? Why do you think that difference exists?
8. What has been your reaction to the family coverage expansion? How well do you think it's working? Why?
9. What could the state do to improve the family coverage expansion? Why would that be an improvement?
10. What are the lessons learned? What advice would you give to anyone considering adding family coverage to their SCHIP program?
11. Is there anything else we should know about the family coverage program?

# **Study of Family Coverage Under the State Children's Health Insurance Program**

## **Site Visit Protocol**

All Others

### **Purpose**

Thank you for agreeing to meet with us to discuss family coverage under the State Children's Health Insurance Program (SCHIP). (Family coverage means enrolling parents into the SCHIP program in addition to their children—so that the whole family may be enrolled into the same program.) The Assistant Secretary for Planning and Evaluation (ASPE) has contracted with The George Washington University Center for Health Services Research and Policy (GWU) for this study to be conducted by the National Academy for State Health Policy (NASHP). NASHP is conducting detailed site visits in three states (New Jersey, Rhode Island, and Wisconsin). We will produce a report from these visits that identifies and describes state efforts to provide family coverage in SCHIP. We wish to emphasize that our purpose is not to review state compliance with federal rules or evaluate the program, but rather to prepare a report to:

- inform ASPE's SCHIP evaluation report due to Congress in December 2001; and
- help other states learn from your experience about how to implement family coverage programs in SCHIP and what to expect when doing so.

We have already met with state staff to gain an understanding of how the program works and their perspective on how they were able to implement it and how well it's working. You are one of a range of stakeholders (consumers, plans, employers, etc.) we are now meeting with to develop a more complete picture of the family coverage in your state. SCHIP agency staff will review a draft of the report and you will receive a copy of the final report.

### **Requested Materials**

Any documents (brochures, letters, policy statements, etc.) information you developed to support (or oppose) the family coverage expansion

### **Questions**

Note: We don't expect you to be able to answer all the question listed here, but want to make sure we don't miss anything because we didn't ask!

1. Did you support or oppose the family coverage expansion before it started? Why? Has your position changed now that the program is operating? Why or why not?

2. What was your role in the family coverage expansion?
3. Has adding family coverage to SCHIP encouraged more families to apply? Why or why not? What else could be done to encourage enrollment?
4. How does enrollment in the program work from your point of view? How well does it work? How do families get into the state's family coverage program instead of the employer's family coverage program?
5. Has the family coverage expansion made private insurance more or less difficult to get? Has it effected employers ability or willingness to provide insurance to employees? Has it effected employees' willingness to take the health insurance their employer offers? Families' willingness to seek individual coverage directly from insurers? If you think family coverage had any affect what was the affect and why do you think it had that affect?
6. What is your assessment of any premiums and co-pays SCHIP enrollees need to make? Are they too high or low? Why? What should the state consider when deciding those amounts?
7. Do you know the employer's role in enrollment into the family coverage expansion? If so what do you think of it? Are the state's expectations of employers reasonable?
8. What has been your reaction to the family coverage expansion? How well do you think it's working? Why? How well do you think SCHIP serves parents?
9. What could the state do to improve the family coverage expansion? Why would that be an improvement?
10. What are the lessons learned? What advice would you give to anyone considering adding family coverage to their SCHIP program?
11. Is there anything else we should know about the family coverage program?