SCHIP Changes in a Difficult Budget Climate:
A Three-State Site Visit Report

David Bergman
Claudia Williams
Cynthia Pernice

April 2004

Prepared with support from the
David and Lucile Packard Foundation

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David Bergman
Claudia Williams
Cynthia Pernice

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by

National Academy for State Health Policy
50 Monument Square, Suite 502
Portland, ME 04101
Telephone: (207) 874-6524
Facsimile: (207) 874-6527
E-mail: info@nashp.org
Website: www.nashp.org

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Texas

State Staff

Texas Health and Human Services Commission

- Trey Berndt, Special Assistant to Director
- Jason Cooke, Medicaid/SCHIP Director
- Jan McGuire, Program Specialist
- Gary Young, Medicaid/SCHIP Quality Improvement Manager

Consumer Advocates:

- Barbara Best, Health Policy Manager (Houston/Harris County), Children's Defense Fund
- Anne Dunkelberg, Senior Policy Analyst, Center for Public Policy Priorities
- Helen Kent Davis, Director of Governmental Affairs, Texas Medical Association
- Carolyn Schwarz, School Program Coordinator, insure·a·kid

Health Plan Representatives:

Community First Health Plans

- Rita Ayala, Products Manager
- Charles Kight, President & CEO
- Eileen Weigum, Vice President, Operations

Superior Health Plan

- Christopher Bowers, President & CEO
- Holly Williams, Vice President of Business Development

Lawmakers:

- Patricia Becker, General Counsel to Senator Kyle Janek
- Meredith Delk-Pruiett, Legislative Aide to Senator Judith Zaffirini
- Representative Garnet Colman
- Jared Wolf, Senior Policy Analyst, Health and Human Services for the Senate and Office of the Lieutenant Governor

Utah

State Staff:
Department of Health
- Amy Bingham, Program Manager
- Michael Hales, Director of Children's Health Insurance and Access Initiatives
- Gaylen Henderson, Policy Specialist
- Roger Price, Actuarial Specialist
- Anna West, Outreach Specialist

Consumer Advocates:
- Karen Crompton, Executive Director, Voices for Utah Children
- Sheila Walsh-McDonald, Health Care Advocate, Salt Lake Area Community Action Program

Health Plan Representatives:
Molina Health Care
- Shawn Abbatiello, Director of Member and Provider Services
- Paul Muench, Chief Financial Officer
- G. Kirk Olsen, Chief Executive Officer
- Geri Suzuki, Director of Medical Services

Public Employees Health Program
- Dennis Kunimura, Underwriting and Data Analysis Manager
- Christy Simpson, Claims Production Director
- Alicia Sylvies, Provider Relations Director
- Julie West, Senior Underwriter

Lawmakers:
- Nathan Checketts, Policy Analyst, Governor's Office of Planning and Budget

Virginia

State Staff:
Department of Medical Assistance Services
- Tom Edicola, Manager of Operations
- Pat Finnerty, Director, Department of Medical Assistance Services
- Cindi Jones, Chief Deputy Director
- Linda Nablo, Director, Division of Child Health Insurance Program

Virginia (continued)

Consumer Advocates:

- Jill Hanken, Staff Attorney, Virginia Poverty Law Center
- Kim McGaughey, Covering Kids & Families Coordinator State Director, and Director of Child Health Insurance Initiatives, Virginia Health Care Foundation
- Deborah Oswalt, Executive Director, Virginia Health Care Foundation

Health Plan Representatives:

- Julie Locke, Director of Medicaid Program, Anthem Blue Cross and Blue Shield
- Megan Philpotts Padden, Director of Medicaid, Sentara Health Management

Lawmakers:

- Delegate Robert Brink
- Delegate Vincent Callahan, Jr.
- Delegate Phillip Hamilton
- Susan Massart, Legislative Fiscal Analyst
- Jane Woods, Secretary of Health and Human Resources

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INTRODUCTION

The National Academy for State Health Policy (NASHP) conducted site visits to three states—Texas, Utah and Virginia—between December 2003 and February 2004 to gather information about programmatic changes to SCHIP in the wake of recent budget debates. The site visits were two days long and included meetings with SCHIP staff, consumer advocates, health plan representatives, and lawmakers. The purpose of the site visits was to gain a deeper understanding of issues and challenges confronting states in the current fiscal environment.

Texas, a geographically large state with a high number of uninsured and large enrollment in Medicaid and SCHIP programs, was selected because it made a variety of changes to its SCHIP program in 2003 due to the budget crisis facing the state.

Utah, a western state, was selected because of the changes it made to its SCHIP program in 2002. The state instituted an enrollment freeze, restricted enrollment to periodic open enrollment periods, raised cost sharing, and reduced dental benefits to maintain its program at current budget levels.

Virginia, a southern state, has experienced rapid enrollment increases in its SCHIP program, following a slow start. The program has made a number of recent changes, mostly to expand access rather than cut costs. These changes include the elimination of monthly premiums, increased access to mental health services, and a streamlined enrollment process.

KEY FINDINGS

Focus on Enrollment

Because children are relatively inexpensive to cover with health insurance, enrollment is the main driver of cost increases. Consequently, when the poor budget climate forced states to examine SCHIP costs, states looked at ways to better control enrollment.

For states seeking to cut costs, slowing the pace of enrollment is seen as a necessity. However, stakeholders are adamant in not wanting to backslide on eligibility levels and prefer to control enrollment by establishing—or re-establishing—new enrollment processes. This presents a difficult irony for states. The success of the SCHIP program drove Medicaid to simplify its enrollment processes over the last few years; now, budget problems are driving the trend in reverse as some states change enrollment processes in SCHIP in order to slow enrollment.

States are using open enrollment periods and changes to eligibility determination to manage enrollment upwards or downwards.

- Texas opted to control enrollment by changing how eligibility is determined, reducing the period of continuous eligibility, and increasing cost sharing. From an enrollment high of more than 510,000 children, these and other administrative measures are expected to decrease enrollment to 346,818 children in 2005. Although Texas did make benefit changes to SCHIP, the major cost savings are expected to come from the anticipated reduction in enrollment.

- In Utah, concern about SCHIP expenditures led to a minor reduction in benefits and the introduction of periodic open enrollment, allowing the state to manage enrollment around an average of about 28,000 children and effectively stabilizing costs. Utah chose this approach in part because it permitted the state to maintain eligibility levels at 200 percent of FPL. If additional resources are identified, as occurred in early 2003, open enrollment periods can be scheduled with greater frequency.

States are avoiding lowering income eligibility levels as a means to reduce enrollment and spending.

In all three states, SCHIP is a very popular program. Given the budget environments, lawmakers—especially those opposed to raising taxes—faced the difficult task of identifying budgetary savings without lowering the eligibility levels in SCHIP.

- During the 78th legislative session, Texas considered lowering eligibility levels from 200 percent of FPL to 150 percent of FPL. There was widespread opposition to this measure from both advocates and lawmakers. Although no explicit change was made to the FPL

eligibility levels, income disregards were eliminated, effectively lowering the income eligibility level for many families, and an asset test was imposed—all moves that are expected to reduce enrollment.

- In early 2003, Utah's legislature entertained a proposal to lower eligibility levels to 150 percent FPL. Despite a projected budget shortfall, this proposal garnered little support. In the end, the state's share of funding for SCHIP was increased from $5.5 million to $7 million.

- In Virginia, there is little enthusiasm for increasing eligibility beyond the 200 percent level, despite the widespread support for the program. Stakeholders, noting the experience of other states, do not want enrollment to increase to an unsustainable level.

SCHIP Funding Strategies

Because SCHIP is not an entitlement program, states may voluntarily determine how and to what degree they wish to fund their programs.

States use special revenue funds to finance SCHIP. Use of these dedicated sources can protect and maintain funding for SCHIP when general revenues are tight.

All states that participated in the site visits used special revenue funding streams to finance their SCHIP programs. These special revenue funds—as distinct from general revenue—can help to insulate SCHIP services from reductions and elimination.

- The state match for Texas' SCHIP program comes from its tobacco settlement pool. SCHIPis the top funding priority for this revenue source. The tobacco settlement pool in Texas does not provide the same security and protection as other states' dedicated funding streams as the biennial legislature and the governor adjust the amounts distributed to various health-related programs during the session, just as they do with general revenue funds.

- Utah initially funded SCHIP with a special assessment on hospitals that generated $6.1 million in the first two years of program implementation. In 2000, the legislature began to fund SCHIP with up to $5.5 million from the state's tobacco settlement pool. Because tobacco funding varies somewhat each year, funding is distributed in the order of priority established by the state. The SCHIP allocation, increased by the legislature from $5.5 million to $7 million in 2003, is the top priority.

  By funding SCHIP through the hospital assessment and then the tobacco settlement pool, Utah has protected the state match for SCHIP from competition with other priorities in the state's general fund. As a result, even in a poor budget climate, SCHIP funding is relatively secure.

- Prior to the implementation of FAMIS (Family Access to Medical Insurance Security) in Virginia, two insurance companies agreed, in exchange for a reduced tax rate, to serve as insurers of last resort by covering all people who had been denied coverage elsewhere. When the state prevented insurance companies from denying coverage to individuals by instituting mandatory guaranteed issue, it eliminated the lower tax rates and used the additional revenue to create the FAMIS Trust Fund.

  Each year, the FAMIS Trust Fund provides about $1.5 million in funding for FAMIS Plus (Medicaid) and between $12 million to $14 million in funding for FAMIS. The remaining $26.2 million in state match for SCHIP comes from Virginia's General Fund.

The federal allocation and the matching rate sometimes drive state decisions about how much to spend on SCHIP.

SCHIP matching rates differ by state because they are based on Medicaid matching rates that also differ by state. SCHIP matching rates range from a low of 65 percent in Virginia and other states to a high of 84 percent in Mississippi.

- Of the states visited, Utah had the highest federal match for its state funds. For every dollar spent by Utah on SCHIP, four dollars come from the federal government. This has proved a decisive factor in the state's funding decisions for its SCHIP program. When the legislature increased the state contribution to $7 million in early 2003, the explicit intent was to take advantage of the high matching rate and draw down the full federal allocation.

- Virginia's federal allocation for SCHIP spending was moderately influential in driving state spending. In the early years of the program, critics argued that substantial sums of federal funding were being left unspent because there were not enough children enrolled to draw down the full amount allocated to Virginia by the federal government. As it has turned out, Virginia's early under-spending on the program and the federal government's decision to continue to make available to states their previously allocated funds have allowed the Commonwealth to weather the current reduction in federal spending for SCHIP.

- Even though Texas has a relatively generous federal match—72 percent or $2.50 for every one state dollar spent—local stakeholders indicate that, in the current tight fiscal environment, the dollar amount of state spending and not the federal allocation or the matching rate drives state decisions about SCHIP funding.

Statutory vs. Regulatory Changes

SCHIP programs can be changed through program administrative rules or legislatively through either statutory change or the budget. If need be, regulatory changes can occur rapidly and with minimal stakeholder input, while statutory changes involve many more people and are generally difficult to reverse. This trade-off between flexibility and permanence was resolved differently by each of the states.

Lawmakers make changes through statute, not the budget process or through administrative rules, when they want to make changes more permanent.

- Most of the recent changes to Texas' SCHIP program were made through legislation. Agency staff provided input and analysis on some of the proposed changes, but other changes were initiated and debated by legislators alone. If the budget situation improves, legislative action will be required to reverse the changes that Texas made to restrict eligibility, namely the elimination of disregards and introduction of the asset test.

- The change to periodic open enrollment implemented by Utah in late 2001 was initially done through administrative rules without legislation. Other possible changes—for example, modifying eligibility levels—would have required legislative action.

- At the urging of the agency staff, many of the changes to Virginia's FAMIS program were done through statute. This was done to institutionalize the program so that as much as possible would remain in place after the current administration changes. Unlike Texas, Virginia's changes are designed to increase enrollment, rather than control it.

SCHIP and Medicaid

Medicaid and SCHIP are complimentary programs linked in a variety of different ways depending on the state. Administratively, many states have chosen to coordinate the enrollment processes for both SCHIP and Medicaid. They have, for example, begun to use common or similar applications, changed eligibility levels to decrease the prevalence of families with children enrolled in both programs, utilized the same or similar eligibility determination procedures, and, in some cases, altered benefit packages to make the programs more alike.

Although SCHIP outreach efforts have always reached Medicaid eligible children, the effect on children's Medicaid enrollment is most pronounced when there is a high degree of coordination between the two programs. The combination of effective SCHIP outreach and highly coordinated enrollment processes has resulted, for many states, in increased enrollment—and expenditures—in both programs.

Outreach for SCHIP drives children's Medicaid enrollment.

- Once application simplification efforts were completed in Texas, SCHIP outreach and Medicaid simplification increased enrollment dramatically in both SCHIP and Medicaid. Medicaid enrollment rose from just below one million children in May 2001, to more than 1.6 million in December 2003. SCHIP enrollment during the same period rose from 332,802 children in May 2001 to 438,164 children in December 2003, having reached a peak of more than 529,211 children in May of that year.

- In Virginia, children's Medicaid enrollment has grown substantially since the state's FAMIS program was reorganized in September 2002 and coordinated with children's Medicaid. Children's enrollment in Medicaid increased by 21.4 percent between September 2002 and February 2004, and SCHIP enrollment increased by 47.9 percent in the same period.

SITE VISIT REPORTS

These site visit reports are intended to serve as case studies and to be used to better understand the common challenges currently faced by many SCHIP programs. The changes in the SCHIP programs in Texas, Utah, and Virginia were obviously the result of very different situations and were made for very different reasons. However, each state faced a serious budget crisis, and each utilized some of the same measures to close the budget gap.

The site visit reports that follow are intended to tell a cohesive story of SCHIP in each state. Accordingly, they detail the history of each SCHIP program, from inception to the time of the site visit. Each report also describes specific features of the SCHIP program, the impact of SCHIP on children's Medicaid, as well as the overall budget environment. Ultimately, the reports aim to convey the dynamic relationship between individual changes in the SCHIP program and the overall environment in each state.

TEXAS

Overview

The SCHIP program in Texas has successfully brought health insurance and healthcare to hundreds of thousands of children across the state. However, as the state's budget climate worsened in late 2001 and early 2002, increasing SCHIP and Medicaid enrollments contributed to a projected two-year state budget shortfall of nearly $10 billion. In an effort to reign-in SCHIP costs, the Texas Legislature made significant changes in cost sharing, benefits, enrollment determination, and administration of the program. It also passed a small reduction in provider payments. These changes had the effect of reducing enrollment from its peak of 529,211 in 2002 to 438,164[1] enrollees in 2003 and are likely to drive down enrollment still further in the future.

Background

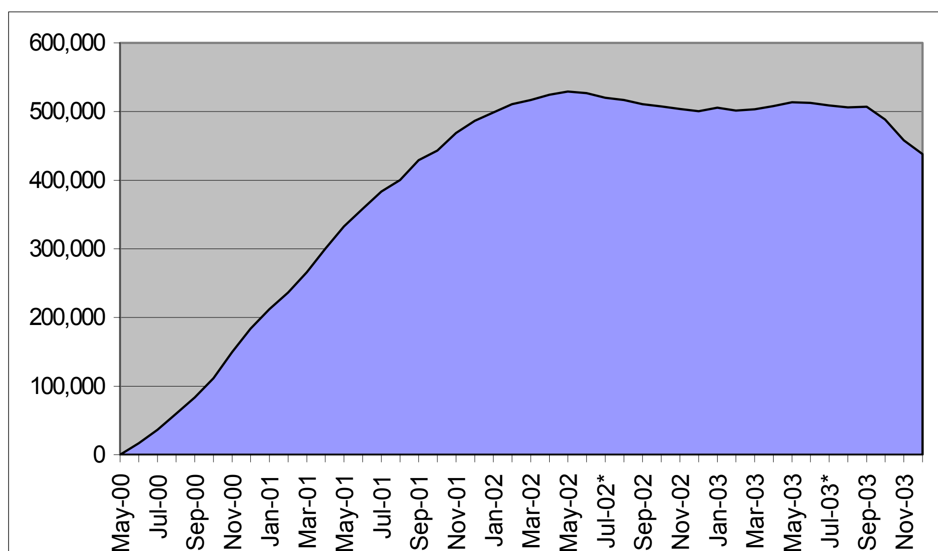
Texas' SCHIP program started as an expansion of its Medicaid program and began to enroll children on July 1, 1998. This initial program successfully enrolled children until the Separate SCHIP program was implemented in May 2000. Once the Separate SCHIP program was fully functional, the Medicaid-Expansion SCHIP was slowly phased-out as children left the program through age and/or attrition.

The Separate SCHIP program—whose benefits were based on the State Employee Benefit Package—began with 30 children in May 2000. Since then, the program has experienced dramatic increases in enrollment. By December 2000—eight months after initial implementation—average monthly enrollment had already grown to 183,597 kids. Throughout the next 18 months, enrollment numbers continued to increase, reaching more than 529,000 kids in early 2002 and causing a projected budget overrun of more than $20 million.

By the fall of 2002, Texas faced a serious fiscal crisis, and as tax revenues declined, Medicaid and SCHIP enrollments, and expenditures, grew. Following an election in late 2002, the legislature convened in early 2003 and began to address a $10 billion shortfall in the state's biennial budget. As with many programs, SCHIP was changed significantly. After deciding to forego a reduction in the eligibility levels and an enrollment cap or freeze, the legislature reduced the benefit package and changed administrative procedures in an effort to reduce enrollment. By the time the session ended, the mental health benefit had been reduced, other benefits had been eliminated, there was a new asset test, the eligibility period had been reduced from twelve to six months, and cost-sharing had been increased significantly.

[1] Http://www.hhsc.state.tx.us/research/CHIP/CHIPEnrollIncomeGroup.html. (January 27, 2004.)

Figure 1 Separate SCHIP enrollment in Texas

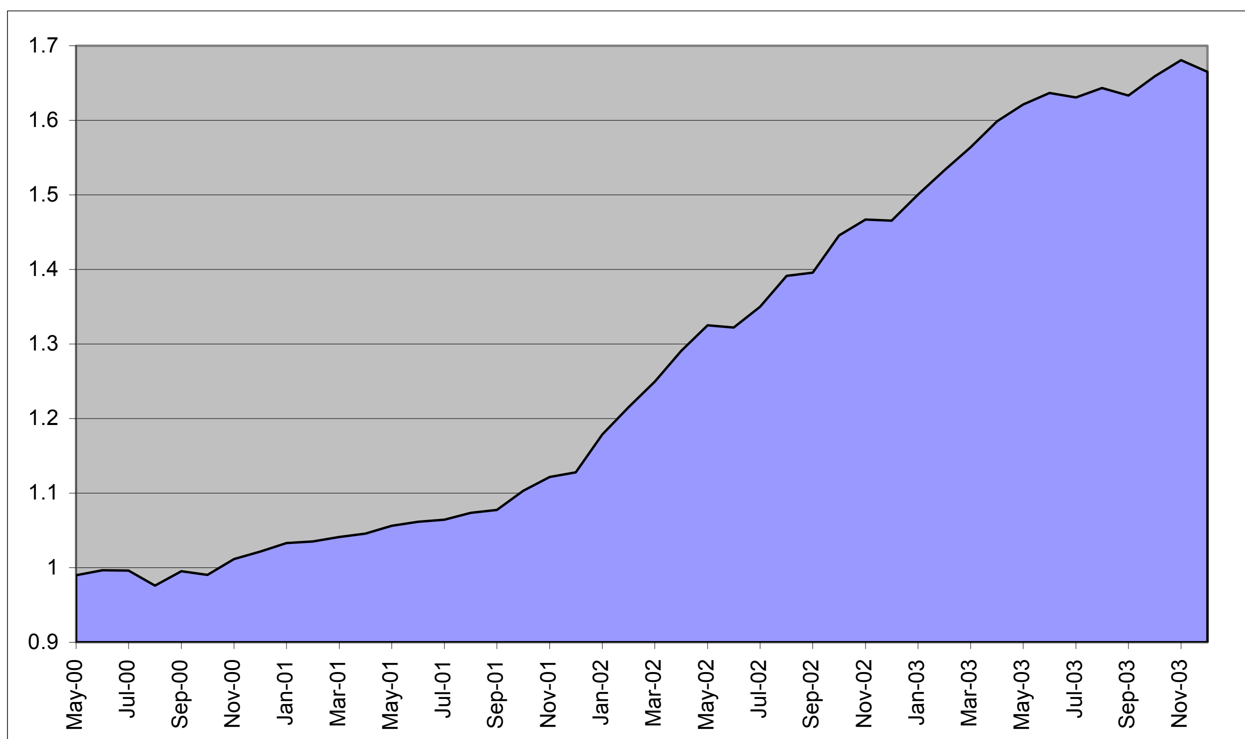


SCHIP's Impact on Medicaid

When the Separate SCHIP program began in May 2000, a complicated and lengthy application process was required for children's Medicaid. Of the 97,512 children referred to Medicaid from SCHIP in the first ten months of the SCHIP program, the vast majority—73,213—failed to enroll in Medicaid. Although many might have been deemed ineligible for Medicaid, the fact that so many failed to complete the process indicated that a simpler application might encourage more families to complete the process.

In 2001, the legislature overhauled the application process for children's Medicaid so it more closely resembled SCHIP. In addition to the adoption of a common application for Medicaid and SCHIP, the new, unified application required the same documentation for both programs. These changes produced a sharp increase in the number of children enrolled in Medicaid. In May of 2002, one year after the changes were implemented, the number of children on Medicaid had grown by more than 25 percent to 1,325,237; by May of 2003, there had been a 54 percent increase in enrollment to 1,621,482 children.

Figure 2 Children's Medicaid enrollment in Texas (in millions)



Funding

Since its inception, the state match for Texas' SCHIP program has been funded by the tobacco settlement pool. As with Utah, Texas has made SCHIP the top priority for funding from this source, helping to ensure the program's future. However, this funding source does not necessarily protect SCHIP, as the Texas legislature and the governor take an active role in managing allocation of the tobacco settlement pool and make biennial adjustments to the amount each program receives. The Texas SCHIP program also receives a small amount of funding from drug manufacturer rebates and through the cost-sharing measures that are built into the program.

Changes

The numerous changes made to Texas's SCHIP program over the course of the 78th legislative session were driven by the budget crisis and by pressures to avoid an enrollment cap or freeze and to maintain eligibility levels at 200 percent FPL. Legislators faced the complicated task of making changes to the program in order to reduce the budget, without access to these powerful programmatic levers.

Ultimately, the changes fell into four categories: Administrative, Eligibility, Cost Sharing, and Benefit Changes, each of which is discussed below.

Policy makers quickly realized that targeting services with low utilization rates in order to minimize the impact on children would, unfortunately, realize few savings. Larger savings could be achieved through reductions in services that were both expensive and widely used. Such reductions were, of course, significantly more painful to make.

All the stakeholders mentioned that there was some discussion of alternatives to the cuts that were ultimately made, including the option of lowering income eligibility without creating other enrollment barriers. However, part of the difficulty in considering alternatives lay in the fact that the bulk of SCHIP enrollees in Texas (72 percent) are in families with incomes below 150 percent FPL. With so few children in the higher income brackets, only a substantial decrease in the income eligibility level would have brought total enrollment down far enough to reach the necessary fiscal targets.

Ultimately, many of the changes to the Texas SCHIP program were outlined in two pieces of legislation. Agency staff provided input and advice on some cost-saving measures, but others—such as the asset test—were conceived of and approved by lawmakers in committee. Accordingly, advocates believe that the decisions were subject to political "horse trading" as opposed to merit-driven policymaking. The measures are now set in statute and will require legislative action to reverse.

Some of these changes to the Texas SCHIP program have generated little controversy. The elimination of hospice and chiropractic care, for example, was mentioned by few of the stakeholders we interviewed. The same was true of the move to a preferred drug list and the reduction in provider payments. Other changes, detailed below, were far more complicated and contested.

Administrative changes

Period of continuous eligibility

Many observers believe that changing the continuous eligibility period from twelve to six months will have a large impact on enrollment. Analyses done by the state indicate that the most common reason for failure to renew coverage is a failure to complete the renewal process. By requiring families to renew twice a year, rather than once, this change will effectively double the opportunities for families to fail to complete the process.

An original provision of the Medicaid simplification initiatives passed by the Texas legislature in May of 2001 would have also given Medicaid children twelve months of continuous eligibility. This change was intended both to make children's Medicaid more accessible, and to make children's Medicaid and SCHIP more alike. As the budget crisis progressed, however, that decision was revisited and has been indefinitely postponed.

90-day waiting period
All children enrolling in SCHIP must now wait 90 days from the time they are determined eligible before their coverage begins, with exceptions for involuntarily dropped coverage and for those whose coverage cost more than 10 percent of family income. Previously, Texas had a three-month retrospective period during which a child could not have had insurance coverage, with the same exceptions. While the look-back period affected only those children who had had insurance, the new prospective waiting period will impact all children. This change allows the state to realize savings by starting coverage of children at a later date.

There is some disagreement about the magnitude of this change. Prior to the 78th legislative session, children had to wait from the time they submitted the application until enrollment before they were covered. Agency staff estimated this time to be 45 to 60 days, while advocates placed it at 35 to 40 days. Advocates now estimate that the delay is between 90 and 105 days, making the wait two to three times longer. Advocates also describe this as a major deterrent to families who interpret it as a barrier to coverage. They note that outreach workers spend a lot of time explaining the waiting period to families.

Eligibility changes

Asset test and income disregards
Because income disregards have only recently been enacted, it is too early to evaluate their impact. Preliminary results are expected in early 2004. The asset test, meanwhile, is scheduled for implementation in May 2004. Legislators inserted the asset test and eliminated the income disregards as the budget bill was nearing completion, without the opportunity for stakeholders to provide comments on these changes.

The use of the asset test (assets cannot exceed $5,000 including the value of cars and liquid assets) was considered a tradeoff for keeping the eligibility level at 200 percent of FPL. Many lawmakers did note that this would result in disenrollment. However, they believed that it was important to maintain eligibility at 200 percent of FPL. Many lawmakers saw it as a way of ensuring that, in a difficult economy, the neediest families continued to be enrolled in SCHIP.

Advocates, meanwhile, believed that the asset test and income disregards would make thousands of families ineligible for coverage. They believed the elimination of some income disregards was particularly unfair because it would result in some income being counted twice. For example, under the old application procedure, child support payments, were excluded from calculations of income for the purpose of determining eligibility for SCHIP. As a result of the changes, that income—for both the payer and the recipient—is included in the calculation.

Cost sharing

Prior to the 78th legislative session, Texas families paid no more than $25 a year to enroll in SCHIP. They were also required to make co-payments on services up to a federally imposed cap of 5 percent of their income. As part of the new legislation, families will be required to pay

monthly premiums and to make co-payments. All parties recognize that this increased cost sharing will create downward pressure on enrollment. However, for those families whose spending on cost sharing is unusually high, there will likely be some relief. As a result of changes at the federal level, families with incomes below 150 percent of FPL, must now cover out-of-pocket expenses up to 2.5 percent of their annual income; for families with incomes between 151 and 200 percent of FPL, the threshold is 5 percent of annual income. In either event, families are required to document their own healthcare expenditures—including co-pays—in order to demonstrate that they have crossed the relevant threshold.

Table 1 Cost sharing (premiums) in the Texas SCHIP program

FPL	Pre-78th Session	Post-78th Session
101-150%	$15/year	$15/month ($180/year)
151-185%	$15/month	$20/month ($240/year)
186-200%	$18/month	$25/month ($300/year)

Lawmakers are largely split in their perception of the use of cost sharing: some see it as a way to encourage personal responsibility in a highly subsidized program. Others view it as an additional and unnecessary burden on families already finding it difficult to make ends meet.

Benefit package changes[2]

Through HB 2292, the Texas legislature eliminated language establishing the State Employee Benefit Package as the benchmark benefit package for SCHIP and proposed new benefit standards, effectively reducing the benefit package for all children enrolled in SCHIP. Changes included the elimination of hospice, chiropractic, dental, vision, and mental health coverage, although some mental health benefits were restored at a later date.

Dental and vision

The dental benefit in Texas, as in many states, is one of the most expensive benefits, in part because it is widely utilized. Few commercial plans in Texas provide dental benefits, causing many legislators to question the fairness or necessity of providing dental services through SCHIP. In addition, some legislators cited unsubstantiated reports of abuses of the dental benefit as a reason to eliminate it.

Advocates found the elimination of both the dental and the vision benefit difficult to understand, in part because few alternatives exist for children in need of these services. Although advocates

[2] In separate SCHIP programs, states have the option of choosing to base the service package on the most common HMO benefit package in the state or the state employee benefit package, or they may seek approval from the Secretary of the U.S. Department of Health and Human Services for an alternative benefit package. When Texas applied for approval to change its existing benefit package in 2003, the Secretary Approved option had only been used by states to offer more substantial benefits than the alternative benchmark benefit package.

reported that the original dental benefit was minimal and did not cover many needed services, it was still preferable to no benefit at all.

Mental health

The 78th session also resulted in the complete elimination of the SCHIP mental health benefit. This change, which required approval from the federal government, was not specifically legislated, but the budget as passed by the legislature did not assume a mental health benefit.

In eliminating the benefit, legislators expressed some concern about unsubstantiated abuses of the mental health benefit, and placed the cut in the overall context of the budget situation. Faced with budget deficits, legislators felt it more important to focus on preserving services for acute needs and for those already being served, than on prevention. Except in the neediest of cases, they felt that mental health was more a preventive than acute care service.

In anticipation of federal approval, the state and the health plans stopped paying claims on September 1, 2003. Early feedback from the U.S. Department of Health and Human Services (DHHS) suggested that the mental health benefit needed to be at least partially restored before approval of the state's new benefit package would be granted. At the time of NASHP's site visit, the mental health benefit had been partially restored, and DHHS approval for the new benefit package was believed to be imminent. It has since been approved.

Both the original cut in the mental health benefit and its partial restoration created substantial administrative difficulties for health plans. At the time the state decided to reinstate the benefit, health plans had already informed consumers and providers that mental health claims would not be paid. Plans then had to re-print materials and revamp management information systems, for the second time, to accommodate the change. Furthermore, because the benefit was retroactive to September 1, all unpaid and previously rejected claims had to be reconsidered. Not surprisingly, health plans expressed significant frustration and dissatisfaction with these developments.

All stakeholders consider the loss of the mental health benefit–if only partial or temporary—to be a major disappointment. Health Plans noted that SCHIP enrollees utilized the mental health benefit at greater levels than their commercial or Medicaid counterparts, indicating this was a needed service.

Stakeholders also expressed concern about the on-going viability of community mental health centers in the absence of SCHIP. A lack of SCHIP funding has the potential to jeopardize the availability of mental health services for the whole community. When the SCHIP program was initially created, the legislature took state funding away from local mental health agencies to help contribute to the local match for the federal SCHIP dollars. It was expected that these agencies would then make up for the loss through revenues from SCHIP clients. For these local agencies, the sharp curtailing of the mental health benefit was expected to have a significant and damaging impact.

The Political and Budgetary Environment

In addition to the budget situation, the elections leading up to Texas' 78th legislative session in early 2003 played an important part in the evolution of the state's SCHIP program. The election resulted in a large number of newly elected lawmakers and significant turnover of the state's leadership with a new lieutenant governor and speaker of the house. Thirty-six of 150 members of the House and seven of the state's 31 senators were freshman lawmakers. In general, advocates did not have prior relationships with the new cadre of lawmakers, many of whom lacked experience in their issue areas.

Throughout the election season, the projected budget shortfall was estimated at $5 billion on a $120 billion biennial budget. Based on this projection, many of the candidates ran on a pledge not to raise taxes, believing the current budget could absorb the cuts without major impacts on government programs. After the election and shortly before the session began, a new budget projection estimated the shortfall at nearly twice the origin number. The new legislators and the state's newly elected leadership upheld their pledges not to raise taxes and, instead, looked for new ways to cut spending.

The new leadership also changed the way decisions were made. In previous years, healthcare related decisions were referred to the Health Committee and recommendations were passed from there to the Appropriations Committee. In the 78th session, however, a new healthcare committee was formed under the auspices of the Appropriations Committee. This maneuver eliminated many of the customary channels through which various stakeholders relayed healthcare concerns. Furthermore, many of the decisions were made without the degree of legislative participation that had occurred under the auspices of the full committee.

Stakeholders

Health Plans

Health plans considered SCHIP a good program and were concerned that the changes would jeopardize its stability. Although none of the health plans we spoke to engaged in any direct lobbying during the 78th session, they did express confidence that their opinions were relayed through a state-wide trade association. Unfortunately, they did not feel as though lawmakers had heard or addressed their concerns, in large part because the financial situation was so dire.

Of the changes that were made, those affecting the benefit package were considered the most difficult for plans, requiring re-printing a large number of materials, notifying both consumers and providers, and altering computer systems. Health plans expressed frustration with these changes, exacerbated by the elimination—and then retroactive reinstatement—of the mental health benefit.

Health plans also noted that they were pleased that Federal Fiscal Relief was used to ameliorate the proposed 5 percent reduction in provider payments by cutting it in half. Although the cut was not a major point of advocacy, the 2.5 percent reduction was preferable.

Advocates

Although many of the respondents had high regard for the quality of information that came from advocates—praised as being "ubiquitous" and of "the highest quality"—the advocates themselves were less confident that their message had been heard. Advocates did not expect SCHIP to come through the budget session unscathed, but all were surprised by the magnitude of the changes. Advocates were concerned that, despite the implementation of administrative barriers that would drive down enrollment, lawmakers would claim credit for upholding the 200 percent of FPL eligibility threshold.

Advocates also reported that during and after the session, there was a great deal of news coverage about proposed changes to the SCHIP program. Because some of the early legislation called for an outright elimination of the SCHIP program, there was some confusion among consumers about whether SCHIP continued to exist. This confusion appears to have contributed to a decline in enrollment well before any changes to the program went into effect.

Legislators/lawmakers

Without exception, Texas lawmakers described the 78th legislative session as a very difficult one. The state faced a large budget deficit, and the legislature was comprised of a large number of new lawmakers. The pledge not to raise taxes, for many, was paramount. In spite of the commitment many legislators had made to the SCHIP program, it was a target for reductions.

Others noted that the budget environment was so serious that they feared cuts in programs such as children's Medicaid, designed for those even poorer than the families served by SCHIP. Consequently, they said the bulk of their energies were devoted to protecting Medicaid, believing that the widely respected SCHIP program would survive and that their efforts would be more effectively spent protecting other programs. Many lawmakers were careful to note that the serious budget environment, not ideological factors, motivated their decision to make cuts in SCHIP.

Table 2 Texas SCHIP program over time

	1998	1999	2002	2003
Program Name	**Texas Children's Health Insurance Program (CHIP)**			
Enrollment numbers				
Medicaid – children (Title XIX)	982,335[3]	975,875[4]	1,465,593	1,665,023
Medicaid SCHIP – (Title XXI)	Not available	Not Available	-	-
Separate SCHIP – (Title XXI)	-	-	500,567	438,164
Uninsured children below 200% FPL[5]	1,084,000	1,040,000	1,013,000	N/A
Eligibility				
Medicaid – children (Title XIX)	Infants up to 185% 1-5 up to 133% 6-14 up to 100%	Infants up to 185% 1-5 up to 133% 6-15 up to 100%	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	Infants up to 185% 1-5 up to 133% 6-18 up to 100%
Medicaid SCHIP – (Title XXI)	15-18 up to 100%	16-18 up to 100%	No program	No program
Separate SCHIP – (Title XXI)	No program	Infants from 185%-200% 1-5 from 133%-200% 6-18 from 100%- 200%	Infants from 185% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	Infants from 185% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%
Benchmark benefit package for Separate SCHIP	N/A	State Employee Benefit Package	State Employee Benefit Package	State Employee Benefit Package
Separate SCHIP benefits				
Mental health/substance abuse	N/A	Covered	Covered	Reduced to 30 days inpatient and 30 days outpatient MH treatment, and to 30 days inpatient and 30 days outpatient SA treatment
Dental	N/A	Covered	Covered	Eliminated
Vision	N/A	Covered	Covered	Eliminated
Chiropractic	N/A	Covered	Covered	Eliminated
Hospice	N/A	Covered	Covered	Eliminated
Administrative changes				
Asset test	$2,000 for Medicaid and Medicaid SCHIP with exemption of 1 vehicle.	$2,000 for Medicaid and Medicaid SCHIP with exemption of 1 vehicle. None for Separate SCHIP.	$2,000 for Medicaid and Medicaid SCHIP with exemption of 1 vehicle. None for Separate SCHIP.	$2,000 for Medicaid and Medicaid SCHIP. $5,000 for Separate SCHIP plus value of vehicles.

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[3] Point-in-time enrollment figure from August 1998.
[4] Point-in-time enrollment figure from August 1999.
[5] Number is a three-year average ending in the tabular year. Source: http://www.census.gov/hhes/hlthins/lowinckid.html. (March 9, 2004.)

	1998	1999	2002	2003
Continuous eligibility period	None for Medicaid SCHIP.	None for Medicaid SCHIP/12 months for Separate SCHIP.	None for Medicaid SCHIP/12 months for Separate SCHIP.	None for Medicaid SCHIP/6 months for Separate SCHIP above 150% FPL to begin early 2004.
Income to determine eligibility	Net	Net	Net	Gross
Waiting period in Separate SCHIP (look back for previous insurance)	N/A	90 days	90 days	90 days
Waiting period prior to enrollment regardless of insurance status	N/A	N/A	N/A	90 days with exceptions
Periodic open enrollment/waiting list	N/A	No	No	No
Single application for TXIX and TXXI	Yes	Yes	Yes	Yes
Cost sharing				
Co-payments	None	Sliding scale based on income and service	Sliding scale based on income and service and increased from previous years	Sliding scale based on income and service (with caps on out-of-pocket expenses?)
Premiums	None	186% to 200% $18 PFPM 151% to 185% $15 PFPM 100% to 150% $15 PMPY	186% to 200% $18 PFPM 151% to 185% $15 PFPM 100% to 150% $15 PMPY	186% to 200% $25 PFPM 151% to 185% $20 PFPM 100% to 150% $15 PFPM
Funding source	Tobacco settlement	Tobacco settlement		Tobacco settlement and federal fiscal relief
Amount of special revenue funds				
Amount of total state match				
Amount of federal allocation (used)				
Amount of federal allocation (total)	561,331,521	$558,680,510	$301,839,575	$311,503,988
Medicaid match rate	62.28%	62.45%	60.17%	(59.99%) 63%
SCHIP match rate	73.60%	73.72%	72.12%	71.99%

UTAH

Overview

Utah's SCHIP program began in August 1998, almost exactly a year after the program was created by Congress. Initial estimates indicated that there were 63,000 low-income uninsured children in Utah, of which 33,000 were thought to be eligible for Medicaid. The target population for Utah's SCHIP program was therefore thought to be about 30,000 children. In its first five months of operation, the SCHIP program enrolled 4,313 children and went on to enroll an additional 9,000 in its first full calendar year. With almost 25,000 children enrolled in 2001, Utah's SCHIP program was on the verge of running at a constitutionally-prohibited deficit. Without additional state funds available, Utah looked for ways to trim costs and manage enrollment. To accomplish this, the state shifted from continuous open enrollment to a system of periodic open enrollment in 2001, and increased cost-sharing and reduced dental benefits in early 2002. Subsequent funding changes and strong support for the program have since allowed the state to expand enrollment to about 28,000 children and restore all of the dental benefit.

Background

Although Utah ranks just 34th in total population, 34 percent of its population is under 19, giving Utah the highest number of children per capita of any state in the country.[6] There is widespread support for children and children's services among state policy makers. U.S. Senator Orrin Hatch (R-UT) was one of the main sponsors of the SCHIP legislation at the national level, and the SCHIP program is strongly supported by state lawmakers of both political parties.

At its inception, benefits for the state's SCHIP program were based on the State Employee Benefit Package and covered kids with family income up to 200 percent of the federal poverty level. The program is split into two parts, A and B, the former covering children in families with income at 150 percent of FPL and lower, and the latter covering kids in families with incomes between 151 percent and 200 percent of FPL. The primary difference between the two programs is in cost-sharing: those in Part B—the higher income bracket—pay higher out-of-pocket expenses than those in Part A.

Program implementation was accompanied by a vigorous outreach effort. In its first few years, the program grew at a relatively constant rate. After five months of operation—at the end of 1998—there were 4,313 kids enrolled; a year later, 13,220 were enrolled. In the third and fourth years of the program, enrollment grew by approximately 7,000 children per year, bringing the total enrollment to 24,983 by the end of 2001.

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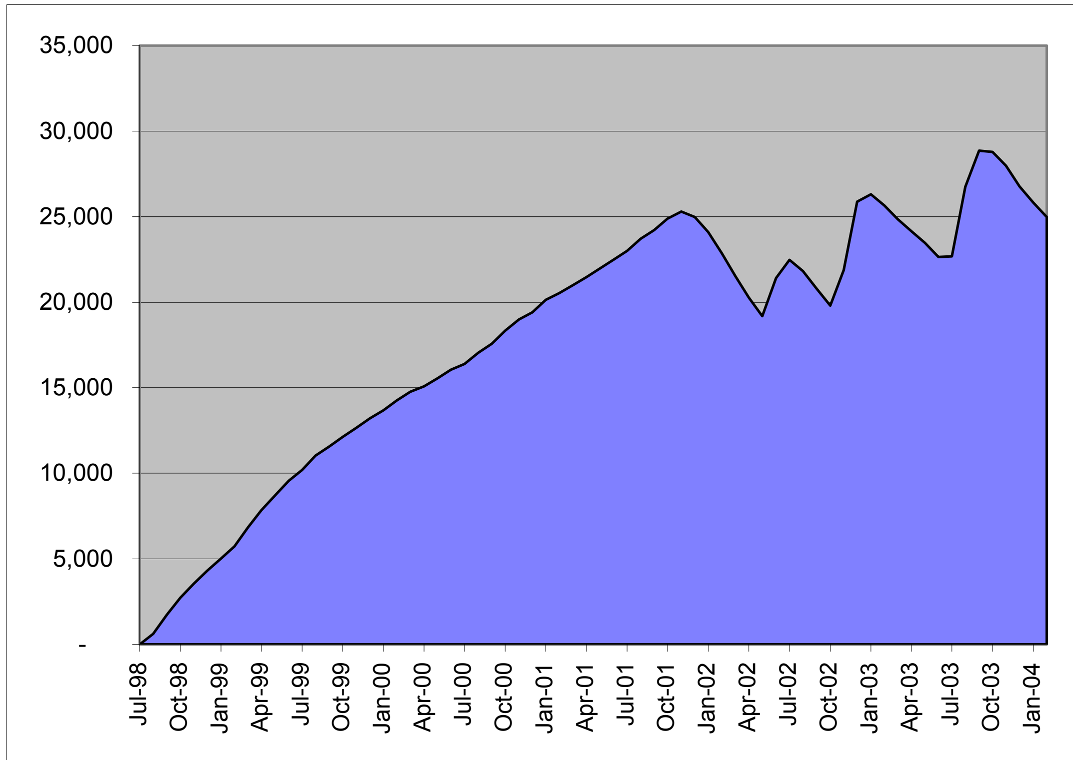
[6] Kaiser State Health Facts: http://www.statehealthfacts.org. Population Distribution by Age, state data 2001-2002, U.S. 2002. (April 1, 2004).

Figure 3 SCHIP Enrollment in Utah (Title XXI)



Facing a budget shortfall in late 2001, the state significantly altered its SCHIP enrollment policies and some benefits in late 2001 and early 2002. By changing from continuous open enrollment to periodic open enrollment, the state was able to manage enrollment around an annual average of 24,000 children. When additional funds were identified by the legislature in early 2003, enrollment was allowed to increase by 4,000 to average around 28,000 children. As of December 2003, 26,759 children were enrolled in Utah's SCHIP program.

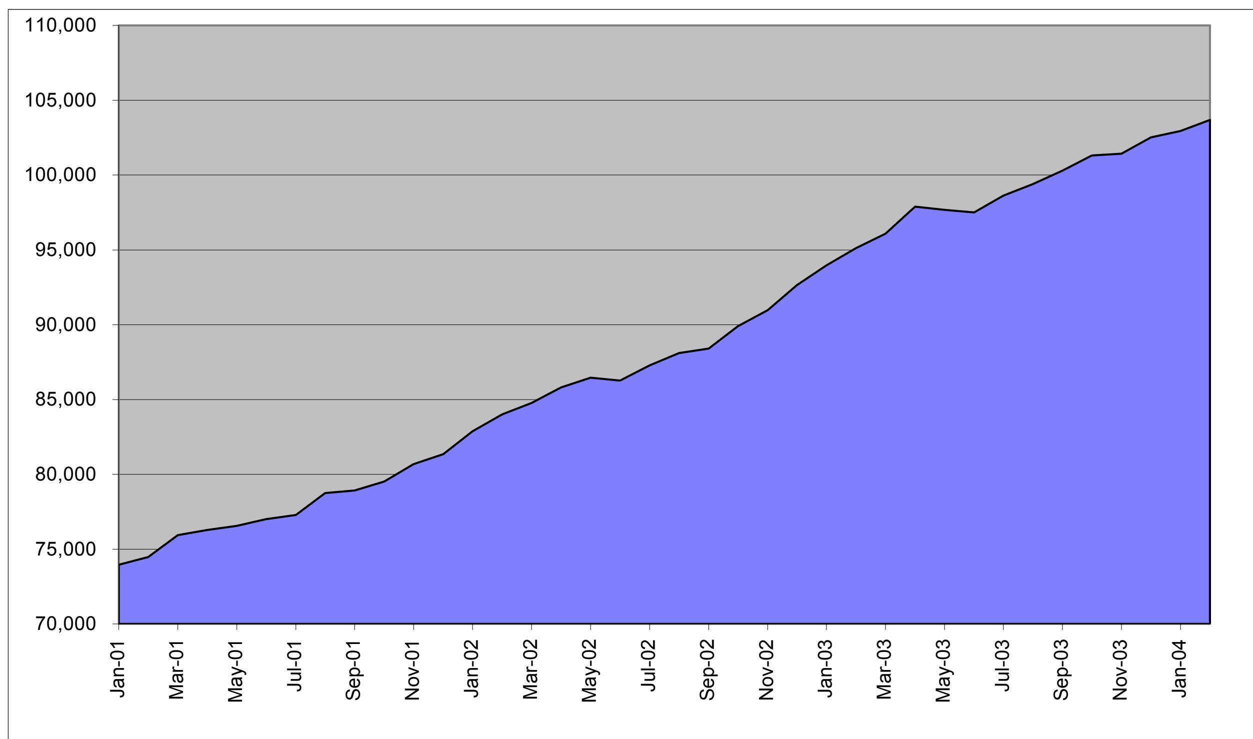
Impact on Medicaid

As in other states, SCHIP outreach has had a significant impact on Medicaid enrollment. The same outreach and marketing effort that increased SCHIP enrollment drove increases in Medicaid enrollment. Partly as a result of those outreach efforts, Medicaid enrollment grew from 197,658 in 1999 to 214,597 in 2001. Children account for 84 percent of the growth during this period.

In order to distinguish SCHIP and Medicaid and to make SCHIP look more like a commercial health insurance plan, Utah's SCHIP and Medicaid programs do not share an application. However, even with separate applications, families can use either application to apply for either program. Furthermore, the SCHIP program contracts with

the Medicaid agency to do eligibility determination during open enrollment periods so that eligibility determinations for both programs can be made at the same time. Consequently, outreach and marketing for SCHIP serve to increase enrollment for Medicaid.

Figure 4 Children's Medicaid Enrollment in Utah



Funding SCHIP

Compared to other states, Utah has a high federal match for its SCHIP program. For every dollar Utah spends on SCHIP, it receives about four from the federal government. State and federal expenditures on Utah's SCHIP program in FY2002 totaled $32.7[7] million. The local contribution was initially funded by an assessment on hospitals. In its first year (FY1999), this assessment funded SCHIP for $2 million; in its second year it raised $4.1 million. These state funds were matched by more than $17.9 million in federal funding.

In early 2000, the legislature revisited the issue of state funding for SCHIP and provided funding of up to $5.5 million each year from the state's tobacco settlement pool. This change served to insulate SCHIP funding from the potential vicissitudes of the state's general fund. Although the tobacco settlement pool is a limited fund that varies in

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[7] Kaiser State Health Facts: http://www.statehealthfacts.org. Utah: Medicaid and SCHIP. (October 10, 2003.)

amount from year to year, health programs that are ranked highest in priority, as is SCHIP, are assured funding.

At the time, the $5.5 million of local funding allowed the state to leverage more than $24 million in federal funds. Even so, it did not allow Utah to exhaust its full federal allocation of approximately $29 million. In early 2003, the state increased its contribution to $7 million in an effort to draw down the full allocation. The additional funding that resulted from this action allowed Utah to reinstate the previously cut dental benefit, as well as increase average enrollment by approximately 4,000 to 28,000 children.

Program Changes

In late 2001 enrollment was up to nearly 25,000 children and showed no signs of tapering off. With state funds capped at $5.5 million, program changes were necessary to keep the program within budget. Because many potential changes—such as those related to eligibility levels and to the benefit package—required legislative action, SCHIP agency staff had a limited number of options it could immediately and independently implement. In December 2001, with the legislature out of session and costs continuing to rise, agency staff announced an end to continuous open enrollment and a new policy of periodic open enrollment. This essentially allowed the agency to monitor and maintain enrollment at an annual average of approximately 24,000 children.

Agency staff members note that they could have pursued other strategies for managing enrollment, including enrollment caps or waiting lists. The decision to avoid waiting lists was made because of pending lawsuits and other negative experiences related to waiting lists for other state-delivered social services.

The first open enrollment period was held during two weeks in June 2002. It drew more than 6,000 applications from families. Another open enrollment period in November 2002 drew 9,413 applications. Of the 34,346 children covered by these applications, 15,105 were ultimately enrolled in the program. The most common reason children were not enrolled was the failure to complete the application process, although the reasons so many failed to complete that process are not known. At the end of 2003, having had a one-week open enrollment period in July of 2003, enrollment was 25,876.

A number of other changes were made to the SCHIP program in early 2002, among them a significant reduction in the dental benefit, an increase in co-payments, and the implementation of premiums. These changes were intended to maximize the number of children covered by SCHIP by diverting scarce dollars from specific benefits to general coverage. It is difficult to evaluate the impact the cost sharing measures have had on enrollment, because the move to open enrollment periods forced agency staff to manage annual fiscal year enrollment around an average of 24,000 children.

Utah began to charge premiums in February of 2002. These varied by family income level and were charged per child per month. This policy was changed in July of 2002 so that families paid a fixed amount, based on their income, regardless of the number of children. To date, families below 100 percent of FPL pay no premiums, although they do make co-payments. Families pay $13 per quarter if their income is between 101 percent and 150 percent of the FPL, and $25 per quarter if their income is between 151 percent and 200 percent of FPL. In mid-2002, slightly more than 300 children were dropped for non-payment of premiums. Since then, however, none have been dropped while the state has completed a major overhaul of the premium database. With the completion of the database upgrade, the next round of closures are planned for early April 2004 and will occur quarterly thereafter.

The 2003 legislative session brought still more changes to the SCHIP program. Although the session began with a discussion about lowering the eligibility levels in SCHIP, it ended with an increase in SCHIP's state allocation to $7 million, using the tobacco settlement pool. The increase in funding for SCHIP in the face of budget difficulties was evidence of the state's commitment to the program and to tapping fully, but not exceeding, the federal contribution to the program.

This funding increase came about in large part because of Utah's generous four to one federal funding match. As noted earlier, the state's SCHIP contribution had been capped at $5.5 million, which meant that Utah did not exhaust its annual federal allocation. Even as Utah was looking to cut services elsewhere in the state's budget, advocates were able to argue that state funding for SCHIP should be increased to maximize the federal match.

Once the decision was made to increase the SCHIP budget, policy makers had to decide how to use the additional money. They could restore the dental benefit and increase SCHIP enrollment by 4,000 children or leave the benefit package without dental coverage and increase enrollment by 6,500 children. After weighing the options, the legislature largely restored the dental benefit. Observers agree that SCHIP fared very well in Utah's 2003 legislative session.

Administrative issues created by open enrollment periods

Shortly after the switch to open enrollment periods, it became apparent to agency staff that open enrollment periods had created unintended problems for families with children eligible for SCHIP. Among the problems:

- Children who become ineligible for Medicaid must wait until the next open enrollment period to sign up for SCHIP;
- Children born or adopted into families where siblings are already in SCHIP must wait until the next open enrollment period to be enrolled;
- Between enrollment periods, families are barred from purchasing insurance—no matter how expensive or inexpensive—lest they be made ineligible for SCHIP.

A little more than a year into periodic open enrollment, agency staff began to explore potential solutions to these issues and have taken action to resolve them. Children born or adopted into SCHIP families are now allowed to enroll in SCHIP, and families who purchase private insurance while SCHIP enrollment was closed will now be allowed to enroll in SCHIP as long as they were eligible when they purchased insurance.

A proposed administrative change would permit children disenrolled from Medicaid for very specific reasons—a change in deprivation status,[8] or because of age—to enroll in SCHIP. This change is currently in the process of official review. Approval is expected in late May or June 2004. The state decided to apply this policy in such a limited fashion in order to maintain the frequency of open enrollment periods. If all SCHIP-eligible children leaving Medicaid were allowed to enroll, and assuming the current enrollment limits, the amount of time between open enrollment periods would stretch to more than sixteen to eighteen months, rather than the current eight to eleven months. Limiting immediate SCHIP enrollment to just these few Medicaid ineligible children increases SCHIP enrollment by an average of 56 children per month.

Having conducted three open enrollment periods—two for two weeks, and one for one week—agency staff noted that keeping the period open for more than one week did not produce a significant difference in enrollment. In fact, the number of applications seemed more a function of the length of time between periods than the length of the period itself. It was hoped that by shortening the periods of open enrollment, they could happen with greater frequency. This does not appear to be the case.

Stakeholders

Although a high degree of confidence and trust generally exists among stakeholders, some stakeholders raised specific concerns.

Advocates

In general, the advocates expressed a high degree of trust and confidence in the abilities and intentions of the agency staff. They did note that the change which came about in December 2001—the shift to periodic open enrollment—was implemented without a great deal of consultation with either advocates or legislators. While they understood that cost and enrollment increases had driven the need for this change, they would have preferred a waiting list for two reasons: it would allow stakeholders to quantify unmet needs, and it would create political pressure on lawmakers to address the problem.

[8] A child is eligible for Family Medicaid—technically deprived—if one parent is absent. The child looses deprivation status and Medicaid eligibility when the custodial parent marries, when a paternity test determines that a man living at home is the father, or when the cause of deprivation (absent, incapacitated, disabled, or unemployed parent) no longer meets the criteria.

Advocates were concerned that open enrollment periods did not occur at predictable intervals, were not announced far in advance, and were too brief. These factors made it very difficult for families to coordinate their enrollment or for advocacy organizations to mount outreach campaigns. Indeed, advocates felt that outreach efforts for the open enrollment periods could be more effective. In particular, they noted the lack of lead time to prepare for the open enrollment periods and the use of "usual suspects" and not very aggressive strategies for outreach efforts. Advocates believe that open enrollment periods could reach additional eligible children with more innovative outreach efforts.

At the time of the NASHP site visit, advocates were engaged in efforts to eliminate Utah's asset test in Medicaid. Although only used for children over six, the test stipulated that assets in excess of $3,000—including bank accounts and the equity value of cars (but not homes)—make a child ineligible for Medicaid. Advocates estimate that 6,000 children were placed into the SCHIP program because they failed the Medicaid assets test. By eliminating the asset test, those children would be covered by Medicaid instead of SCHIP, making room for additional children in SCHIP.

Advocates are pleased by the success of their efforts to educate legislators on the importance and magnitude of the federal match. These efforts were instrumental in increasing the SCHIP state match by $1.5 million to $7 million. That increase was used to reinstate the previously-cut dental benefit as well as to provide coverage for 4,000 additional children. While advocates would have preferred that the entire amount be used to cover more children, they felt the reinstatement of the dental benefit was a necessary compromise to garner support in the legislature.

Heath Plans

Heath plans described themselves as satisfied with the SCHIP program. Utilization and therefore cost in the program is relatively constant. They feel they have good relationships with and access to agency staff. They regard regular stakeholder meetings as an effective forum for raising major concerns and note that agency staff are sensitive, if not always responsive, to their issues.

The health plans are paid on an estimated capitation rate. However, in the event that costs are significantly higher than expected, plans have an opportunity at the end of the fiscal year to reconcile their costs. The cost settlement agreement is different for each plan. One plan is a cost settlement type plan where any overage is returned to the state, and any deficit is paid to the plan. The other is an at-risk contract where additional funding is not provided if a deficit is incurred. Efforts are under way to revise the contracts to include some additional degree of risk- and profit-sharing.

Like the advocates, plans noted that they were not given an opportunity to provide input on the decision to move to periodic open enrollment, which they would have opposed. For plans, the open enrollment periods often result in large swings in enrollment: just before an open enrollment period enrollment is very low; just afterwards it is very high.

Even so, one plan said the challenges of periodic open enrollment are preferable to the administrative complications of a waiting list.

Of greatest concern to heath plans, however, is the perceived inadequacy of reimbursement rates, particularly for specialists. Looking at utilization of services, plans note that hospitalization rates are highest for mental health issues, underscoring the importance of the mental heath benefit for this population. One plan speculated that this was in part due to pent-up need, also demonstrated by the downward trend in overall utilization the longer a child was enrolled in SCHIP.

The dental benefit, as in many states, is a carved-out service. The dental benefit is managed by a single health plan for the entire state. In general, utilization for this benefit is considered high. Because SCHIP originally had some dental services eliminated and then restored in early 2003, the health plan managing the dental benefit described dentists as reluctant to agree to serve SCHIP consumers. There are also on-going concerns about access to providers in the large rural counties in Utah, although these rural access issues apply across the board, not just with SCHIP enrollees.

Table 3 Utah SCHIP program over time

	1999	2001	2002	2003
Program name	**Utah Children's Health Insurance Program (CHIP)**			
Enrollment numbers				
Medicaid – children (Title XIX)	73,375	81,335	92,645	102,514
Separate SCHIP – (Title XXI)	13,220	24,983	25,876	26,759
Uninsured children below 200% FPL[9]	48,000	44,000	46,000	N/A
Eligibility				
Medicaid – children (Title XIX)	0-5 up to 133% 6-18 up to 100%	0-5 up to 133% 6-18 up to 100%	0-5 up to 133% 6-18 up to 100%	0-5 up to 133% 6-18 up to 100%
Medicaid SCHIP – (Title XXI)	No program	No program	No program	No program
Separate SCHIP – (Title XXI)	0-18 up to 200%	0-18 up to 200%	0-18 up to 200%	0-18 up to 200%
Benchmark benefit package for Separate SCHIP	State Employee Benefit Package	State Employee Benefit Package	State Employee Benefit Package	State Employee Benefit Package
Separate SCHIP benefits				
Mental health/substance abuse	Covered	Covered	Covered	Covered
Dental	Covered	Covered	Reduced to cover preventative and emergency dental only: fillings, stainless steel crowns, and space maintainers no longer covered.	As of 7/03 dental benefits were increased to cover fillings, stainless steel crowns, and space maintainers, as well as other services.
Vision	1 exam every 24 months	1 exam every 24 months	1 exam every 12 months	1 exam every 12 months
Chiropractic	Covered	Covered	Covered	Covered
Hospice	Covered	Covered	Covered	Covered
Administrative changes				
Asset test (Medicaid/Separate SCHIP)	Yes. Children 6 years to 18 years: $3000 countable asset limit allowed for households of two (2), $25 per additional person/No	Yes. Children 6 years to 18 years: $3000 countable asset limit allowed for households of two (2), $25 per additional person/No	Yes. Children 6 years to 18 years: $3000 countable asset limit allowed for households of two (2), $25 per additional person/No	Yes. Children 6 years to 18 years: $3000 countable asset limit allowed for households of two (2), $25 per additional person/No
Continuous eligibility period	12 months with numerous exceptions/12 months	12 months with numerous exceptions/12 months	12 months with numerous exceptions/12 months	12 months with numerous exceptions/12 months
Income to determine eligibility	Gross/Gross	Gross/Gross	Gross/Gross	Gross/Gross
Waiting period in Separate SCHIP (look back for previous insurance)	3 months if voluntarily terminated.	3 months if voluntarily terminated.	3 months if voluntarily terminated.	3 months if voluntarily terminated; certain exceptions for children who

[9] Number is a three-year average ending in the tabular year and includes children who may be eligible for Medicaid. Source: http://www.census.gov/hhes/hlthins/lowinckid.html. (March 9, 2004.)

	1999	2001	2002	2003
				qualified for CHIP but bought private health insurance when CHIP was not accepting applications.
Waiting period prior to enrollment regardless of insurance status	N/A	N/A	N/A	N/A
Periodic open enrollment/waiting list	No	Capped enrollment in 12/02.	Periodic open enrollment: 2-week periods (2) in 2002.	Periodic open enrollment: 1 in 2003.
Single application for TXIX and TXXI[10]	Separate and common	Separate and common	Separate and common	Separate and common
Cost sharing				
Co-payments	Sliding scale based on income and services between $2 and $10.	Sliding scale based on income and services between $2 and $10.	Sliding scale based on income and services increased from 2001.	Sliding scale based on income and services increased from 2002.
Premiums	None	None	100% to 150% $5 PMPM 151% to 200% $10 PMPM (2/02). Later that year in an effort to simplify began charging quarterly per family instead of monthly per child: 151% to 200% $25 PFPQ 101% to 150% $13 PFPQ	151% to 200% $25 PFPQ 101% to 150% $13 PFPQ
Funding source	Hospital assessment reauthorization fund	Hospital assessment reauthorization fund	Tobacco funds	Tobacco funds
Amount of special revenue funds				
Amount of total state match			$5,500,000	$5,500,000
Amount of federal allocation (used)			$20,690,500	$21,822,400
Amount of federal allocation (total)	$24,126,675	$452,531,213	$23,017,975	$24,693,700
Medicaid match rate	71.78%	71.44%	70%	(71.24%) 74%
SCHIP match rate	80.25%	80.01%	79%	79.87%

[10] Utah maintains separate applications for SCHIP and for children's Medicaid; however either application may be used to determine eligibility for either program.

VIRGINIA

Overview

Virginia's SCHIP program has undergone a number of changes since its inception in 1998. The first incarnation of the program, a separate SCHIP program, was known as the Children's Medical Security Insurance Program (CMSIP). The successor to this program, Family Access to Medical Insurance Security (FAMIS), began as a separate SCHIP program in September 2001, but added a Medicaid Expansion in 2002 for children aged 6 to 18 in families between 100 and 133 percent of the FPL. The program includes a premium assistance component that has only enrolled a modest number of families. Since reorganization and simplification efforts were completed in September 2002, FAMIS enrollment has grown from about 38,000 to more than 56,000 children. Today, despite the poor budget climate in Virginia, FAMIS is continuing to expand and is strongly supported by the governor, the legislature and other stakeholders.

Background

As with many states, Virginia was eager to capitalize on SCHIP funding after Congress authorized the program in 1997. The first incarnation of Virginia's SCHIP program, the Children's Medical Security Insurance Program (CMSIP), was a Medicaid look-alike, Separate SCHIP program that covered children in families up to 185 percent of the FPL. As with the state's Medicaid program, eligibility for SCHIP was determined in the local offices of the Department of Social Services.

Enrollment in the program was slower than expected given the number of uninsured children in Virginia, and advocates expressed frustration that there were few outreach and marketing efforts. After five months of operation, 4,621 children were enrolled, 7.4 percent of the target population. Meanwhile, Utah had enrolled 14.6 percent of its population in its first five months, and Texas had enrolled 17.2 percent.[11]

FAMIS

In August 2001, CMSIP was abandoned. The new Title XXI program–named Family Access to Medical Insurance Security, or FAMIS—was designed to look and act like private health insurance and to be distinct from Medicaid. As one result, FAMIS was not well coordinated with Medicaid: each utilized different applications with different eligibility requirements and no ability to transfer applications back and forth between the programs. Furthermore, Medicaid applications were processed at local offices of the Department of Social Services, while all FAMIS applications were processed at a central

[11] Enrollment data for Texas is based on the first five months of the state's Separate SCHIP program, which began in May 2000. The state's Medicaid Expansion SCHIP, which began enrolling children in July 1998, has been slowly phased out in favor of the Separate SCHIP.

processing unit. For families with children in both programs, the lack of coordination caused the family to have to navigate two different service systems with different reporting requirements, different applications, different benefits and different cost-sharing requirements. These and other administrative barriers prevented the program from substantially increasing enrollment as intended.

Among the new features of this program was a premium assistance program to enroll eligible employees into their employer's health coverage, using subsidies from the state. Although the program was explicitly designed to provide children with insurance coverage, an intentional byproduct was assisting adults with health insurance, too. In order to participate, an employer must pay for at least 40 percent of a family premium, and it must be cost effective for the state. Even though health insurance is commonly provided by employers in Virginia, it is rarely cost effective to cover families in this manner. To date, approximately 60 children receive health insurance through this option. Virginia is currently engaged in efforts to redesign the premium assistance program in order to encourage greater participation.

Despite the creation of FAMIS in 2001, Virginia continued to lag behind other states in enrollment. Some legislators at the time believed that agency staff were dragging their feet on properly implementing the program and aggressively enrolling children. Advocates, meanwhile, believed that ideological opposition to SCHIP by then Governor Jim Gilmore was standing in the way of a streamlined, efficient program. In any case, thousands of potentially eligible children were not getting covered.

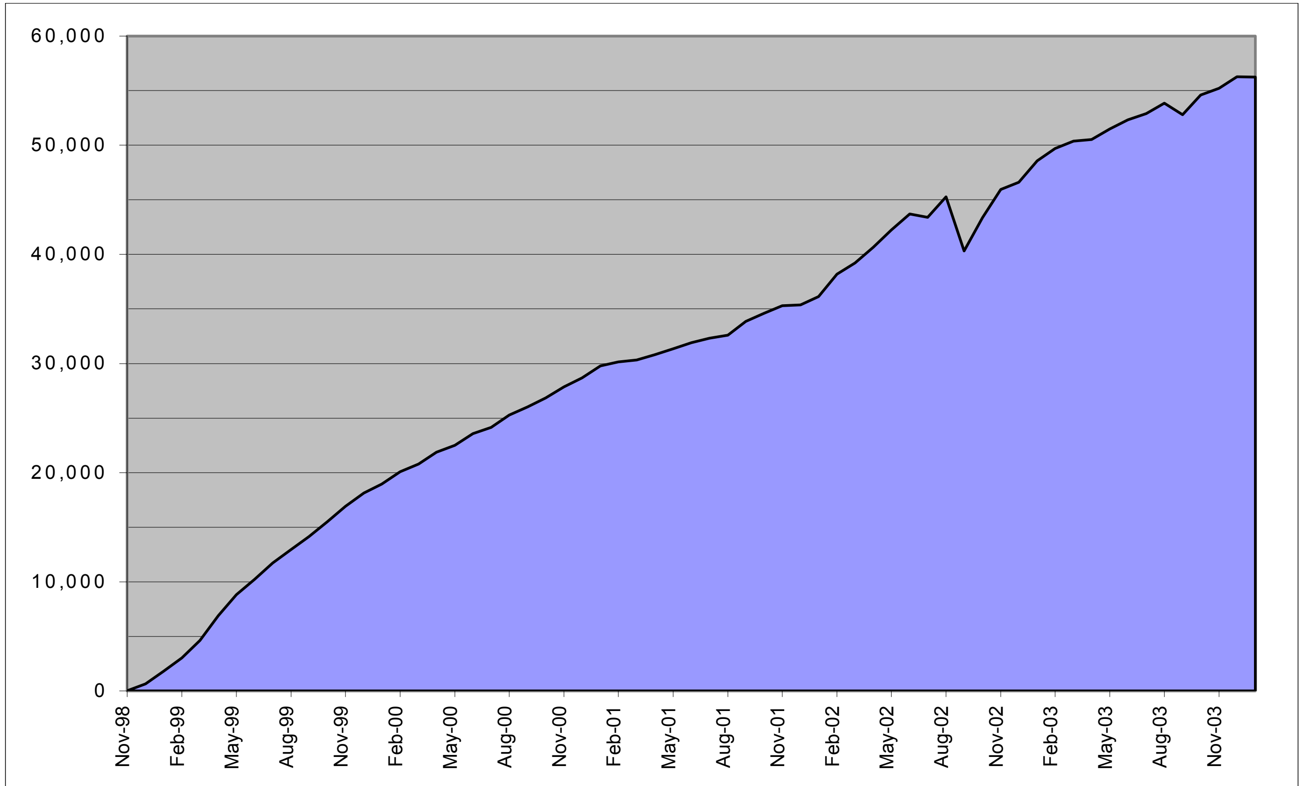
FAMIS redesign

To remedy many of the administrative problems, a number of changes were undertaken in September 2002. To prevent families from having different children enrolled in both programs at the same time, a Medicaid expansion SCHIP program was added for children between the ages of six and eighteen in families with incomes up to 133 percent of FPL. Thus, all children in families at or below this income level would be eligible for the same or similar benefits. Renewed marketing and outreach efforts accompanied a new, common application with common income verification procedures. Families were allowed to apply for either program at a Department of Social Services office or through a central application-processing center. Once they had applied, both Medicaid and FAMIS used the same verification procedures, so eligibility determination was seamless and did not require any additional documentation. Finally, FAMIS eliminated premiums, believing they created a barrier to enrollment and based on data showing that the cost of collections exceeded the value of premium revenues.

The effect of these changes was pronounced. The average monthly increase in enrollment in Title XIX and XXI has risen substantially in the time since these changes were implemented. Prior to the changes, net enrollment increased by 1,292 children per month; since then, it has increased by an average of 4,336 children per month. From

September 2002 to September 2003 the percentage of eligible children enrolled in Medicaid and FAMIS increased from 72 percent to 86 percent.

Figure 5 SCHIP Enrollment in Virginia (Title XXI)



In August 2003 the waiting period for children with prior private coverage was reduced from six to four months and FAMIS moved to a twelve-month period of continuous eligibility. Although income in excess of 200 percent of FPL at any point will trigger disenrollment, a twelve-month eligibility period still helps maintain enrollment for families, and eliminates opportunities to fail to complete the reauthorization process.

At the same time, FAMIS increased the benefit for community mental health services. Prior to this change, FAMIS and Medicaid had different benefits for mental health services, creating some problems when families had additional income.

FAMIS Plus

In an attempt to capitalize on the positive public image associated with FAMIS, all children's health programs began to be marketed under the FAMIS brand, at the urging of advocates. Accordingly, in August 2003, the Medicaid and Medicaid expansion

SCHIP programs were re-named FAMIS Plus; the Separate SCHIP program continues to be known as FAMIS.

The major changes in FAMIS from September 2002 have contributed to the continuous upward trend in enrollment. In particular, renaming children's Medicaid FAMIS Plus has made Medicaid and SCHIP relatively indistinguishable. In SCHIP, the average net monthly enrollment increased from 419 in the thirteen months before September 2002, to 1,319 in the twelve months following September 2002. Total enrollment for FAMIS and FAMIS Plus grew 25 percent between September 2002 and February 2004, increasing from 297,030 at the time of the reorganization to 370,752 covered children in February 2004.

Funding

Prior to 1998, some health plans in Virginia received a special tax rate in exchange for serving as insurers of last resort. Around the same time that Virginia was creating its SCHIP program, the state instituted a new guaranteed issue requirement for all plans and eliminated the special tax rate. Instead of diverting the increased revenue to the state's general fund, the legislature used it to create a trust fund for SCHIP and Medicaid. The majority of these funds—between $12 million and $14 million annually—supports the state match for Title XXI services. A smaller amount of approximately $1.5 million provides state match for Medicaid to help defray the cost of increased Medicaid enrollment attributed to SCHIP outreach. The remaining matching funds for SCHIP come from Virginia's general fund. In 2003 the general fund allocation totaled $26.2 million, including approximately $1.9 million in administrative costs.

The slower than expected enrollment that characterized the early years of Virginia's SCHIP program has provided an unexpected benefit. Beginning in 2002 and extending through 2004, the federal allocation for SCHIP is at its lowest level of $3.15 billion, the so-called "SCHIP Dip." The maximum amount states can receive through their federal match is consequently reduced. In Virginia's case, this amounts to an annual reduction of about $21 million. However, because Virginia did not fully expend its federal allocation in past years (and because federal regulations allow each annual allocation to be spent over three years), some of these funds are available to fill the gap created by the reduction in the federal allocation. Given current utilization and projected cost increases, and assuming appropriation of the full amount of state matching funds, agency staff estimate that FAMIS and FAMIS Plus will have adequate funding through 2007, when federal SCHIP funding will be up for reauthorization.

Virginia has faced serious budget shortfalls over the last few years. Since January 2002 annual budgets of about $27 billion have had to absorb a shortfall of more than $6 billion. Even in this poor budget climate, expenditures for FAMIS and FAMIS Plus have nonetheless increased. FAMIS and Children's Medicaid have collectively increased enrollment by 93,555 since August 2001. This has resulted in budget increases in these programs of $142.3 million.

While children's healthcare has enjoyed a reprieve during the poor budget climate, other areas have had to absorb additional cuts. Elsewhere in healthcare, some providers' reimbursements have been frozen or reduced. Serious cuts have been made in the Department of Transportation where road repairs have been delayed, and offices of the Department of Motor Vehicle have been closed.

"Aligning of the Stars"

Perhaps the biggest changes in FAMIS have been brought about by what many stakeholders—legislators, agency staff, and advocates—have called an "aligning of the stars." Governor Mark Warner was elected in 2002 having run on pledges to improve FAMIS and increase the number of children with healthcare. Governor Warner was also the founding chairman of the Virginia Health Care Foundation, an organization that promotes public-private partnerships to increase access to primary health care services for the uninsured.

Additionally, many new executive branch staff in key positions have extensive experience working to improve health care for children in the state. For example, a former legislator associated with child health insurance efforts was made Secretary of Health and Human Resources, two legislative staff members who wrote special studies on the performance of child health insurance programs were named Director and Chief Deputy Director of the state Medicaid agency, and a child health insurance advocate was recruited to serve as the FAMIS director. These policy makers came to the executive branch highly respected by former colleagues. The net result of this cross-pollination is an environment of trust that has allowed stakeholders to work constructively on the FAMIS program.

Stakeholders

All stakeholders praised the changes made to the program over the last two years.

Advocates

Advocates expressed strong confidence that, despite the current budget climate in Virginia, FAMIS and FAMIS Plus would survive unscathed or with only minor changes. They believe that Governor Warner's emphasis on the program has created such a high degree of public support that it would be politically difficult to reduce enrollment in subsequent years.

In general, advocates believe that the policy decisions regarding the FAMIS program were driven by data; often provided by advocates to spur program changes. Advocates noted that their early efforts to publicize the low rate of enrollment frequently employed unflattering comparative data showing Virginia lagging behind neighboring states. They

also made the case that Virginia's enrollment was so low that the program might forego $40 million to $60 million in federal funds.

In addition, a number of independent, uncoordinated efforts came together around the same time and helped drive the simplification of the program. Among those initiatives was a report from the Joint Legislative Audit and Review Commission (JLARC) which described many of the problems with the FAMIS program and made recommendations for changes. A privately funded enrollment effort by the Virginia Health Care Foundation examined the barriers to obtaining care and completing the application process. Stakeholders believe this information proved valuable in demonstrating to legislators the value of a streamlined SCHIP program, as well as which barriers to remove.

Advocates did express concern about a shortage of dental providers for children enrolled in FAMIS and FAMIS Plus as well as in commercial plans. Of about 120 dental areas in Virginia, 54 are currently officially designated as shortage areas. Advocates voiced concerns that reimbursement rates are so low that dental providers do not want to participate.

Advocates expect that their next major legislative effort will be to increase the eligibility level for pregnant mothers from its current level of 133 percent FPL to 200 percent FPL. No efforts are currently under way to increase the overall eligibility level for children beyond the existing 200 percent FPL.

Health Plans

In general health plans were enthusiastic about FAMIS and FAMIS Plus. Representatives described the move from CMSIP to FAMIS as a major effort that required a lot of work, acceptable so long as comparable changes are not made every year.

Health plans also felt confident that, through regular meetings and other intermittent contact with agency staff, their major concerns are communicated and addressed. In particular they described agency staff as sensitive to their operational issues.

Health plans expressed the greatest concern about access issues. Dental services are all but non-existent in some areas of the state—for FAMIS, as well as for other health plans. They also indicated that some providers were beginning to close enrollment to new FAMIS and FAMIS Plus children. They noted that this tends to have a domino effect: when a few providers close enrollment, others must take the extra patients, which can result in these providers eventually closing to new enrollment. The problem is, in part, due to the low reimbursement rate for Medicaid. Typically, Medicaid pays between 70 percent and 72 percent of Medicare rates and while these rates were not cut in the last legislative cycle, neither were they increased.

Although health plans were pleased to have received an 8 percent increase in payments this year, the increase simply covered rising costs in the provision of healthcare services due to increased utilization. DMAS works with an actuarial contractor to establish cost increases in FAMIS and FAMIS Plus, and health plans must either accept the new rate or sever their contract with the state.

Lawmakers

Legislators describe themselves as strongly supportive of SCHIP and frustrated by the slow early implementation of the program. For some legislators, the 2 to 1 federal match of state SCHIP funding was an important contribution to support, others did not mention it. All attribute the most recent changes to Governor Warner's support of the program. Some mentioned in particular their pleasure at the newly streamlined, common application for both FAMIS and FAMIS Plus, and believe it was an important factor in the enrollment increases. There are no plans during the current session to cut FAMIS or FAMIS Plus or to slow the pace of enrollment.

Table 4 Virginia SCHIP program over time

	10/1998	8/2001	9/2002	8/2003
PROGRAM NAME	Medicaid and CMSIP (The Children's Medical Security Insurance Program)	Medicaid and FAMIS (Family Access to Medical Insurance Security Program)	Medicaid for Children and FAMIS	FAMIS Plus/ FAMIS
Enrollment numbers				
Medicaid – children (Title XIX)[12]	262,208	241,455	250,499	273,642
Medicaid SCHIP – (Title XXI)	-	-	9,427	20,749
Separate SCHIP – (Title XXI)	-	32,587	28,603	32,132
Uninsured children below 200% FPL[13]	123,000	111,000	104,000	N/A
Eligibility				
Medicaid – children (Title XIX)	0-5 up to 133% 6-18 up to 100%	0-5 up to 133% 6-18 up to 100%	0-5 up to 133% 6-18 up to 100%	0-5 up to 133% 6-18 up to 100%
Medicaid SCHIP – (Title XXI)	No Program	No Program	6-18 from 100% to 133%	6-18 from 100% to 133%
Separate SCHIP – (Title XXI)	0-5 from 133% to 185% 6-18 from 100% to 185%	0-5 from 133% to 200% 6-18 from 100% to 200%	0-5 from 133% to 200% 6-18 from 133% to 200%	0-5 from 133% to 200% 6-18 from 133% to 200%
Benchmark benefit package for Separate SCHIP	Medicaid look-alike	State employee benefit package	State employee benefit package	State employee benefit package
Separate SCHIP benefits				
Mental health/substance abuse	Medicaid look-alike	Covered	Covered	Added community mental health benefits
Dental	Medicaid look-alike	Covered	Increased orthodontia coverage (10/02)	Covered
Vision	Medicaid look-alike	Covered	Reduced vision co-pay (10/02)	Covered
Chiropractic	Medicaid look-alike	Covered	Covered	Covered
Hospice	Medicaid look-alike	Covered	Covered	Covered
Administrative changes				
Asset test	None	None	None	None
Continuous eligibility period	None	None	None	None for FAMIS Plus/12 months for FAMIS (unless over 200%)
Income to determine eligibility[14]	Gross with disregards/Gross	Gross with disregards/Gross	Gross with disregards/Gross	Gross with disregards/Gross

[12] Historical Medicaid data only available for children under 21. Reported values are average monthly enrollment for the calendar year as reported for the purpose of state forecasting. (State form MME370.)
[13] Number is a three-year average ending in the tabular year and includes children who may be eligible for Medicaid. Source: http://www.census.gov/hhes/hlthins/lowinckid.html. (March 9, 2004.)

	10/1998	8/2001	9/2002	8/2003
Waiting period in Separate SCHIP (look back for previous insurance)[15]	12 months	6 months	6 months w/ cost exception	4 months w/ cost exception
Waiting period prior to enrollment regardless of insurance status	N/A	N/A	N/A	N/A
Periodic open enrollment/waiting list	N/A	N/A	N/A	N/A
Single application for TXIX and TXXI	Yes	No	Yes	Yes
Cost sharing (Separate SCHIP only)				
Co-payments	None	Families at or below 150% FPL are subject to co-payments ranging from $2 to $15 per inpatient admission. For families with incomes above 150% FPL, co-payments range from $5 to $25.	Families at or below 150% FPL are subject to co-payments ranging from $2 to $15 per inpatient admission. For families with incomes above 150% FPL, co-payments range from $5 to $25.	Families at or below 150% FPL are subject to co-payments ranging from $2 to $15 per inpatient admission. For families with incomes above 150% FPL, co-payments range from $5 to $25.
Premiums	None	151% to 200% $15PMPM w/$45 max PF	Eliminated	None
Funding source	General fund; the Virginia Children's Medical Security Insurance Plan (VCMSIP) Trust Fund	General fund; the Family Access to Medical Insurance Security (FAMIS)Trust Fund	General fund; the Family Access to Medical Insurance Security (FAMIS)Trust Fund	General fund; the Family Access to Medical Insurance Security (FAMIS)Trust Fund
Amount of special revenue funds				
Amount of total state match				$24,686,487
Amount of federal allocation (used)				$46,599,933
Amount of aederal allocation (total)	$68,314,915	$75,491,290	$54,662,752	$53,437,771
Medicaid match rate	51.6%	51.85%	51.45%	(50.53%) 54.4%
SCHIP match rate	66.12%	66.13%	66.02%	65.37%

[14] CMSIP used Medicaid methodology to calculate income, including income disregards. FAMIS increased income limit to 200% FPL but eliminated use of income disregards.
[15] There were some exceptions to the waiting period from the beginning of CMSIP. However, the most important exception, affordability of prior premiums, was instituted in September 2002.