

State Experience with Enrollment Caps in Separate SCHIP Programs

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We are grateful to the David and Lucile Packard Foundation for its generous support of NASHP's SCHIP Implementation Center. In an effort to address emerging concerns and issues identified by state SCHIP officials, the Center has begun to host a series of "rapid response calls" on various topics concerning SCHIP implementation. In November 2003, NASHP held a call with state SCHIP directors in an effort to respond to the many inquiries it was receiving concerning state policies related to capping enrollment in separate SCHIP programs and implementing waiting list or open enrollment periods. At the time, six states had various levels of experience with such policies and procedures, and those states shared their experiences with others participating in the call.

This issue brief grew out of that conference call. Additional information was obtained from state Web sites and follow-up phone conversations.

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Overview

The State budget shortfalls of the last two years have presented a variety of challenges for SCHIP programs. States around the country have sought to cut discretionary spending and to reduce their liability for entitlement and/or non-discretionary spending. Despite their success in reducing the number of uninsured children, SCHIP programs have not been immune from these budget cuts.

Unlike many other programs in which the Federal government plays a role, the SCHIP regulations were designed to provide states with considerable flexibility in tailoring programs to their individual needs. In addition to allowing states to choose from several different program designs, states were allowed to institute different eligibility levels, different levels and types of cost sharing, and different benefit packages.

With the strength of the economy and the growth of state budgets in the late 1990s, this flexibility made possible the rapid expansion of SCHIP programs. As state budgets have contracted in recent years, that same flexibility has made it possible for states to implement a variety of cost cutting measures within their SCHIP programs.

Some states have chosen to contain costs by limiting enrollment in their SCHIP programs either by capping or freezing enrollment. An **enrollment cap** allows a state to establish a certain number of eligibility slots for children: as some children leave the program, new children are enrolled to take their place. An **enrollment freeze**, on the other hand, prevents new applicants from enrolling after a certain date. Enrollment declines as children leave the program and continues to decline until enrollment is reopened and new applications are accepted.

In instituting either an enrollment cap or freeze, states have relied on several different strategies for managing enrollment. One approach requires states to continue to accept applications and establish a **waiting list** from which to draw, as slots become available. (Medicaid home and community-based waiver programs use this method to fill the set number of slots identified in the waiver and approved by CMS.) States have also designated **open enrollment periods**, similar to those in the private health insurance market. Application and enrollment take place only during a time-limited period, which usually occurs once or twice per year. The time limit assures that enrollment cannot continue to grow throughout the year and makes it unlikely that all potential eligibles can or will apply within the given time frame.

Federal Requirements

In spite of the significant flexibility accorded to states in the development and implementation of their SCHIP programs, Federal law requires states to submit an amendment to CMS no more than 60 days after imposing waiting lists, enrollment caps, and enrollment closures. States must – in a timely manner – make available to potential applicants, applicants, and enrollees information about enrollment restrictions. To that end, States must inform individuals:

- if an enrollment cap is in effect or if the State is using a waiting list
- with a description of the procedures relating to the cap or waiting list, including the process for deciding which children will be given priority for enrollment,
- how children will be informed of their status on a waiting list, and
- the circumstances under which enrollment will reopen.

A states must also include in its plan a description of its policies governing enrollment and disenrollment; its processes for screening applicant children for Medicaid eligibility and, if eligible, for facilitating their enrollment in Medicaid; and its processes for implementing waiting lists and enrollment caps.

Plans must also ensure that:

- The procedures developed are followed for each child applying for a separate SCHIP program before placing the child on a waiting list or otherwise deferring action on the child's application; and
- Families are informed that a child may be eligible for Medicaid if circumstances change while the child is on a waiting list for the separate SCHIP program.

State Policies and Procedures

As of November 2003, six states had or have a capped enrollment in their separate SCHIP program:

- *Alabama* has a waiting list.
- *Colorado* hosts open enrollment periods.
- *Florida* instituted a waiting list as of July 1, 2003, and will move children from the list to coverage, as space becomes available. As of November 2003, no children have been moved off the waiting list.
- *North Carolina* initially froze enrollment on January 1, 2001. It began taking children off the waiting list in July of that year, and reopened to new enrollments on October 8, 2001. The intention of the freeze was to reduce the number of enrolled children, which had reached a high of 77,000, to an annual average of 68,000. However, the waiting list had over 34,000 children on it when the freeze was rescinded. The state now has enough funds for an annual average enrollment of between 100,000 and 105,000 children and currently has 103,000 children enrolled. Utilization of the program by these children has

been consistent with state budget projections, so the state is not anticipating a renewed waiting list/freeze in the immediate future.

- *Montana's* SCHIP program recently received enough state general funds to enroll all of the children who had been on its waiting list (1,334); these children were enrolled effective November 1, 2003. Since then more children have been determined eligible, and these children are on a waiting list.
- *Utah* hosts open enrollment periods.

Table 1 Snapshot of states with enrollment caps/freezes currently in effect

	AL	CO	FL	MT	UT
Enrollment freeze began	9/03	11/03	7/03	2001	12/01
Enrollment freeze ended	-	Expect 7/04	-	-	-
Number of children enrolled in separate CHIP program (as of)	62,449 (9/03)	55,000 (11/03)	260,008 (6/03)	10,691 (11/03)	23,792 (7/03)
Enrollment cap/ freeze limit	--	52,965	MediKids 35,870 Healthy Kids 271,267 CMSN 9,034	--	24,000 (2003) 28,000 (2004)
State keeps wait list	Y	N	Y	Y	N
Number of children on wait list	2,400 (11/03)	N/A	38,952 (11/03)	151 (11/03)	N/A
Average length of stay on wait list	Too soon to tell	N/A	Since 7/03 no one has moved off list	1-2 months	N/A
State hosts open enrollment periods	N	N – has authority to do so but does not	Y	N	Y
Note: North Carolina is not shown in this chart because it no longer has an enrollment freeze/cap.					

Alabama

The Alabama Department of Public Health announced a freeze on enrollment in its SCHIP Program, ALL Kids, effective September 1, 2003. In spite of the freeze, the state continues to process applications. If a child is under the income eligibility guideline, his or her application is forwarded to the Medicaid agency. If the child is over the SCHIP eligibility guideline, the application is forwarded to the Alabama Child Caring Foundation,¹ and if the child meets the state's SCHIP eligibility criteria, he or she is placed on the waiting list in the order the application is received.

Children who are currently enrolled in ALL Kids may remain on the program, if – at renewal – they continue to meet all eligibility criteria.

Colorado

Colorado's SCHIP program, CHP+, instituted an enrollment freeze effective November 1, 2003. Applications received after that date are screened for Medicaid eligibility. If the applicant is potentially eligible for Medicaid, the application is forwarded to Medicaid for a final determination. If the applicant is Medicaid eligible, he or she is enrolled in that program. If the applicant is not Medicaid eligible, the family receives a letter notifying them that the SCHIP program is no longer accepting new applicants. There are no exceptions.

Florida

Florida KidCare has four components: MediKids for children between 1 and 5 years of age; Florida Healthy Kids for school-age children ages 5 through 18; Children's Medical Services Network for children with special health care needs; and Medicaid, for children in lower income families. As of July 1, 2003, Florida KidCare instituted a wait list for new enrollees for each of the KidCare programs, with the exception of Medicaid. All new applicants to the program are processed for eligibility and, if eligible, are placed on a wait list for the program for which they qualify.

As space becomes available through attrition, children will be moved from the wait list to coverage. Because the rate of attrition is much lower than originally anticipated, as of December 1, 2003, Florida KidCare planned to initiate a "hard cap" policy in which children already enrolled in the program will be unable to automatically transition from one program component to another. For instance, a child who ages out of MediKids and who would otherwise transfer automatically to Florida Healthy Kids on his 5th birthday will be placed after December 1st on the

¹ The Alabama Child Caring Foundation (ACCF) was created in 1987 by Blue Cross/Blue Shield of Alabama as a means of providing Alabama's uninsured children with the health care they need. The first child was enrolled in March of 1988, and by the end of 2003 more than 45,000 children had received help from the ACCF's Caring Program for Children. Family income must be below 235 percent FPL for a child to be eligible for the Caring Program, and if a child is eligible for Medicaid or SCHIP or has private health coverage, she can not enroll in the program.

Florida Healthy Kids' waiting list. There is one exception: children already enrolled in any of the KidCare program components who become eligible for Children's Medical Services are exempt from the "hard cap" policy and will be transferred to CMSN.

Montana

Montana has limited state funds with which to enroll children in its separate SCHIP program. When the maximum number of children has been enrolled, the enrollment is capped and a waiting list is established. The state uses the following processes to administer its waiting list:

- The waiting list is for children determined eligible for SCHIP but for whom space is not available. Children are placed on the waiting list in the order in which they are determined eligible. Applicants are notified in writing if their children are eligible and placed on the waiting list. Applicants are also informed that they can contact SCHIP to inquire about their child's position on the waiting list. The wait for children on the waiting list to become enrolled ranges from 1 to 10 months.
- Spaces become available at the end of each month when enrollment ends for currently enrolled children who:
 - turned age 19,
 - became eligible for Medicaid,
 - became eligible for state employee health insurance,
 - obtained coverage under another insurance,
 - moved out of state,
 - failed to reapply, or
 - reapplied but were determined ineligible.
- When space becomes available at the 1st of each month, children are removed from the waiting list and enrolled in SCHIP until all spaces are filled. Applicants are notified in writing when their children are taken off the waiting list and are enrolled in SCHIP. Children are enrolled based on when they were determined eligible. Families with more than one eligible child on the waiting list will have all children enrolled at the same time and have the same enrollment date for all children.
- If a child who is determined eligible for SCHIP has a sibling already enrolled in SCHIP, the child is not placed on the waiting list. The newly eligible child is enrolled the first of the month after the eligibility is determined. The renewal date for the newly eligible child will be the same as those of his or her siblings who is currently enrolled.

North Carolina

While North Carolina does not currently have an enrollment freeze, it was the first to institute one and has mechanisms in place to reactivate a freeze should that become necessary. The state freezes enrollment when enrollment in NC Health Choice, its separate SCHIP program, exceeds

the actuarial estimates of needed available dollars. New enrollment is accepted when enrollment levels are deemed to be within the budget parameters. The purpose of the plan is to limit enrollment in a manner that does not require families to file multiple applications, and it allows children to enroll as slots become available, rather than waiting for a pre-established date.

When enrollment is frozen, families can continue to file applications, and counties will determine eligibility as usual. If a child is determined eligible for Medicaid, then the application is approved, and the child is issued benefits. If the child is determined ineligible for any program, the application is denied. If the child qualifies for NC Health Choice, the application will be denied and the family will be notified that the child qualifies for the program but that no funds are available for the program. The state's Eligibility Information System establishes a computerized waiting list and adds the child to the waiting list. Information about the child will not be transmitted to the claims processing agent until such time as the child is ready to be enrolled.

Should the family be an existing NCHC family and re-enroll during the 10-day grace period, the children will continue to have coverage.

When the North Carolina Division of Medical Assistance determines that it is financially possible to allow for new enrollees, it notifies the Division of Information Resources management of the number of slots that can be filled. At the point of application, a registration number is filed so that the application can be sequenced chronologically according to the date originally registered in the Eligibility Information System. The applications are reactivated on a first-come, first-served basis according to this chronological order. When a child's application is reactivated, he or she is removed from the waiting list. The family is mailed notification that its application has been re-opened. The notification letter asks that the family confirm its address and uninsured status and return this information to the state. This permits the state to act on the family's behalf and reactivate the application. A maximum of 45 days processing time will be allowed for the application to be considered and for the family to provide any needed information. If the family does not return the reactivation notice, the county checks agency records to see if an address change has occurred and mails a second notice. Once the necessary information is received from the family, the county social services department completes the application. The department notifies the family if there is any enrollment fee due, and the family is asked to pay it. The family is officially notified of the outcome of the reopened application and the child's record is transmitted to the claims processing agent.

Benefits begin the month the application was re-activated and continue for 12 consecutive months. Should a family not reply within 45 days, the "re-activated" application is denied. The number of slots represented by the children in the family become available; the children do not return to the waiting list. The family can reapply at any time.

In the event that the budget shortfall is corrected, the backlogged wait-listed children must be enrolled in the program before the process returns to one with no waiting list.

Utah

Utah froze SCHIP enrollment in December 2001 and moved from allowing continuous enrollment to holding periodic open enrollment periods. Since then, the state's SCHIP program has held three open enrollment periods. The first two were held in 2002, enrolling 6,429 children between June 3 and 14, and 8,856 children between November 12 and 22. The third open enrollment period was held from July 28 to August 1, 2003, and enrolled 8,921 children.

During open enrollment periods, all applicants who submit applications and are found eligible are enrolled in the program, even if the number of applicants exceeds the state's enrollment cap. The state is able to enroll more than the enrollment cap since its cap is an annual monthly average. It can be exceeded as long as, within the fiscal year, the state maintains an average monthly enrollment of 24,000 children in 2003 and 28,000 in 2004.

For applications received outside of enrollment periods, Utah follows procedures similar to those in Colorado. These applications are first screened for Medicaid eligibility. If the applicant is potentially eligible for Medicaid, the application is forwarded to the Medicaid agency for a final determination, and, if found to be eligible, the child is enrolled in Medicaid. Those not eligible for Medicaid are notified by letter that the SCHIP program is not currently enrolling new children and are encouraged to check the SCHIP website for announcements of open enrollment periods.

The public is notified of open enrollment periods about a month before they go into effect, and notification continues during the open enrollment periods. Notification is conducted through the media, the SCHIP website, and the program's hotline. In addition, enrollment kits are sent to partners in the community. Ten days prior to the open enrollment period, Utah conducts a media campaign using statewide television, radio, and print ads to alert the public of the dates. During the actual open enrollment period, the message of the media campaign shifts, encouraging families to "enroll now."

Challenges and Considerations for States

Although enrollment caps and freezes may be appealing as a relatively simple strategy to implement, states do report a number of unanticipated administrative challenges. States have had to address a number of questions in implementing caps and freezes, among them:

- Will there be any exceptions to the waiting list for various populations such as Medicaid graduates, newborns, or the medically needy? If so, how are these determinations made?
- What happens if an older sibling is enrolled in SCHIP and has a younger sibling who ages out of Medicaid and into SCHIP? Will the younger sibling be placed on a waiting list or be frozen out of the program, leaving some children in the same family insured and others uninsured?
- For those states with anti-crowd-out measures, will wait-listed children be made ineligible if their parents find and pay for alternative coverage?

States with enrollment caps all report different strategies for dealing with these challenges. While some states make exceptions for certain categories of children—Medicaid graduates, those with siblings on SCHIP, and those with chronic and/or acute illnesses—others decided that the task of establishing and maintaining a priority list was too difficult.

Among the other changes that an enrollment cap may require is a re-examination of processes. States reported that, while CMS does allow for waiting lists, states must still screen for Medicaid. States that have implemented an eligibility cap have also found it necessary to re-educate their customer service staff in order to properly convey the changes to families.

Of concern to many states is the ongoing impact of enrollment caps and freezes on families. States with enrollment caps have reported that fear of relegation to a waiting list has driven parents to pay more attention to re-enrollment timelines and processes. It did not take long for families to discover that a failure to renew in the allotted timeframe would force their children to the bottom of a waiting list and that covered healthcare services would quickly become out-of-pocket expenses. Montana's retention rate soared to nearly 90% in the years after its enrollment cap was implemented. Other states report that when the waiting list is less than 2 to 3 months, most families are pleased to know that their children are eligible and would soon be enrolled. Some families made arrangements to postpone treatments or surgery where possible. Families with children with chronic or serious illness or injury were understandably less amenable to the wait.

Conclusion

Although no state was enthusiastic about implementing an enrollment cap for its SCHIP program, many felt it was the least painful way to curb costs. Exercising this option—rather than implementing benefit cuts, eligibility reconfigurations, or other strategies—allowed programs to stay within a prescribed budget; furthermore, many states favor enrollment caps because they believe they can be lifted with less difficulty and fewer lasting consequences than other options. However, one state with a SCHIP eligibility level not much higher than the minimum level for Medicaid has noted that reducing eligibility would not have a significant impact on costs.

Some states have attempted to avoid implementing a cap by reducing benefits and increasing cost sharing but most found that savings from these actions were not sufficient to keep their SCHIP programs within budget. Furthermore, most states that have implemented a freeze or cap have also increased cost sharing in the last year.

While recognizing that the difficult budget climate is driving the search for efficiencies and cost saving measures across all discretionary spending in states, the decision to institute an enrollment cap in a state's SCHIP program must be considered carefully. The states mentioned here have implemented their caps in a variety of different ways and utilize many of the different options that are open to states because of the inherent flexibility in the SCHIP regulations.

In addition to questions about where exactly to place the cap, states must also consider:

- What kind of cap: waiting list or periodic open enrollment?
- Whether the cap will have exceptions for needy kids, Medicaid graduates, and/or siblings of SCHIP enrollees.
- Cost and materials associated with re-training staff.
- Amount of money that will be saved by the cap.
- How to combine with other administrative changes—adjustments to eligibility levels, cost sharing, etc.—to save the most money with the least impact on health.