

**Building on Success to Effectively Integrate Current Children's Coverage
with National Health Reform: Ideas from State CHIP Programs**

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The Children's Health Insurance Program (CHIP), created in 1997 to provide health coverage for low-income uninsured children, has been recognized widely as a highly successful program. Operating through a federal-state partnership, CHIP balances core program requirements with state flexibility to cover nearly 10 million children and pregnant women nationwide in 2009¹. Earlier this year, CHIP got a bipartisan vote of confidence from Congress and the Obama Administration through enactment of the Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA. The four and a half year reauthorization incorporated new requirements and tools for states to further simplify and strengthen enrollment and to enhance benefits and quality in both CHIP and Medicaid coverage for children. Federal and state agencies are now in the midst of implementing these substantial policy and program changes. At the same time, proposals for national health reform suggest major changes in Medicaid and CHIP, including the possible end of CHIP in 2013, requiring the projected 14 million children and pregnant women enrolled during that year² to move to new exchange plans or Medicaid.

This National Academy for State Health Policy (NASHP) brief was developed with state CHIP directors. It discusses key considerations for policy makers and stakeholders working on national health reform to sustain gains and support improvement efforts for children's coverage now underway through both CHIP and Medicaid. As President Obama has stated "reform should be guided by a simple principle: we fix what's broken and build on what works." A key test for reform will be how well it builds on what has worked for children, solidifying their gains, and incorporating the extensive lessons learned through CHIP in health system reform. A fundamental challenge will be to ensure that the over 40 million children enrolled in CHIP and Medicaid³ make a smooth transition to any new forms or structures for coverage, and retain the coverage features that are essential to their obtaining the benefits and quality care they need for healthy development. An estimated 9.9 million children and pregnant women will be enrolled in CHIP during 2013. Maintaining coverage without disruption and continuity of preventive, primary and special needs care will be essential to their healthy growth and development.

This brief first describes CHIP successes that state CHIP program leaders believe should be built on or integrated with national health reform, and then turns to ideas for assuring a smooth transition for publicly insured children. As part of NASHP's ongoing work with all state CHIP programs, this brief was developed with a workgroup of state leaders representing varying CHIP program types from across the country who discussed key issues specific to child health coverage that they believe should be taken into consideration in national health reform. This group met by phone and communicated electronically during July 2009, and reviewed and commented on a draft of this brief. While this brief is not intended to and does not capture all of the views of all of the states on all of the issues relevant to children's coverage in national health care reform, we believe it conveys the views of most state CHIP program directors on issues of priority concern to them.

Building on Success

Enacted in 1997 and reauthorized in 2009 with bipartisan support, the CHIP program focuses on the specific coverage needs of children, which are distinct from adults due to children's developmental needs and dependence on families or other caretakers. States now have well over a decade of experience and expertise in providing health coverage through CHIP and in coordinating and improving children's coverage under Medicaid. CHIP's focus on covering children has led to child and family-centered best practices for enrollment and retention of coverage as well as organization and delivery of health services. Key lessons learned that state CHIP programs urge national policy makers to build on in health reform follow.

1. Children's unique needs require explicit focus in system design

CHIP is uniquely designed to meet the specific coverage needs of uninsured children, targeting those who fall within the coverage gap between Medicaid and family access to affordable private or employer-sponsored coverage. States have created new policies and programs to bridge this gap, including higher public coverage eligibility levels with cost sharing, premium assistance, and buy-in programs designed specifically for children and families. To reach and enroll eligible uninsured children, state CHIP programs have targeted outreach and enrollment messages and strategies to parents, adolescents, and specific vulnerable populations. CHIP benefit packages similarly have been tailored to the health and developmental needs of children, being based either on Medicaid's comprehensive children's benefits⁴, or benchmark plans that include preventive, dental and specialty care benefits. CHIPRA further strengthened dental and mental health benefits. Studies of CHIP's impact have demonstrated improvements in child specific quality measures. Children enrolled in CHIP are less likely than uninsured children to have unmet health needs, are more likely to use preventive care and to have a regular source of care. Studies also have shown that children enrolled continuously in CHIP and Medicaid have increased dental care utilization, that enrollment in CHIP can have benefits in care of certain childhood chronic conditions such as asthma, and that academic performance improves once a previously uninsured child receives coverage through CHIP.⁵ CHIP programs around the country have established a reputation for quality and coverage for children. In Utah for example, an opinion survey of public perceptions scored CHIP at nearly the same level as Medicare.

CHIP also has contributed strongly to more child and family centered approaches in state Medicaid programs. CHIP led outreach and enrollment initiatives often result in enrolling more Medicaid than CHIP eligible families. Simplified and streamlined forms and processes developed through CHIP have been adopted by Medicaid in many if not most states.

CHIP's focus on children is viewed by many states and stakeholders as a major key to its success. CHIP's success strongly suggests that national reform must maintain a focus specifically on children's coverage if we are to maintain gains and make further progress in ensuring that children have health insurance coverage that translates into access to quality services that promote healthy development from infancy through adolescence.

2. Improving outreach, enrollment and retention is integral to covering the uninsured

Spurred by CHIP, states have developed and refined a range of outreach, enrollment and retention strategies that have demonstrated success in enrolling children- and in many states parents as well⁶ - that hold lessons for broader systems reforms. CHIPRA reinforces and builds on these successes through performance bonuses for states which have adopted certain best practices and increased enrollment over a baseline, and through a \$100 million allocation to advance outreach and enrollment of eligible uninsured and underserved children into Medicaid and CHIP. CHIPRA also provides an enhanced federal matching rate in CHIP and Medicaid for translation and interpretation services for families for whom English is not the primary language.

Simplification of enrollment and renewal is a state success story that now continues to evolve with new chapters and innovations. Since CHIP was created, states have focused their efforts on simplifying enrollment and renewal processes for children and families in both Medicaid and CHIP as a means of reaching more eligible children.⁷ Research and state experience indicate that simplifying enrollment and renewal processes promotes enrollment of eligible children, reduces unnecessary loss of coverage and results in continuous coverage.⁸ States vary in the extent to which they have adopted different enrollment simplification strategies, but most states have implemented three key strategies for both Medicaid and separate CHIP programs: 1) elimination of the asset test; 2) elimination of in-person interviews; and 3) use of joint Medicaid-CHIP applications.⁹ These three strategies are among eight identified in CHIPRA; others include 12 month continuous eligibility, express lane eligibility, and paperless verification at renewal. To encourage states to implement such strategies, CHIPRA includes performance bonuses for states adopting at least five of the eight strategies and increasing enrollment over a baseline.

Even prior to the potential of bonus payments, states used the flexibility of CHIP to simplify enrollment and renewal processes, which drove improvements in Medicaid processes. For example, in 2001, Louisiana began “ex parte” renewals for CHIP and Medicaid, using information from other programs such as Food Stamps¹⁰ to establish continuing eligibility for Medicaid and CHIP without the need for a signed renewal form.¹¹ Prior to implementing the ex parte approach, 22 percent of Louisiana children up for renewal lost coverage due to failure to submit forms, compared with less than 1% in August 2008.¹²

State CHIP program directors look to national policy makers to sustain, support and build on outreach, enrollment and retention strategies and systems that states have put in place and are now working hard to improve further. States’ best practices and lessons learned from CHIP outreach efforts also could be adapted and incorporated in national reform to reach millions of uninsured adults.

3. Affordability is critical to enrollment, appropriate utilization and good outcomes

Current federal guidelines provide cost-sharing protections for low-income children and families enrolled in public coverage. The guidelines established for CHIP define a ceiling or maximum percentage of family income (5%) that a state can require a family to pay towards their health coverage. According to a 2008 survey of state CHIP programs, most states require families to contribute to the cost of their coverage by paying premiums and co-payments. Most states that require premiums calculate them on a sliding scale based on the family’s income and number of children enrolled in the coverage. The co-payments required for office visits by most states range

from no charge for well-child visits to \$10 for specialist visits. Coverage obtained through the private sector tends to involve higher cost sharing regardless of an enrollee's income.^{13 14} The evidence shows that for low-income families, cost-sharing can affect access to care and health outcomes adversely.¹⁵

Both state experience and research strongly suggest that increasing cost-sharing requirements could reverse the recent strides states have made to cover children continuously and reduce churning. Churning occurs when children enroll, drop, and re-enroll in coverage in a short period of time. This creates coverage instability that affects millions of children and families each year, and it exacts a considerable toll on families' ability to obtain needed health care in a timely and cost-effective setting.^{16,17} State experience has indicated that although cost sharing disproportionately affects those with the lowest incomes, increases in cost sharing also have led to disenrollment among those with incomes above 150 percent of the poverty level.¹⁸

State CHIP programs urge national policy makers to study these experiences and lessons learned about the implications of cost sharing for enrollment, access and outcomes, particularly for the children and families currently enrolled in public coverage which limits cost sharing.

4. State administration and flexibility can promote coordination and accountability

States now have over a decade of experience and have developed expertise and capacities in designing, implementing, managing, coordinating and continuously working to improve their children's coverage programs. This experience and expertise has had a broader impact on administration of Medicaid and other state programs. These state capabilities should be built on in systems reform, and the lessons learned about coordination and accountability applied in structuring roles and relationships between existing programs and new structures under reform.

The state flexibility that was an integral part of the CHIP program's design has been a key to its success. States have tailored marketing, enrollment, benefits, service delivery systems, and other key features of their programs to the circumstances and culture of their states. This state tailoring has led to broad-based support at state and national levels. CHIP directors believe maintaining flexibility to tailor programs to local conditions is vital to meeting needs at the ground level.

While state agency and program structures vary considerably across states, state level administration of CHIP, Medicaid, insurance regulation, public health, social service and other programs gives states the ability to implement and coordinate these programs to achieve their interrelated purposes to support the health and well being of their residents. Although state success in such coordination varies across states and across programs, CHIP has built strong ties to Medicaid, private health plans, schools, and other programs. CHIPRA gives states additional tools to coordinate state and local efforts, such as new premium assistance program flexibility and options to conduct "express lane eligibility" coordinated with other benefit programs.

CHIP and Medicaid work in tandem. For over a decade, even as more states implemented separate CHIP programs, they also worked to improve coordination between Medicaid and CHIP. As of January 2008, for example, the vast majority of states with a separate CHIP program used the same application for Medicaid and CHIP.¹⁹ Other common strategies to

promote coordination between the programs include: aligning eligibility criteria and employing the same staff to determine eligibility for both programs; expanding the locations at which, and technologies through which, families can apply for coverage; developing administrative verification capability; and adopting presumptive eligibility.²⁰ These efforts to coordinate, simplify eligibility and streamline the application process have been critical to improving enrollment and retention in both programs.

Medicaid and CHIP coordination of rules and procedures has had documented positive effects on enrollment and on administrative costs. Virginia implemented a “No Wrong Door” policy in the fall of 2002, allowing applicants to complete a joint application for Medicaid and Family Access Medical Insurance Security of FAMIS (the state’s CHIP program) and submit the application either at the Department of Social Services office or the Central Processing Unit (which previously accepted only CHIP applications). During the quarter this change was implemented in 2002, Virginia saw its quarterly new entries into Medicaid increase by 43 percent, from 16,000 to 23,000.²¹ Indiana reported that having a joint Medicaid/CHIP application form reduced its printing costs and cut in half the time state workers spent verifying information.²²

State CHIP program directors also want to highlight continuity of coverage as a benefit of Medicaid and CHIP coordination efforts. Many low-income families experience fluctuations in income that affect which coverage their children are eligible for. Aligning Medicaid and CHIP systems to electronically transmit referrals between the two programs benefits consumers and programs, facilitating children’s movement from one program to another and generating administrative cost savings. Iowa and Pennsylvania have successfully implemented electronic referral systems between their Medicaid and CHIP systems and data from both demonstrate that effective coordination is preventing gaps in health coverage for eligible children and families.²³

States also have experience in forging public-private systems of coverage and delivery. In 2005 approximately 70 percent of all children enrolled in CHIP were in managed care plans and almost 90 percent of CHIP plans using managed care contracted with one or more plans that primarily served the commercial market.²⁴ State choices reflect state-specific needs and available insurance systems and networks. State CHIP program directors believe that such public-private partnerships are a model that can be built upon as part of health reform.

State CHIP program directors suggest that national policymakers carefully examine and consider state experience and the respective strengths and the appropriate balance in federal and state roles in administering coverage programs. State CHIP directors urge that policymakers ensure that federal and state responsibilities and means for coordination and accountability for enrollment, benefits and quality are based on such careful consideration, and are clear and feasible. Effective means for coordination between existing programs administered by states and any new insurance exchange structures will be especially critical to efficient, consumer oriented and family-centered coverage enrollment and access to care.

5. Coverage is only the first step to achieving access to care

Spurred in part by CHIP’s enactment and growth, states have been working for some time to build provider networks that focus on prevention, primary care and coordination. States have

developed delivery systems that meet state-specific needs and build on state specific resources, including private health plans and providers as well as public systems. Many states now are developing policy and financing strategies to implement “medical home” approaches in CHIP and Medicaid.

States are keenly aware of the relationship between provider reimbursement rates and access. Those that have expanded coverage through Medicaid and CHIP often have found they need to raise primary care reimbursement rates to assure access. In 2006, when Illinois implemented its AllKids program, the state also established Illinois Health Connect, a primary care case management (PCCM) program to ensure all enrolled children were connected with a primary care physician (PCP).²⁵ As an incentive, every physician enrolled as a PCP in the Illinois Health Connect program receives a nominal monthly care management fee for each participant whose care they are responsible to manage. Illinois also increased reimbursement for several types of primary and preventive care visits.

There is substantial evidence that on key measures of access to preventive and primary care, children enrolled in public coverage fare better than low-income children with private coverage.²⁶ This may result in part from Medicaid and CHIP’s extensive use of fully capitated networks or primary care case management models. Public coverage also establishes clear public accountability for meeting children’s needs. Another factor in public programs’ successful efforts in assuring access to care is the frequent inclusion of child and adolescent specific providers located in accessible and familiar settings, such as school based health clinics that offer care that is age appropriate, culturally sensitive and coordinated with other providers.²⁷

State CHIP program directors urge national policymakers to ensure adequate policy and financing supports for participation of providers needed specifically by children and youth, including those with special health care needs, as well as for adults.

Maintaining and Supporting Improvements in Children’s Coverage through the Transition to National Health Reform

Proposals being advanced in Congress include the possibility of ending CHIP when its current authorization expires September 30, 2013, or substantially changing its role from comprehensive coverage to wrap around for plans offered through insurance exchanges. These major changes have substantial implications for children’s coverage from now through 2013 as well as afterward.

1. States need continued support and incentives for fully implementing CHIPRA

As we move toward health reform, CHIP directors believe steps should be taken to ensure that states are supported as they continue implementing CHIPRA improvements. Implementation of CHIPRA provisions not only will increase enrollment and retention of eligible but uninsured children before reform is fully implemented, but can continue to provide important lessons about enrolling and retaining eligible populations generally. Right now, states are working on further

simplifying and improving enrollment and retention, and are designing express lane eligibility systems which hold promise for improving efficiency as well as enrollment.

Given the possibility for substantial changes in, if not termination of, the CHIP program, state CHIP programs need support and encouragement to continue to implement system improvements and increase enrollment. One way to encourage states to adopt the tools provided in CHIPRA would be to make the law's performance bonuses more attainable. Despite states' continuing progress in enrolling children, the enrollment increases required under CHIPRA to qualify for these bonuses are unachievable for most states, and the bonus money set aside may go largely unclaimed. Revising the enrollment levels needed to qualify for the performance bonuses would incentivize states to continue implementation of simplification efforts despite changes that may come as a result of health reform.

Proposals for federal health reform already are causing states to pause and reconsider plans for improving children's coverage. State CHIP program directors ask national policymakers to consider the implications of proposals for current efforts to improve children's coverage, and endeavor to harmonize CHIPRA and national health reform provisions. Federal financing and maintenance of effort (MOE) provisions will be critical influences on states, with the latter potentially serving as disincentives to states in continuing to expand and improve children's coverage.

2. Moving millions of children from current coverage systems to new ones requires careful planning and safeguards

State CHIP program directors are concerned that there be adequate planning and protections for maintaining coverage, access and quality of care for the 14.1 million children and pregnant women expected to be covered by CHIP during 2013 and who may be moved either to exchange plans or to Medicaid. We want to learn from rather than repeat mistakes of the past, such as those that occurred when we tried to abruptly move millions of low-income seniors and people with disabilities from Medicaid drug coverage into new Medicare Part D plans. While the move from CHIP to exchange plans which do not yet exist is of strong concern, state directors also are concerned about the many children who would move from CHIP to Medicaid. Twenty-one states currently cover children and adolescents from six to 18 with family income between 100 percent and 133 percent of the FPL in separate CHIP programs, and their coverage would switch from CHIP to Medicaid in proposals currently under consideration in Congress.²⁸ Effecting such a large change even from one public program to another will necessitate substantial administrative planning and systems change to assure continuity of coverage and adequacy of provider networks. Revisiting another major shift within public coverage for children is instructive here. An estimated 926,000 to 1.37 million fewer children were enrolled in Medicaid between 1995 and 1998 in the wake of welfare reform, which broke the program linkages between welfare and children's Medicaid coverage.²⁹

State CHIP directors strongly suggest that measures be included in national health reform to address the transition of children from CHIP (and Medicaid, if affected by reform provisions) to other forms of coverage. Options that directors and others have identified include:

- Reauthorize CHIP beyond 2013 and continue operating the program until we have a few years of experience with new structures and forms of coverage. Dismantle the program only when we know that health insurance exchanges work well for children and adolescents.
- Continue CHIP for children at and under 200% FPL while using the exchange for higher income families.
- Guarantee that children will receive comparable coverage, access and cost-sharing protections if they are moved from CHIP to new exchange plans.
- If CHIP is preserved to provide supplemental or wrap around benefits to ensure comprehensive coverage, as included in one proposal, state CHIP directors suggest that this coverage system should be piloted before current CHIP programs are dismantled. While some states are currently operating apparently successful wrap-around programs, because there is no published evidence on the effectiveness of this coverage for children, there are questions about administrative costs, communication issues, cost shifting, coordination and accountability.³⁰
- Another option for wrap around benefits is to offer them in conjunction with plans in the exchange, similar to the concept of riders to private health insurance.

CHIP has had over a decade of successful experience in covering children and adolescents, and more improvements are underway as a result of CHIPRA. State CHIP directors urge national policymakers to build on this experience and success in national health reform; to support and encourage states to continue with CHIP enrollment and improvements; and to assure that the 14 million children and pregnant women who will be enrolled in CHIP in four years continue to receive the coverage they need to obtain access to quality care that promotes healthy growth and development.

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National Academy for State Health Policy
 1233 20th Street NW, Suite 303
 Washington, DC 20036
 202-903-0101
 info@nashp.org
 www.nashp.org

¹ Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2009 Baseline: Children's Health Insurance Program" (March 2009)

² Ibid

³ Ibid and Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2009 Baseline: Medicaid" (March 2009)

⁴ The Early, Periodic Screening, Diagnosis and Treatment (EPSDT) program

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