



NIHCM

## BRIGHT FUTURES and MANAGED CARE

# Action Brief

March 1998, No. 1B

---

### *Practitioners Discuss the New Children's Health Insurance Program*

Congress recently made available approximately \$40 billion in new federal funds over a 10-year period to help states extend health insurance coverage to uninsured, low-income children.

At a December 1997 forum held in Washington, D.C., more than 70 participants, representing key stakeholders—federal and state officials, child health experts and managed care executives—discussed state plans for expanding health coverage for children, using the newly available funds, and the potential role that private sector health plans can play in these initiatives.

The forum was the first in a series entitled, "Bright Futures and Managed Care." NIHCM is conducting this series of forums with support from the Maternal and Child Health Bureau of the U.S. Health Resources and Services Administration under a cooperative agreement.

### Introduction and Summary

**Debbie Chang**, Director of Legislation for the Health Care Financing Administration (HCFA) and Co-Chair of the federal Children's Health Insurance Program Implementation Team, keynoted the forum and gave an overview of the new federal legislation.

States can use the new federal matching funds either to make more children eligible for their Medicaid program or to set up a separate health insurance program. The separate program approach has fewer federal requirements and gives states more flexibility, while the Medicaid approach builds on an existing program.

States will lose their allotment of federal funds for fiscal 1998 if they do not have a children's health insurance plan approved by the federal government by September 30. Therefore, said Ms. Chang, HCFA is "really encouraging states to get their plans in [to HCFA] as soon as possible."

**Charlie LaVallee**, Executive Director of the Western Pennsylvania Caring Foundation for Children, created by Highmark Blue Cross Blue Shield, talked about their Caring Program for Children, a public/private partnership which grew

into Pennsylvania's Children's Health Insurance Program, one of the prototypes for the new federal program. Addressing the many state officials present, Charlie emphasized the importance of "know[ing] your goals" and listening to the families. Improving children's health is one key goal, of course, but another is empowering families to "climb the ladder of self-sufficiency" and move into the mainstream. "To the families," said Charlie, "it's of paramount importance that their dignity be maintained."

Following the two keynote presentations, a panel of state officials from Georgia, Indiana and Texas talked with health plan executives about the issues they are facing as they consider the best way to cover more children in their states and what role(s) they see managed care plans playing in these new initiatives. (See the box on the next page for panel participants.) Key insights from the day were:

- Because it is easier to build on an existing program, some states are choosing to expand Medicaid, at least for the first phase of their children's health insurance programs; but other states are reluctant to expand Medicaid because it is an entitlement and because doing so raises issues of equity and personal responsibility among working poor families.
- Effective outreach will be critically important to make the new programs a success, but there is concern that funds available for outreach may not be sufficient.
- An important contribution from managed care will be to assure that children actually receive primary and preventive care. Lack of managed care plans in many rural areas is a concern.
- Measurable goals and clear expectations are critically important, both to facilitate effective partnerships between states and managed care plans and to allow policy makers to determine whether the new programs are meeting their goals.

The remainder of this *Action Brief* outlines the new program and summarizes the key issues and insights from the December forum.

*Speakers at the December 1997 Forum on Child Health and Managed Care*

**Keynote Presentations**

Ms. **Debbie Chang**, Director of Legislation, Health Care Financing Administration, and Co-Chair, HHS Children's Health Insurance Program Implementation Team

Mr. **Charlie LaVallee**, Executive Director, Western Pennsylvania Caring Foundation for Children

**Panel Discussants**

Ms. **Trish Riley**, Executive Director, National Academy for State Health Policy (also a member of Maine's child health insurance commission)

Dr. **Michael D. McKinney**, Commissioner, Texas Health and Human Services Commission

Dr. **James Ledbetter**, Executive Director, Georgia Health Policy Center

Ms. **Katie Humphreys**, Director, Children's Health Insurance Program, Office of the Governor of Indiana.

Dr. **Mark Kishel**, Executive Vice President and Chief Medical Officer, Blue Cross Blue Shield of Georgia

Mr. **John Monahan**, General Manager, Medi-Cal Programs, Blue Cross of California

Mr. **David Bick**, Vice President, Government Programs and Managed Care, Blue Cross Blue Shield of Texas.

**Program Overview**

The new program is called the "State Children's Health Insurance Program" ("S-CHIP" or, sometimes, simply "CHIP"). It is also referred to as "title XXI," because it was codified as a new title of the Social Security Act.

(This *Brief* focuses on the major issues discussed at the December forum. Additional information is available on HCFA's web site: [www.hcfa.gov](http://www.hcfa.gov).)

Beginning October 1, 1997, states can use the new federal matching funds either to make more children eligible for Medicaid or to set up a separate health insurance program for children, or they can combine the two approaches.

States that choose to expand Medicaid must provide full Medicaid benefits (including EPSDT) and follow all Medicaid rules. Under the Medicaid

approach, eligible children remain legally entitled to benefits, even if the special federal funds run out. States would have to continue coverage at the regular (lower) Medicaid matching rate.

The separate program approach does not confer an individual entitlement, has fewer federal requirements and gives states more flexibility. Nevertheless, certain federal requirements must be met. These relate primarily to the benefit package, enrollee cost sharing, and the categories of children who may be enrolled.

**Benefit Package Requirements / Service Coverage**

The benefit package under a separate S-CHIP program must be relatively comprehensive, though not as broad as under Medicaid. States have several options to choose from. They may:

1. offer a "benchmark benefits package" (see box);
2. offer coverage that includes certain "basic services" and has an aggregate actuarial value equivalent to one of the benchmark packages; or
3. seek Secretarial approval for a different benefit package.

(Florida, New York, and Pennsylvania may continue to use the benefits packages they offer under their existing child health coverage programs.)

"Benchmark" plans include:

- the standard Blue Cross Blue Shield PPO service benefit plan offered to federal employees;
- a health benefits plan that is offered and generally available to state employees in that state; and
- the HMO plan that has the largest non-Medicaid commercial enrollment in the state.

If a benchmark package is offered, its patient cost-sharing requirements will likely have to be adjusted to meet the federal cost-sharing rules.

**Cost-Sharing**

Title XXI limits the amount of premiums and other cost-sharing that may be imposed on families under S-CHIP. These limits apply regardless of whether the state uses a "benchmark" plan or a "benchmark-equivalent" plan.

- No cost-sharing may be imposed for preventive services (well-baby and well-child care, including immunizations).

- For families with incomes at or below 150% of the federal poverty level (see chart), Medicaid guidelines apply. This means premiums must be on a sliding scale by income and family size and cannot exceed \$19 per month. Other out-of-pocket payments are limited to at most a few dollars per service.
- For higher income families, premiums, deductibles, cost sharing or similar charges may be imposed on a sliding scale related to income; but, taken together, they may not exceed 5 percent of the family's annual income for all covered children.

Medicaid rules forbid imposing cost-sharing (other than premiums) on any services for children.

Federal Poverty Guidelines, 1998		
Percent of Poverty Level	Family of 3	Family of 4
100%	\$13,650	\$16,450
150%	\$20,475	\$24,675
200%	\$27,300	\$32,900

**Who Can Be Covered?**

States can target which low-income children they wish to cover by age and family income or resources. If they set up a separate program, they can also target by geography (i.e., they need not offer coverage statewide), length of state residence, other available health coverage, etc. Because a separate program is not a federal entitlement to individuals, states can limit duration of enrollment in the program and could even suspend enrollment in order to stay within available funds.

To qualify for the new federal funds a “targeted low-income child” must:

- meet the state eligibility standards;
- be under 19 years of age;
- have a family income at or below 200% of the official federal poverty level (some states may use higher standards);
- not be eligible for (pre-title-XXI) Medicaid or enrolled in any other insurance (except state-only subsidized coverage); and
- not be eligible for coverage as a dependent under a state-sponsored public employee health

benefits plan, even if they are not current enrolled in that plan (unless the state elects a Medicaid expansion).

States can also claim the higher federal matching rate if they elect to accelerate Medicaid coverage of older teenagers in poor families. (Mandatory Medicaid coverage of poor teenagers is currently being phased in by age.)

States cannot make their Medicaid eligibility rules tighter than they were on June 1, 1997. If they do, they cannot access the new federal funds at the higher matching rate.

An open issue is whether children covered by charitable programs such as Blue Cross Blue Shield Caring Programs will be considered to be “insured,” and therefore not eligible to enroll in the new program, when there is no state contribution toward the coverage. Generally, a child enrolled in a true insurance plan will not be eligible for the new program, even if their current insurance does not cover primary and preventive care.

**State Plans Must Be Submitted Soon**

States will lose their allotment of federal title XXI funds for fiscal 1998 if they do not have a children's health insurance plan approved by September 30, 1998, the end of the fiscal year.

Although the law requires HCFA to act on a state's plan within 90 calendar days after it is submitted (and although HCFA is making every effort to expedite its review), the process can take longer if HCFA finds that additional information is needed from the state. Therefore, states are advised to submit their plans well in advance of July 1, 1998.

So long as an approved state plan is in place by the end of the fiscal year, the state is permitted to carry over any unused portion of its allotment. Unused allotments can be used in either of the next two (federal) fiscal years. Moreover, a state plan can be amended at any time.

For these reasons, some states—Alabama is one early example—are submitting plans that propose very modest Medicaid expansions, such as covering older teenagers up to the poverty level. Doing so preserves their federal allotment for 1998 while allowing them more time to plan a broader program.

“We are really encouraging states to get their plans in as soon as possible and to submit ‘miniplans’ [if necessary],” said **Ms. Chang**, “They can always submit an amendment later.”

## Comparing Approaches for Covering Uninsured Children

Medicaid Expansion	Separate Program
<p>Extensive, detailed federal requirements</p> <p>Design and implementation relatively straightforward</p> <p>Very comprehensive benefits due to federal EPSDT mandates</p> <p>Individual entitlement</p> <p>Hard to avoid "welfare stigma"</p> <p>Risk of budget overrun</p> <p>Federal match continues after title XXI allotment is used up</p> <p>Contracts only with HMO-style closed-panel private health plans (but new law fixes several complaints plans have had)</p>	<p>Substantial state flexibility</p> <p>Room for creativity in design and implementation</p> <p>Significant state flexibility. Federal requirements based on typical private-sector plans.</p> <p>Not an individual entitlement</p> <p>Easier to avoid "welfare stigma"</p> <p>Greater budget controllability</p> <p>No additional federal funds once title XXI allotment is used up</p> <p>Very few requirements about what kinds of plans states can contract with (but cost-sharing rules will likely restrict PPO or POS designs)</p>

### Issues Discussed

#### *Medicaid Expansion or Separate Program?*

Although designing a children's health insurance program requires states to address a wide variety of important issues, a threshold question is whether to expand Medicaid or to offer an insurance product through a new, separate program. The arguments on each side are summarized in the accompanying box. Participants expanded on many of these issues during the panel discussion.

In general, children's advocacy organizations are strongly advocating expansion of Medicaid, while some legislators are reluctant to expand an entitlement program that has often been the fastest growing item in state budgets. "When you say 'entitlement,'" said **Dr. McKinney of Texas**, "you lose about half the legislature immediately." Severe reimbursement cuts in some states, driven by budgetary pressures, have also made Medicaid a program providers "love to hate."

In many states, the discussion about subsidizing health insurance for children has raised philosophical issues that relate to the entitlement question but are in some ways broader.

#### *Concerns About Equity And Personal Responsibility Among Working Poor Families.*

Panelists noted that many working people, including state employees and legislators in the states represented on the panel, have incomes between 150 and 200 percent of poverty. Many such families pay out of their own pockets to give

their children health insurance (usually as part of an employer's plan). Legislators in these states are therefore very reluctant to expand Medicaid, which is essentially free to participants, above 150% of poverty. "If I have to pay for my kids, they should have to pay," is how one participant characterized the prevailing attitude.

**Dr. McKinney** summed up the issue succinctly: "Let me put that in perspective. ... A hundred and fifty percent of poverty is greater than \$24,000 a year for a family of four. ... That's higher than the average teacher's salary in the State of Texas. That's higher than the salary for a whole lot of people who work every day and feel responsible for buying insurance for their kids, and they have a hard time understanding why it is their responsibility to pay taxes so that somebody that makes more than them doesn't have to cover their kids. I'm telling you that that is a serious, serious issue."

Other state panelists agreed. While considerations of equity and personal responsibility may make some states reluctant to expand Medicaid, however, election-year politics is making governors and legislators eager to move quickly and make changes later if needed. And this leads them to look at starting with Medicaid, both because a Medicaid expansion can be done more quickly and because the Medicaid benefit package is well suited to poor and near-poor children who have a greater tendency toward disability and chronic illness.

One approach states could take, noted **Ms. Riley**, would be to create a separate, non-entitlement program that is essentially a clone of Medicaid, except for premium and cost-sharing rules. By



the children of these families, states and care providers are going to have to think creatively, not just about outreach and application processes, but also about making services available when and where children can access them. "If all we do with this money is insure kids and go home and pound our chests and say, 'Boy, haven't we done a good thing!' but they still can't get into the same old broken system, we haven't done a darn thing," said Ms. Humphreys.

**Barbara Berger** noted that utilization rates rose in the Ohio Caring Program after the Program focused on asking families to choose a primary care physician and make an initial appointment within 60 days after enrollment. **Charlie LaVallee** added that simply asking for the name of the child's physician on the application form has helped to get children into care more quickly.

Both aspects of outreach—getting children enrolled and getting them into care—will be discussed at the next forum in this series in March 1998.

### *Is there enough money for outreach?*

States can use title XXI funds to identify and enroll eligible children, as well as for routine administrative costs of their S-CHIP programs, but there is a potentially significant limitation. The total of the amounts spent for administration, outreach, direct services to children and "other child health assistance" cannot exceed 10 percent of total state expenditures under the program.

This limitation creates two main problems. First, because the limitation is a percentage of state expenditures under the program, rather than a percentage of the state's allotment, states may not be able to recover administrative costs related to program start-up, at least not right away. (Administrative and outreach costs that exceed the limit in any given fiscal quarter can be claimed in later quarters, if there is room.)

Second, as **Trish Riley** pointed out, "10 percent is not a lot of money." Administrative costs under Medicaid have traditionally averaged 3 to 5 percent of total program costs. As states shift from simply paying claims to purchasing health care on behalf of enrollees, particularly those who are disabled or have special needs, they are finding that it costs more than they anticipated to establish good, clear contracting expectations and monitor plan performance. As basic administrative costs rise above 5 percent, the funds available for outreach will be squeezed. This suggests, said Ms. Riley, that it is "likely states will ask the plans to take onto themselves activities in outreach." (The 10 percent limitation applies to state expenditures. Amounts spent by health plans for administration or outreach are not subject to the limit.)

**Dr. McKinney** noted that his "biggest administrative headache will be managing the contract" and that Texas would be looking for help with outreach. Under Medicaid, however, the trend has been toward greater state restrictions on a health plan's ability to directly contact recipients who are not already enrolled in that plan. Indeed, the same Balanced Budget Act of 1997 that created the S-CHIP program also imposed new marketing restrictions on health plans that contract with Medicaid, including a requirement for prior state approval of all marketing materials and a complete prohibition on "cold calls," whether door-to-door or by telephone. (There are no specific federal marketing prohibitions with respect to non-Medicaid programs under title XXI.)

### *A Role for Managed Care*

"Managed care [has] got to play a role," said **Dr. McKinney of Texas**, who emphasized that he wants to use managed care principles, "not managed finance. ... [T]aking care of patients, doing preventive care, doing primary care, doing early treatment—that's what managed care I think can contribute."

A problem is that many areas of Texas have no managed care at all. The same holds true for Georgia, where many managed care plans serve Atlanta and the other urban centers, but few or none serve rural areas. **Dr. Ledbetter** questioned whether the S-CHIP program would be large enough to stimulate the development of managed care in the more rural areas. Georgia's Medicaid program has been having a difficult time encouraging plans to participate, due to low rates. The lack of managed care alternatives in rural Georgia suggests that the state would have to establish and run a different program (in effect) in rural counties if it wanted to contract with managed care plans in urban counties.

"At what cost managed care?" asked **Dr. Ledbetter**. Children are a relatively inexpensive population, especially those aged 6 through 18. It may be cheaper for the state to run a fee-for-service program for that population than to enroll them in managed care.

Doing so would not encourage the growth of managed care, of course, nor would it necessarily do much to assure that enrollees actually received primary and preventive care. It would be much like traditional Medicaid, which **Dr. McKinney** characterized as just giving people a hunting license and saying, "Good luck, find somebody that will treat you."

**Dr. Kishel of Georgia BCBS** noted that, if a fee-for-service approach is used, it may be difficult to find enough providers to care for all the newly

enrolled children. There is a limit to how many patients traditional Medicaid providers can handle.

**David Bick of Texas BCBS** noted that managed care organizations that contract with Medicaid already have in place the infrastructure necessary to serve needy children. Quality guidelines are in their contracts, access issues have been addressed (following federal and state regulations), and networks are in place to guarantee access. Since the necessary administrative systems have already been developed and are in place, a new category of enrollees (the CHIP children) can be added very economically.

**Charlie LaVallee** emphasized the importance of effective partnerships: "At the heart of partnerships is what we expect of each other"—federal government and state government, state government and contractors. Partnerships work well only when all partners benefit from participating. If a state wants to gain the benefits of private health coverage for its children, it will have to structure its program in a way that encourages private health plans to participate and to seek out the children who need the most help. If it does not do so, the program will not reach its full potential.

In Pennsylvania's CHIP program, for example, the low bidder sets the price, and other plans can participate at the same price. Because there is no risk adjustment, however, if one plan does more effective outreach to children with special health care needs, that plan is in trouble. The lack of risk adjustment may discourage plans from trying to find the children who need help the most.

**Dr. McKinney** had a different perspective on the partnership question. He said, "I want a contractor, I want a vendor, I don't want a partner." But he agreed about the importance of having clear expectations—"roles and rules," he called them.

### ***A Benefit Package That Works for Children***

**Charlie LaVallee** asked, rhetorically, why would we offer children a benefit package designed for adults? Doesn't it make sense to define the benefits around what children need?

**David Bick** emphasized the importance of getting children into EPSDT, "because that's going to guarantee that [children] get immunized and seen in the office [rather than in an emergency room]. That is true preventive care in the nature of an HMO and an MCO [managed care organization] in this environment. It makes sense to do that."

Prior to the enactment of title XXI, Georgia had applied for and been selected as a "Healthy Kids" replication state by the Robert Wood Johnson Foundation, so they initially looked at the benefit package used by Florida's "Healthy Kids" Program, according to **Jim Ledbetter**. Now, he

said, they are considering starting with the benefit package used by Georgia's Blue Cross Blue Shield HMO, which is the largest in the state, and augmenting that package with dental, vision and better mental health benefits.

One of the approaches Georgia is considering to keep down the cost of its benefit package is a formal linkage with all existing services. "If a child is severely physically disabled, we believe that child would be [better] served in the Children's Medical Services Program for those outlier services," said **Dr. Ledbetter**. "If the child is severely emotionally disturbed, the child will be served in the state's severely emotionally disturbed program." The goal is to make sure every child gets the services she or he needs while keeping the program's premium low so they can serve as many children as possible.

### ***Obtaining the Necessary Appropriations***

Although most states are in better fiscal shape now than they have been in many years, there is still strong competition for available budget dollars. And, in some states, procedural matters may make it difficult to obtain legislative authorization in time to qualify for title XXI funds in fiscal 1998.

Texas, for example, is on a biennial budget that began September 1, 1997. Because that budget was developed before title XXI was enacted, it did not include any funds for children's health insurance. There is a surplus in the state treasury, but it is unappropriated and therefore cannot be spent. The legislature is not scheduled to hold a regular session in 1998, so a special session would be required in order to obtain the necessary appropriation. But holding a special session of the legislature costs about \$500,000. Faced with this situation, **Dr. McKinney** expressed frustration about the tight federal deadlines and the statutory restrictions on what funds are matchable (the same restrictions as under Medicaid).

### ***Reporting Requirements and Performance Measures***

**Dr. Mark Kishel of Georgia BCBS** noted the importance of having well-defined, measurable goals so that 3 years from now we will be able to determine whether the new program has been effective in making children healthier.

**Ms. Chang** pointed out that title XXI specifies strategic objectives and performance measures in a number of areas and requires each state to implement some kind of performance or quality measures. Though the law is very general, HCFA has developed a state plan "template" or model application to guide states through all the significant requirements. The template includes a draft set of reporting requirements, which allow

states to use HEDIS or other measures of their choice. States have discretion in this area but must clearly describe in their state plan what they intend to use.

With respect to quality assurance, states may choose to require review by an external organization, as many now do under Medicaid, or they may use other approaches. Title XXI requires a quality assurance mechanism but does not specify what it must be.

**Dr. McKinney** noted that his program does not "write contracts without goals or performance measures." The goal is healthy children, but the contract will contain proxy measures.

### **Crowd-Out?**

"Crowd-out" occurs when publicly subsidized health coverage replaces existing private coverage, especially employer-provided coverage. There are two concerns: First, families who currently have to pay some amount out of their own pocket to cover their children under private insurance might drop that coverage if the new public coverage is less expensive for them. Second, knowing public coverage is available, employers with many low-wage workers might charge them more for dependent coverage or stop offering it entirely.

The "crowd-out" phenomenon has been studied in the context of the Medicaid expansions for children and pregnant women that took place in the early 1990s. Different studies have reached different conclusions about the extent to which "crowd-out" occurred. Title XXI requires states to describe how their coverage does not substitute for current private group coverage. A frequently used approach is to require applicants to have been without any insurance for a period of several months before being allowed to enroll in publicly subsidized coverage.

Under its Healthy Families Program, for example, California plans to deny coverage to children who have had health insurance in the past 3 months. In addition, the California law prohibits agents from referring dependents who are already covered and makes it an unfair labor practice for employers to refer dependents.

Panelists differed in their assessments as to how significant the crowd-out problem is likely to be. **David Bick of Texas BCBS** believes it will give an employers another reason to drop or cut back on health insurance coverage.

**Ms. Riley** noted that Rhode Island, which has expanded Medicaid eligibility up to 250% of the poverty level, does not worry about possible crowd-out. If employers do not pay for dependent coverage, the state reasons, they will have more

money available to hire new workers or will pay more in state taxes.

**Jim Ledbetter** said that some Georgia employers have asked to be "crowded-in," and the state is considering whether to provide support for employer-provided dependent coverage. California plans to offer credits to help families buy dependent coverage through their employers, where it is offered.

**Charlie LaVallee** noted that, in Pennsylvania, Caring Program coverage is often a stepping stone to private coverage. About 15% of their enrolled children move out of the program into employment-based coverage in a 12-month period. The average length of stay in the program is only 18 months. "A lot of kids ... leave our program every year, and that's very important," he said. "That's about enabling them to move to self-sufficiency."

## **Meeting the Challenge of Children's Health**

The final question is: how do we move forward to get these new state programs started so that children can get covered and get into care?

**Rep. Charlie Brown of Indiana** emphasized the importance of the political aspect and urged participants to speak to their legislators.

**Charlie LaVallee** urged participants to avoid the temptation to look for a "magic wand" or a "cookie-cutter" approach and to think strategically about their state's unique strengths and weaknesses and what is politically feasible.

Rather than try to do everything all at once, he said, the important thing is to start, to put together a reasonable program and begin, even if it does not meet every need at the outset. Once the program gains some success, it can keep building, as happened in Pennsylvania.

Noting that with every great opportunity comes a great responsibility, Mr. LaVallee urged the participants to begin. "If we are going to succeed at S-CHIP," he said, "we have to learn how to succeed now. ... We can't afford, and the children can't afford, to wait another 30 years."

This *Brief* was prepared with support from the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, under cooperative agreement No. MCU-116091. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Maternal and Child Health Bureau. The *Brief* was written by Edward Neuschler, NIHCM's Senior Director of Policy and Research.