STATE HEALTH POLICY BRIEFING

APRIL 2008

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

Covering All Children: Issues and Experience in State Policy Development

MAUREEN HENSLEY-QUINN AND CATHERINE HESS, NASHP
BARBARA LADON AND SHARON STEADMAN, ARPEGIOHEALTH

Executive Summary

This paper is based primarily on interviews conducted in early summer of 2007 with senior administrators from eight state Medicaid or State Children's Health Insurance Programs (SCHIP) in California, Illinois, Louisiana, Massachusetts, New York, Oregon, Pennsylvania, and Washington. These states have been among those in the vanguard of pursuing the goal of covering all children and youth.

STATE APPROACHES

This report briefly describes some of the most common strategies states are using to achieve universal children's coverage, including expanding public programs and creating other opportunities for families with uninsured children, such as through buy-in programs and premium assistance programs. The interviews reinforced some general conclusions about state approaches, such as states need to work with what they have and build their programs from the models they have developed over the years. A clear message from state informants was each state is different and will develop programs that reflect the culture of the state, the history of programs around children and children's health care, the political configuration of the state, and the leadership in place at the time. State informants consistently cautioned against attempting to import one state's program into another state environment without significant analysis and detailed state-to-state discussions about the approach.

One of the common general themes in regard to addressing issues successfully was the importance of having a strong governor to champion the initiative and work closely with the state legislature.

POLICY ISSUES AND RESPONSES

There also were some consistent policy issues that arose in all states, although the specific nature of the issues varied from state to state. Concern with reaching children already eligible but not enrolled in public coverage was reported as being crucial to state discussions of covering children at higher income levels. Where it occurred, opposition to state expansion proposals often rested on this concern. This concern was later echoed in national SCHIP reauthorization discussions in late 2007. Using experience and flexibility, state program officials were able to offer recommendations to garner the support of state policy makers. Our informants shared some state strategies focused on reaching and enrolling eligible children. These improvements included simple messaging about all children being covered and program re-branding. Some states also made operational

NATIONAL ACADEMY *for* STATE HEALTH POLICY

State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

"Covering All Children: Issues and Experience in State Policy Development," State Health Policy Briefing, Vol. 2, Issue 7 (Portland, ME: National Academy for State Health Policy) April 2008.

improvements to better reach currently eligible children within their initiatives to cover all children.

Also foreshadowing some concerns in the national SCHIP debate, states found as income levels for eligibility in public programs increased and new options for coverage were created, crowd-out became more of an issue for some state legislatures and with the Centers for Medicare and Medicaid Services (CMS). States at the forefront of covering all children used both traditional and newer approaches to minimize crowd-out. Strategies included establishing breaks in coverage and new methods of data collection, monitoring, and evaluation.

These leading states varied in the extent to which coverage for immigrant children was addressed. This is an area where state politics and history were reported to be very important. California, Illinois, and Washington had new or proposed coverage programs in which all children were included, regardless of immigration status. Pennsylvania did not offer coverage to undocumented children prior to its expanded coverage initiative and did not attempt to change the state's policy for fear the issue would stall the progress of its entire proposal to cover all childen. Previously, Massachusetts and New York had established state health care programs that provided coverage to undocumented children, so it was not a major issue as these states developed their most recent coverage initiatives.

A somewhat less contentious issue that emerged in state consideration of initiatives to cover all children was the fear some legislators felt about possibly becoming a magnet state for uninsured children in surrounding areas. States also grappled to a lesser extent with cost sharing, health insurance affordability, and income disregards.

All states interviewed in mid-2007 agreed that the timing was right for moving to cover more children. Since states are so different in their current program configurations and political goals, informants urged states considering universal health coverage for children to look to other states with similar backgrounds and history and assess specific policies that have worked in those states.

Background and Context

This paper was written in response to suggestions from states that the National Academy for State Health Policy (NASHP) help identify and address policy issues that arise when state executive branch agencies propose to move toward covering all children. The focus of the research for the paper was on identifying key federal and state policy challenges that state executive branch agencies have faced in attempting to obtain state authority or federal approval for new policies or programs that move toward universal children's coverage. The paper is based primarily on semi-structured interviews with senior administrators from eight state Medicaid or State Children's Health Insurance Programs (SCHIP) in California, Illinois, Louisiana, Massachusetts, New York, Oregon, Pennsylvania, and Washington. The interviews were conducted in May and June 2007. NASHP has been tracking and documenting these and other states' efforts and has provided states and other interested stakeholders with ongoing information through the web page "Covering all Kids, All the Time" on www.nashp.org.

The states interviewed are at the forefront of strategies and programs for increasing health coverage for children. In mid-2007, these states were at varying stages of the process of developing, proposing, approving, and implementing new policies and programs:

- Some had active discussions underway in state legislatures when the interview was conducted (California, Louisiana, Oregon);
- Two had passed legislation within a few months prior to the interview (New York, Washington);
- Three were implementing new policies and programs (Illinois, Massachusetts, and Pennsylvania).

This paper is not intended to cover all operational issues that states face in implementing expansions. It is focused on policy challenges encountered with state policy makers and with the Centers for Medicare & Medicaid Services (CMS) as state program officials advanced proposals to move toward universal children's coverage.

The interviews reinforced some general conclusions about state children's coverage approaches, such as states need to work with what they have and grow their programs from the models they have developed over the years. A clear message from state informants was that each state is different and will develop programs that reflect the culture of the state, the history of programs around children and children's health care, the political configuration of the state

About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government.

NASHP resources available at: www.nashp.org

Portland, Maine Office:
10 Free Street, 2nd Floor, Portland ME 04101 Phone: (207) 874-6524

Washington, D.C. Office:
1233 20th St., NW, Suite 303, Washington, DC 20036 Phone: (202) 903-0101

at the time, and the leadership in place. The state informants cautioned consistently against attempting to import one state's program into another state environment without significant analysis and detailed state-to-state discussions. Nevertheless, the interviews yielded themes that were heard rather consistently across states at the forefront of increasing coverage for children.

STATE MOMENTUM TO COVER ALL CHILDREN

The movement to provide health care coverage for all children has been growing over the last seven to ten years and has intensified recently. Through our tracking efforts, NASHP has identified approximately 25 states that are considering, developing, or implementing initiatives aimed at covering all uninsured children. Of those states, NASHP considers 15 to be "covering all kids states" based on our definition. The definition requires that a state's governor has an expressed goal to cover all children and that the state has a plan to work towards reaching that goal. More information can be found on our Covering All Kids, All the Time Web page on www.nashp.org.

Most of the states we interviewed have a history of working aggressively toward the goal of universal coverage for children. For example, Massachusetts' efforts developed over the past ten years. The state's recent comprehensive reform is not focused strongly on children because programs aimed at providing coverage for most children had been developed previously and were already in place. In California, the county-level Children's Health Initiative (CHI) has been influential within and outside of the state. Studies of CHIs have demonstrated the positive effect of providing health care coverage on children's health status and on improving access to other public programs. California now has 24 county programs that cover approximately 100,000 children not eligible currently for Medicaid or SCHIP. The county-based children's coverage grew in California as a result of strong public support and foundation and county-based funding. Since 2001, enrollment in CHI programs has grown dramatically, with a significant related increase in the Medi-Cal and Healthy Families programs, the California Medicaid and SCHIP programs.[1]

IMPACT OF SCHIP REAUTHORIZATION AND OTHER FEDERAL POLICY CHANGES

The then-pending reauthorization of SCHIP was discussed with key informants in the early summer 2007 interviews. At that time, none reported that their governor or legislature was reluctant to enact new child coverage legislation because of the unknown nature of the SCHIP program after reauthorization. States at the forefront of "Covering all Children" had to make decisions about program structure and financing without knowing the effect that reauthorization would have on their efforts to expand health coverage for children. States made decisions based on 2007 SCHIP allocations and program requirements. However, many did express concern that if there were not sufficient funds, or if eligibility rules changed dramatically in the future, it would make it more difficult for states to continue increasing coverage to reach more children.

Given that the interviews were done in May and June 2007, the conversations did not reflect later developments in reauthorization or other federal policy issues, including the August 17, 2007, CMS letter to state officials.[2] This letter included new requirements related to crowd-out for states that have or were planning expansion of SCHIP income eligibility limits above 250 percent of the federal poverty level (FPL).

Many of the issues raised at state levels as reported by our state informants in mid-summer of 2007 were echoed in the national SCHIP reauthorization debate. These issues include an interest in enrolling children already eligible but uninsured, and a concern about crowd-out, or substitution of public coverage for private coverage. As this paper describes, state program officials were able to devise responses to these concerns that secured the support of state policy makers.

While SCHIP has not yet been reauthorized and the impact of CMS's August 17, 2007 letter on the states aiming to cover all children is still unknown, subsequent NASHP communications with the states interviewed for this paper and others suggest they are continuing to move toward universal children's coverage. However, as a result of these recent federal policy developments, states aiming to cover all children are experiencing additional challenges not described within this paper. (Note: NASHP has released recently a separate brief on the issues in regard to the August 17 letter, *The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs*, available at www.nashp.org/Files/shpbriefing_cmsdirective.pdf.)

State Approaches to Covering All Children

States moving to cover all children approached the goal in many different ways, but using a similar set of tools. As determined from previous NASHP study of these states, and confirmed in the interviews, all states used some blending

of the components described below – but each configuration was different. The discussion of the states' strategies appears in the next section of this paper. However, several broad elements of initiatives were referenced consistently throughout the interviews with states. Although these elements are relevant to other states aiming to cover more children, it is important to note that informants consistently stressed the uniqueness of their state and encouraged other states pursuing the goal of universal coverage for children to build on their own existing programs and consider the distinct political culture of their state. Even when using similar tools, the states interviewed developed initiatives and program designs which varied based on the following:

- **The starting point**. States had different configurations of Medicaid and SCHIP as a result of the flexibility they have for optional design features and how the two programs evolved over the past decade.
- **The governor's vision**. Governors had different views of how to cover all children.
- **The legislative process**. Plans changed over time. In some states, the governor's plan passed as submitted. More often, changes were made as plans went through the legislative process. State administrators reported that these changes did not, for the most part, substantially alter the state's ability to achieve the overall goal of covering all children. Areas that were modified most commonly were eligibility levels for SCHIP, financing, treatment of immigrant children, and the rules regarding crowd-out.

GOVERNOR'S LEADERSHIP

A number of themes about state approaches echoed the conclusions of prior NASHP reports,[3] including the importance of having a strong governor to champion the initiative and work closely with the legislature. The key informants for this paper reported that their governors saw covering all children as a highly popular proposal with the potential for relatively quick success. Most state informants reported that governors viewed health coverage for children as a first but less controversial step toward universal coverage. Governors from both Illinois and Pennsylvania considered children's coverage a top priority, and once their states began implementing initiatives aimed at covering all children, they looked for ways to advance a similar goal for adults. (To date, legislation to cover all adults in both states has been unsuccessful.)

Not unexpectedly, it was easier for governors in the states interviewed to reach consensus when the legislative houses reflected their own political party. Democratic legislatures were reported to embrace the children's coverage proposals quickly; Republican legislatures were willing to support coverage for children, but had significantly more concern about crowd-out and providing government support to families at higher income levels. In California, the Republican legislature also had significant concerns about covering undocumented children, which were included in proposals at the time of the interviews. Oregon reported that it was not clear whether the state would obtain the majority needed in the legislature to pass funding for the governor's plan to cover all children. Oregon's funding proposal was a tobacco tax, which required a "mega" majority that was unlikely to be achievable (at the time of the survey).[4] The legislative concerns are addressed in the specific issue discussions found in the "Policy Issues and State Experiences in Addressing Them" section of this paper.

BUILDING ON THE BASES: MEDICAID AND SCHIP EXPANSION

Most states interviewed had made considerable progress by using Medicaid funding for children's coverage, although many of them also could identify additional potential Medicaid expansions that were possible. Some respondents mentioned the opportunity for other states to utilize Medicaid to the fullest extent possible – even if that was not a preferred strategy in their own states. Medicaid expansion was an area in which political concerns were seen to influence the selection of coverage strategies. Some state legislatures might not be supportive of expanding Medicaid even if it is cost effective to do so.

Some respondents commented on the positive reputation of the SCHIP program, and the desire to build on it as part of children's health coverage expansion. The enhanced SCHIP federal match and the program's flexibility made expanding SCHIP an attractive option. All states interviewed included a SCHIP expansion to higher income levels as part of their approach to covering all children. Illinois' approach was unique in utilizing federal SCHIP funds to subsidize coverage for children with family incomes only up to 200 percent of FPL. All of the other states interviewed have or sought to increase SCHIP eligibility to utilize federal funds for children in families with incomes up to 300 percent of FPL or greater within their initiatives to cover all children. States' flexibility to set their eligibility levels, however, has now been called into question by the CMS August 17, 2007 letter.

CREATING OPTIONS FOR EMPLOYERS AND FAMILIES: PREMIUM ASSISTANCE AND BUY-IN PROGRAMS

Premium assistance and buy-in programs are both options that states are using to make coverage more available to children, particularly those uninsured children from working families with modest incomes who do not qualify for public coverage. Through a premium assistance program, the state provides financial assistance to help pay the premiums for employer-sponsored health insurance when it is offered to employees. Illinois, Massachusetts, Oregon, and Washington have incorporated a premium assistance component into their efforts to cover all children. By helping families with the affordability of the premiums for their employer-sponsored coverage, parents as well as children can benefit from the program.

Buy-in programs give families the option to purchase public health care coverage for their children when they otherwise would not qualify. Through buy-in programs, states allow families to buy-in to the public program at the state negotiated group rate both with and without premium subsidies. Even at full cost, the public health coverage is less expensive than similar coverage available through the private market. Most of the states interviewed have or are considering incorporating a buy-in option for families with incomes above the state's SCHIP eligibility limit. Governors see buy-in programs as a way to support the uninsured who are not eligible for fully subsidized public health care coverage. New York, Illinois, Massachusetts, Pennsylvania, and Washington have all either enacted legislation or implemented buy-in programs for children. At the time of our interviews, discussions were occurring within California, Louisiana, and Oregon regarding the enactment of buy-in programs for children.

STATE-ONLY FUNDED PROGRAMS

Several of the states in the forefront of covering all children have programs funded using only state dollars that interface with Medicaid and SCHIP to cover low-income children not otherwise eligible for other programs. These state-only programs tended to exist prior to recent reforms, and continue to play an important role in states' efforts to cover all children. Establishing a program funded solely with state dollars allows the state to determine the program details without having to consider federal requirements that dictate how and for whom federal funds can be utilized. States determine the program's eligibility limits, benefit packages, and cost-sharing requirements, as they are responsible for the full cost of the program.

Illinois, Massachusetts, New York, Oregon, and Washington all created programs using state-only funding to cover children ineligible for the state's SCHIP and Medicaid programs, which are funded jointly using state and federal dollars. These state-funded programs generally provide health coverage to children who are ineligible for SCHIP and Medicaid due to their immigration status. For example, the Children's Medical Security Plan (CMSP) in Massachusetts was implemented to provide coverage for uninsured children regardless of immigration status; it was enacted prior to the state's most recent health reform. The "Coverage for Immigrant Children" section of this paper provides more information on how the states interviewed handled coverage for undocumented children within their reform efforts.

FOCUSING ON CHILDREN WITHIN BROADER REFORM PLANS

In some states, children's health coverage reforms are intertwined with broader comprehensive reform. California, which has a history of strong county-based children's health coverage initiatives, was trying to move to coverage for all children as part of efforts to cover all Californians. Other states built on the success of their children's health coverage initiatives to develop comprehensive health care reforms statewide. Governors in both Illinois and Pennsylvania sought to build on their states' initiatives to cover all children, although these efforts were not successful in 2008.

Policy Issues and State Experience in Addressing Them

States reported approaching their goal by using similar tools, and also identified similar policy issues that needed to be addressed when moving toward covering all children. As mentioned previously, each state adapted coverage strategies to fit its political culture and build upon its existing programs.

PRIORITIZING ENROLLMENT OF PREVIOUSLY ELIGIBLE CHILDREN

Making coverage more accessible to children who are eligible but not enrolled was mentioned consistently in interviews as a key issue in state deliberations around increasing coverage options. State informants reported that legislatures and advocacy groups both were interested in a state commitment to focus on enrolling eligible but uninsured children. In response to this concern, state program admin-

istrators stressed that the funding packages within state reform proposals were developed to carry out this objective. From their own and other states' experiences, state administrators have found that increases in income eligibility levels tended to bring in already eligible children, especially when coupled with aggressive marketing and outreach.

State administrators reported that they expected coverage reform efforts to result in a disproportionate increase in enrollment among the uninsured who had been eligible previously rather than other populations because:

- Children at lower incomes are disproportionately more uninsured;
- The message of "covering all children" would resonate with lower income working families who did not enroll their children previously because they believed they were not eligible, and, therefore, did not apply.

State informants also cited anecdotal evidence from Santa Clara County, California, and Illinois where covering all children initiatives had resulted in higher enrollment for children with family incomes below 200 percent of FPL. According to officials in Illinois, approximately 70 percent of the 166,000 newly enrolled children in the state's All Kids program had been uninsured, but eligible, for the state's existing SCHIP and Medicaid programs that provide coverage to children with family incomes up to 200 percent of FPL.

New York reported that an estimated 93 percent of the funding required for the state's proposed SCHIP eligibility increase from 250 percent to 400 percent FPL would be used to enroll and provide coverage for uninsured children with incomes below 250 percent FPL, or those who were eligible prior to the increase. Other states reported slightly lower percentages of new funding devoted to coverage of previously eligible children, but still expected the greater share of new dollars intended for coverage of children to be used on those already eligible but unenrolled.

National estimates for children's coverage expansion suggest a similar expectation for reaching previously eligible children with dollars budgeted for expansion. House Resolution 976 (H. R. 976), the Children's Health Insurance Program Reauthorization Act of 2007 included bipartisan agreement to allow states to increase their program's income eligibility limit to 300 percent of FPL. The Congressional Budget Office (CBO) estimated that 3.2 million of the 3.8 million newly covered children (84 percent) would be eligible already for SCHIP coverage using current eligibility limits.[5,6]

According to our informants, since this was an important issue identified within state legislatures as the bills were debated, states focused on several ways to prioritize the enrollment of children previously eligible. One strategy was to focus on further streamlining enrollment and renewal processes. Another was to make a commitment to use marketing and outreach to target very low income populations. Funding was provided by legislatures for marketing, outreach, and the administrative costs of changing systems to accommodate streamlining.

Strategies for streamlining

As part of their children's health reform initiatives, the states interviewed relied on the following strategies to streamline Medicaid and SCHIP enrollment and retention, utilizing them to varying degrees depending on program design:

- **Continuous eligibility for Medicaid and SCHIP**. Twelve-month continuous eligibility was the approach mentioned most frequently for streamlining a state's eligibility processes. One state that had incorporated 12-month continuous eligibility into its SCHIP program decided to do so within its Medicaid program as well. Other states, including Oregon, mentioned they were extending their program's continuous eligibility to the full 12 months. Massachusetts reported that it was maintaining 12-month continuous eligibility; previously, the state had reduced its continuous eligibility to 6 months, which resulted in enrollment declines. New York was adding 12-month continuous eligibility for parents with the belief that parents are more likely to enroll (and renew) coverage for their children when the entire family is covered.
- **Simplified application process**. Shorter and on-line applications were mentioned consistently by informants, along with on-line applications without a signature requirement, as tools that simplified the enrollment process. The state of Washington utilized both a two-page application and an on-line application. New York and Oregon also reported including application assistance and simplification in their children's coverage proposals.
- **Administrative renewals**. To the extent possible, states were moving to an administrative renewal approach, which allows them to use information from other programs (especially Food Stamps, which already collects income and immigration information), to determine continuing eligibility. Advocacy groups were supporting approaches to minimize duplicate collection of information among public programs.
- **One door approach**. States were maximizing processes that allow families to enroll their children at multiple sites, encouraging them to enroll wherever they

touch the system. This is consistent with the idea of simplifying processes and letting families know that health insurance is available for all children.

Marketing and messaging

The state informants we talked with spoke of the importance of developing a simple message declaring that health insurance is available for all children. States used different messaging methods, such as re-branding the new coverage program or developing a theme that emphasizes the program is for all children. Illinois branded its coverage initiative 'All Kids.' Illinois decided to use one name although the initiative combines several programs (i.e. Medicaid, SCHIP, a buy-in program) to keep the message simple for the public. Pennsylvania's message is "Pennsylvania's Children's Health Insurance Program: We Cover All Kids." The state informants explained that developing a new brand or theme helps to distinguish the initiative from the state's previous public health coverage program, which may be associated with a certain stigma or perception that includes income limits.

Informants consistently referred to Santa Clara County's Children's Health Initiative in California[7] and Illinois' All Kids because of the impact their simple "all kids are covered" message has had in reaching uninsured children. Mirroring the efforts of those programs, states are starting to consider messaging strategies when creating new program images, when developing new applications, and when creating new training for staff to build public awareness of these programs. In addition to simplifying the program's message, states also reported that there was a commitment to substantive change – a real streamlining of processes – and not just a new name.

Outreach and enrollment

As mentioned, informants consistently noted that state legislatures highlighted the importance of outreach targeted particularly toward previously eligible but uninsured children. State legislators were, for the most part, willing to pass legislation that increased SCHIP income eligibility limits and create more affordable coverage opportunities for all children, because they believed these strategies also would help reach the most needy low-income children. Language directing outreach efforts toward low-income uninsured children was included in the enacting legislation in some states.

States we interviewed were considering a variety of strategies to reach and enroll eligible uninsured children. Strategies focused on educational marketing, simplifying applications, and making applications accessible via the internet or through community partners. Washington and Oregon are working with community-based organizations as a way to target marketing and outreach to low-income populations. Illinois credits application agents, such as community-based organizations, day care centers, medical providers, and local government offices as having a positive impact on increased enrollment numbers.

There was recognition that it was the state's responsibility to develop strategies for public education and streamlining programs if the new efforts at reaching both the previously and newly eligible populations were to be successful. Louisiana reported that enrolling previously eligible uninsured children was not as much of an issue because of the state's success in enrolling eligible children before proposing its reform effort. Such success is attributed to an effort to transform the culture of the state's Medicaid agency, as well as its policies and procedures. Front line staff are proactive in their efforts to enroll children into the state's health coverage program.

CREATING ADDITIONAL COVERAGE OPPORTUNITIES THROUGH BUY-IN PROGRAMS

All of the states interviewed were either considering, proposing, or implementing buy-in programs, which allow families to purchase health coverage through the state's SCHIP program. Families pay for a significant portion (or all) of the cost the state incurs for the coverage.[8] States are using buy-in programs with different configurations, some of which include state subsidies and some that do not. Informants reported that when establishing a buy-in program they had to consider the strength of the state's private health insurance market and the public policy around private health insurance. Some states reported that the biggest challenge was minimizing crowd-out, which is discussed in the next section of this paper. It was a challenge for some to find agreement within their states on a way to allow uninsured children with family incomes above the eligibility limit for public programs to purchase coverage at the buy-in rate while keeping families already insured from dropping their private insurance.

Massachusetts and Illinois have implemented buy-in programs for uninsured children with family incomes above the SCHIP eligibility limit. As mentioned previously, over the years Massachusetts had taken incremental steps to reduce the number of uninsured children in the state. The state had implemented the Children's Medical Security Plan (CMSP), which is funded using state-only dollars, prior to the state's most recent coverage reform. Through the CMSP, families with uninsured children have the option to buy coverage

on a sliding premium scale ($8-$40 per month per child) regardless of their income or immigration status. The CMSP benefit package includes basic medical and dental services used frequently by children and adolescents. Illinois' All Kids program offers comprehensive benefits that mirror the state's SCHIP benefit package. Regardless of income or immigration status, families with uninsured children in Illinois have the option of buying into the public program on a sliding scale that is determined by their income, with premiums that range from $40 to $300 per month per child.

Pennsylvania also has implemented a buy-in program for families with incomes greater than 300 percent FPL. Families are given the option to purchase the public health coverage at the full cost to the state, which is approximately $150 per child per month. During the debate to enact the state's initiative to cover all children, there was some push-back from legislators who were concerned about crowd-out. State administrators argued that affordability had to be taken into account. Through a statewide study, it was shown that families with incomes above the SCHIP eligibility income limit did not have access to affordable comprehensive health insurance coverage through the private market. State proponents of the initiative documented that private coverage that included similar benefits to SCHIP cost families more than 150 percent of what the proposed buy-in program would cost families. The study helped to assure legislators that the state would be providing coverage options that were unavailable previously rather than substituting public coverage for existing private options.

Other states also are looking to incorporate a buy-in option as a part of their children's health reform efforts. Washington included the establishment of a buy-in program in its enacted legislation; it will be implemented in 2009. At the time the interviews took place, concepts for buy-in programs were included in coverage reform proposals being debated in both Oregon and California legislatures.

While a buy-in program is recognized as an approach to increase access to health coverage for those without access, some worry about the impact of these programs on the private health insurance market. This was a significant issue in Louisiana where legislators voiced concerns about negatively impacting the private health insurance market with a buy-in program. Legislators and the governor agreed it was important to reduce the number of uninsured children, which the state had been doing by being aggressive about enrolling the already eligible but uninsured. To continue the momentum, the legislature enacted unanimously a children's health reform bill that increased the income eligibility limit for the state's SCHIP program from 200 to 300 percent of FPL. While the bill did not include language that established a buy-in program, legislators agreed to further discuss the idea during next year's legislative session.

CROWD-OUT

Minimizing or deterring crowd-out, which is the substitution of publicly-funded coverage for private health insurance, continues to be a significant issue for public discussion. This was true in the summer of 2007 when these interviews were conducted. Attention to the issue has since escalated with the release of the August 17 state health official letter from the Centers for Medicare and Medicaid Services, which set forth a number of new conditions that states must meet as they create new coverage opportunities.

In a 2005 Congressionally mandated evaluation of the SCHIP program, a literature review found that research studies suggest a crowd-out rate ranging between 10 and 56 percent.[9] However, using data collected from states, the evaluators reported that substitution of public coverage for private insurance ranged from 7 to 15 percent, depending on whether or not affordability was treated as a voluntary reason for dropping private coverage.[10]

There have been many studies centered on the issue of crowd-out – some relying on data generated from Medicaid expansions in the early 1990s and some using data related to the impact of SCHIP's creation in the late 1990s and early 2000s. A synthesis project sponsored by The Robert Wood Johnson Foundation determined that despite all the research on the topic, there is no consensus on the magnitude of crowd-out.[11] Measuring crowd-out is difficult across time periods and programs, in part because of the differences in program design, enrollee characteristics, and economic conditions.[12] While researchers warn policy makers to be skeptical of definitive and broad statements regarding the extent of crowd-out, they also acknowledge that to achieve meaningful reductions in the number of uninsured, some crowd-out seems inevitable.

One area where there is consistency in the literature is on the strategies states use for deterring crowd-out, even while there is debate on the efficacy of these specific strategies. An Urban Institute survey of 18 states identified the following strategies being used in 17 of these states to deter crowd-out:

1. Imposing a waiting period in which children must be uninsured for a specific period of time before being able to enroll in the SCHIP program;
2. Monitoring health insurance status by including questions on the application that inquire about health insurance status;

3. Verifying insurance status and not relying on self-declaration;
4. Imposing cost sharing in the form of premiums, enrollment fees, and co-payments;
5. Subsidizing employer-based coverage to capitalize on private sector resources and continue to strengthen the private sector, employer-based health insurance system; and
6. Imposing obligations on employers or insurers. At the point of the Urban Institute study, California had imposed a legal obligation on employers and insurers not to alter their coverage policies in response to SCHIP.[13]

Findings from a more recently published NASHP study reiterate that instituting a waiting period is the most frequently used state strategy to deter crowd-out.[14] More than half of all states have waiting periods, which range from one month to six months. However, most states report requiring a six month waiting period between leaving private coverage and joining SCHIP. It is important to note that most states include exceptions to the waiting period requirement, allowing children to enroll immediately for reasons such as death of a parent or loss of job or employer-sponsored coverage.

As was mentioned previously, concern about crowding-out private coverage was a consistent theme reported by our state informants as health coverage reform proposals were debated within their state legislatures. States looked for effective ways to both minimize the risk of families discontinuing private coverage (if it was available to them) and employers from dropping dependent coverage while still reducing the number of uninsured children at all income levels.

All of the state informants reported that their states developed methods to deter crowd-out. Each state addressed this issue somewhat differently. The take-home message from the interviews was that state administrators need to anticipate this issue and develop creative and flexible solutions that meet their state's unique political configuration and are acceptable to CMS when federal funds are used. Our state informants reported that crowd-out provisions were negotiated with CMS. Developing parameters within which a state can work, and planning in advance for modifications to proposals, will speed up the negotiation process with CMS. As mentioned in a previous section of this paper, the August 17 directive may have a significant impact on state negotiations with CMS.

Our informants' approaches to address crowd-out issues were consistent with the approaches delineated in the Urban Institute report discussed above.[15] More detail of state approaches follow below. These methods are usually applied to children with family incomes above 200 percent FPL. While informants did not discuss crowd-out approaches for their state's SCHIP program prior to the coverage reform proposals, they did say that crowd-out rules for previously covered children had not changed. Also, traditional exceptions to periods during which children "go-bare," such as loss of employment, changes in the employer-sponsored coverage, or becoming ineligible for other public coverage, had been maintained. The following are crowd-out strategies utilized by the states leading the way in covering all children.

Establishing breaks in coverage

While there was variation in the length of breaks in coverage, most states established breaks in coverage of two to six months for newly eligible enrollees; there are sometimes longer breaks at higher income levels up to 12 months. The Illinois legislature debated whether to establish a 6-month or 12-month break in coverage requirement for the All Kids program. To resolve the issue, a compromise was reached. For the first six months of Illinois' All Kids program, the state required a 6-month "go-bare" or period of uninsurance for children with incomes above 200 percent of FPL. Each month thereafter, the go-bare requirement was extended another month until the program's one year anniversary at which time the requirement would extend to 12 months. So, as of July 2007, children with incomes above 200 percent of FPL enrolling in the All Kids program must be uninsured for 12 months. As have most states, Illinois recognizes exceptions to the state's year-long uninsurance requirement.

At the same time, states established exceptions that are tailored to specific populations with special health coverage needs. For example, Pennsylvania successfully pursued an exception to the state's break in coverage requirement for children younger than two years of age. The pediatric community supported continuous coverage for children under two years of age because any gap in coverage during this period affects a child's accessibility to necessary immunizations, visits, and screenings. While continuous coverage is important for children of all ages, these very young children are particularly vulnerable given their rapid growth and development. Pennsylvania received support from the American Academy of Pediatrics on this issue. This provision required extensive negotiation with CMS and was approved eventually, albeit with a requirement for data collection and monitoring. Similarly, New York has proposed a six-month waiting period as a crowd-out strategy for enrollees above 250 percent of FPL, but has included exceptions for certain populations, such as pregnant teens and

for children for whom affordability of health insurance is an issue. Illinois also has some exceptions, such as for newborns.

Monitoring

As mentioned previously, most states monitor applicants' health insurance status by including questions about their previous coverage experience on applications for coverage. By using this strategy, states can attempt to determine the number of children leaving private insurance for public coverage and why. Crowd-out monitoring also includes monitoring changes in the rate of private health insurance for the targeted populations. Some states are now tracking health insurance coverage for more specific populations. Pennsylvania agreed to track data on children less than two years of age to see if new enrollees had insurance previous to enrolling in the state's coverage program. The state also is tracking the two-to-five year old age group, which is not exempt from the go-bare period, to make comparisons. Pennsylvania is using a new alternative to collect the data, contracting with a private company that tracks health insurance coverage in the private sector. Rather than require administratively complex verifications from the applicant, Pennsylvania contracted with the private third party to validate insurance coverage/loss of coverage for the applicants. Oregon also reported that crowd-out was a significant issue during the legislative process and the state also planned to track changes in private health care coverage as well.

Premium assistance programs

States are attempting to leverage employer-based insurance with public dollars (for Medicaid and or SCHIP) to assist families with buying commercial insurance. Through premium assistance programs, states support private insurance and leverage all available funds to maximize available insurance coverage. In its recent coverage reform, Massachusetts included a premium assistance provision within a mandatory employer-sponsored insurance program for enrollees with income greater than 250 percent of FPL. Program administrators are able to access an available employment database to determine if an employer offers health insurance. If the employer offers family coverage, the family (with income above 250 percent of FPL) has to purchase the employer's coverage, using a state subsidy to assist them. This policy is seen as a way to maintain private health insurance, provide support to needy families, and minimize public expenditure.

New York also included a premium assistance program within its children's coverage reform, which officials view as one component of their attempt to deter crowd-out. The state's enacted premium assistance program is voluntary for children in families with income below 250 percent FPL, and mandatory for children with family incomes above 250 percent FPL. Other states such as Illinois have instituted a voluntary program. Illinois pays up to $75 a month to families with income between 134 and 200 percent of FPL to offset the cost of their employer-sponsored private insurance coverage. While the state does offer coverage options for children in families with income above 200 percent FPL, these options do not include premium assistance.

Employer-sponsored coverage is governed by separate regulations than is public coverage. So, when linking public and private coverage by adopting a premium assistance program, it is important to ensure that the state's private insurance regulations support this linkage. For instance, there are strict rules regarding when an employee can enroll himself or herself or dependents in employer-sponsored coverage. There is a specific time period usually occurring once a year known as open enrollment, in which an employee and/or an employee's dependents can enroll in the employer-sponsored private coverage. Once open enrollment has concluded, only the occurrence of a qualifying event allows enrollment. Typical qualifying events include a new hire, birth of child, or a marriage. In order to implement a premium assistance program, the state's insurance regulations must allow for Medicaid or SCHIP enrollment to be considered a qualifying event for private insurance. This allows the family to enroll in private employer-sponsored coverage at the same time that it is enrolling in the public program. Otherwise, the family would be limited to the annual open enrollment program for the private insurance coverage.

CMS does not require a waiver to implement premium assistance programs for employer-sponsored insurance as long as a state's program complies with federal regulations. However, our state informants reported that federal premium assistance regulations are so restrictive that many states *are* using waivers to implement these programs. The state informants also reported that CMS is encouraging states to include premium assistance programs within their SCHIP waiver requests and State Plan Amendments that request an increase in SCHIP income eligibility limits.

RELOCATING FOR HEALTH INSURANCE

As states addressed the needs of the uninsured children within their states' borders, some legislators also raised questions about possibly becoming a magnet state for families with uninsured children in other states. Some legislators expressed concern that families with children needing insurance, particularly sick or disabled children, would move to the state as a result of better access to health coverage. To

address state legislative concerns, program administrators are agreeing to collect data around many issues, including any influx of families from other states and are documenting coverage expansions in neighboring states to address the issue as it is raised.

COVERAGE FOR IMMIGRANT CHILDREN

Half the states we interviewed reported that they did not attempt any changes to the coverage of undocumented immigrant children as a part of their coverage initiatives. California and Illinois are among the notable exceptions. In California all of the legislative reform proposals (several proposals were being debated during the time of the interviews) offered coverage to undocumented immigrant children in the current Medicaid and SCHIP program using state-only funding. In Illinois, the All Kids program provides coverage to all uninsured children regardless of income or immigration status using state-only funds. State informants recognize that at the time Illinois' legislature was considering the All Kids bill, immigration was not the dividing issue it may be now for other states pursuing legislation to cover all children. Illinois reported that covering undocumented children within the state's All Kids program made it easier to market the program using simple messages of "all."

Both Washington and Oregon reported that coverage of immigrant children was a significant and contentious issue in the discussion of children's health care reform. Through its reform efforts, Washington re-implemented a program aimed at covering undocumented children that had been cancelled previously. The program uses state-only funds to provide coverage for undocumented children with family incomes up to 250 percent of the federal poverty level (increasing to 300 percent of FPL in January 2009). In an attempt to reach all uninsured children, beginning in January 2009, Washington will allow families with incomes above 300 percent FPL the opportunity to buy-in to the coverage regardless of their immigration status.

In his original proposal, Oregon's governor called for coverage of all children regardless of immigration status. However, due to push-back from state legislators on the issue of immigrant coverage, a legislative compromise was reached. The legislation attempted to assure access to care for undocumented immigrant children by increasing funding for safety-net clinics that provide health care services to immigrant children, but it did not allocate funds for insurance coverage of undocumented children. [16]

New York and Massachusetts reported that undocumented immigrant children were covered already under previously established state funded programs. Neither state reported that the issue of covering undocumented children was contentious. New York's program for immigrant children mirrors the state's Medicaid and SCHIP programs in the design of its benefit package. Massachusetts uses its Children's Medical Security Plan (details of the plan are provided in previous sections of this paper), also funded using state-only dollars.

Prior to developing its children's health coverage reform initiative, Pennsylvania did not provide coverage for undocumented children. Officials believed that if the state attempted to address immigration issues in the children's health initiative, the program might not have passed the legislature. To ensure that Pennsylvania's "Cover All Kids" legislation was enacted, coverage for undocumented children was not included in the proposal.

When states consider reforms aimed at covering all children, the states we interviewed recommended that states assess their local situation and plan for solutions to provide coverage to immigrant children. There was recognition, however, that the political landscape has changed and that this is likely to be a contentious issue for states attempting coverage of undocumented immigrant children for the first time.

Maintaining available federal funds for coverage of undocumented children through Medicaid

The issue of how to maintain federal funding for emergency Medicaid services when undocumented children are enrolled in a state-funded plan was also identified by states as an issue that needs to be considered. For instance, Washington is attempting to develop a seamless coverage strategy by using managed care organizations to administer the coverage for all children regardless of whether they are enrolled in Medicaid, SCHIP, or the state-funded program. The state will pay the managed care organization(s) a capitation rate for each participating child enrolled in the program. The state wants to include emergency care within the managed care capitation rate. This has proven to be complicated because the state wants to assure that it receives the federal match for emergency services but use state dollars to fund other care for undocumented children. At the time of the interview, the state was working with CMS to determine how to maintain the federal funding stream for appropriately billed services when an immigrant child is in a state-funded, capitated managed care plan.

ASSURING ACCESS TO CARE

A number of states, including Illinois, recognized access to care as an important component of their initiative to

cover all children. One approach used by states to assure an adequate provider network was to address provider reimbursement rates. Within its All Kids legislation, Illinois included language that increased provider rates for children and adolescent preventive services. Illinois also used the All Kids legislation to decrease the payment cycle for providers, reducing the period of time between the provider's claim and payment for the service.

AFFORDABILITY OF HEALTH INSURANCE

Affordability of health insurance in general came up in conversations with every state; the issue impacts states' program designs in many different ways. Oregon used an affordability analysis as a way to develop public support for the state's child health coverage initiative. The state solicited input from the public on the affordability of health insurance well in advance of the legislative session. Similarly, Louisiana used public testimony on the affordability of insurance as a way to move the eligibility limit increases for the public programs through the legislature. As referenced in the crowd-out section above, Pennsylvania utilized an affordability study in its efforts to justify its covering all children initiative.

State officials from Louisiana and New York echoed concerns about the "cliff effect," in which families with limited incomes can become ineligible for public assistance programs due to a slight increase in income. Both states' informants believe that the issue of supporting working families as they move up the economic scale is important and continues to resonate with policy makers. Through its children's health coverage reform, New York aims to expand the state's SCHIP eligibility limit from 250 to 400 percent FPL to decrease the cliff effect and support working families. To deter a cliff effect, Illinois implemented a sliding scale cost-sharing structure that escalates at higher income levels.

COST SHARING

Cost-sharing issues were not reported in the interviews as causing legislative or federal approval obstacles. Federal rules allow cost sharing in SCHIP to a maximum of five percent of a familiy's income and there are stringent rules in Medicaid around cost sharing for children. States did request assistance and more research around the affordability of cost-sharing strategies at the higher income levels that are now being included within state coverage initiatives. One state in particular said that the issue of affordable cost sharing for families earning 200 percent of FPL or less has been well studied and documented in literature. However, states aiming to cover all children are passing legislation with cost-sharing requirements for children with family incomes above 200 percent of FPL. There is little if any available information on the appropriate level of cost sharing or reasonable cost categories within income bands for families with incomes above the traditional eligibility limit. In the absence of tested and affirmed strategies, states are creating varied approaches. Some are implementing multiple cost-sharing categories which are administratively burdensome, and some are requiring the same amount in premiums for all families with incomes above the eligibility limit for SCHIP coverage. For example, Illinois uses a sliding scale premium system according to the family's income and Pennsylvania has adopted a single amount for all families with incomes above 300 percent of the federal poverty level.

INCOME DISREGARDS

Income disregards, which are income amounts that are not included in calculations for determining eligibility levels, were not identified in the interviews as a policy issue for state policy makers. Disregards were reported to be contentious potentially with CMS depending on how they were configured. Some states reported that CMS accepted income disregards used to raise the coverage level to 300 percent of the federal poverty level under SCHIP coverage, but when states proposed expanding coverage above 300 percent FPL, CMS questioned the methodology. States reported receiving many questions from CMS on this subject during the State Plan Amendment process. States recommend that others considering coverage expansions identify states that have already expanded with a similar proposal and replicate the policy language in the State Plan Amendment application they submit to CMS. There was no one format or language that was recommended consistently. Several states recommended that states consider the income disregard authority to maximize coverage expansions. Since the time of these interviews, the debate around SCHIP reauthorization and the administration's approach to maintaining SCHIP as a program for low-income children brings into question the viability of this method in the future.

Conclusion

While there were variations in the set of general approaches states used in their efforts to cover all children, consistent themes emerged throughout the states' experiences. Interviews with officials in eight states reinforced the understanding that states need to build their existing programs from the models that they have developed over the years. A clear

message from the respondents was that each state is different and will develop programs that reflect the culture of the state, the history of existing programs covering and serving children, the state's political configuration, and the leadership in place. Another common theme was the importance of having a strong governor to champion the initiative and work closely with the legislature.

Most of the eight states at the forefront of expanding health care coverage for children employed similar tools to increase coverage availability for uninsured children. Building on their existing bases, most states increased the income eligibility limit for Medicaid and SCHIP, their jointly funded federal/state public health coverage programs. Some states used state-only funds to finance programs to cover populations of children that were otherwise uninsured, such as undocumented immigrant children. All of the states interviewed considered, and most were adopting, other coverage options such as buy-in and/or premium assistance programs.

Similar policy issues surfaced on a national level while these states were developing and seeking approval of proposals aiming to cover all children. Prioritizing the enrollment of already eligible but uninsured children and working to minimize the risk of crowd-out were not only state concerns, but became national policy issues during the recent SCHIP debate and subsequent federal agency action. The issue of providing coverage for undocumented immigrant children was very contentious in some states and prompted compromise, as was the case in Oregon, or was not addressed, as was the case in Pennsylvania. States also found ways to minimize legislative fears that sick, uninsured children from other areas would move into a state for the health coverage opportunities. States also tackled issues of affordability, cost sharing, access to services, and more.

State informants urged that those working on universal children's coverage proposals in other states be prepared to be flexible and have alternative strategies at hand to use if needed. Although each state varied in its use of the identified coverage tools and dealt with the emerging issues in somewhat different ways, it is likely that other states can learn from their experiences and possibly adapt their strategies when proposing future children's coverage initiatives.

NATIONAL ACADEMY *for* STATE HEALTH POLICY

Acknowledgements

The National Academy for State Health Policy and the authors would like to extend their appreciation to the following officials in eight states who participated in interviews and reviewed an early draft of this report:

- Lesley Cummings and Janette Lopez, California
- Theresa Eagleson and Jacquetta Ellinger, Illinois
- J. Ruth Kennedy, Louisiana
- Robin Callahan, Massachusetts
- Judy Arnold, New York
- Jeanene Smith, Oregon
- George Hoover, Pennsylvania
- MaryAnne Lindeblad, Washington

We also would like to express our gratitude to the funders who have supported NASHP's work with states on child health coverage. The W. K. Kellogg Foundation supported the development of this report. The David and Lucile Packard Foundation helped build the foundations for this work through a decade of support for assisting states in implementing and expanding state children's health coverage programs. NASHP's child health coverage work also is supported by the Robert Wood Johnson Foundation and The Atlantic Philanthropies. Barbara Ladon and Sharon Steadman of ArpegioHealth conducted the state interviews and prepared initial drafts of this paper. Maureen Hensley-Quinn, Policy Specialist, and Catherine Hess, Senior Program Director, of NASHP supplemented and revised the draft to produce the final paper. Elizabeth Osius, NASHP Research Assistant, provided assistance in the final editing process.

Notes

1 The Institute for Health Policy Solutions, *California Counties' Children's Health Initiatives: A Success Story* (CA: 2006).

2 Centers for Medicare & Medicaid Services, State Health Official letter: SHO #07-001, Aug. 17, 2007.

3 Uchenna A. Ukaegbu and Sonya Schwartz, *Seven Steps Toward State Success in Covering Children Continuously* (Portland, ME: National Academy for State Health Policy, October, 2006).

4 The Oregon state legislature did not pass the tobacco tax needed to fund the state's initiative to cover all children. The question of whether to increase the tobacco tax to fund the state's all children program was put to the voters through a ballot initiative in November 2007. The ballot was defeated. For more information, go to NASHP's *Covering All Kids, All the Time* web site at www.nashp.org.

5 Congressional Budget Office, "CBO's Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under the House Amendments to the Senate Amendments to H. R. 976, the Children's Health Insurance Program Reauthorization Act of 2007," September 24, 2007.

6 Edwin Park, *CBO Estimates Show SCHIP Agreement Would Provide Health Insurance to 3.8 million Uninsured Children* (Center on Budget and Policy Priorities, September 2007).

7 Christopher Trenholm, *Expanding Coverage for Children: The Santa Clara County Children's Health Initiative* (Princeton, NJ: Mathematica Policy Research, Inc., June 2004).

8 Cynthia Pernice and David Bergman, *SCHIP Buy-In Programs* (Portland, ME: National Academy for State Health Policy, May 2006).

9 Judith Wooldridge et al., *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress* (Princeton, NJ: Mathematica Policy Research, Inc. and Washington, DC: The Urban Institute, October 2005).

10 Ibid.

11 Gestur Davidson, et al., *Public program crowd-out of private coverage: What are the issues?* Research Synthesis Report No. 5, (The Robert Wood Johnson Foundation, June 2004).

12 Ibid.

13 Amy Westpfahl Lutzky and Ian Hill, *Has the Jury Reached a Verdict? States' Early Experience with Crowd-out under SCHIP* (Washington, DC: Urban Institute, June 2001).

14 Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, ME: National Academy for State Health Policy, September 2006).

15 Westpfahl Lutzky and Hill, op. cit.

16. Oregon enacted the "Healthy Kids" legislation in November 2007, but did not pass the separate funding legislation (a tobacco tax).