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**Congressionally
Mandated Evaluation
of the State Children's
Health Insurance
Program**

*Site Visit Report: The
State of New York's
Child Health Plus
Program*

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CONTENTS

Chapter		Page
I	PROGRAM OVERVIEW	1
II	BACKGROUND AND HISTORY OF SCHIP POLICY AND PROGRAM DEVELOPMENT.....	7
III	OUTREACH	11
	A. INTRODUCTION.....	11
	B. STATEWIDE/MEDIA EFFORTS.....	12
	C. COMMUNITY-BASED EFFORTS	14
	D. EXPERIENCES AND LESSONS LEARNED	17
IV	ENROLLMENT AND RETENTION.....	23
	A. INTRODUCTION.....	23
	B. ENROLLMENT PROCESS	25
	C. REDETERMINATION PROCESS	32
	D. EXPERIENCES AND LESSONS LEARNED	33
V	CROWD OUT.....	39
	A. INTRODUCTION.....	39
	B. POLICY AND PROGRAM CHARACTERISTICS.....	40
	C. EXPERIENCES AND LESSONS LEARNED	41
VI	BENEFITS COVERAGE.....	43
	A. INTRODUCTION.....	43

CONTENTS *(continued)*

Chapter		Page
	B. PROGRAM CHARACTERISTICS.....	43
	C. EXPERIENCES AND LESSONS LEARNED	44
VII	SERVICE DELIVERY AND PAYMENT ARRANGEMENTS	47
	A. INTRODUCTION.....	47
	B. POLICY AND PROGRAM CHARACTERISTICS.....	48
	1. Service Delivery Arrangements	48
	2. Payment Arrangements	50
	C. EXPERIENCES AND LESSONS LEARNED	50
VIII	COST SHARING	55
	A. INTRODUCTION.....	55
	B. PROGRAM CHARACTERISTICS.....	55
	C. EXPERIENCES AND LESSONS LEARNED	57
IX	FAMILY COVERAGE.....	61
X	FINANCING.....	63
XI	OVERARCHING LESSONS LEARNED.....	65
	REFERENCES.....	69

APPENDIX A: KEY INFORMANTS

TABLES

Table		Page
1	SCHIP STATE PLAN AND AMENDMENTS.....	2
2	MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS, EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL	3
3	SCHIP AND MEDICAID ELIGIBILITY POLICIES.....	26
4	APPLICATION AND REDETERMINATION FORMS, REQUIREMENTS AND PROCEDURES	27
5	ENROLLMENT TRENDS	34
6	COST-SHARING POLICIES.....	57
7	SCHIP ALLOTMENTS AND EXPENDITURES, IN MILLIONS, 1998-2000.....	64

I. PROGRAM OVERVIEW

New York's Title XXI program—*Child Health Plus*—is a “combination program” comprising both a Medicaid expansion and a separate state program.¹ The program has its roots in a state-funded initiative of the same name, begun in 1990, to provide preventive, primary, and outpatient care to children up to the age of 13 living in families with incomes below 222 percent of the federal poverty level (FPL). Over the early years of its history, *Child Health Plus* was expanded to cover both more children (children up to the age of 17 were added in 1996, and up to the age of 19 in 1997), and broader benefits (with inpatient hospital services added in 1996). Throughout, the program used state funds to also extend coverage to non-citizen children. With the passage of the Balanced Budget Act of 1997 and the creation of the State Children's Health Insurance Program (SCHIP), New York's program was one of three that was “grandfathered” into Title XXI; that is, *Child Health Plus* was pre-approved (along with the programs of Florida and Pennsylvania) for federal funding based on its successful track record as a well-established, state-funded child health insurance initiative.

As detailed in Tables 1 and 2, New York submitted its SCHIP plan to the federal government in November 1997. Approved and implemented in April of the following year, the plan included an expansion of Medicaid eligibility to 100 percent of poverty for children under age 19, along with newly federally-matched coverage of children under age 19 at 222 percent of poverty for the separate state program. In March of 1999, the state submitted a plan amendment

¹As of October 1, 2002 the federal mandate for phased-in poverty-level coverage of children under age 19 born after September 30, 1983 will be complete. Thus, New York's initial accelerated coverage of 16-18 year-old children under Title XXI will be subsumed within Title XIX.

TABLE 1: SCHIP STATE PLAN AND AMENDMENTS

Document	Dates			Description
	Submitted	Approved	Effective	
Original Submission	11/5/97	4/1/98	4/15/98	Obtained federal matching funds for existing child health program, <i>Child Health Plus</i> , up to 222% of the FPL (gross income) covering children under age 19. Existing benefits package “grandfathered” by SCHIP legislation.
Amendment 1	3/27/98	NA ^a	NA ^a	Sought retroactive enhanced matching payments
Amendment 2	3/30/99	9/24/99	1/1/99	Following the passage of the New York Public Health Law, requested an income eligibility increase for <i>Child Health Plus</i> up to 230% FPL in 1999 and up to 250% FPL (gross income) in July 1 2000. Also requested a Medicaid expansion for children between ages 16 and 19 to 100% of the FPL (net income), and all children up to 133% once 50 percent of Medicaid eligibles are enrolled in Medicaid Managed Care. Also added benefits and reduced cost sharing in Child Health Plus.
Amendment 3	4/12/01	7/12/01	4/1/00	Requested approval to apply income disregards to set aside certain types of family income for the income eligibility determination.

SOURCE: Centers for Medicare & Medicaid Services (CMS), *New York Title XXI Program Fact Sheet*. CMS web site <http://www.hcfa.gov/init/chpfsny.htm>; New York Governor’s Press Office, *Child Health Plus Expansion Means Healthier Kids*. Press Release June 18, 1998; Department of Health and Human Services, *HHS Approves Changes In New York SCHIP Program*, HHS News, July 12, 2001

NOTES: SCHIP=State Children’s Health Insurance Program. FPL=federal poverty level. NA=not applicable.

^aDenied 4/1/98. Resubmission was withdrawn.

TABLE 2: MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS, EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL

	Age (in Years)			
	Up to 1	1-5	6-17 ^b	17-18 ^c
Medicaid standards in effect 3/31/97 ^a	Up to 185%	Up to 133%	Up to 100%	Up to 87%
SCHIP Medicaid expansion ^d	NA	NA	NA	87-100%
SCHIP separate child health program (Child Health Plus)	185-250%	133-250%	100-250%	100-250%

SOURCES: Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000. American Academy of Pediatrics, *Improving Access to Children's Health Insurance in New York*. AAP: 2000 website: <http://www.aap.org/advocacy/chi2/ny.pdf>

NOTES: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

^aIncome standards are net of deductions, except for the 250 percent upper income standard for Child Health Plus, which is a gross income standard.

^bChildren born after September 30, 1983, who are more than 5 years of age. The eldest children in this group are now age 17. In January 1999, when the new components of New York's Title XXI program were implemented, the age range covered under Title XIX Medicaid up to 100 percent of the FPL was 6-15 years.

^cChildren born on or before September 30, 1983, who are less than 19 years of age. The youngest children in this group are now age 17. In November 1998, when the new components of New York's Title XXI program were implemented, the age range covered under Title XIX Medicaid up to 10 percent of the FPL was 15-18.

^dExpansion up to 133% approved, but will not be implemented until April 2002.

to the (then) Health Care Financing Administration for expanded Medicaid coverage of all children under age 19 to 133 percent of FPL, and *Child Health Plus* coverage of children in families with income below 230 percent of poverty (with a proposal to expand further—to 250 percent—in mid-2000). The amendment also included expansions of several benefits, including inpatient and outpatient mental health and substance abuse services, durable medical equipment, dental care, and speech, vision, and hearing services. Approved in September 1999, all provisions but two were implemented retroactive to January 1999. The expansion to 250 percent was retroactive to July 2000, and the Medicaid expansion to 133 percent of poverty was expected to be implemented in April 2002.

Child Health Plus is administered by the Division of Planning, Policy and Resource Development in the New York State Department of Health; other divisions within the same department administer the state's Medicaid program. The program uses a managed care model statewide, contracting with 30 risk-bearing managed care organization. The state share of funding for *Child Health Plus* comes from an assessment on providers. (In contrast, half of the state share of New York's Medicaid funding—or 25 percent of total program funding—is provided by counties, an arrangement that adds a layer of complexity and political sensitivity to Medicaid program administration.)

Child Health Plus has the highest enrollment of any SCHIP program in the nation—in February 2001, 516,381 children were covered under the program. New York's program was also one of just four states in the country to have spent its entire fiscal year (FY) 1998 federal allotment of funds. The program enjoys an extremely high level of political support in the state, and recent developments to further improve *Child Health Plus* have focused on aligning Medicaid and SCHIP eligibility rules and procedures in order to create a more seamless public health insurance program for low-income children. The most ambitious component of this effort, implemented in 2001, involves a community-based enrollment initiative called “facilitated enrollment.” Most recently, however, New York has faced new challenges with regard to retention and efforts to *keep* children enrolled in *Child Health Plus*.

This report is based primarily on information gathered during a visit to New York in May and June of 2001. During the five-day visit, 19 interviews were carried out with a broad range of key informants at the state and local levels, including state program administrators, Governor's staff, state legislators and their staffs, child health advocates, managed care organizations, health care providers, local social services officials, and staff of community-based organizations involved with outreach and enrollment (See Appendix A for a list of key informants). In

addition to our interviews in the state capitol of Albany, we spent time in three local areas—New York City (which has the highest concentration of uninsured children and program enrollees in the state), Syracuse (a medium-sized city in Onondaga County in central upstate New York), and Cortland County (a rural area in the south-central upstate region). Combined, the regions we visited account for 45 percent of the state’s population and 61 percent of the population currently enrolled in *Child Health Plus*.²

²February 2001 state point in time enrollment

II. BACKGROUND AND HISTORY OF SCHIP POLICY AND PROGRAM DEVELOPMENT

During the late-1980s, a broad-based coalition of providers, advocates, and policymakers formed and implemented the “Campaign for Healthy Children.” The coalition undertook a study of children’s needs and identified both high rates of uninsurance and a severe lack of access to primary and preventive care among the state’s child population. In response, and after studying the efforts of other states, the coalition developed and advocated for a proposal to extend health insurance to these children. With the state enjoying a fairly strong fiscal climate, there was broad-based support for such a proposal but many different views on what shape it should take. After considering several options for program design, consensus was reached on a program of somewhat modest proportions—the *Child Health Plus* program was created in the model of private health insurance (as there was significant legislative resistance to expanding children’s entitlement to coverage under Medicaid), with funding set at \$20 million to provide coverage of preventive and primary care only for children up to age 13 in families with incomes below 222 percent of poverty. The decision to exclude inpatient hospital coverage was based on the perception that the state’s hospital safety-net system was already well-funded and capable of meeting the inpatient needs of uninsured children.

Child Health Plus was implemented in August 1991. In modeling itself after private insurance, the program included provisions for patient cost sharing. Specifically, while the program was free for families with incomes below 160 percent of poverty, an annual enrollment fee of \$25 per child per year was imposed on families with incomes between 161 and 222 percent of poverty (with a cap of \$100 per family per year). Of note, families with incomes above 222 percent were also permitted to purchase *Child Health Plus* coverage on a non-

subsidized basis for the full premium cost. Services were delivered using managed care and by July 1997, over 140,000 children were enrolled in the program, receiving care through a network of 25 managed care organizations. As stated above, *Child Health Plus* was expanded at several points during its early history. As popularity and political support for the program grew, eligibility was expanded to children under age 17 in 1996, and to children under age 19 in 1997. In addition that year, inpatient hospital benefits were added to the program's coverage in response to a growing concern that the program needed to provide more comprehensive coverage for the state's uninsured children.

Even before passage of federal legislation to create SCHIP, policymakers and advocates in New York were aware of the proposals being considered before Congress and were anxious that these proposals not “disrupt” the state's program (which had been in place for nearly seven years). Intensive lobbying of members of Congress led to the “grandfathering” of *Child Health Plus* in its existing form.

Once the federal legislation was signed into law, debates in Albany turned to the issue of whether, or how much, to expand Medicaid as part of Title XXI. With the urging of the Children's Defense Fund, the Democratically-controlled Assembly proposed a plan that would significantly expand Medicaid—to 185 percent of poverty for all children—while also expanding *Child Health Plus* coverage to 300 percent of FPL. However, a very broad group of advocates, providers, and insurers, as well as the Republican-controlled Senate, supported the concept of a “private insurance model” for children and strongly resisted the notion that Medicaid coverage should be expanded to the point where many current *Child Health Plus* participants would be switched to Medicaid. Political forces feared the potential budgetary exposure that a broader entitlement would bring. But others, in particular prominent child advocates, were more focused on their belief that considerable “stigma” surrounded the Medicaid program, stigma that would

undermine a Medicaid expansion's ability to successfully attract and enroll families with uninsured children. Providers traditionally held the program in low regard due to reimbursement rates that were perceived to be chronically and unfairly low, while consumer stigma had grown primarily from a welfare-based enrollment process that was viewed as both cumbersome and intrusive. These advocates, also witnessing the strong political support that had grown for *Child Health Plus*, believed that the prospects for success were much greater with further expansion of the private model embraced by *Child Health Plus*. In the end, a compromise was reached whereby Medicaid accelerated its implementation of federal rules to provide poverty-level coverage of all children under age 19, while the separate program component was implemented to cover children up to 222 percent of poverty.

The early months of implementation for the now federally-subsidized *Child Health Plus* program were fraught with sometimes tense negotiations between federal and state officials. Department of Health officials were frustrated to learn that there were limits to the concept of "grandfathering," as HCFA required the state to modify its cost sharing, crowd out, and enrollment (specifically, "screen and enroll") policies to conform with the federal legislation. By 1999, New York had reduced and restructured cost-sharing requirements, established a protocol for monitoring crowd out, and began enforcing rules that would lead to more rigorous screening of *Child Health Plus* applicants for Medicaid eligibility. In addition, the state developed a series of plan amendments for HCFA that reflected various provisions passed in state law the prior year, including further expansion of Medicaid to 133 percent of poverty (thereby removing all age-based variations in Medicaid's coverage of children), further expansion of *Child Health Plus* to 230 percent, and then 250 percent of poverty, and expansion of program benefits to include broader coverage of inpatient mental health and substance abuse services, durable medical equipment, dental care, speech, vision, and hearing services, and coverage of nonprescription

drugs. All of these provisions had been enacted by the time of our site visit, save for the Medicaid expansion to 133 percent of poverty which is contingent on federal approval of aspects of New York's Medicaid Section 1115 demonstration program.

III. OUTREACH

A. INTRODUCTION

For most of its history, including the years before federal matching funds were available, *Child Health Plus*' outreach efforts comprised two major strategies:

- A statewide media campaign to raise the public's awareness of the importance and availability of health insurance, run centrally out of the Department of Health; and
- Direct marketing by the managed care health plans with whom the state contracts for the delivery of care.

State officials have always placed a high priority on the need to broadly publicize *Child Health Plus* and establish a strong and positive "brand identity" for the program. In addition, the state embraced the notion that health plans possessed unique expertise in marketing and, thus, constituted the best avenue for reaching and enrolling children at the local level. To augment this two-pronged approach, the state also contracted for several years with the New York Association of Health Plans to fulfill two additional functions: the staffing and management of a toll-free "hotline" for the program; and the coordination of additional community-based outreach targeted to vulnerable populations.

In recent years, however, state officials have recognized the need for more aggressive and concerted efforts to enroll "hard to reach" populations. Fueled in large part by the need to also implement a more accountable system for enrolling eligible children in both SCHIP and Medicaid (and conduct more rigorous "screen and enroll" procedures), the state designed a new initiative called "Facilitated Enrollment." Under facilitated enrollment, grants have been provided to community-based organizations (and their subcontractors) primarily to support these organizations' efforts to enroll children into *Child Health Plus* and Medicaid. These grants have

also served as a financing base from which these organizations have conducted a broad range of outreach activities, tailored to their specific local needs, to make families aware of the programs, promote the importance of health insurance for their children, and assist them with applying for coverage. Each of these outreach strategies is discussed in more detail below.

B. STATEWIDE/MEDIA EFFORTS

The Public Affairs Group (PAG) of the Department of Health has overall responsibility for designing and implementing statewide outreach efforts, and oversees a \$2 million annual budget for this purpose. During the early years of the program, PAG designed and developed all *Child Health Plus*' messages, logos, materials, and advertisements, contracting with print and media vendors only for production purposes. In addition, as discussed above, the state let a contract to the New York Association of Health Plans (NYAHP) to run a toll-free information "hotline" for *Child Health Plus*, and to oversee and coordinate a limited number of community-based outreach efforts. (The Association, in turn, subcontracted with several existing Perinatal Networks, organized regionally across the state, to "piggyback" SCHIP outreach efforts upon the efforts they more generally undertake to promote maternal and child health at the local level.)

The principal slogan, logo and message of New York's outreach campaign is "Growing Up Healthy." All promotional materials, including the application, posters, print and media advertisements, the hotline, and "give aways," use this phrase in conjunction with the program's name, *Child Health Plus*. Additional sub-messages conveyed in print and media materials have, at various points, promoted the program as one with "comprehensive benefits," as "affordable health care for kids," and as "coverage for your kids, regardless of their citizenship." The program is branded as a health insurance program, not a government entitlement program. Bright and attractive materials, typically using primary colors and photographs of children of all ages and ethnic backgrounds, have been used throughout. Perhaps the most identifiable image of

the program is that using a blue sky and fluffy clouds as a backdrop, with infant and child “angels” (complete with wings) perched happily atop the clouds, with “Child Health Plus” written in a child’s handwriting.

Importantly, “Growing Up Healthy” had long been the slogan only for New York’s SCHIP program; Medicaid, if it was marketed at all, was done so entirely separately from *Child Health Plus*. Beginning in 2000, however, an explicit decision was made to market the programs jointly. As part of the broader initiative to implement facilitated enrollment and a new, joint application (discussed in detail in the next section), New York also renamed Medicaid as *Child Health Plus “A,”* with the existing *Child Health Plus* program picking up the suffix “B.” Since then, the slogan of “Growing Up Healthy” and the name *Child Health Plus*, have been used to market Medicaid and SCHIP jointly, as a single initiative.

The key components of the state-level outreach effort can be summarized as follows:

- ***Radio and television advertisements.*** Numerous radio and television advertisements have been developed, prominently featuring Governor George Pataki, who has lent his enthusiastic support to the program. Over time, the state has put increasing financial support behind the purchase of prime time space for airing television advertisements.
- ***Print media and materials.*** A wide array of print advertisements, including posters, billboards, brochures and flyers, as well as ads in numerous local and ethnic newspapers have been used. Brochures are a primary promotional item distributed at health fairs and other venues. They have been mailed to a broad range of local health and social service agencies, and also been included as inserts in mailings of utility bills, phone bills, motor vehicle administration mailings, and the like.
- ***Toll-free hotline.*** The NYAHP has run a toll-free hotline for *Child Health Plus* since 1997. The hotline number is featured prominently in all of the program’s advertisements and materials. Staff of the hotline primarily provide basic information about the program to callers, and also take names and addresses in order to mail out blank applications when they are requested. In the last year, with the implementation of facilitated enrollment, the volume of calls has increased dramatically, and the nature of calls has changed considerably, with an increasing proportion of calls focused on questions related to how to fill out the new joint application (which, as will be discussed below, is considerably more complicated than the previous SCHIP-only form). In addition, hotline operators refer callers to designated “facilitated

enrollment” sites in their communities. (Over the coming year, in recognition of the growing need for a hotline with more extensive capacity, the state plans release a Request for Proposals to procure a new hotline, one that will take calls centrally for all child health-related programs in the state.)

C. COMMUNITY-BASED EFFORTS

At the local level, the two primary entities involved with outreach are managed care plans and community-based facilitated enrollment agencies. Each of these groups is discussed below.

Health Plan Marketing. As stated above, health plans under contract with the state to serve *Child Health Plus* enrollees have always been permitted to directly market their services and, by extension, the program. This decision was explicitly made by state officials to take advantage of plans’ business acumen and expertise in advertising. In addition, state officials felt comfortable that they had learned many lessons about inappropriate marketing practices by health plans during the early years of Medicaid managed care implementation, and were now in a strong position to monitor plan behavior and enforce rules designed to prevent such inappropriate practices. In turn, and with obvious financial incentives to recruit and enroll children within their particular plans, managed care organizations have put considerable time, energy, and resources behind their marketing of *Child Health Plus*.

Each year, the 30 health plans under contract with the state are required to develop and submit to the Department of Health for approval their plans for conducting SCHIP marketing. Plans are permitted to, and do, design and produce their own marketing materials, including brochures, pamphlets, “give aways,” billboards, and radio and TV spots. They are required, however, to identify *Child Health Plus* prominently on these materials, with the specific health plan logos actually occupying a smaller, less prominent place on the advertisements than that of *Child Health Plus*. (Of note, the image of the child “angels” floating in a sky of fluffy clouds

was initially designed by one of the health plans operating in New York City.) In addition, many plans have created their own toll-free hotlines and feature these numbers on their advertisements.

Health plans typically employ large marketing staffs—as many as 60 fulltime equivalent staff in several of the larger New York City-based plans we interviewed, with a large proportion of the staff being bi- or multi-lingual. These staff attend health fairs, visit local social services and health departments, meet with and educate providers, and network with countless community-based organizations in their communities. Rather than being viewed as “salesmen,” these staff are more likely to be positively viewed as partners of the state in pursuit of the goal of enrolling children into health insurance, according to key informants we interviewed. In addition, since the program’s inception and continuing with the advent of facilitated enrollment, marketing staff are permitted to directly assist families with completing the SCHIP application form.

Importantly, health plan marketing staff are *not* permitted to “cold call” families in their community, nor are they permitted to give potential enrollees any direct incentives, in the form of gifts, to entice them to enroll. Marketers cannot, in any way, convey a message that they *are* the *Child Health Plus* program or that they are the only plan providing services to *Child Health Plus* enrollees. In fact, when assisting families with applications, they are required to identify and discuss each of the health plan options available to enrollees in a given community and are forbidden from directly promoting the attributes of their plan when it’s time for a family to choose one.

Some examples of alternative marketing strategies used by health plans that we interviewed include:

- In Brooklyn and other boroughs of New York City, *Health Plus* concentrates much of its marketing on strategies to reach the many ethnic populations in its service areas.

A large proportion of the plan's marketing staff are bi- or multi-lingual, and advertising materials for local newspapers, brochures, and hand-outs are printed in as many as 13 languages.

- In the Bronx, the *Bronx Health Plan* has purchased several recreational vehicles in the last year and deploys them in local communities to publicize *Child Health Plus*, disseminate brochures and other materials, and assist families with completing SCHIP applications.
- In Syracuse, *Total Health Care* employs a small marketing staff who concentrate primarily on phone calls to follow up with families that have called the plan's hotline. During these calls, which are made by staff with the appropriate and needed language skills, staff answer questions about the program, educate families about the importance of insurance, and help families to complete the application.

Facilitated Enrollment Agencies. At the time of our visit, 32 agencies had been awarded grants to serve as "lead agencies" for facilitated enrollment. These agencies represent a diverse range of organizations including county health departments, county social services offices, perinatal networks, hospital associations, rural health networks, senior citizen centers, and Jewish community centers. These lead agencies, in turn, subcontract with a vast array of other community-based groups, literally hundreds at the time of our visit, to be the "arms" in the community that function primarily to enroll children in *Child Health Plus* and Medicaid. Importantly, these agencies also conduct outreach in order to find families, discuss the programs, and encourage their signing up.

Similar to health plans, facilitated enrollment agencies conduct a broad array of activities to this end. Staff attend health fairs and street fairs, visit and talk to parents at supermarkets and Laundromats, approach employers in their communities, and partner with nurses, teachers, and other staff in local schools. Perhaps the most consistent and prominent strategy used by the facilitated enrollers we spoke with was what they termed "inreach." That is, given limited resources, staff of community-based agencies incorporate information-sharing and education related to *Child Health Plus* into their normal day-to-day activities, activities which bring them

into daily contact with families that might have uninsured children. Such “inreach” was identified as perhaps the most efficient and effective method for getting the word out about the programs. Some other specific examples of outreach by facilitated enrollers include:

- In the Ridgewood/Bushwick Senior Citizens Council, staff running a broad array of youth employment, housing assistance, education, literacy, citizenship and senior and home health programs now routinely discuss and distribute materials regarding *Child Health Plus*. In addition, each staff person in the agency has been trained to help families complete the application form.
- In Cortland County, enrollers from the Family Health Network build upon its strong ties to community providers to distribute branded pens, stickers, posters, and applications to patients waiting for services in physicians’ and clinic offices.

Importantly, not all of the outreach related to *Child Health Plus* and Medicaid is being carried out by health plans and facilitated enrollers. In fact, county Departments of Social Services, traditionally responsible for conducting eligibility reviews for Medicaid, TANF, and Food Stamps, have received 1931(b) monies to conduct outreach to Medicaid-eligible families. In addition, in conjunction with the state, outreach is being carried out in the four communities under the auspices of the Robert Wood Johnson-funded “Covering Kids” initiative. And, in New York City, Mayor Rudy Giuliani introduced *HealthStat*, a citywide initiative designed to identify, inform and enroll eligible but uninsured New Yorkers into public health insurance programs such as *Child Health Plus* and Medicaid. Rolled out in June 2000, the initiative involves more than 20 city agencies in partnership with private organizations under the direction of the Mayor’s Office of Health Insurance Access.

D. EXPERIENCES AND LESSONS LEARNED

There is a high level of satisfaction with the effectiveness of outreach efforts in New York, as expressed by virtually all of the key informants we interviewed, including state officials, health plan administrators, legislative staff, local officials, and child advocates. There was broad

consensus that the state had done an admirable job of designing, implementing, and sustaining a statewide media campaign aimed at publicizing *Child Health Plus*. Critically, state officials were praised for complementing this campaign with additional efforts targeted to the community level. Combined, these efforts have appeared to result in high levels of awareness of the program and increasing enrollment.

The statewide campaign, in particular, is widely attributed with encouraging high rates of enrollment. Critical has been the widespread nature of the advertising—it is hard to miss—and the branding power of *Child Health Plus*: the name, the support of Governor Pataki on TV, its portrayal in the media as desirable, upbeat and positive. *Child Health Plus* is now perceived as a health insurance program, with no stigma attached. According to state officials, radio and TV campaigns have been most effective (in terms of numbers of children reached), while event-based outreach, such as health fairs, have been less effective.

Community based outreach by community-based organizations has proved a valuable counterpart to the statewide program, especially in attracting hard-to-reach populations. Moreover, that the health plans can conduct outreach was described as a “real driver” in their efforts to enroll more children. For both health plans and facilitated enrollment agencies, crucial has been the ability to:

- Design and adapt strategies to the dynamics of the local community;
- Build trust among community members “from the bottom up;” and
- Conduct “inreach” to community members already involved with the local organizations and their services.

Take, for example, outreach to farmers upstate. Staff of the Family Health Network were finding health fairs to be an ineffective means for encouraging families to apply, so enrollers adapted and took their booths to farm shows, meeting with much greater success. Similarly, staff

of the Children’s Aid Society in upper Manhattan changed their strategy from one that relied on fliers to one that emphasized spoken communication, after finding that the largely Hispanic community it targeted was more trustful of personal contact. Interestingly, the Children’s Aid Society found that fliers worked very well in lower Manhattan because the largely Chinese community there placed more trust in information conveyed in writing. In this Chinese community, building a strong personal relationship with an employer also proved essential as a means of outreaching to garment factory employees. Being a visible presence in the community can also be an effective means of building up trust. According to The Bronx Health Plan, their recreational vehicles are now a “landmark in the community” where people can always “come to talk to someone they trust.” Educating providers and distributing materials in their offices has also proved an effective strategy. They are now the source of numerous referrals. Following on from these more formal outreach efforts, informants indicated that word of mouth has brought many people into SCHIP. According to one interviewee, “Word of mouth has been the most important outreach strategy.”

To ensure the potential participant can receive follow-up information after hearing about *Child Health Plus*, the hotlines—both state- and community organization-based have been of fundamental importance. Officials of the NYAHP reported that, especially after the advent of facilitated enrollment, “phones began ringing off the hook,” with parents eager to find out how to fill out the “Growing Up Healthy” application.

Although efforts to reach hard-to-reach populations are considered generally successful, some barriers still remain. These barriers relate to the “public-charge” issue and the fear among immigrants that applying for coverage through *Child Health Plus* or Medicaid will adversely affect their citizenship applications. State officials have reportedly succeeded in alleviating much of this fear; for example, the new joint application and many of the state’s marketing

materials explicitly state that the immigration status of applicants is irrelevant and that submitting an application for, or gaining coverage under, either program will not affect anyone's ability to gain a green card or citizenship. And at the local level, several community-based organizations reported that fears of public charge had largely dissipated in the last two years since the Immigration and Naturalization Service (INS) released its clarification on what programs do and do not constitute a "public charge." Still, some fears persist that the information from applications will be sent to the INS, an issue particularly pertinent in New York State because illegal immigrant children are allowed to apply, and many legal children are born to illegal parents. Facilitated enrollers in Bushwick, for example, reported several instances where immigrant families in this largely Hispanic community resisted the program. Officials at The Bronx Health Plan reported similar fears.

Another identified barrier to enrollment was related to the large "informal" working sector in New York City. Specifically, the fact that so many immigrant parents work "off the books" contributed to both employee and employer resistance to the notion of identifying oneself to a government agency.

Finally, there were diverse opinions regarding the state's decision to change the name of Medicaid to *Child Health Plus "A."* While state-level advocates believe the strategy to be a fundamentally important building block that (finally) permits the state to actively market Medicaid (and not just SCHIP), most organizations at the community level felt the change was of little import to either families or providers—both seemed well aware that the program was still Medicaid.

Overall, key informants were both impressed by the amount of marketing that the state was able to accomplish with its relatively small annual budget of \$2,250,000, and happy that the state had consistently sustained funding for this "vital" function. Many informants were also

frustrated, however, that such a small budget was earmarked for such an important undertaking. In fact, the annual state outreach budget is significantly less than 10 percent of the amount New York spends on services for SCHIP enrollees. Thus the federal cap on administrative expenses has never been a limiting factor with regard to outreach spending. At the local level, in particular, facilitated enrollment agencies stated that additional funding to support their efforts would be welcomed.

IV. ENROLLMENT AND RETENTION

A. INTRODUCTION

From the program's launch in 1991, *Child Health Plus*' application process was designed to be very simple and straightforward, much in the model of private health insurance. Specifically, health plans designed their own application forms, typically one page in length; families could either fill out the form and mail it in to plans, or complete it with the assistance of health plan marketing staff; verification requirements were kept to a minimum, with eligibility determined based on a simple comparison of family gross income to *Child Health Plus*' upper income limit; no assets test was conducted; and children were determined eligible for a 12-month period (although 12-month continuous eligibility is not guaranteed).

This simple process could not have contrasted more starkly with that in place for New York's Medicaid program. Medicaid eligibility, throughout the 1990s, continued to be determined by staff in county Departments of Social Services (DSS). Moreover, while a one-page application form was available for determining Medicaid-only eligibility for pregnant women and children, DSS staff more often than not employed a much longer, more complex application form to determine entire families' eligibility not only for Medicaid, but also for TANF and Food Stamps. The Medicaid process required that face-to-face interviews take place between applicants and DSS workers, and families, as part of the process, were required to submit verification of not only income, but also of residency, citizenship status, as well as social security numbers for all family members. Finally, DSS staff reviewed income levels net of disregards for work and child care expenses (as opposed to using a gross income test). Like *Child Health Plus*, however, Medicaid also used a 12-month eligibility cycle and required

families to notify their county DSS office of any change in income or circumstance that might affect their eligibility within 10 days of the changes.

Not surprisingly, then, when families with uninsured children observed that they could apply for coverage under either *Child Health Plus* or Medicaid, they often chose *Child Health Plus* and its simpler, less intrusive, and non-welfare-related enrollment process. In addition, before the advent of federal matching funds under Title XXI, there existed no requirements that families possessing incomes below Medicaid levels be placed in that program. Therefore, health plans were free to enroll any child with income below *Child Health Plus*' upper limit into the program, and were not required to conduct any "screen and enroll"-type reviews to assess children's potential eligibility for Medicaid. This situation led to the enrollment of many Medicaid-eligible children into *Child Health Plus* during the program's pre-Title XXI years; according to one estimate by the New York State Controller, as many as 41 percent of *Child Health Plus* enrollees might have actually been Medicaid eligible in 1998.³ (State officials disagreed with this estimate, believing the proportion to be far smaller. Indeed, while data are imperfect, experience to date seems to indicate that fewer Medicaid-eligible children were enrolled in *Child Health Plus* than was estimated by the Controller.)

With the introduction of federal funds under Title XXI, however, "screen and enroll" became mandatory and state officials realized they needed to address the numerous disconnects between the two programs' eligibility rules and procedures. In addition, they needed to confront the reality that many Medicaid-eligible children were likely enrolled in *Child Health Plus* and devise a system for placing these children in the program for which they were eligible. As a

³News Release, New York State Controller, H. Carl McCall, June 3, 1998. *McCall Calls For Expanded Health Coverage For New York's Uninsured Children; Urges Governor, Legislature to End Delays And Act to Improve Access*

temporary fix, the Department of Health issued new guidance to health plans instructing them to review all applications for potential Medicaid eligibility and, when children were found that looked like they might be eligible for that program, urge them to visit their local DSS office and complete an application. Importantly, however, health plans were still permitted to enroll these children into *Child Health Plus* on an indefinite “temporary” basis, and were only required to disenroll them when they received notification from the county that the referred child had been made eligible for Medicaid.

To resolve the problem in a more structured and accountable way, however, New York officials set out to redesign their entire application process. At the center of the strategy was the creation of a joint application form that could be used to determine eligibility simultaneously for both programs. In addition, as mentioned above, a new process was created called “facilitated enrollment” through which community-based organizations, with grant support from the state, would provide direct, hands-on assistance to families in completing the joint application form. New York’s reformed eligibility process, and state and local agencies’ experiences implementing it, are discussed in more detail below.

B. ENROLLMENT PROCESS

As stated above, the first step required in reforming the *Child Health Plus*/Medicaid eligibility process and creating a more seamless system was to devise a new, joint application form. To do so, state officials had to compare the eligibility policies of the two programs, side by side, identify the key differences, and decide how best to merge them. This process, carried out in late 1999 and early 2000, resulted in a set of administrative rules changes that, essentially, brought *Child Health Plus* rules into alignment with those of Medicaid. Specifically, as detailed in Tables 3 and 4, *Child Health Plus*:

TABLE 3: SCHIP AND MEDICAID ELIGIBILITY POLICIES

Policy	SCHIP	Medicaid ^a
Retroactive eligibility	No	Yes, 90 days from first day of month of application
Presumptive eligibility	Yes, 60 days	No ^b
Continuous eligibility	No, but 12 month recertification cycle	Yes, 12 months
Asset test	No	No
U.S. citizenship requirement	No (undocumented children are covered with state-only funds)	Yes, or qualified alien ^c

SOURCE: Deborah Bachrach, Karen Lipson and Anthony Tassi, *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State*. The Commonwealth Fund, March 2001. Centers for Medicare and Medicaid Services (CMS), *Framework for Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act: New York State* November 2000. CMS website, <http://www.hcfa.gov/init/charny99.pdf>

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

^aChildren's coverage groups.

^bPresumptive eligibility for children was approved in the 1998 New York Health Care Reform Act but has not been implemented.

^cSince the Aliessa ruling in June 2001, the qualified alien group includes people who have been in the U.S. for less than five years and Persons Residing Under the Color of Law (PRUCOL). These groups are funded by state-only dollars.

TABLE 4: APPLICATION AND REDETERMINATION FORMS, REQUIREMENTS AND PROCEDURES

Characteristic	SCHIP	Medicaid ^a
APPLICATION		
Form		
Joint form	Yes ^b	Yes ^b
Length	4 pages	4 pages
Languages	2 (English and Spanish)	2 (English and Spanish)
Verification Requirements		
Age	Yes	Yes
Income	Yes ^c	Yes
Deductions	NA	Yes
Assets	NA	NA
State residency	Yes	Yes
Immigration status	No	Yes
Social security number	NA	Yes
Enrollment Procedures		
Mail-in application	Yes	No ^d
Phone application	No	No
Internet application	No	No
Hotline	Yes	Yes
Outstationing	No	Yes
Community-based enrollment	Yes	Yes
REDETERMINATION		
Same form as application	Yes	Yes
Pre-printed form	No	No
Mail-in redetermination	Yes	No ^d
Income verification required	Yes	Yes
Other verification required	Yes, if any changes	Yes

SOURCE: Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, October 2000; Centers for Medicare and Medicaid Services (CMS), *Framework for Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act: New York State* November 2000. CMS website, <http://www.hcfa.gov/init/charny99.pdf>

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

^aChildren's programs.

^bForm is also used by the Supplemental Nutrition Program for Women, Infants and Children (WIC) and Prenatal Care Assistance Program (PCAP)

^cSelf-declaration is permitted as a last resort.

^dA face-to-face interview is required, but may be with a facilitated enroller.

- Changed its definition of “household composition,” adopting Medicaid’s more generous, yet more complicated methodology;
- Required all applications to be reviewed using a “net” income test (which disregards from countable income certain amounts of work and child care expenses) so that potential eligibility for Medicaid could be accurately determined; and
- Changed its verification requirements, asking applicants to submit four consecutive pay stubs to verify income (as opposed to a signed tax return and one other form of income documentation).

This alignment of *Child Health Plus* and Medicaid rules, which made the SCHIP application process somewhat more complicated than it had been, enabled the state to design its new “Growing Up Healthy” application form. The new form, which is seven pages long and includes a “screen and enroll” income worksheet, was rolled out in April 2000.

The second step in reforming the system was the creation of facilitated enrollment. This strategy was designed to achieve multiple goals for the programs—namely, to improve the ability of *Child Health Plus* and Medicaid to reach and enroll “hard to reach” populations at the community level; and to institutionalize a process through which effective “screen and enroll” could take place. The Request for Proposals for facilitated enrollment was released in May 1999, and awards totaling \$10 million were made in October 1999. Grant monies were directed to 32 “lead agencies” who, along with their community-based subcontractors located in all of the state’s counties, agreed to receive training in how to assist families with completing the Growing Up Healthy application and then implement ongoing efforts to reach and enroll uninsured children. As stated above, lead agencies included a broad array of agencies and community-based organizations, including regional perinatal councils, hospital associations, local health departments, local DSS agencies, rural health centers, Jewish community centers, and senior centers. Proposals that demonstrated the formation of coalitions that went beyond traditional child-related organizations (e.g., child care centers and child health clinics) to include a broader

array of community, family, and ethnic group service organizations received more favorable consideration. Importantly, health plans were permitted to apply for designation as facilitated enrollment agencies, and many successfully did so.

Critically, these facilitated enrollers were delegated the authority to have their meetings with clients constitute the face-to-face interview which was previously required by local DSS agencies. That is, once facilitated enrollers meet with families and assist them with the application, no further face-to-face interview with DSS is required for those families that are determined to be Medicaid eligible. Facilitated enrollment was implemented statewide in June 1999.

Thus, as the system is currently set up, families have multiple avenues through which they can apply to *Child Health Plus* and Medicaid. Specifically, they can:

- Apply directly through a health plan (whether or not the plan is a facilitated enrollment agency);
- Apply through a facilitated enrollment agency; and
- Apply directly with a local DSS agency; and

The typical steps a family would complete through each of these avenues, while quite similar, are delineated below.

Application through a health plan. Still the most common method through which families apply for child coverage, application through a health plan typically proceeds as follows:

- Parents may contact health plan personnel by phone in response to a *Child Health Plus* or Growing Up Healthy advertisement (or, conversely, health plan marketing staff may approach and talk to parents about *Child Health Plus* in a community setting). If the parent is interested in making an application on behalf of their child(ren), they can request an application, complete it, and mail it in to the plan. Alternatively, they can set up an appointment with enrollment staff to receive help in filling out the form. During the call to set up this appointment, marketing staff

typically explain the various items that parents will need to bring to the appointment (i.e., income verification, etc.).

- During the appointment, enrollment staff work with parents to complete the application and eligibility worksheet and collect all necessary verification documents.
- If enrollment staff determine that the applicant is eligible for *Child Health Plus*, and all the required documentation has been submitted, then they are enrolled in the program.

If, however, the applicant is determined eligible for *Child Health Plus* but has not brought in all of the required documentation, then the plan may grant the child *presumptive* eligibility for a period of 60 days. Parents are asked to submit all required documentation during that 60-day period so that formal eligibility can be established; if they do not, they are disenrolled at the end of the 60 days.

Finally, if the applicant is judged to be Medicaid eligible, the health plan can grant the child *temporary* eligibility for a period of 60 days (during which time they can receive services from the health plan), the application is forwarded to the local DSS agency for review, verification, and approval, and the family works with DSS to ensure that the application is complete so that the child can be enrolled in Medicaid.

Application through a Facilitated Enrollment Agency. Making application through a facilitated enrollment agency generally entails the same steps as applying through a health plan. Specifically,

- Facilitated enrollment staff, working in the community, talk to parents about *Child Health Plus* and, if they have children who lack insurance, try to persuade them to apply. If the families are interested, an appointment is made to meet either at the community-based organization, or the family's home, or in some neutral location. Once again, parents are told what documents they will need to provide during the appointment.
- At the appointment, the application and eligibility worksheet is completed and all verification is submitted. The facilitated enroller then makes an eligibility determination. If the child appears to be eligible for *Child Health Plus*, parents are asked to select a health plan. Importantly, if the parent has not provided all the necessary documentation, the facilitated enroller is required to follow up with the family and persist until all materials are gathered. (Unlike health plans, facilitated enrollers have no authority to grant presumptive eligibility to applicants who are still gathering verification.)
- Once the application is complete, facilitated enrollers submit the packet to their lead agency who is responsible for conducting a "quality control" review. Lead agency staff review the application to ensure that the eligibility determination decision is correct, the forms are complete, and that all verification is submitted. If the

application is complete and the child is eligible for *Child Health Plus*, the lead agency forwards the materials to the health plan the family selected. If the application is complete and the child is eligible for Medicaid, the lead agency forwards the materials to the local DSS office for review and approval. If the application is incomplete, then it is sent back to the facilitated enroller for further follow up.

Application through a local DSS office. Under this scenario, a parent may either call or visit a local DSS office (or a health care provider site with an outstationed DSS eligibility worker) and inquire about applying for *Child Health Plus* or Medicaid. In either case, DSS staff set up an appointment with the parent and discuss the materials that must be brought to the meeting. At the appointment, eligibility staff discuss with parents the various programs for which they and their family might be eligible. In some offices—typically those in New York City—staff allow parents to choose to simply apply for health insurance for their children and, in these cases, help the family complete the Growing Up Healthy form. More commonly, however, staff in DSS offices will encourage families to complete the longer multi-program eligibility form in order to explore their potential eligibility for cash assistance, Food Stamps, and Medicaid for the entire family. If this route is chosen, parents may benefit by obtaining much broader benefits than they originally sought. On the other hand, this route entails the completion of a much more complicated application, and requires the submission of considerably more information and documentation (related to, for example, absent parents and child support paid by someone outside the home). If the child is found to be Medicaid eligible, then DSS will approve the case and refer the family to persons who will help them with the selection of a health plan.⁴ If the child is found to be eligible for *Child Health Plus*, parents are asked to select a health plan immediately, and the application is forwarded to the selected plan.

⁴In New York City and Long Island, an enrollment broker—Maximus—is used for this function.

C. REDETERMINATION PROCESS

Eligibility redetermination for both *Child Health Plus* and Medicaid begins with a fairly similar step: 60 days prior to the end of a child's 12-month eligibility cycle, health plans and local DSS offices send out notices to the parents of SCHIP and Medicaid enrollees, respectively, notifying them of their need to re-certify their eligibility. From this point, the process differs in subtle, but important ways.

- For *Child Health Plus*, health plans send out a new, blank copy of the Growing Up Healthy application form and ask families to fill it out and mail it in; documentation is requested only for income and any other items that may have changed since the child was first enrolled (e.g., address information). If families do not respond to the first notice, health plan marketing staff typically follow up with some combination of additional letters, phone calls, or even visits to families' homes. Families can request assistance from health plan staff in completing the renewal application, or can be referred to other community-based facilitated enrollers to receive assistance. If a family responds before the end of their eligibility period, then their renewal application is reviewed and a determination is made—children remaining eligible for *Child Health Plus* remain enrolled with their plan; children who have become eligible for Medicaid have their application referred to the local DSS office; and children who are no longer eligible for either program are disenrolled. If a family does not respond to any of the renewal notices or contacts, then they are disenrolled at the conclusion of their 12-month eligibility period.
- For Medicaid, DSS offices also send out a blank application form (with the specific form corresponding to the various program(s) in which the child is enrolled). In the redetermination notice, an appointment time is also designated for the parent to appear at the local DSS office for a face-to-face interview to complete the redetermination. Families may phone DSS to reschedule the appointment if the chosen time is not convenient, but a face-to-face interview is eventually required as part of the process. Families must complete the appropriate application form(s) and re-submit all verification materials. Unlike health plans, DSS offices are much less likely to send additional reminder notices to families beyond the initial letter; attempts to directly contact families by phone are rare. As a result of the face-to-face interview, families are either continued in Medicaid, referred to *Child Health Plus* if their income has risen above Medicaid levels, or disenrolled if the child is no longer eligible for either program.

Importantly, facilitated enrollment agencies *may* get involved in the eligibility redetermination process. Specifically, if a family needs help with completing either a Growing Up Healthy or Medicaid renewal application, they can visit the facilitated enroller and receive

that help. For Medicaid enrollees, this meeting can serve as the face-to-face interview required by DSS.

D. EXPERIENCES AND LESSONS LEARNED

One look at New York's enrollment figures indicates that the state has been quite successful in enrolling children in *Child Health Plus*. As shown in Table 5, enrollment in *Child Health Plus* has risen steadily, peaking at nearly 530,000 in late 2000. Furthermore, the March supplement to the 2000 Current Population Survey reports that rates of uninsurance among children actually dropped in New York for the first time since 1999. Nearly every key informant we interviewed for this study expressed considerable pride in New York's enrollment success, but also readily cautioned that more work was needed as the baseline of uninsured kids seemed to "always be going up."

One of the leading reasons why informants were guarded in their optimism was that New York has experienced significant challenges in *keeping* children enrolled in *Child Health Plus*. State officials and health plan administrators estimate that rates of disenrollment among children have ranged from 30 to 40 percent since the start of the program, depending on the health plan, stating that children are "leaving the program almost as fast as we can sign them up." Whether these children are permanently lost from the program or are only temporarily losing coverage is unclear at this time. State officials have estimated that roughly 20 percent of children disenrolled in any given month later re-enroll in the program—a phenomenon they call "churning."

Interestingly, despite much fear and trepidation among policymakers, health plan administrators, and advocates, the massive "transfer" of *Child Health Plus* enrollees (who were really supposed to be Medicaid eligible) to Medicaid does not appear to have occurred in the aftermath of facilitated enrollment. The reasons for this are unclear. Some informants we

TABLE 5: ENROLLMENT TRENDS

Enrollment Measure	1998	1999	2000	February 2001 ^a
Number ever enrolled in federal fiscal year (FFY)	282,741	519,401	769,457	NA
Number enrolled at year end (point in time)	270,683	425,552	529,149	516,381
Percent change in point-in-time enrollment	—	+57%	+24%	-2.4%

SOURCE: Vernon K. Smith, *CHIP Program Enrollment: June 2000*. Kaiser Commission on Medicaid and the Uninsured, January 2001. Centers for Medicare and Medicaid Services (CMS), *Framework For State Evaluation Of Children’s Health Insurance Plans Under Title XXI of the Social Security Act, 1999*. March 2000 website: <http://www.hcfa.gov/init/nyeval98.pdf>. Centers for Medicare and Medicaid Services (CMS), *State Children’s Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999* website: <http://www.hcfa.gov/init/fy99-00.pdf>; New York State Department of Health Child Health Plus statistics website <http://www.health.state.ny.us/nysdoh/chplus/childrenr.htm>

^aMost recent enrollment data available.

interviewed theorize that the many policy changes made to *Child Health Plus* rules ended up making the program more inclusive, and thus families that on the surface appeared Medicaid eligible actually turned out to be SCHIP eligible. On the other hand, the fact that state officials explicitly chose to address the “transfer” problem through the eligibility redetermination process—that is, during each child’s recertification, more rigorous “screen and enroll” procedures by health plans and facilitated enrollers would result in children being placed in the appropriate program—probably means that no one will ever be able to know precisely which children are disenrolling from *Child Health Plus* because they are no longer eligible for the program in the absolute, versus which children are being transferred and never belonged in *Child Health Plus* in the first place. Regardless, policymakers are today more confident that children are enrolled in the appropriate programs for which they are eligible—recent audits by the Office of the State Controller have verified this—and state officials hazard the guess that so-called

transfer cases probably comprise no more than 20 percent of all disenrollment from *Child Health Plus*.

Over time, policymakers and other key informants report they have learned many valuable lessons about factors that contribute to, or undermine, successful enrollment. In the last year, in particular, much has been learned about the challenges of reforming Medicaid eligibility processes and integrating them with those of *Child Health Plus*. These lessons are summarized below.

- ***Using health plans as a partner in marketing and enrollment may be critical.*** Key informants of virtually all types acknowledged that New York’s strategy of giving managed care plans the authority to market *Child Health Plus* and to directly enroll children into care has been critical to the program’s positive enrollment experience. Health plans, it was reported, possess considerable expertise in these areas and have obvious financial incentives to invest in aggressive marketing and enrollment. At the same time, state officials appear to have reached a comfort level with their ability to monitor plan practices and feel that they have guarded against inappropriate marketing techniques that could take advantage of vulnerable families.
- ***Facilitated enrollment has added a critical new facet to New York’s enrollment strategy.*** If there was any weakness in New York’s original battery of strategies for enrolling children into *Child Health Plus*, it was the program’s limited success in reaching “hard-to-reach” populations, including various ethnic minority communities and immigrant populations who were reluctant to enroll in public programs. By most accounts, facilitated enrollment has succeeded in addressing this weakness and has created and supported a new infrastructure for carrying out more targeted outreach and enrollment at the local level and with “hard-to-reach” populations. Time after time during our site visit interviews, we heard providers, advocates, and staff of community-based organizations report that facilitated enrollment has permitted *Child Health Plus* to reach families that “never would’ve been reached before,” and “that would simply have not responded to a billboard or TV ad to apply for the program.” Furthermore, facilitated enrollment staff were repeatedly described as providing the critically important “trusted voice” in the community to engage families in direct discussions about health insurance, alleviating fears and misunderstandings about participation in public programs, and persuading parents to submit applications on behalf of their children. Of utmost importance, the process was praised for enabling community groups the flexibility to adapt their strategies and assist families in a manner tailored to their needs.
- ***Supporting facilitated enrollment agencies through “seed money” grants appears to be a successful strategy.*** State officials, in designing facilitated enrollment, chose to provide financial support and incentives to community-based agencies in the form of

up-front grants, as opposed to retroactive reimbursement (or “finders’ fees”). This approach was widely praised by the community-based groups participating in the program for it provided them with resources to actually hire staff and build the capacity to take on and carry out this complex new function on top of their normal every-day duties. While no agency felt that they were receiving sufficient funds to fully support their application assistance efforts, they were happy to have received money to support the effort up front, rather than having to bill for and await reimbursement for completing applications as is the practice in many states across the country.

- ***Building trust and strong working relationships between community-based organizations, health plans, and county social services agencies is challenging, but achievable.*** The first year implementing facilitated enrollment and the new Growing Up Healthy application was fraught with challenges and disputes between health plans, community groups, and local DSS agencies. Health plans were frustrated to have to undertake a more complex and time-consuming application process, community groups struggled to learn the complex new process and balance their desires to help families with the need to rigorously enforce and follow application rules and procedures, and county DSS agencies had to confront the reality that a growing number of organizations in their communities were taking on responsibility for determining eligibility for Medicaid, a function they alone performed for years and years. In fact, during the first months of implementation, it appears that both plans and community groups had difficulty learning to implement the new application, and rejections from DSS of incomplete or incorrectly completed applications were common. Over time, however, both groups have appeared to gain skill in helping families complete the process, and DSS agencies have begun to trust that their community “partners” are carrying out their work diligently. In two of the three DSS offices we visited, staff were delighted with the progress of facilitated enrollment and welcomed the “help” these groups were providing in reviewing applications from needy families, stating that “facilitated enrollment makes our life easier,” and “...reduces our workload.” The very positive goal of enrolling children in health insurance appears to have been embraced by almost all parties and has helped foster an air of cooperation in most of the communities we visited.
- ***Presumptive and Temporary Eligibility may be important strategies for granting more immediate and continuous coverage, but can be confusing for families and challenging to implement.*** As discussed above, *Child Health Plus* health plans grant children 60 days of presumptive eligibility if they appear eligible for the program but their parents still need to produce verification or other information to complete the application. In addition, temporary coverage is offered to families that apply with a plan, but are found to be Medicaid eligible. Both strategies were generally praised; the former for providing children with immediate coverage in the hope (or expectation) that their parents will complete the process, the latter for also providing immediate coverage and, presumably, more continuous care with the family’s selected health plan, while Medicaid and its enrollment broker complete the plan selection process with parents required under Medicaid rules.

However, both policies have potentially serious shortcomings. Health plans report that between 30 and 50 percent of children granted presumptive eligibility are disenrolled before they receive full coverage because parents do not complete the application by collecting and submitting required verification. Plan officials suggested that perhaps presumptive eligibility “lulls” parents into thinking their children have coverage and that no additional steps are needed. In addition, temporary eligibility can create problems. For example, we heard cases where families were confused when they were contacted by DSS and Maximus informing them that they were required to select a health plan, when they already thought they had already done so. Furthermore, some informants expressed skepticism of the policy for it provides health plans with 60 days of capitated payments even for families that ultimately opt not to accept the Medicaid coverage for which they are eligible.

- ***Family resistance to Medicaid is strong, but overcoming the welfare stigma surrounding it is possible.*** As discussed above, *Child Health Plus* was conceived and implemented in the model of private health insurance specifically because negative views of the New York Medicaid program were widespread (among legislators, providers, and consumers). When federal rules required New York to begin enforcing more rigorous “screen and enroll” rules, advocates and health plan officials (in particular) voiced significant concern over the prospect of transferring large numbers of families from *Child Health Plus* to Medicaid, and predicted that many families would simply “walk away” when they were told they were no longer eligible for SCHIP. Similarly, early views of the joint application form were that it was far too “cumbersome,” and many believed that enforced referrals of Medicaid eligibles to county DSS offices would put a significant chill on enrollment efforts.

Encouragingly, it appears that health plans and facilitated enrollers are succeeding in overcoming families’ resistance to Medicaid. On one hand, almost without exception, marketers and enrollers reported that families were to varying degrees unhappy when they applied for *Child Health Plus* but were found to be Medicaid eligible—resistance was borne out of previous bad experiences with the application process, concerns that DSS workers would “get into my business,” and/or pride among working families that did not consider themselves “welfare” recipients. However these same workers also almost uniformly reported that they were able to convince families that they should accept Medicaid and enroll in the program. Primary strategies for persuading families to do so focused on explaining to parents that Medicaid offered broader coverage than *Child Health Plus*, that Medicaid could pay for any medical bills that had been incurred in the past three months and, importantly, that parents would not have to go through a face-to-face interview in a DSS office. Perhaps most important, families tended to be persuaded to accept Medicaid when they were informed that they would likely be able to keep their same provider; the very close overlap of health plan participation in both *Child Health Plus* and Medicaid in New York was cited as critical in this regard.

Still, there are many policymakers and advocates that fear that Medicaid stigma is still working against the programs. Problems with retention, in particular, were cited

as possibly related to families' resistance to Medicaid and desire to drop out of a program they don't like.

- ***Changing Medicaid's name may or may not be making a difference.*** We heard mixed reviews of the impact and effectiveness of changing the name of Medicaid for children to *Child Health Plus A*. Nearly everyone agreed that the name change was “fooling no one,” not the least being providers or consumers. However, advocates and policymakers were strong in their belief that the name change would become more important over time, as the state continued to market the two programs jointly, and as the image of Medicaid as a health, and not a welfare program, took hold.
- ***Retention is now a significant challenge needing further attention and a policy response.*** Beginning in late 1999 and early 2000, as the first waves of federally-funded *Child Health Plus* enrollees came up for eligibility renewal, the challenges associated with retention became increasingly apparent. Like most states, New York had worked hard at outreach and simplifying the initial enrollment process, but had paid less attention to the eligibility recertification processes for SCHIP and Medicaid. Indeed, New York soon was faced with disenrollment rates of between 30 and 40 percent. In response, health plans describe undertaking what can be described as heroic efforts to keep their enrollees signed up—it is now the norm for health plan marketers to spend as much time on eligibility renewals as initial enrollment, and, in New York City, these staff routinely make multiple phone and/or home visits in an attempt to reach families and have them submit their renewal applications. Still, even the most aggressive plans have only managed to achieve 75 percent retention rates. High turn-over appears to be due to a combination of factors—some families' children are simply no longer eligible for coverage, as they have “aged out” of the program or parents have obtained private coverage; but others, it appears, are discouraged by or too distracted to undertake the process of re-applying for coverage and re-submitting materials and verification that was previously submitted. At the time of our visit, much focus was being placed on the need for simplifying the renewal process; pre-printing renewal applications with information already gathered from the initial application was the strategy most often mentioned as holding promise.
- ***New York will likely further simplify the Child Health Plus application and renewal process.*** An unfortunate outcome of the development of the joint application for *Child Health Plus* was that application for SCHIP coverage actually became *more* difficult, even as application for Medicaid was made easier. Policymakers are well aware of this and hope to further simplify the combined process. At the time of our site visit, a bill was before the state legislature that would: change the income test for *Child Health Plus* (*i.e.*, both *A* and *B*) to gross rather than net; eliminate all face-to-face interview requirements, including that required for Medicaid renewal; eliminate the requirement that applicants produce verification of Social Security Numbers and residency; allow self-declaration of income; adopt continuous coverage for a two-year period; and pre-print eligibility renewal forms. While no one was optimistic that *all* of these provisions would be passed into law, there was general agreement that New York's recent efforts to build a more seamless SCHIP/Medicaid system had “opened the door” to further simplification, and that the state would likely continue to incrementally change and improve its programs.

V. CROWD OUT

A. INTRODUCTION

In most states, the concern that SCHIP would somehow lead to a substitution of government-sponsored health insurance for existing employer-based coverage—so-called “crowd out”—was significant, and debates over how to prevent crowd out were prominent during the program’s initial policy development phase.⁵ In New York, however, a very different situation existed. Namely, the phenomenon of crowd out was not particularly recognized, or at least didn’t cause concern, in 1990 when officials were first establishing *Child Health Plus*. At that time, the relatively limited insurance product that was being put in place didn’t seem to hold much potential for replacing the more comprehensive coverage that was often provided through employers. Over time, even as *Child Health Plus* was expanded, state officials and policymakers did not perceive that significant levels of crowd out were occurring. Therefore, when New York’s program was grandfathered into Title XXI, crowd out was not a concern and no policy discussions focused on whether the state should implement provisions to prevent its occurrence.

It was only when the Health Care Financing Administration reviewed New York’s state plan that crowd out became an issue. Specifically, HCFA’s interpretation of the Title XXI statute was that any states with income eligibility thresholds above 200 percent of poverty must take steps to prevent crowd out, even if only to monitor the degree to which it was occurring. As a result, New York officials negotiated an agreement with HCFA whereby they would design and implement a crowd-out monitoring protocol, and only implement a more direct deterrence strategy—such as a waiting period—if measurable crowd out exceeded a certain threshold.

B. POLICY AND PROGRAM CHARACTERISTICS

To monitor crowd out, New York added a series of questions to the *Child Health Plus* application form related to applicants' current and previous health insurance status:⁶

- The number of children who have had health insurance in the past six months;
- The number, of those, that had this insurance through an employer; and
- The number who dropped that insurance for any of the following reasons:
 - a. The employer discontinued offering dependent coverage or is no longer contributing toward a premium for dependent coverage;
 - b. The premium was increased beyond a level that was affordable to the family;
 - c. *Child Health Plus* was judged to be a more affordable alternative;
 - d. *Child Health Plus*' benefits were judged to be better; and
 - e. The parent was no longer working for the employer who offered health insurance.

To calculate the level of substitution of public for private insurance, New York sums the total of responses to questions a, c and d, and divides by the total number of applicants to arrive at a statewide percentage of total SCHIP enrollees that are on the program as a result of the crowding out of existing employer-based coverage. In its agreement with HCFA, New York will implement a waiting period of some length for persons with existing insurance if measurable crowd out exceeds 8 percent over any nine month period.

(continued)

⁵Ian Hill. "Charting New Courses for Child Health Insurance." *Policy and Practice*. Vol. 58, No. 4, December 2000.

⁶A Westpfahl Lutzky and Ian Hill, 2001. *Has the jury reached a verdict? States' early experiences with crowd-out under SCHIP*. Washington, D.C; The Urban Institute

C. EXPERIENCES AND LESSONS LEARNED

To date, state officials reported that crowd out (as defined above) has hovered between four and six percent since the advent of federal funding under Title XXI. Therefore, they have not needed to implement a waiting period (a policy that no one we spoke with was anxious to adopt). Today, state officials, legislators, health plan officials, and advocates alike are “not worried” by the prospect of crowd out.

Still, at the local level, we heard reports that crowd out may be occurring, in particular among families who are paying extremely high out-of-pocket costs for their current dependent coverage. For example, in rural Cortland County, facilitated enrollers described how some self-employed families pay as much as \$600 per child in monthly premiums, plus high deductibles and copayments, often in return for a limited range of benefits. Many local officials considered it was perhaps reasonable for such “underinsured” children to switch over to *Child Health Plus*.

However, when asked what they said to families who already possessed insurance for their children, enrollers both upstate and in New York City consistently reported that they always discouraged families from dropping their current private coverage, and explained that if the applicant dropped it they risked not being able to re-obtain that private coverage if they were subsequently found ineligible for either *Child Health Plus* or Medicaid. Furthermore, the prospect of a waiting period was identified as a direct incentive for health plans to discourage families from dropping their private coverage in order to enroll their children in SCHIP.

VI. BENEFITS COVERAGE

A. INTRODUCTION

The state-funded *Child Health Plus* program was initially launched with a rather limited benefits package. In 1991, the program offered coverage only for a basic package of preventive, primary, and outpatient hospital services. The program was designed to address an identified gap in children's access to preventive and primary care, and the state's safety-net hospital system was envisioned as a back up for those children needing more acute care. Over time and as enrollment in the program grew, advocates and policymakers recognized the need to expand the scope of coverage available under *Child Health Plus* and, in 1996, added inpatient hospital services to the package. Then, after the passage of Title XXI, consensus existed that the program needed to offer a model of comprehensive care to children, and thus the legislature approved further benefits expansion for 1998. Specifically, *Child Health Plus* was amended to include additional coverage of dental care, speech, vision and hearing services, durable medical equipment, nonprescription drugs, and broader inpatient and outpatient mental health and substance abuse treatment services.

B. PROGRAM CHARACTERISTICS

Overall, the benefits covered under *Child Health Plus* are quite broad and compare well with those of Medicaid—the program covers a broad range of preventive, primary, acute, therapeutic, and behavioral health services. Compared to Medicaid, the only services explicitly omitted from the package are:

- Emergency and non-emergency transportation;
- Orthodontics;
- Case management; and

- Long term care.

In addition, *Child Health Plus* imposes limits on several services, including occupational, physical, and speech therapies; medical supplies and durable medical equipment; and mental health and substance abuse treatment. As such, these represent additional examples of how and where the package falls short of that covered by Medicaid (which, under EPSDT rules, must provide all services needed by a child for a condition identified during an EPSDT screen, regardless of whether or not the service is covered in the state Medicaid plan). Importantly, though, *Child Health Plus* has adopted the same well-child screening periodicity schedule used by Medicaid and endorsed by the American Academy of Pediatrics.

C. EXPERIENCES AND LESSONS LEARNED

There was universal agreement among the key informants we interviewed, including child health advocates, that the *Child Health Plus* benefit package was very generous and appeared to be meeting the needs of enrollees. While not quite the equivalent of Medicaid, the package was described as “very comprehensive,” and providers and health plan officials were quick to point out that it offered coverage that was typically much broader than that of private insurance policies in the state, especially with regard to its coverage of such services as vision, hearing, and dental services, as well as over-the-counter drugs.

Informants could identify very few or no cases where they had heard of children who needed services that simply were not covered. Even advocates, state maternal and child health officials, and legislators reported that the package seemed to be working well for the full range of children, including children with special health care needs. Exceptions to this rule were a small number of cases where children with hemophilia were not able to obtain certain supplies and blood factors not covered by *Child Health Plus*, and an anecdote from a provider in New York

City who stated that the children she served needed much more speech therapy than was covered within the program's limits. Beyond this, the only service gap that was identified repeatedly was that of transportation. Administration officials hoped that this gap would be addressed "very soon." In fact, the Assembly passed a bill last year to fund emergency transportation but it was vetoed by the Governor (who reportedly preferred that the matter be dealt within the larger *Child Health Plus* reauthorization bill in the 2001 budget). Importantly, though, child advocates said that it was too early to assume that *Child Health Plus* was meeting everyone's needs, stating "We know the package is not as broad as Medicaid, and we simply don't know yet who might be falling through the cracks."

VII. SERVICE DELIVERY AND PAYMENT ARRANGEMENTS

A. INTRODUCTION

From the outset, New York's goal was to deliver *Child Health Plus* services exclusively through capitated managed care arrangements. Over time, the state has developed contracts with multiple plans in all but one county. In contrast, New York's Medicaid program is moving somewhat more slowly toward mandatory managed care. At the time of this writing, under a Section 1115 demonstration that was approved in 1997, the state had phased in mandatory managed care in selected areas in New York City and in 13 counties upstate. Thus far, all mandatory enrollment has been among TANF and TANF-related populations (including poverty-related children), although mandatory enrollment for the SSI population is also part of the demonstration plan.

The state has worked hard to align the *Child Health Plus* and Medicaid managed care networks. Achieving this goal has been challenging, especially in 1996/97 when, after significant cuts in Medicaid capitation rates, several commercial health plans dropped out of that program. Medicaid rates were raised, however, in 1999 and state officials persisted with their informal policy of requiring plans that wanted to participate in SCHIP to also participate in Medicaid. Today, New York has nearly achieved the alignment it sought: by mid-2001, the *Child Health Plus* program had contracted with 30 health plans across the state, with all but two also participating in Medicaid; and the Medicaid program had also contracted with 30 plans with, again, all but two participating in *Child Health Plus*.

Both state program administrators and child advocates believe that this alignment is critical if the programs hope to provide seamless coverage to children who move from one program to the other. At the time of this writing, there remained two key areas where the delivery systems

of SCHIP and Medicaid continued to differ. First, in the parts of the state where Medicaid managed care has not yet been implemented, the providers available to *Child Health Plus* and Medicaid enrollees are not the same. Second, a plan with a high proportion of *Child Health Plus* enrollees in New York City, Empire Blue Cross/Blue Shield, decided not to participate in Medicaid because it considered the reimbursement rates inadequate. This decision has caused significant disruption for families who have switched from *Child Health Plus* coverage to Medicaid and, as a result, been forced to select a new health plan and sometimes a new primary care provider.

B. POLICY AND PROGRAM CHARACTERISTICS

1. Service Delivery Arrangements

Participating managed care plans in both *Child Health Plus* and Medicaid are dominated by health plans sponsored by hospitals and/or Community Health Centers, alternately referred to as both Provider Sponsored Plans (PSPs) and Prepaid Health Services Plans (PHSPs). PHSPs have no commercial lines of business and instead serve only Medicaid and *Child Health Plus* enrollees. As of mid-2001, these plans enrolled more than 70 percent of both Medicaid's and *Child Health Plus*' enrollees in New York City and more than half of these enrollees statewide.⁷ The remaining enrollees are in commercial or private/not-for-profit HMOs, dominated by BC/BS (which only accepts Medicaid in some counties, not including New York City⁸).

According to informants interviewed for this study, the health plans that participate in both *Child Health Plus* and Medicaid typically offer to program enrollees identical (in the case of

⁷New York State Coalition of Prepaid Health Services Plans. *Managed Care Enrollment Trends Spring 2001 Reports*

⁸Empire, in New York City, is for-profit and does not take Medicaid, BCBS Central New York and Western New York are non-profit and take Medicaid in some counties.

PHSPs), or at least very similar (in commercial plans), networks of providers. This, too, was seen as a strength of the programs and a contribution to more seamless coverage for children moving between the programs.

While the array of participating health plans, as well as the networks they offer to *Child Health Plus* and Medicaid enrollees are very similar, their contracts to operate under these programs differ. Under *Child Health Plus*, health plans negotiate a single contract with the state Department of Insurance in Albany. In contrast, in Medicaid, health plans must negotiate individual contracts with the DSS offices in each county in which they operate. What's more, the actual size, content, and requirements of the contracts between DSS agencies and Medicaid plans were described as much larger and more complex than those written for *Child Health Plus* plans. Combined, these two factors explain why health plans reported that "doing business" with *Child Health Plus* was significantly easier and more straightforward than doing business with Medicaid. At the same time, health plan administrators were disappointed that SCHIP contracts have gotten "more and more like Medicaid contracts" over the last two years as Department of Health administrators have beefed up requirements related to "screen and enroll," data reporting, and quality monitoring.

The scope of services that are within the responsibility of *Child Health Plus* plans also differ somewhat from that of Medicaid. Most prominently, *Child Health Plus* plans are responsible for either delivering or arranging for the delivery of dental care to enrollees, while Medicaid plans have the option of taking responsibility for dental or having it "carved out" of their contracts (in which case, plan enrollees would seek and obtain dental care through the traditional fee-for-service system). Similarly, *Child Health Plus* plans directly administer the program's pharmacy benefits, whereas under Medicaid, prescription drugs are carved out. Behavioral health,

however, is included in managed care contracts for both *Child Health Plus* and Medicaid; most plans subcontract these services to managed behavioral health organizations.

2. Payment Arrangements

The payment arrangements used by *Child Health Plus* and Medicaid are strikingly different. For *Child Health Plus*, each plan negotiates with the state to identify a single average rate for enrollees of all ages, genders, and geographic locations. Across participating plans in 2001, this rate ranged between \$100 and \$130 per child per month. In contrast, Medicaid plans submit proposed rates based on their actuarial experience and the Department of Health sets rates through a complex process of negotiations subject to a pre-designated upper ceiling. Ultimately, plans are paid capitations within numerous rates cells that vary considerably depending on a child's age, gender, geographic location, and categorical eligibility group. For this reason, it is extremely difficult to make a simple comparison of *Child Health Plus* and Medicaid rates. Historically, however, because 25 percent of the costs of Medicaid are borne by counties (and financed by local property taxes), there has been considerable downward pressure on Medicaid rates. In contrast, *Child Health Plus* is funded entirely by state and federal dollars and enjoys considerable political support in the legislature, support that has tended to bolster relatively generous reimbursement rates.

C. EXPERIENCES AND LESSONS LEARNED

Overall, key informants we interviewed tended to rate both *Child Health Plus* and Medicaid highly for providing good access to care. Perceptions of access did vary by region of the state, however, with better access reported in New York City—"8 to 9 on a scale of 10" for both medical and dental care—than in upstate and rural regions—just "6 or 7 on the scale of 10." Dental access, in particular varied tremendously between upstate and downstate. In New York

City, where there is a competitive market and an ample supply of dentists, informants saw no problems with dental access. Upstate however, serious shortages of dentists were reported; dentists there can pick and choose which clients they serve and, typically, they choose not to participate in public programs.

The expansion of managed care statewide was described as having strengthened the delivery systems of both *Child Health Plus* and Medicaid. Key informants broadly agree that managed care has helped guarantee that children can select and receive care from a primary care doctor; these individuals also were of the opinion that, for Medicaid enrollees, a much larger pool of primary care providers was now available through managed care networks than had previously been available under fee-for-service. By extension, access for Medicaid enrollees was described as “much better” in mandatory managed care regions than in fee-for-service regions. Finally, once again, the fact that *Child Health Plus* and Medicaid contracted with nearly identical sets of managed care organizations was widely praised as a strength of the system in New York. This overlap gave policymakers and advocates, among others, confidence that the two programs provided very similar levels of access, and helped promote a more seamless system of care.

Beyond the problem with access to dental care upstate, reports of other access problems were small in number. In rural Cortland County, providers complained loudly about limited access to child psychiatry,⁹ stating that “...though SCHIP is a program promoted as having mental health benefits, in reality in Cortland it does not.” In other areas of the state, we heard some reports of shortages of pediatric mental health beds, pediatric orthodontists, and some pediatric sub-specialists.

⁹Cortland reportedly experiences rates of child abuse and behavioral health problems that are higher than the state average.

That health plans eagerly participate in *Child Health Plus* is largely a result of the state paying what are considered generous and fair payment rates. All of the health plan officials we interviewed stated that they “made money” on the program, with the only shortcoming noted with regard to rates paid for newborns. Medicaid, too, has become a more “viable product” for health plans, following the rate increases that were enacted in 1999, though health plan officials do not believe that the new rates have yet offset the large losses they experienced between 1996 and 1999. Interestingly, throughout its history, *Child Health Plus* has been widely perceived as the program that pays “much better” than Medicaid. However, when asked about the payment rates for both programs, health plans reported that SCHIP and Medicaid rates were now actually quite comparable. More specifically, when individual Medicaid rate cells were combined and weighted by the distribution of children enrollees, the average per child per month rates under Medicaid were described as “...within a dollar or two of *Child Health Plus*.” For dental care, however, it does seem clear that *Child Health Plus* plans reimburse dentists (or managed dental organizations) more generously than Medicaid fee-for-service.¹⁰

A critical reason why health plan officials reported earning profits on *Child Health Plus* is that they have found utilization rates for SCHIP enrollees to be lower than Medicaid enrollees. State officials, however, admitted that they had not carefully monitored utilization data to date, and were just beginning to analyze data that health plans were submitting through the state’s quality assurance reporting requirement system. For the year 1999 (the most recent reporting period), plans were able for the first time to report selected utilization rates for both SCHIP and

¹⁰Fees for Medicaid are about to increase following a legal case taken against the state by the dental association. In return, the dentists must open up to Medicaid. As a result, expenditure over four years will go up by \$546 million, and the reimbursement for the dentists will go up, for example, from \$8 to \$40 for a filling and \$5 to \$20 for an x-ray.

Medicaid enrollees. Advocates were quite vocal in their concern that they and the state “knew nothing about the degree to which children were actually receiving care under *Child Health Plus*,” and felt strongly that this was a critical area for future scrutiny. “We all feel very good about this program, but really, we don’t know what’s going on in terms of access.”

VIII. COST SHARING

A. INTRODUCTION

Child Health Plus was always modeled after private insurance and, by definition, targeted working families with incomes above those that would qualify them for Medicaid. As such, the inclusion of patient cost sharing in the model was important for several reasons. Philosophically, there was the sense among policymakers that it was appropriate to ask higher-income families to contribute to the cost of their coverage. In addition, to the extent that *Child Health Plus* might serve as a bridge between Medicaid and private insurance, then the inclusion of cost sharing would help families understand and gain experience with payment policies that are common within private insurance. Finally, many felt that it was critical to distinguish *Child Health Plus* from Medicaid and to build an image for the program that was “non-governmental.” To do so, it was believed, would greatly improve the chances that the program would be attractive to working families that might otherwise be resistant to a government “welfare” program. Of course, policymakers could not lose sight of the fact that the program was, indeed, targeting low-income children and that setting cost-sharing requirements at unaffordable levels would undermine the program’s fundamental purpose—to provide children with insurance.

B. PROGRAM CHARACTERISTICS

It was with this set of goals and constraints that state officials designed the original cost-sharing rules for *Child Health Plus*. As it was originally designed, *Child Health Plus* was fully subsidized for all children in families with incomes below 160 percent of poverty; an annual enrollment fee of \$25 per child was imposed on families with incomes between 161 and 222 percent of poverty; and families with incomes over 222 percent of poverty could buy into the

program for the full premium price. In addition, the program imposed nominal copayments for physician office visits and emergency room visits.

When eligibility and benefits were expanded in the pre-Title XXI *Child Health Plus* program in 1996, the Governor and legislature felt that enrollees should pay a little more for the increased benefits of the program. The state thus abandoned its annual enrollment fee and replaced it with a monthly premium of \$9 per child for families between 151 percent and 159 percent of the Federal Poverty Level (FPL), and \$13 per child for families between 160 percent and 222 percent of the FPL. When *Child Health Plus* began to receive federal matching funds under Title XXI, New York was required by HCFA to institute further changes to its cost-sharing structure. The premium for families with incomes less than 160 percent of FPL was removed, and families between 160 and 222 percent of the FPL were now charged \$9 per month per child, up to a maximum of \$27 per family. When the state expanded income eligibility to 250 percent of poverty, a second premium tier was introduced—\$15 per child per month, with a maximum of \$45 per family—for families with incomes between 223 and 250 percent of FPL. The state retained the option of allowing families with incomes over 250 percent to buy into the program for the full premium of \$115, on average. However, when they learned that federal rules would require them to monitor and ensure that total family out-of-pocket costs could not exceed five percent of family income, state officials decided to do away with all copayments and thus simplify the program. This cost sharing structure is summarized in Table 6.

For families with incomes falling within the premium-paying ranges, premium payment is required as a condition of eligibility. That is, families must submit their first month's premium as part of their application in order to establish coverage. In addition, families must pay premiums on a monthly basis to their health plans. (Families are given the option of paying premiums on a quarterly or annual basis, but no discounts are offered for doing so, and thus

TABLE 6: COST-SHARING POLICIES

Policy	SCHIP
Enrollment fee	No
Premiums by family income	Yes
< 160% FPL	None
161-222% FPL	\$9/month per child, up to a maximum of \$27/month per family
223-250% FPL	\$15/month per child, up to a maximum of \$45/month per family
>250% FPL	Full premium (amount varies with health plan selected, but amount is about \$115/month per family)
Consequences for non-payment of premiums	Yes
Disenrollment	Yes, after 30-day grace period
Black-out period	No
Copayments	No
Deductibles	No

SOURCE: Centers for Medicare & Medicaid Services (CMS), *New York Title XXI Program Fact Sheet*. CMS web site <http://www.hcfa.gov/init/chpfsny.htm>

NOTE: SCHIP=State Children’s Health Insurance Program (Title XXI)

practically none choose to do so.) Families are invoiced for premiums each month, and are required to submit payments by the first of each month of enrollment. Families are permitted a 30-day grace period if they fall behind in their payment, but if no payment is received by the 30th of a given month of coverage, health plans are required to disenroll the child. (State statute forbids plans from waiving or otherwise forgiving family premium payments.) Disenrolled children can reapply immediately for coverage, as there is no “blackout period” before re-enrollment is permitted.

C. EXPERIENCES AND LESSONS LEARNED

New York officials report that approximately 60 percent of *Child Health Plus* enrollees have consistently fallen within the fully-subsidized group (of families with incomes below 160 percent of poverty); that roughly 38 percent fall within the premium-paying group; and that less than 2 percent of enrollees are from families that buy into the program.

There was a remarkable degree of consensus among the key informants we interviewed that premiums under *Child Health Plus* were nominal and were not posing a barrier to enrollment for low-income families. Almost universally, payments of \$9 or \$15 per month were described as “very affordable,” and many strongly believed that these premiums made the program *more* attractive to working families. Even child advocates were convinced that nominal premiums were succeeding in making families “feel good” about participating in the program, and helping families to place more value on the insurance they received because they were paying for part of its cost. Input from most of the community-based enroller staff we interviewed supported these claims—in fact, working families from New York City to rural upstate were reportedly more likely to remark about “how cheap” the program was compared to the private insurance they may have purchased in prior years. When New York implemented facilitated enrollment and some families began to be transferred from *Child Health Plus* to Medicaid, we heard many reports from enrollers that families offered to continue paying premiums “so that they could stay in *Child Health Plus*” rather than being forced to accept Medicaid (for free). Only the “jump” from \$15 to \$115 per month (for families with incomes above 250 percent of poverty) was widely viewed as too steep and too expensive for families.

Of note, the problems that have surfaced surrounding premiums have apparently related more to logistical issues than affordability issues. Health plans consistently reported that the *Child Health Plus* payment schedule was too rigid and inflexible, that families often fell behind in making their monthly payments, and that the lack of a longer grace period was fueling a lot of unnecessary disenrollment and churning among families and their children. In some cases, the problem appeared to grow from a genuine difficulty in some families in understanding how insurance works and why they must pay for health care (in the form of a premium) before

actually obtaining a service; this type of problem was not uncommon among various immigrant groups from countries with more socialized models of health care delivery (like Mexico).

Some people question whether non-payment of premiums and enrollee churning is due purely to logistical problems. Rather, they posit that such behavior could indeed reflect problems with families' ability to afford monthly premiums, or at least reflect the value families on limited budgets place on insurance relative to other fundamental needs (e.g., housing, food, clothing). Data collected by the Bronx Health Plan raise these questions—they found that rates of disenrollment were higher among premium payers compared to fully-subsidized children, and also that these families often re-enrolled when their children needed care. Children in the premium-paying group were also found to have overall higher utilization rates, which suggests that the existence of premiums could fuel some level of adverse selection among these higher-income families. Health plans officials uniformly believed that a longer grace period would help ease this problem.

Despite the disenrollment and adverse selection problems that were identified in relation to premiums, all key informants except one child advocacy group supported the state's cost-sharing policies. Many praised the sense of "individual responsibility" cost sharing brought to the program, and families appeared to appreciate the ownership it brings. On a different note, the ability to buy-in at full cost was also considered a positive aspect of the program (even though it affected a relatively small number of children) because it creates an environment where "...potentially every child in the state could have insurance."

IX. FAMILY COVERAGE

For New York, there was really no question of whether Title XXI funds could be used to support the extension of health insurance coverage to the parents of children enrolled in *Child Health Plus*—the state is already spending its full allotment of funds (and more) on coverage of children and no unspent funds are available for this purpose. Interestingly, however, New York has pursued the development of a parental coverage program under Medicaid and, during our site visit, actually received federal approval of its Medicaid Section 1115 demonstration proposal to create the *Family Health Plus* program. While the details of the initiative are still to be worked out, state officials explained that the program will be patterned after the successful model of *Child Health Plus* and piggy-back on the new application procedures recently implemented for the program. In this regard, several of the key informants we spoke with, in health plans, community-based agencies, and advocacy settings, expressed considerable concern—while everyone was supportive of the need to extend insurance to parents, they were also very concerned that the expansion would further complicate the already complicated application process and potentially undermine the success that has been achieved with children’s enrollment.

X. FINANCING

Details of New York State’s spending and funding allotments are shown in Table 7. The state annually receives the fourth largest allotment in the country and was one of just four states to spend its full 1998 allotment. New York also received the largest re-allocation of federal Title XXI funds in 2001. State officials believe that the amount New York is allotted is insufficient to address the need, noting that California receives three times the money for a target population is just one-and-a-half times larger.

The state share of funding for *Child Health Plus*—35 percent—is funded with Health Care Reform Act (HCRA) dollars generated from surcharges imposed on providers across the state. The fact that *Child Health Plus* is funded entirely by state and federal funds, and *not* also supported by county governments like Medicaid, was consistently described as an advantage. Many informants discussed how the historical reliance on county governments for 25 percent of Medicaid’s costs was an important factor that underpinned the very conservative approach that counties traditionally take in conducting eligibility determinations for the program. Simply put, “...every expansion or simplification that gets proposed for Medicaid has direct implications for county expenditures and, by extension, local property taxes. State legislators never like to come home and tell their constituents that their property taxes are going up!”

As *Child Health Plus* has grown, and along with it its expenditures, political support for the program has not waned in the slightest. Indeed, every informant we interviewed remarked on the incredible political support that exists for the program and the fact that every politician liked to associate him or herself with the program. “It’s apple pie and Chevrolet, and everyone loves it,” remarked one legislative staffer. As such, we heard little or no concern over whether *Child Health Plus* would continue to receive both political and financial support from the state

TABLE 7: SCHIP ALLOTMENTS AND EXPENDITURES, IN MILLIONS, 1998-2000

FFY	Federal Allotment	Expenditures	Expenditures as Percentage of Allotment for the Year	Percentage of Year's Allotment Spent by End of FFY 2000	Redistributed Amount
1998	\$255.6	\$50.1	20%	100%	
1999	\$254.4	\$239.4	94%	100%	
2000	\$286.8	\$448.4	156%	63%	\$434.9

SOURCE: Centers for Medicare & Medicaid Services (CMS), Memo from Center for Medicaid and State Operations to State, January 25, 2000; Federal Register Notice, May 24, 2000; Kenney et al., *Three Years into SCHIP: What States Are and Are Not Spending*. Urban Institute: September 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI); FFY=federal fiscal year.

government. The federal fiscal outlook, however, was cause for somewhat more concern as state officials feared that they would easily continue to spend their federal allotments, and likely not be able to expect large re-allocations of funds year after year.

XI. OVERARCHING LESSONS LEARNED

From several perspectives, New York's *Child Health Plus* can be viewed as a success. The program has established a very positive and well-known identity across the state, which has fueled very high rates of enrollment. A large number of managed care plans have chosen to participate in the program, and this has contributed to what is perceived as very good access for children. Politically, the program is held in high regard, and thus the future outlook for ongoing funding and support is promising. Importantly, state officials have also worked hard to integrate *Child Health Plus* with the much larger Medicaid program and attempted to build smooth and strong links between the programs in hopes of creating a seamless public insurance system. Still, many challenges remain, especially with regard to integrating the two programs and achieving seamless coverage for children. Over the course of New York's system development, many overarching lessons have been learned by the various key informants we interviewed, which are described below.

- ***Achieving strong rates of enrollment takes time.*** State officials, while very pleased with the rapid enrollment that has occurred under *Child Health Plus* since 1997, are quick to point out that they had a seven-year head start on most other states implementing child health insurance programs under SCHIP. These officials acknowledged that it takes time for a new health insurance program, like any new product, to build a brand identity and become a well-recognized and positive program for families.
- ***Incrementalism, while sometimes painful, can work when undertaking systems change.*** A review of *Child Health Plus*' developmental history reveals a long record of gradual, incremental change. From its beginnings as a preventive and primary care program for young children, the program was expanded to cover broader benefits, older children, and families with higher incomes. In addition, federal funds were leveraged to support much broader and more intensive public awareness campaigns and more extensive and ambitious outreach and enrollment initiatives. Finally, the state confronted the necessity of merging its SCHIP program with the more complex and arcane Medicaid system, a move that was extremely difficult for everyone but that is already proving successful. All the while, the program accumulated greater

and greater amounts of public and political support. Many policymakers and individuals with statewide perspectives attributed this “success story” to the careful and deliberate incremental steps that the program took to expand and improve itself. “Success was built one step at a time.”

- ***The creation of a separate state program was necessary given the negative climate that had long surrounded Medicaid. However, the policy choice has also resulted in ongoing challenges related to coordinating and integrating the two programs.*** There was almost universal agreement among the state and local officials we spoke with that the success of *Child Health Plus* was fundamentally linked to the fact that it was a program separate from Medicaid and modeled after private insurance. We heard time and time again that SCHIP would never have succeeded in New York if it had taken the form of a Medicaid expansion—lack of political, provider, and consumer support would have undermined the program from the start. The obvious trade-off, however, of choosing to implement a separate state program has been the ongoing challenges that the state has had to face in attempting to coordinate and integrate the two programs, and build a more seamless system for families and their children. From a program administration perspective, it has helped that both *Child Health Plus* and Medicaid are run out of the same agency. Furthermore, New York has managed to recruit managed care organizations into both programs such that children enjoy nearly identical access (at least on paper) to health plans and providers regardless of which program they are in. The much tougher task, however, has been to merge the programs’ eligibility rules and application procedures, and early steps in this direction actually sacrificed some of the ease that had surrounded the process of applying for *Child Health Plus* in order to make Medicaid easier. The state is effectively grappling with this challenge too, however, and has already identified a series of next incremental steps that promise to simplify both programs’ enrollment rules.
- ***State officials have fostered ownership and buy-in among local officials, and this appears to have had a very positive effect on implementation.*** With the advent of facilitated enrollment, in particular, state officials provided local agencies with both the means and the mandate to design locally-tailored outreach and enrollment strategies. Community-based organizations, many of whom have never before worked with Medicaid or other state health programs, have enthusiastically joined the effort, learned complex new rules and procedures, and accepted responsibility for enrolling children in *Child Health Plus* and Medicaid. In just its first year of experience, these groups are already exhibiting great creativity in adapting outreach strategies to the needs and perspectives of local residents. Importantly, while state officials have extended considerable autonomy to these agencies to carry out their work, they have also created forums for supporting and fostering their efforts; regularly scheduled meetings among state officials and local grantees have proven effective at identifying and smoothing out problems related to implementation.
- ***Even in a time of growing economic uncertainty, the political and fiscal outlook for Child Health Plus looks strong.*** From the start, political and popular support for *Child Health Plus* was strong, and over the years, it has grown stronger and stronger. Politicians learned early on the political costs that could be associated with cutting or

capping the program—in 1993, when state budget pressures required that a freeze be placed on *Child Health Plus* enrollment, the public outcry and political fall-out were huge. We heard, repeatedly, that legislators and the Governor never wanted to revisit those days, particularly in light of the ever-growing size and popularity of the program. Therefore, even with the state’s economy slowing down and fiscal stresses looming, it seems certain that support for *Child Health Plus* will continue. This likelihood speaks volumes to the effect that a well-run and apparently effective health insurance program can have on government, and the potential that such programs have for popular and political support when they are delinked from welfare. It will be interesting to watch whether or how much of this positive capital will accrue to the Medicaid program as further steps are taken to improve its image and simplify its rules and procedures.

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APPENDIX A

KEY INFORMANTS

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