Utah FOUNDATION Research Report

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Highlights

- Overall, the number of low-income children without health insurance in Utah dropped during the late 1990s, from approximately 45,203 in 1996 to 42,489 by 2000.
- Utah has one of the most restrictive CHIP programs relative to its cohort states.
- Premiums for Utah CHIP participants are lower than in other states that require premiums. However, Utah requires all CHIP enrollees to pay premiums.
- Utah receives high marks from researchers for its outreach program and the emphasis the state places on CHIP as insurance rather than "welfare."
- However, Utah's parents are more likely than parents in other states to say the decision to apply for CHIP was a difficult one.
- Federal policymakers expressed concern over Utah's Primary Care Network, a benefit program for low-income adults in Utah, whether they have a child enrolled in CHIP or not. The GAO has been especially critical, estimating that the PCN program costs the federal government $59 million more in CHIP funding to Utah.

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Utah's Children's Health Insurance Program (CHIP): How Well Are We Doing?

Introduction

In November of 2000, Utah Foundation released an initial analysis of the Children's Health Insurance Program or CHIP. That report provided an overview of the program and its purpose as well as discussing first year results and health care reform in Utah. It concluded by detailing the state's plan for operation as well as the measurement tools used to determine how successful CHIP was in reaching its goals. The original report is available online at http://www.utahfoundation.org/reports.html or by contacting Utah Foundation.

Since the original report in 2000, there have been changes, both within the CHIP program and in government-managed health care; therefore, the state's CHIP program merited a second look. In this report, data and information supplied in the first report will be updated. Additionally, new analysis will be provided comparing Utah's program to other "cohort" states. Finally, Utah Foundation will look at customer satisfaction with CHIP and Utahns' experience with the program relative to those in other states.

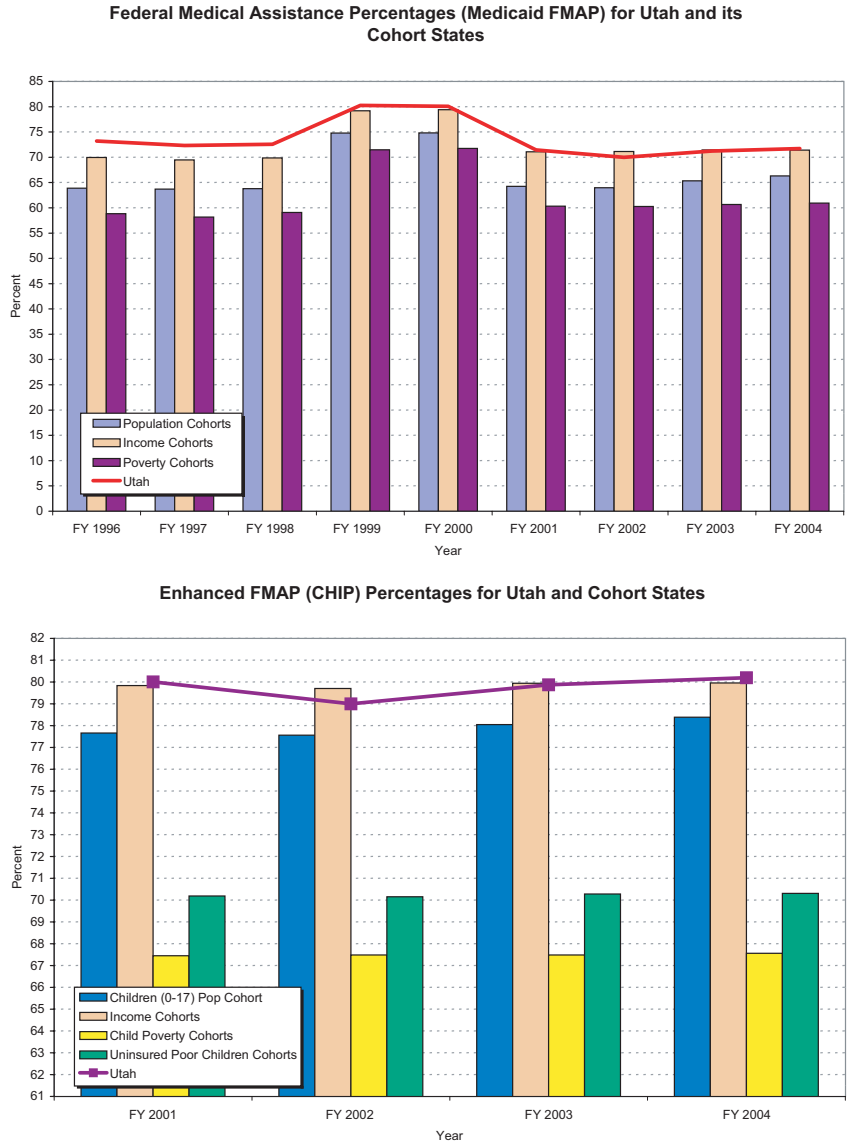
Background on SCHIP and Utah's Program

The State Children's Health Insurance Program was created in 1997 as part of the federal Balanced Budget Act and implemented through Title XXI of the Social Security Act. Congress allocated funds for SCHIP[1] in the form of block grants based on a variety of factors including the number of all low-income children, the number of low-income uninsured children living in each state and the cost of health care in each state compared to other states. Annual allotments of the block grants were originally added onto a state's Medicaid program funding. Since fiscal year 2001, however, SCHIP funding has been separated from Medicaid and the annual Federal Medical Assistance Percentages or FMAP for CHIP programs appear to be contingent upon a state's per capita personal income. Figure 1 details the FMAP for both CHIP and Medicaid for Utah and cohort states. The graphs indicate the federal CHIP funding formula mimics closely the PCPI formula of Medicaid. Correlations between the current year's CHIP FMAP and the prior year's PCPI add strength to this argument, with a value of –0.91. This means that the differences in states' per capita personal income explain 91 percent of the variance between FMAP amounts. The relationship is negative, meaning that the lower a state's PCPI, the higher the FMAP amount. Additionally, the federal matching rate is higher for CHIP than Medicaid. During fiscal year 2004, for every dollar spent in Utah for Medicaid, the federal government will pay 71.72 cents while the state will pay 28.28 cents. For CHIP, the federal reimbursement is 80.20 cents, which means the state will provide a little less than a fifth of the funds needed for CHIP. This allows states such as Utah that have a low per capita personal income to receive a larger federal match and provide services to a greater number of children than those states might otherwise be able to assist.

In the original legislation, SCHIP was meant to provide health care for uninsured children whose parents earn too much for those children to qualify for Medicaid. There has been some deviation from this original mission, a

Figure 1

A Comparison of FMAP Over Time



Source: U.S. Department of Health and Human Services (DHHS).

handful of states offer CHIP coverage to parents of CHIP enrolled children as well as pregnant women, and some states offer CHIP enrollees assistance in paying premiums for private insurance. Utah recently received approval of a waiver to use CHIP funds for the Primary Care Network, a low-cost preventative care program for all adults to age 64 that do not qualify for Medicaid. Adults can sign up for the Primary Care Network (PCN) even if they do not have a child enrolled in CHIP. The approval of Utah's PCN waiver caused some consternation among policymakers in Washington D.C.[2] A second waiver was recently granted by the U.S. Department of Health and Human Services to allow adults who cannot afford their employer's health plan to purchase private insurance. According to a Utah Department of Health press release dated 5/31/03, enrollment is anticipated for 6,000 Utahns and will be called the "Primary Care Network Covered at Work" program. Enrollment will begin in August 2003.

States had some latitude in designing their CHIP programs. Some states chose to extend Medicaid coverage to children above the traditional income threshold. Others, including Utah, created an entirely separate program, while a final group of states combined these two approaches. The states are almost equally distributed among the three options. There are 14 states that expanded Medicaid, 16 states that created separate programs and 20 states that combined the two. Each approach has advantages and disadvantages. The advantage to simply expanding Medicaid coverage to higher income groups was twofold. First, the mechanisms to provide services are already in place. Second, Congress offered the incentive of continuing to cover Medicaid SCHIP recipients if the CHIP program was phased out. For states that set up separate programs the incentive was to provide coverage that was on parity with private programs rather than the sometimes unwieldy and expensive set of Medicaid mandates. Additionally, policymakers in these states felt that parents were more likely to sign up their children and utilize the program if it did not have the stigma of "Medicaid" attached to it. For this reason, each state that has a separate program provides different services and coverage to its CHIP participants. In a subsequent section, a comparison between Utah and its cohort states' programs is offered.

Utah is one of at least 15 states funding CHIP through tobacco settlement funds.[3] Figure 2 shows the amount of state and federal revenue to the program since its first funding cycle during fiscal year 1999. In Utah, all state money for CHIP has come either in the form of restricted funds, i.e. tobacco settlement money, or through dedicated credits. Dedicated credits are "user fees" and in this case mean the quarterly premium payments made by CHIP enrollees. Originally, CHIP coverage in Utah was free of charge. Since 2002, a Utah family with an income between 101 and 150 percent of the Federal Poverty Level pays $13.00 a quarter while families with incomes between 151 and 200 percent of the FPL pay $25.00 a quarter. These premium payments were initiated as a way to cover costs. Other cost saving measures the Utah Department of Health has undertaken include allowing new applicants only during open enrollment periods, usually twice annually, and some benefits have been reduced or eliminated. Utah is not unique in realigning program benefits, procedures and funding to cover costs. Utah does stand out from the states with a similar per capita personal income in that it has chosen to offer the program to children at or below 200 percent of the Federal Poverty Level. Of the states within Utah's income cohort, three of them, Louisiana, Montana, and Oklahoma, offer benefits to children at or below 185 percent of the Federal Poverty Level, thus reducing the number of eligible children and costs associated with them. Additionally, Utah's premium payments are some of the lowest among its cohort states, primarily because they are to be paid quarterly whereas the other states require monthly premium payments. However, in all the states analyzed for this report, enrollees' out-of-pocket expenses for things like premiums and co-pays cannot exceed five percent of a family's annual income. If a family reaches that point, CHIP will pay 100 percent of any subsequent medical expenses for that year, excluding over-the-counter drugs, except in Kansas, Illinois, Georgia, Delaware and New York where over-the-counter medications are included as a benefit of the program. Figure 3 calculates the dollar value of the 5 percent maximum out-of-pocket expenditures for families at 150 and 200 percent of the Federal Poverty Level (FPL).

Figure 2

History of Utah CHIP Funding by Budget Category

Utah's CHIP Budget	FY 1999	FY 2000	FY 2001	FY 2002	Authorized FY 2003	Appropriated FY 2004
General Fund	$0	$0	$0	$100	$0	$0
Federal Funds	5,532,600	12,427,000	20,159,100	24,027,000	22,453,900	28,472,300
Dedicated Credits	0	0	0	517,000	1,675,000	1,675,000
Restricted Funds	2,000,000	4,154,500	5,500,000	5,495,800	5,496,800	7,003,200
Transfers In/Out	-638,400	-929,600	-2,032,300	104,900	105,000	105,000
Total	$6,894,200	$15,651,900	$23,626,800	$30,144,800	$29,730,700	$37,255,500

Source: State of Utah, Governor's Office of Planning and Budget.

Utah's premium payments are some of the lowest among its cohort states.

For Utah families with incomes under 151 percent of poverty, the annual premium payments for two or more children equal $52. This, coupled with the fact that co-pays are nominal and CHIP will cover large expenditure items, such as inpatient hospital stays, ambulance transportation, lab work and x-rays as well as ER visits and surgeons' bills at 100 percent or for a maximum co-pay of $3, makes it unlikely that families at this income level will meet their out-of-pocket ceiling. For families with incomes above 151 percent, the possibility of reaching that ceiling seems much greater. First, co-payments are higher and some large expenditure items, such as hospital stays and mental or substance abuse counseling are reimbursed at 90 percent or less of the billed amount. Additionally, families pay 50 percent of the cost for prescription drugs not on the approved list. According to the Utah Department of Health, two

Figure 3

CHIP Income Guidelines and Out-of-Pocket Medical Expense Ceiling

For the 48 Continental States and Washington D.C.

Family Size	2003 FPL	150% of FPL	5% Maximum at 150% FPL	200% of FPL	5% Maximum at 200% FPL
1	$8,980	$13,470	$674	$17,960	$898
2	12,120	18,180	909	24,240	1,212
3	15,260	22,890	1,145	30,520	1,526
4	18,400	27,600	1,380	36,800	1,840
5	21,540	32,310	1,616	43,080	2,154
6	24,680	37,020	1,851	49,360	2,468
7	27,820	41,730	2,087	55,640	2,782
8	30,960	46,440	2,322	61,920	3,096

Source: U.S. DHHS. Calculations by Utah Foundation.

Figure 4

Utah's CHIP Program Benefits for 2003

	Plan A: Family income at or below 150% of the FPL	Plan B: Family income between 151and 200 % of the FPL
Benefits		
Out of Pocket Maximum	5 % of family's gross annual income	5 % of family's gross annual income
Office Visit or Urgent Care Center Visit	$3 co-pay per visit*	$15 co-pay per visit*
Immunizations and Well Child Exams	No co-pay, plan pays 100%	No co-pay, plan pays 100%
ER	$3 co-pay per visit*	$35 co-pay per visit*
Pre-existing Condition Waiting Period	No waiting period	No waiting period
Pharmacy	$1 per prescription on approved list* $3 per prescription not on approved list*	$5 per prescription on approved list* 50% of allowed amount for prescriptions not on the approved list*
Laboratory	$1 co-pay if less than $50 $2 co-pay if greater than $50*	$5 co-pay if less than $50 Plan pays 90% if more than $50*
X-Rays	$1 co-pay if less than $100 $3 co-pay if greater than $100*	$5 co-pay if less than $100 Plan pays 90% if more than $100*
Outpatient hospital	$3 co-pay*	Plan pays 90%
Inpatient hospital	$3 co-pay*	Plan pays 90%
Surgeon	Plan pays 100%	Plan pays 100%
Hospital Inpatient & Outpatient Physician Visits	$3 co-pay*	$15 co-pay*
Ambulance-Ground and Air	Plan pays 100%	Plan pays 100%
Medical equipment & supplies	Plan pays 100%	Plan pays 80%
Limited Benefits		
Dental Services		
- Cleaning, exams & fluoride	Plan pays 100% for cleanings, exams, fluoride	Plan pays 100% for cleanings, exams, fluoride
-Selected x-rays & sealants	Plan pays 100% for SELECTED x-rays and sealants	Plan pays 80% for SELECTED x-rays and sealants
-Selected fillings, space maintainers, pulpotomies, & stainless steel crowns	$3 co-pay for SELECTED space maintainers, fillings, extractions, pulpotomies and stainless steel	Plan pays 80% for SELECTED space maintainers, fillings, extractions, pulpotomies and stainless steel crowns
Hearing Screening	Plan pays $30 per child for hearing screening, limit one exam every 12 months*	Plan pays $30 per child for hearing screening, limit one exam every 12 months*
Vision Screening	Plan pays $30 per child for eye exams, limit one exam every 12 months*	Plan pays $30 per child for eye exams, limit one exam every 12 months*
Mental Health & Substance Abuse (combined totals) Inpatient/Outpatient conversion available	Inpatient - $3 co-pay for each visit 30 days per plan year, per child plan limit* Outpatient- $3 co-pay for each visit 30 visits per child, per year plan limit*	Inpatient - Plan pays 90% for the first 10 days, 50% for the next 20 days 30 days per child, per plan year limit Outpatient- Plan pays 50% per visit 30 visits per child, per plan year limit
Physical, Occupational, & Chiropractic Therapy (combined totals)	$3 co-pay per visit, 16 visits total per plan year, per child*	$15 co-pay per visit, 16 visits total per plan year, per child*

Source: Utah Department of Health.

enrollees have exceeded their out-of-pocket ceiling so far this year; one of them had an income over 150 percent of the FPL. Figure 4 delineates the differences between program benefits for the two income groups.

The differences between out-of-pocket expenditures for these two groups highlights a larger trend among low-income earners; those with low to mid incomes, from $20,000 to $49,999 annual adjusted gross income, have significantly higher out-of-pocket costs for health care than those with the lowest annual adjusted gross incomes of less than $20,000. Almost all of the families that can qualify for either Medicaid or CHIP have incomes that fall within these two groups; the outliers are those with large families of seven or more or those that live in states that offer CHIP coverage to those with incomes higher than 200 percent of the Federal Poverty Level. Internal Revenue Service data from 2001 show that only 3.7 percent of tax filers with incomes under $20,000 had medical and dental expenses in excess of 7 percent of their adjusted gross income (AGI). For tax filers with low to middle incomes or between $20,000 and $49,999, that percentage was 9.1 percent nationally. Among the states, the figures vary widely, with Utah mirroring closely the national percentages. In so doing, that ranks the state 13th for the percentage of low to middle income filers that had excess medical and dental expenditures. Figure 5 lists all

the states, and their percentage of low to middle income filers that had medical and dental expenditures exceeding 7% of their adjusted gross income during tax year 2001. States in italics are Utah's cohort states for the purpose of this report. While there are some cautions to using this data; for example, in the lowest income brackets, the data does not distinguish between teenagers living at home and working while having insurance coverage through their parents from poor heads of household that qualify for government health care assistance, this still helps highlight the concern that many citizens in low to middle income categories are uninsured or underinsured and paying a larger percentage of their income than those in other income brackets.

Figure 5

Percentage of Low- to Moderate-Income Tax Filers Claiming Excess Medical and Dental Expenses

Tax Year 2001

Percent of tax filers claiming excess medical expenses	Income Brackets from $0.01 to $19,999	Income Brackets from $20,000 to $49,999	Rank
Alabama	*4.4%*	*12.3%*	*2*
Alaska	1.5%	4.6%	49
Arizona	5.9%	11.8%	4
Arkansas	*3.2%*	*8.6%*	*19*
California	3.8%	7.8%	24
Colorado	4.4%	8.0%	22
Connecticut	4.4%	7.7%	27
Delaware	*3.0%*	*6.1%*	*42*
Florida	4.4%	9.8%	11
Georgia	*3.4%*	*10.0%*	*10*
Hawaii	4.0%	8.3%	21
Idaho	5.1%	11.2%	6
Illinois	*3.7%*	*7.3%*	*31*
Indiana	3.1%	6.3%	41
Iowa	*5.8%*	*9.3%*	*14*
Kansas	*4.4%*	*8.4%*	*20*
Kentucky	3.5%	7.4%	30
Louisiana	*2.0%*	*7.6%*	*28*
Maine	3.6%	7.4%	29
Maryland	4.7%	11.1%	7
Massachusetts	*4.3%*	*7.1%*	*33*
Michigan	3.5%	6.0%	43
Minnesota	4.8%	8.7%	18
Mississippi	*2.3%*	*8.9%*	*16*
Missouri	3.5%	7.3%	32
Montana	*6.4%*	*14.5%*	*1*
Nebraska	*4.3%*	*8.0%*	*23*
Nevada	3.9%	6.9%	34
New Hampshire	4.0%	6.7%	37
New Jersey	6.3%	11.9%	3
New Mexico	3.0%	7.8%	25
New York	*3.6%*	*9.1%*	*15*
North Carolina	4.4%	10.6%	8
North Dakota	3.5%	6.7%	38
Ohio	2.6%	4.6%	48
Oklahoma	*4.0%*	*10.0%*	*9*
Oregon	7.3%	11.3%	5
Pennsylvania	*3.2%*	*5.8%*	*45*
Rhode Island	3.3%	6.4%	40
South Carolina	3.4%	9.7%	12
South Dakota	2.9%	5.9%	44
Tennessee	2.4%	5.7%	46
Texas	1.9%	5.0%	47
Utah	**3.7%**	**9.5%**	**13**
Vermont	3.7%	6.5%	39
Virginia	3.6%	8.8%	17
Washington	4.2%	6.9%	35
West Virginia	1.4%	3.5%	50
Wisconsin	4.7%	7.7%	26
Wyoming	2.9%	6.7%	36
United States	3.7%	9.1%	

Source: IRS Statistics of Income Series. Calculations by Utah Foundation. Cohort states in italics.

The "Health" of Utah and its Cohort States

Additional indicators are used by the U.S. Department of Health and Human Services (DHHS) to gauge the success of states in providing health care programs to its residents. Four of those will be discussed here and the states that are similar to Utah will be listed. These cohorts are simply those states that are found above and below Utah in rank. For example, if Utah ranked 15th for a particular indicator, states ranked 13th, 14th, 16th and 17th are considered cohorts, regardless of geographic location or those states' relative rankings in other indicators. Later in the report, these are the states against which Utah's CHIP program will be compared. These indicators, as far as the data are available, will be examined both prior and after the advent of CHIP.

Returning to the Enhanced FMAP graph in Figure 1, the legend provides the four indicators used in this report. The first is the children population cohort or those states that have approximately the same number of children ages 0-17 as are residing in Utah. This specifies the size of the potential pool of applicants for the program. Not every child will qualify but outreach and marketing efforts must reach as many as possible. Population is an estimate of how large that outreach effort must be. States with a similarly sized child population to Utah are Mississippi, Iowa, Kansas and Arkansas.

The second indicator used is that of Per Capita Personal Income or PCPI. This was chosen for two inter-related reasons. First, federal matching monies seem to be awarded based on PCPI and second, the lower a state's PCPI, the more likely residents of that state are living at or close to poverty. Utah's cohorts for this indicator are Alabama, Oklahoma, Louisiana and Montana.

The third indicator is the rate of child poverty within a state. These children, living at or below 200 percent of the Federal Poverty Level, may or may not be receiving medical services through Medicaid or CHIP. Utah's child poverty cohort states are Illinois, Massachusetts, Nebraska and Pennsylvania.

The final indicator chosen for this report is the most important. Data released from the U.S. Census Bureau provides a three-year average, by state, of the number and percent of low-income children without health insurance. Twenty-one of the 50 states have set 200 percent of the FPL as

Figure 6

Selected Health Insurance and Poverty Indicators Highlighting Utah and its Cohort States

State (States in Italics are Utah's Cohorts)	1996 Child Population	2000 Child Population	2000 Rank	1996 PCPI	2000 PCPI	2000 Rank	2001 PCPI	1996 Children at or Below 200%	2000 Children at or Below 200%	2000 Rank	2001 Children at or Below 200% FPL	1996 Low-income Uninsured	2000 Low-income Uninsured	2000 Rank	2001 Low-income Unisured
Alabama	*1,079,316*	*1,123,422*	*23*	*$19,527*	*$23,521*	*43*	*$24,477*	*47.1%*	*44.6%*	*10*	*46.0%*	*25.2%*	*16.6%*	*32*	*14.0%*
Alaska	186,641	190,717	47	25,667	29,642	14	31,027	29.4%	30.3%	43	30.6%	19.0%	25.8%	13	22.6%
Arizona	1,220,841	1,366,947	19	20,050	24,988	37	25,878	53.1%	49.7%	4	46.4%	33.5%	29.7%	2	27.8%
Arkansas	*660,835*	*680,369*	*34*	*18,141*	*21,995*	*47*	*22,750*	*52.8%*	*48.6%*	*5*	*50.5%*	*25.8%*	*21.1%*	*23*	*17.2%*
California	8,896,999	9,249,829	1	24,339	32,149	8	32,655	49.4%	45.1%	9	43.1%	26.9%	26.1%	10	24.2%
Colorado	996,054	1,100,795	24	24,289	32,434	7	33,455	32.0%	28.4%	44	31.0%	27.0%	28.2%	5	27.9%
Connecticut	790,205	841,688	29	31,381	40,702	1	42,377	34.2%	23.5%	49	27.3%	18.2%	18.4%	27	17.6%
Delaware	*177,124*	*194,587*	*46*	*24,992*	*31,012*	*13*	*32,166*	*38.5%*	*35.6%*	*28*	*29.8%*	*21.4%*	*16.7%*	*31*	*12.9%*
Florida	3,412,523	3,646,340	4	22,942	27,764	23	29,048	47.8%	42.3%	15	42.4%	24.3%	24.9%	14	26.6%
Georgia	*1,956,000*	*2,169,234*	*9*	*21,806*	*27,794*	*22*	*28,523*	*44.8%*	*43.4%*	*13*	*42.3%*	*23.2%*	*17.8%*	*28*	*17.5%*
Hawaii	304,388	295,767	42	25,234	27,851	21	29,034	39.8%	36.1%	25	35.2%	11.7%	14.5%	40	13.8%
Idaho	348,070	369,030	39	19,425	23,727	41	24,506	47.0%	43.1%	14	43.2%	19.0%	27.9%	7	25.6%
Illinois	*3,159,624*	*3,245,451*	*5*	*25,379*	*31,856*	*10*	*32,990*	*39.2%*	*33.7%*	*32*	*32.9%*	*14.9%*	*22.1%*	*18*	*20.3%*
Indiana	1,484,616	1,574,396	13	21,623	26,933	30	27,522	38.2%	33.2%	34	34.2%	19.6%	23.5%	15	18.5%
Iowa	*724,084*	*733,638*	*31*	*20,985*	*26,431*	*33*	*27,225*	*36.7%*	*31.0%*	*41*	*29.2%*	*22.8%*	*15.0%*	*38*	*12.6%*
Kansas	*687,138*	*712,993*	*33*	*21,771*	*27,374*	*27*	*28,432*	*43.2%*	*36.1%*	*25*	*34.9%*	*16.1%*	*19.2%*	*26*	*20.6%*
Kentucky	970,587	994,818	26	19,056	24,085	39	24,878	48.4%	38.3%	22	38.5%	22.7%	20.6%	24	17.8%
Louisiana	*1,218,423*	*1,219,799*	*22*	*19,314*	*23,090*	*45*	*24,454*	*55.6%*	*53.2%*	*2*	*51.5%*	*25.4%*	*26.0%*	*11*	*25.6%*
Maine	299,344	301,238	41	20,142	25,380	36	26,853	36.1%	31.7%	37	34.5%	25.2%	15.7%	36	9.6%
Maryland	1,267,524	1,356,172	20	26,650	33,482	5	35,279	34.4%	22.7%	50	22.8%	21.3%	26.0%	12	20.1%
Massachusetts	*1,440,216*	*1,500,064*	*15*	*27,689*	*37,704*	*2*	*38,864*	*31.8%*	*35.2%*	*29*	*33.2%*	*15.2%*	*12.1%*	*45*	*11.2%*
Michigan	2,541,067	2,595,767	8	23,934	29,127	17	29,629	37.5%	31.4%	38	31.9%	13.8%	13.8%	41	12.2%
Minnesota	1,243,962	1,286,894	21	24,295	31,935	9	33,059	32.6%	25.0%	48	23.1%	13.6%	14.7%	39	13.3%
Mississippi	*756,445*	*775,187*	*30*	*16,984*	*20,900*	*50*	*21,653*	*59.6%*	*47.2%*	*6*	*48.7%*	*23.7%*	*23.2%*	*16*	*15.7%*
Missouri	1,395,796	1,427,692	16	21,873	27,206	29	28,221	39.1%	31.3%	39	30.9%	19.8%	12.4%	44	8.5%
Montana	*231,138*	*230,062*	*44*	*18,592*	*22,518*	*46*	*24,044*	*48.1%*	*47.2%*	*6*	*44.9%*	*15.8%*	*27.6%*	*8*	*22.4%*
Nebraska	*442,196*	*450,242*	*37*	*21,903*	*27,630*	*26*	*28,861*	*36.9%*	*35.2%*	*29*	*31.7%*	*15.3%*	*12.7%*	*43*	*15.6%*
Nevada	419,630	511,799	35	24,897	29,506	15	30,128	38.5%	37.9%	23	38.0%	28.0%	29.5%	3	29.7%
New Hampshire	294,115	309,562	40	24,750	33,169	6	33,969	27.8%	25.4%	47	23.1%	22.0%	11.1%	47	10.7%
New Jersey	1,982,516	2,087,558	10	28,851	37,118	3	38,625	28.0%	28.0%	45	26.1%	27.6%	16.1%	33	20.6%
New Mexico	497,980	508,574	36	18,435	21,931	48	23,081	59.6%	54.0%	1	53.8%	30.4%	28.0%	6	27.8%
New York	*4,528,569*	*4,690,107*	*3*	*27,163*	*34,689*	*4*	*35,878*	*45.3%*	*40.9%*	*16*	*40.0%*	*19.4%*	*17.5%*	*29*	*15.2%*
North Carolina	1,834,883	1,964,047	11	21,462	26,882	31	27,308	42.1%	39.8%	21	41.1%	22.4%	20.1%	25	18.3%
North Dakota	167,091	160,849	48	18,899	24,708	38	25,798	35.0%	43.5%	12	40.2%	15.6%	22.7%	17	16.7%
Ohio	2,844,939	2,888,339	7	22,790	27,977	20	28,699	38.7%	36.1%	25	35.3%	17.0%	16.1%	34	16.3%
Oklahoma	*876,074*	*892,360*	*27*	*19,144*	*23,650*	*42*	*24,945*	*49.8%*	*44.0%*	*11*	*45.7%*	*30.8%*	*27.4%*	*9*	*25.7%*
Oregon	804,470	846,526	28	22,362	27,660	25	28,222	43.4%	40.4%	20	38.0%	21.9%	22.1%	19	20.9%
Pennsylvania	*2,876,402*	*2,922,221*	*6*	*23,439*	*29,504*	*16*	*30,752*	*37.7%*	*33.3%*	*33*	*33.3%*	*16.2%*	*11.2%*	*46*	*12.8%*
Rhode Island	236,404	247,822	43	23,389	29,113	18	30,256	35.1%	31.3%	39	29.4%	20.5%	10.5%	48	10.4%
South Carolina	949,632	1,009,641	25	19,221	24,000	40	24,840	51.0%	40.7%	18	40.0%	24.4%	21.4%	21	16.7%
South Dakota	202,455	202,649	45	19,588	25,958	34	26,566	41.4%	32.8%	35	32.3%	11.1%	21.9%	20	14.3%
Tennessee	1,319,216	1,398,521	17	21,449	25,946	35	26,808	48.8%	40.8%	17	40.3%	22.3%	8.8%	50	8.8%
Texas	5,478,703	5,886,759	2	21,209	27,752	24	28,472	50.6%	46.3%	8	46.2%	36.3%	35.2%	1	34.3%
Utah	**683,422**	**718,698**	**32**	**18,508**	**23,436**	**44**	**24,033**	**38.7%**	**34.8%**	**31**	**33.4%**	**17.1%**	**17.0%**	**30**	**17.5%**
Vermont	145,695	147,523	49	21,135	26,848	32	28,756	39.1%	37.2%	24	34.6%	9.2%	9.5%	49	6.0%
Virginia	1,621,475	1,738,262	12	24,202	31,120	12	32,338	38.4%	26.7%	46	28.0%	17.8%	28.5%	4	21.5%
Washington	1,434,867	1,513,843	14	23,660	31,230	11	31,976	36.7%	32.7%	36	33.1%	20.0%	15.7%	35	18.6%
West Virginia	420,842	402,393	38	17,882	21,738	49	22,862	51.6%	52.2%	3	49.9%	14.1%	15.4%	37	15.4%
Wisconsin	1,344,388	1,368,756	18	22,365	28,100	19	29,196	33.4%	30.8%	42	30.3%	12.4%	12.8%	42	13.0%
Wyoming	133,386	128,873	50	21,216	27,372	28	29,587	40.1%	40.6%	19	38.0%	25.9%	21.4%	21	20.0%

Source: U.S. Census Bureau and Bureau of Economic Analysis. Calculations by Utah Foundation.

their upper income limit for their CHIP programs, thus making the percentage of low-income children without health insurance an important bellwether for their programs. Utah is one of these 21 states and its cohort states are Georgia, New York, Delaware and Alabama. Figure 6 provides this information as well as the actual figures for each state listed and the years 1996 and 2001 provide snapshots of before and after the advent of CHIP. Utah does not stand out as having a particularly high or low percentage of either low-income or low-income uninsured children, ranking 31st and 30th respectively.

Calculations to determine the actual number of low-income children without health insurance puts Utah 35th, approximately 42,489 low-income children were without coverage during 2000. The U.S. Department of Health and Human Services data available shows during fiscal years 2000 and 2001, a rough proxy for calendar year 2001, that Utah's CHIP enrollment averaged 29,975. Figure 7 details the estimated number of low-income uninsured children by state for 1996 and 2000 and provides CHIP

enrollment figures from fiscal year 1999 to 2002. It is difficult to estimate how many of these enrollees would have been added to the low-income uninsured figures had CHIP not been an option for them. Further research needs to be done to answer that question; however, it is safe to posit that many of these children would have relied on a variety of free or reduced-cost clinics for routine care or would have gone without.

Analysis of Program Benefits

As CHIP benefits vary from state to state, it is important to examine these differences and the possible effects they have on access and quality of health care received by CHIP enrollees. For this section of the report, Utah Foundation reviewed all 50 states' summaries of their CHIP plans and benefits, available through the Department of Health and Human Services Office of Health Policy website,[4] and created a matrix of key components and compared Utah to its cohort states. These components include data regarding eligibility requirements, cost-sharing, benefits offered, and program accountability, all areas that may influence the perceptions of CHIP participants and their parents regarding the program's value.

Figure 7

A Comparison of the Number of Low-Income (under 200% FPL) Uninsured Children and CHIP Enrollments

	Estimated Low-income Uninsured Children			CHIP Enrollments			
State	1996	2000	2000 Rank	FY 1999	FY 2000	FY 2001	FY 2002
Alabama	*127,972*	*83,025*	*20*	*38,980*	*37,587*	*68,179*	*83,359*
Alaska	10,452	14,885	44	8,033	13,413	21,831	22,291
Arizona	216,997	201,541	6	26,807	60,803	86,863	92,705
Arkansas	*89,985*	*69,712*	*26*	*913*	*1,892*	*2,884*	*1,912*
California	1,183,880	1,088,751	1	222,351	477,615	693,048	856,994
Colorado	85,994	88,226	17	24,116	34,889	45,773	51,826
Connecticut	49,055	36,387	36	9,912	18,804	18,720	21,346
Delaware	*14,613*	*11,545*	*46*	*2,433*	*4,474*	*5,567*	*9,691*
Florida	395,809	383,313	3	154,594	227,463	298,705	368,180
Georgia	*203,238*	*167,753*	*8*	*47,581*	*120,626*	*182,762*	*221,005*
Hawaii	14,134	15,514	42	0	2,256	7,137	8,474
Idaho	31,113	44,342	34	8,482	12,449	13,276	16,895
Illinois	*184,328*	*242,148*	*5*	*42,699*	*62,507*	*83,510*	*68,032*
Indiana	111,039	122,633	12	31,246	44,373	56,986	66,225
Iowa	*60,473*	*34,114*	*37*	*9,795*	*19,958*	*23,270*	*34,506*
Kansas	*47,789*	*49,309*	*32*	*14,443*	*26,306*	*34,421*	*40,783*
Kentucky	106,639	78,622	22	18,579	55,593	66,796	93,941
Louisiana	*172,231*	*168,785*	*7*	*21,580*	*49,995*	*69,579*	*87,675*
Maine	27,268	14,979	43	13,657	22,742	27,003	22,586
Maryland	92,713	79,892	21	18,072	93,081	109,983	125,180
Massachusetts	*69,392*	*63,662*	*27*	*67,852*	*113,034*	*105,072*	*116,699*
Michigan	131,498	112,695	13	26,652	37,148	76,181	71,882
Minnesota	55,174	47,393	33	21	24	49	
Mississippi	*106,852*	*84,802*	*19*	*13,218*	*20,451*	*52,436*	*64,805*
Missouri	108,112	55,500	29	49,529	73,825	106,594	112,004
Montana	*17,603*	*29,956*	*39*	*1,019*	*8,317*	*13,518*	*13,875*
Nebraska	*24,966*	*20,154*	*40*	*9,713*	*11,400*	*13,933*	*16,227*
Nevada	45,156	57,252	28	7,802	15,946	28,026	37,878
New Hampshire	17,948	8,737	48	4,554	4,272	5,982	8,138
New Jersey	152,966	94,370	16	75,652	89,034	99,847	117,053
New Mexico	90,365	76,788	24	4,500	6,106	10,347	19,940
New York	*398,891*	*335,320*	*4*	*521,301*	*769,457*	*872,949*	*807,145*
North Carolina	172,723	157,353	10	57,300	103,567	98,650	120,090
North Dakota	9,138	15,860	41	266	2,573	3,404	4,463
Ohio	186,759	167,479	9	83,688	111,436	158,265	183,034
Oklahoma	*134,387*	*107,659*	*15*	*40,196*	*57,719*	*38,858*	*84,490*
Oregon	76,345	75,482	25	27,285	37,092	41,468	42,976
Pennsylvania	*176,147*	*108,647*	*14*	*81,758*	*119,710*	*141,163*	*148,689*
Rhode Island	16,995	8,165	49	7,288	11,539	17,398	19,515
South Carolina	118,103	88,055	18	45,737	59,853	66,183	68,928
South Dakota	9,313	14,540	45	3,191	5,888	8,937	11,183
Tennessee	143,253	50,152	31	9,732	14,861	8,615	
Texas	1,006,548	958,085	2	50,878	130,519	500,950	727,452
Utah	**45,203**	**42,489**	**35**	**13,040**	**25,294**	**34,655**	**33,808**
Vermont	5,258	5,227	50	2,055	4,081	2,996	6,162
Virginia	110,582	132,327	11	16,895	37,681	73,102	67,974
Washington	105,319	77,708	23	0	2,616	7,621	8,754
West Virginia	30,570	32,396	38	7,957	21,659	33,144	35,949
Wisconsin	55,568	53,933	30	12,949	47,140	57,183	62,391
Wyoming	13,833	11,212	47	0	2,547	4,652	5,059

Source: U.S. DHHS and Census Bureau. Calculations by Utah Foundation.

Figure 8 uses the matrix of key components and attempts to rate states as to how inclusive or restrictive their programs are. In so doing, states that simply expanded Medicaid eligibility up the income ladder were eliminated from the analysis. Other than deciding at what percentage of the FPL to cap benefits, these states have little control over the design of their programs. This reduced the cohort pool by three, Oklahoma, Louisiana and Nebraska. However, for reference, the complete matrix for Utah and all of its cohorts is located at http://www.utahfoundation.org/datafiles/rr659-appendix.htm and will be referred to in this section as well.

In rating the programs, certain components were ranked on a scale of zero to five, a score of five being the most inclusive. In Figure 8 this includes the categories of "Upper Income Limit," "Percent of the FPL that Premium Payments Begin," "Cost of Premium Payments," "Mandatory Period of No Coverage," and "Other Medical Services Offered." Since

Figure 8

A Comparison of Benefits Offered to CHIP Participants in Utah and its Cohort Separate State and Combination State Programs

Utah and Cohort Combination or Separate State Programs	Upper Income Limit	Presumptive Eligiblity	% of FPL that Premium Payments Start	Cost of Premium Payments	Mandatory Period of No Coverage	OTC Drugs	Disposable Medical Supplies	Dental Coverage	Premiums for Private Coverage	Enabling Services	Other Medical Services Offered	Total	Possible	Score
Massachusetts	3	1	2	2	5	1	1	1	1	1	3	21	31	67.7%
Pennsylvania	3	0	5	5	5	0	1	1	0	0	1	21	31	67.7%
Arkansas	3	0	5	5	1	1	1	1	0	0	3	20	31	64.5%
Kansas	3	0	2	4	1	1	1	1	0	1	4	18	31	58.1%
Mississippi	3	0	5	5	3	0	1	1	0	0	0	18	31	58.1%
Montana	2	0	5	5	3	0	0	1	0	0	2	18	31	58.1%
Alabama	3	0	2	4	5	0	1	1	1	1	2	17	31	54.8%
Illinois	2	0	2	2	3	1	1	1	0	1	3	16	31	51.6%
Georgia	3	0	0	3	3	1	0	1	0	0	3	14	31	45.2%
New York	2	1	1	1	5	1	1	1	0	0	1	14	31	45.2%
Utah	3	0	0	5	3	0	1	1	0	0	1	14	31	45.2%
Iowa	3	0	2	3	1	0	0	1	0	0	2	12	31	38.7%
Delaware	3	0	0	3	1	1	1	0	0	0	1	10	31	32.3%
Total Possible	5	1	5	5	5	1	1	1	1	1	5	31		

Source: U.S. DHHS Office of Health Policy and Utah Department of Health.

Utah, with a score of 45.2, ranks third from the bottom in terms of inclusiveness, just ahead of Iowa and Delaware and tied with New York and Georgia.

state programs vary greatly from each other in these areas, a scale of relative ranking was the simplest way to analyze the data. The other components rate specific aspects of the programs and either the state includes them as part of the CHIP benefit package or does not. Therefore, these components are given a score of one for "yes" and a score of zero for "no." From the scores in all of these categories a state total is derived and compared against the total possible. The final score is the percentage calculated from this comparison. The states are then ranked based on this score. Among its cohorts, Utah with a score of 45.2 percent ranks third from the bottom in terms of inclusiveness, just ahead of Iowa and Delaware and tied with New York and Georgia. Massachusetts and Pennsylvania rank at the top with scores of 67.7 percent. In the category "upper income limit," Utah scored a three, like the other states that offer CHIP benefits to families at or below 200 of the FPL. Utah was also in the middle of the states in the amount of time a family must be without health insurance before being eligible for CHIP. In Utah as in Mississippi, Montana, Illinois and Georgia, families must be uninsured for three months or longer prior to applying for CHIP. This mandatory period of no coverage is to protect against families "crowding out" others in the system. Crowd-out is experienced when a family with employer provided health care voluntarily drops coverage because CHIP provides a better or less expensive alternative. The utilization of CHIP and CHIP funds by these families may prevent other more needy families from enrolling in the program.[5] Three months is the most common waiting period, but some states require a family to be uninsured for 6 months or longer while others do not have a waiting period at all. Those without waiting periods generally fall into two categories; either Medicaid expansion states and subject to Medicaid guidelines or states that offer employers the opportunity to "buy into" CHIP or utilize the program for their employees while reimbursing the state for a portion of the costs. These states include Alabama, Massachusetts, Pennsylvania and New York.

Utah scores the highest and the lowest in two inter-related categories-those dealing with premiums. Utah receives a "0" for requiring all families participating in CHIP to pay a premium. Utah, Delaware and Georgia are the only states among the cohorts that have such a requirement. In the other states, premium payments are not required unless a family has an

income above at least 133 percent of the FPL. Conversely, Utah has the lowest premium payments, at $13 or $25 a quarter, of any of the cohorts and ranks at the bottom nationally, along with Michigan and North Carolina. While requiring premium payments from the poorest families appears to be regressive in the same manner that certain taxes place an inordinate burden on the poor, there is some evidence that by holding premium payments as low as they are, most families in Utah are able to meet these obligations and, furthermore, they are more satisfied with the program, because these premium payments are perceived to negate the idea that CHIP is a "welfare" program. Instead, families view it as a legitimate health insurance policy.[6]

The final ranked category is perhaps the most subjective. A part of the DHHS database asks states to detail any other medical services offered to their CHIP participants that were not enumerated in other parts of the database. All of the cohort states included some description of these other services. However, some states listed services that could legitimately be considered part of the standard package of benefits. For example, Arkansas listed "immunizations" as an additional medical service offered CHIP enrollees. However, another state may consider immunizations as part of their physician or clinical services offered. This "double counting" of services was considered when rating each state's program, however some states did not provide detailed enough descriptions of their benefit package to ensure that all of the duplication of services was removed. Utah scored as one of the most restrictive in this category, since the only additional benefits provided to enrollees are vision and hearing screenings, limited to one screening per child every 12 months, with payments by the plan capped at $30 per screening. Utah's benefits do not cover eyeglasses whereas other cohort states do cover, at least in part, corrective lenses. Kansas, the state with the highest rating in this category, has benefits ranging from nutritional evaluations to infertility coverage and breast reduction surgery. Here it must be noted that these ratings are based on quantity of additional services and not quality or appropriateness to the program.

By holding premium payments as low as they are, most families are able to meet these obligations, and premium payments help negate the idea that CHIP is a "welfare" program.

The other components of this analysis include whether or not a state offers dental coverage, will pay for over-the-counter medication and disposable medical supplies, offers enabling services, will assist a CHIP-eligible family in paying the premiums for a private insurance policy, and whether a family is presumed eligible for CHIP by virtue of applying for the program.

One of the concerns among advocates for low-income families is that government health programs often have little or no provision for dental coverage and that children in these families suffer long-term health consequences from not having access to preventative dental care.[7] Thus, noting if children have this access through state CHIP programs is an important measure of the overall comprehensiveness of these programs. Of Utah's cohort states, only one, Delaware, does not offer dental benefits as part of CHIP.

Perhaps the most controversial benefits offered to CHIP beneficiaries are those that pay for over-the-counter medications and disposable medical supplies. If private insurance plans do not cover the expense of purchasing a bottle of aspirin or a box of bandages, why should a government program do so? Montana and Iowa do not offer these benefits to CHIP participants, but every other cohort state has a provision for either OTC drugs or disposable supplies, or both. The answer to this question lies with one segment of the population: low-income diabetic insulin-dependent children. A fact little known to the general population is that insulin, syringes and

testing supplies can be purchased without a doctor's prescription. However, insulin and testing supplies are very expensive. A single bottle of insulin can cost around $30. Diabetics with health insurance can circumvent some of these costs by having their physician write a prescription for insulin. So too could CHIP participants; however, by allowing reimbursement for these expenses as OTC purchases, families can avoid extra trips to the doctor's office and potential confusion regarding the responsible party for payment of insulin purchases plus any out-of-pocket co-payments.

Enabling services include such things as non-emergency transportation, translation services and other assistance a family may need to keep doctor's appointments, complete paperwork properly, and understand medical instructions. Enabling services are often viewed as a non-essential part of government health programs and are subsequently extremely restricted or unavailable. Only four states in the cohort group, Massachusetts, Kansas, Alabama and Illinois offer enabling services to their CHIP participants.

Some states are experimenting with allowing CHIP enrollees to "purchase" private health insurance plans and paying the enrollees' premiums. This allows the state to avoid many of the administrative costs that are associated with health plan management as well as giving enrollees a greater choice in their health care options. Massachusetts and Alabama offer this service to their CHIP participants.

Massachusetts and Alabama are experimenting with allowing CHIP enrollees' to purchase private health insurance plans and paying enrollees premiums. This avoids administrative costs and gives enrollees greater choice in health care options.

The final component in this analysis is concerned with initial eligibility. When families apply to the CHIP program, they are required to submit some type of income statement and in some states, a statement about assets. Until this information has been processed and verified, applicants cannot take advantage of CHIP benefits. To circumvent this waiting period, a few states offer what is termed "presumptive eligibility", that is an applicant is presumed eligible until proven otherwise and can begin using benefits immediately. Since wait times are usually no more than a few days, this component isn't nearly as important to recipients as it has been in the past. However, presumptive eligibility has been a traditional "hallmark" of more liberal and wealthy state programs, since if a family is later found to be ineligible, whatever costs they incurred are often paid by the state or the providing institution in the form of charity care. Therefore, it is included in this analysis. Only New York and Massachusetts presume that all applicants are eligible for the CHIP program.

Once each state is rated in all of these areas and compared against the total possible score, they can be ranked on their level of inclusiveness. Figure 9 shows Utah and each of its cohort states rated on a spectrum from "most restrictive" to "most inclusive". Utah is more restrictive than many of its cohort states, however this is mainly due to the differences with which premiums are administered in Utah relative to other states and the lack of additional medical services offered. It is important to note that this spectrum does not assume that Utah's restrictive program is necessarily "bad" or is providing inadequate services to its participants. In order to get a sense of the quality of Utah's program and especially how CHIP enrollees view the program, it is necessary to move to other sources that more adequately address these issues.

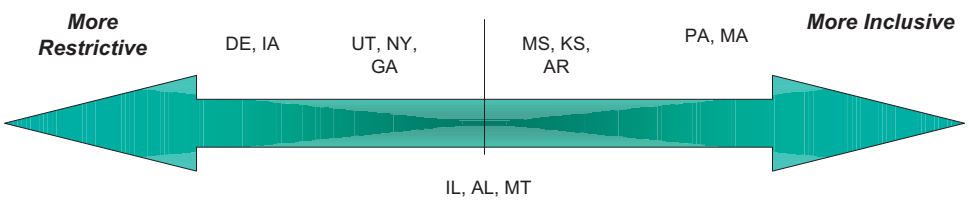
Comparison of Customer Satisfaction

Unlike the DHHS database that compares CHIP benefits, outcomes information is more fragmented among federal and state agencies. States report customer satisfaction and other quality indicators, such as percentage of immunized children in the program when they submit their HEDIS or

Health Plan Employer Data and Information Set to the National Committee for Quality Assurance (NCQA). Customer satisfaction is gauged through a standardized set of survey instruments commonly referred to as CAHPS (Consumer Assessment of Health Plans). CAHPS surveys participants in Medicaid, including CHIP, Medicare, and commercial health plans to provide comparisons between these population subsets regarding enrollees' feelings about their experiences with their primary care provider, any specialists, and other aspects of the health care system.

Figure 9

On the Continuum: Utah's CHIP Program Relative to its Cohort States



Since CHIP is still a relatively new program and has a small population when compared with other health insurance options, CAHPS data is sketchy. Later this fall, the author of this report will publish an analysis of those states in which CHIP participants are surveyed through CAHPS. The data is not finalized yet, but the paper will be released through Brigham Young University. In the meantime, other more qualitative surveys performed within a number of states can help to provide a gauge of customer satisfaction. These surveys are usually taken on behalf of a state's health department and cover such topics as satisfaction with the availability of physicians within the program and reasons participants did not re-enroll in the program after their initial year of CHIP coverage.

Qualitative surveys performed within a number of states, including Utah, provide a gauge of customer satisfaction with CHIP.

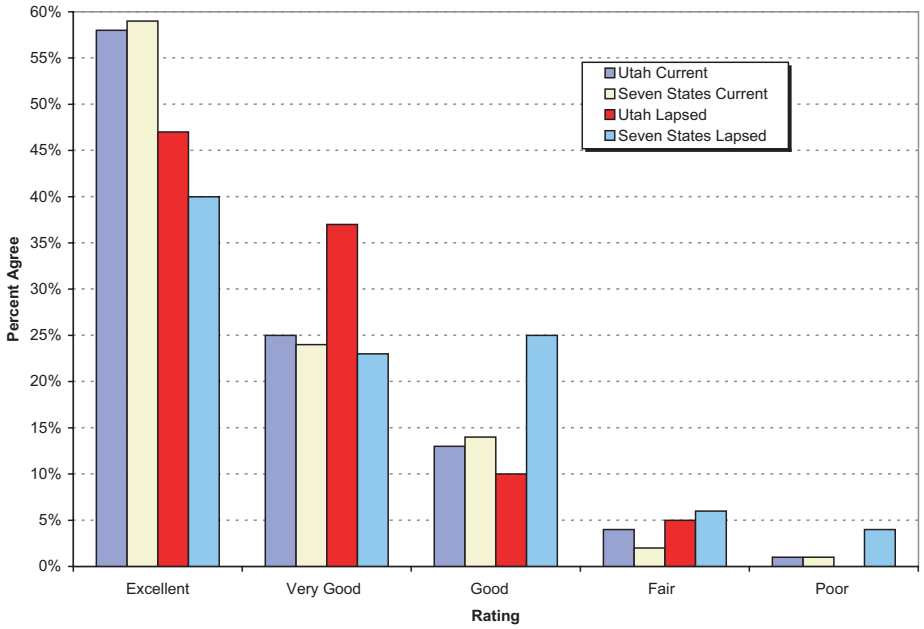
Contained in Utah's annual report on CHIP is a section that provides the results from a survey that compared the attitudes of parents of currently enrolled children with parents of eligible children who have left the CHIP program. Although the survey is intended to provide information regarding retention, parental comments provide insights into aspects of the program and how well CHIP participants' needs are met.

Six states in addition to Utah and the National Academy of State Health Policy participated in the creation and execution of this survey. The six states include three of Utah's cohort states: Alabama, Georgia, and Iowa, as well as Arizona, California, and New Jersey. In Utah, 356 families participated, including 337 who were enrolled at the time of the survey and 19 whose enrollment had lapsed. The surveyors note that this sample size is small and findings that are statistically insignificant are highlighted throughout the report. However, the researchers stress and Utah Foundation would like to reiterate that since these findings come from a carefully selected number of participants within a relatively small pool of CHIP enrollees that the answers still provide valuable insights into aspects of the program that are working well and those that need improvement. For the seven states participating in the study, the sample size is 3,780 of which 1,000 had lapsed enrollment.

Figure 10 highlights the ratings given to the CHIP program overall in Utah and the other six states for both current enrollees and those that were no longer participating in the program. Current CHIP enrollees in Utah rated the program very similarly to current enrollees in other states. Most rated the program as "very good" or "excellent". Lapsed families in Utah were more likely to give the program high marks than in other states; 84 percent rated the program as "very good" or "excellent" in Utah, while in other states, the percentage of

Figure 10

Current and Lapsed CHIP Enrollees Rating of the CHIP Program, 2001



Source: Utah Department of Health and the National Academy of State Health Policy.

families agreeing with those statements drops to 63 percent.

Specific program benefits were then rated, and the results are listed in Figure 11. Current enrollees in Utah as well as the six other states give high marks to each of the three benefit areas while lapsed families are less enthusiastic about some aspects of the program. Dental benefits seemed to rate the lowest, with many families, current and lapsed, unfamiliar with the benefits and unsure how to rate them. This may be reflective of the fact that dental services are the most likely to be "tinkered" with by administrators when budget constraints force them to reduce benefits or it may reflect a general lack of knowledge. As was mentioned earlier, dental care is one of the most difficult benefits to obtain under Medicaid, since very few dentists will accept Medicaid recipients as patients. If many of these CHIP families have come from the Medicaid program, they may assume that utilizing CHIP dental benefits will be as difficult as Medicaid was.

Figure 11

Rating Utah's CHIP Benefits Compared with Other States', 2001

Benefits	Utah		Seven State	
Basic Medical Care	Current Enrollees	Lapsed Families	Current Enrollees	Lapsed Families
Excellent	53.0%	47.0%	57.0%	46.0%
Very Good	33.0%	10.0%	26.0%	25.0%
Good	13.0%	42.0%	13.0%	21.0%
Fair	1.0%	0.0%	2.0%	3.0%
Poor	<.05%	0.0%	1.0%	1.0%
Don't Know	<.05%	0.0%	1.0%	3.0%
Prescription Coverage				
Excellent	49.0%	53.0%	52.0%	40.0%
Very Good	25.0%	16.0%	23.0%	20.0%
Good	14.0%	26.0%	14.0%	22.0%
Fair	4.0%	5.0%	4.0%	3.0%
Poor	1.0%	0.0%	1.0%	2.0%
Don't Know	6.0%	0.0%	5.0%	12.0%
Dental Coverage				
Excellent	37.0%	32.0%	43.0%	34.0%
Very Good	21.0%	5.0%	21.0%	16.0%
Good	14.0%	26.0%	15.0%	20.0%
Fair	11.0%	16.0%	5.0%	4.0%
Poor	5.0%	5.0%	4.0%	5.0%
Don't Know	12.0%	16.0%	12.0%	21.0%

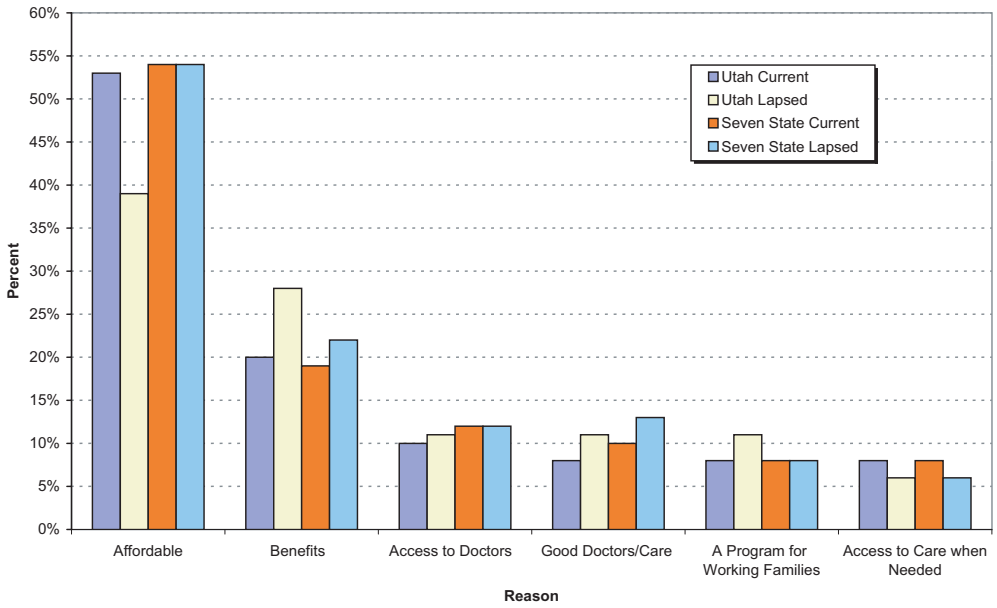
Source: Ibid.

Parents in both subsets who gave the overall program a rating of "good" or higher were then asked an open-ended question regarding what they liked best about the CHIP program. Affordability tops the list for all parents, followed by the benefits offered. Figure 12 highlights the answers given by at least 5 percent of participants. Since multiple answers were accepted, the totals exceed 100 percent. One area of concern when comparing current and lapsed families in Utah is that fewer lapsed families were likely to consider the program affordable. At the time of the survey in 2001, Utah had not yet instituted quarterly premium payments, which add a greater financial burden to families unable to keep up with co-pays and other out-of-pocket expenses. With this in mind, it is interesting to note the discussion researchers had with current and former enrollees regarding premium payments. In the other six states, which did require premium payments at the time of the survey, between 83 and 90 percent of families thought the amount was reasonable. Even among families that were removed from the program for lack

of premium payment and families currently enrolled and paying a premium higher than $20 a month, a majority (86 and 75 percent respectively) felt their premiums were reasonable.[8]

Figure 12

Parental Reasons for Positive View of the CHIP Program



Source: Ibid.

Focus group discussions in Utah around the idea of premium payments were also positive, since participants suggested that co-pays helped make them feel like they were contributing to the health care of their child and/or "paying their own way." This seems to suggest that parents do not associate CHIP, despite the origin of it's funding, with a government "welfare" program, but rather as a viable health insurance policy for their children. The promotion of CHIP as an insurance alternative for low-income families was a major goal of policymakers and program administrators. The general consensus was to avoid the stigma of another Medicaid-type program, since that may discourage enrollment. If this small sample of current and former participants is an indication, they have succeeded. It will be interesting, as the information becomes available, to compare these results against states that simply expanded their Medicaid programs to a larger pool and see if participants in those programs are satisfied with their health care.

Concerns and Challenges for Utah's CHIP program

For Utah's CHIP program, as with any joint federal/state program, the greatest challenge lies in obtaining enough state funding to leverage federal dollars and provide benefits to all those that are eligible and interested. During difficult budgetary times, this becomes an even greater challenge.

Parents who pay premiums and co-pays are more likely to feel they are paying their own way.

Another challenge, especially in attracting and retaining eligible children to the program seems to be parental pride or guilt over utilizing CHIP benefits. Focus group discussion, especially with lapsed families, suggest that for many, the decision to apply for CHIP was a difficult one to make because it signaled they were incapable of providing for their children. These families also expressed that it was a source of pride for them once they qualified for private insurance. The researchers note that these feeling seem to be more prevalent in Utah than in the other six states.[9] Parents also suggested that CHIP administrators and outreach efforts may have greater success in persuading reluctant families to enroll if emphasis is placed on the fact that the program is something that they, as taxpayers, pay for. Additionally, if parents understand that, through co-pays and premium payments, they are shouldering some of the cost for their children's health care, this understanding may alleviate some of those

negative feelings Utah parents have regarding participation in CHIP.

A final concern of parents is that renewal and verification of income and availability of other insurance is still too complex or time consuming. This is a complaint common to all government programs that require participants to periodically prove they are still eligible. Food Stamp and Medicaid participants in a study done by Mathematica Policy Research, Inc. echoed these concerns, and researchers urged that administrators seek ways to simplify application and reapplication processes across all state-administered assistance programs.[10]

Returning to funding concerns, policymakers at the federal level have raised serious questions regarding Utah's CHIP program expansion to cover childless adults under the age of 65 through its PCN program. Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive many statutory requirements of Medicaid, CHIP and other programs instituted through the Social Security Act, in the case of experimental, pilot or demonstration projects that are likely to "promote program objectives." During 2001, DHHS began to allow states greater latitude in using section 1115 waivers to modify Medicaid and SCHIP programs. Of specific concern for this report is the section 1115 initiative to expand health care coverage to uninsured populations commonly known as HIFA or Health Insurance Flexibility and Accounting Initiative. This was the initiative under which Utah received its section 1115 waiver for the PCN program.

GAO stated that Utah's PCN program was going to cost the federal government $59 million more in Medicaid and CHIP funding than if the program had been denied.

Utah, like most states, has always had a program that provided medical care to those that were not insured, did not qualify for Medicaid, and could not afford care. This program is funded entirely through state monies and is know as UMAP or Utah Medical Assistance Program. With the successful application for a section 1115 waiver, Utah can now expect the federal government to contribute 71 percent of the funds necessary to cover costs. The state is required to contribute an amount at least equivalent to what it would have spent on the UMAP program, $5.6 million in FY 2001.[11] Additionally, hospitals in Utah will contribute $10 million to support the PCN; this figure is approximately the amount hospitals provided in care, which was not reimbursed, to the medically indigent during 2001. Needless to say, using state funding to leverage federal monies for this waiver is exceedingly complex. However, the U.S. General Accounting Office was highly critical of the program. It stated in a report to the Senate Finance Committee that despite the tradition within the DHHS that all waiver projects must be "budget neutral," that is costing the federal government nothing to implement, Utah would expend $59 million more of federal funds on Medicaid and CHIP programs than if the PCN program waiver had been denied.[12]

Utah was not the only state that GAO reviewed. Their report also discusses programs in Arizona, California and Illinois. Beyond the additional costs to the federal government and consequentially to the taxpayer, the main concern that GAO has is that these programs expand health care coverage beyond the boundaries that Congress set when passing both Medicaid and CHIP legislation under Titles XIX and XXI of the Social Security Act. This "mission creep" leads to allegations that career employees of the Department of Health and Human Services are actually legislating new policy through their ability to change program rules and regulations, thereby ignoring the wishes of elected officials and pursuing their own policy objectives. It may be premature to level these allegations, especially since this report reviews only four experimental programs, and the costs of these programs is rather modest compared against legislation

in Congress to extend prescription drug coverage to all senior citizens through Medicare. Additionally, this is not the first time the DHHS has provided waivers to states to experiment with federal/state programs. It did so during the early 1990s, allowing states to broaden welfare-to-work projects under the old AFDC program. These pilot projects led to the 1996 welfare reform legislation and a decrease in welfare rolls. For this reason, it will be interesting to see how Utah's PCN experiment affects future national legislation in the area of health care coverage for low-income families.

Finally, SCHIP was reauthorized in 2002 at the federal level as a part of the reauthorization of the 1996 welfare reform legislation. Currently, SCHIP funding is authorized through 2007 and annual funding continues to increase during that time.[13] However, there is some question whether the federal funding level is adequate to cover the greater demand anticipated as CHIP programs become more well known throughout the country.

Conclusion

Overall, the rate of low-income children without health insurance dropped during the late 1990s. How much credit SCHIP can take for this is still a matter of discussion, especially in light of the economic boom of the late 1990s. However, CHIP enrollment continues to increase as outreach efforts convince more parents that the program works.

It will be interesting to see how Utah's PCN experiment affects future national health care policy.

Utah compares well against other states on the percentage of low-income children overall and low-income children without health insurance that reside in the state. Still, during the year 2000, there were an estimated 42,489 children in Utah that did not have health insurance. CHIP provided health coverage to an average of 29,975 children during that time. While it cannot be said that without CHIP, 71,000 children would have been without health insurance, since some of those might have found private coverage at costs higher than CHIP, it can be assumed that many more than the 42,489 would have been without coverage or would be dependent on non-routine forms of care.

Utah receives high marks from researchers for its outreach program and the emphasis the state places on CHIP as insurance rather than "welfare." However, some parents still feel that stigma and are reluctant to enroll.

Benefits in the state are not as generous as elsewhere, still parents generally give the program benefits high ratings, but their main reason for participation in the program is its affordability.

Endnotes:

[1] SCHIP and CHIP are used interchangeably. Generally, SCHIP refers to the national program while CHIP is state-specific. Utah's program is called CHIP and will be referred to as such. Other states may call their programs by different names, but they still fall under the CHIP label.

[2] See, the GAO July 2002 report, "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns." Number GAO-02-817.

[3] Information from the Kaiser Family Foundation and the National Association of State Business Officers (NASBO).

[4] Database available at http://aspe.hhs.gov/health/schip2/ .

[5] All definitions of program phenomenon and acronyms are cross-referenced with the 2003 edition of the "Glossary of Terms Commonly

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We have moved. Please note our new address below. Our new phone and fax numbers are as follows:

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Used in Health Care," published by AcademyHealth and available at http://www.academyhealth.org/publications/glossary.htm.

[6] See Section F of the Utah CHIP Annual Report FFY 2001.

[7] See, Robinson et al, "A longitudinal study of schoolchildren's experience in the North Carolina dental Medicaid program, 1984 through 1992," American Journal of Public Health 88 (11) pp. 1669-1673; November 1998.

[8] Section F, Utah CHIP Annual Report FFY 2001, p. 36.

[9] Ibid, p. 40.

[10] Mittler and Hyzer, "State of Utah Improving Food Stamp, Medicaid and SCHIP Participation: Strategies and Challenges," MPR Reference No: 8661-201, May 2002.

[11] State of Utah Budget Summary 2003, Health Department Budget UMAP line item, excludes federal funds and dedicated credits. The Budget Summary is available at http://governor.utah.gov/budget/fy2003/summary/budgetsummary2003.pdf.

[12] Ibid. Endnote 2.

[13] Section 2104 of the Balanced Budget Act states that total allotments will be $3.15 billion for fiscal years 2002-2004; $4.05 billion for fiscal years 2005-2006; and $5 billion for fiscal year 2007.

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