


No. 1, March 2001
Forum Brief

Kansas Health Policy Forums

2001



**The State of Children's Health Insurance:
*A Work in Progress***

Friday, March 9, 2001 • 11:30 am — 2:00 pm
212 SW Eighth Avenue, Topeka, KS • Basement Conference Room

A DISCUSSION FEATURING

Cindy Mann, *Director*
Family and Children's Health Program
Group, Center for Medicaid State Operations
Health Care Financing Administration

Trish Riley, *Executive Director*
National Academy for State Health Policy

Janet Schalansky, *Secretary*
Kansas Department of Social
and Rehabilitation Services



KANSAS HEALTH INSTITUTE

Healthier Kansans through informed decisions



Kansas Health Policy Forums are presented by the Kansas Health Institute. Funding is provided by a grant from the Robert Wood Johnson Foundation (RWJF), Princeton, NJ, and the Kansas Health Foundation, a Wichita-based philanthropy dedicated to improving the health of all Kansans.

Kansas Health Policy Forums are a series of interactive sessions for policymakers examining a broad array of health issues. Forums present a wide range of **expert views** on current health policy issues followed by facilitated discussion and **dialogue** in a non-partisan setting. **Forum Briefs** take an in-depth look at an issue, examine relevant data and information and are prepared in advance of each Forum.

The State of Children's Health Insurance: A Work in Progress will examine key issues regarding Medicaid and the State Children's Health Insurance Program (SCHIP called HealthWave in Kansas). Discussion will focus on public health insurance approaches taken by other states, strengths and limitations of Medicaid and SCHIP, effective program features, public/private partnerships, challenges and opportunities ahead, and what policymakers need to know regarding the future of children's health insurance.

KEY QUESTIONS FOR POLICYMAKERS

- What are the state's goals / priorities in providing health insurance to children? (eligibility, extent of coverage, state funding and access to care)
- How does a state design and implement a program that reaches these goals? (Outreach, enrollment, retention, delivery system)
- How are other states dealing with hot issues such as outreach, enrollment, retention, crowd-out, churning, program integration, stigma/perception, expansion, etc.?
- What are the opportunities and challenges for expanding coverage?
- What are some of the challenges facing Kansas in implementing successful programs?

SPEAKER BIOS

Trish Riley has served as Executive Director of the National Academy for State Health Policy (NASHP) and President of its Corporate Board since 1989. NASHP is a non-profit forum of health policy leaders from the Executive and Legislative branches of state governments dedicated to excellence in health policy and practice. Previously, Riley held appointive positions under four Maine governors in the areas of aging, Medicaid, state health agencies, health planning, licensing and certification programs. Riley has published and presented widely about state health reform. She serves as a member of the Kaiser Commission on Medicaid and the Uninsured, and as a member of the Institute of Medicine's Subcommittee on Creating an External Environment for Quality. She also previously served as a member of the Board of Directors of the National Committee on Quality Assurance.

Cindy Mann is the Director of the Family and Children's Health Program Group (FCHP) for the Center for Medicaid and State Operations at the Health Care Financing Administration (HCFA). FCHP oversees federal Medicaid policy and implementation for children and families and has primary federal oversight responsibility of the State Children's Health Insurance Program. Mann has more than 20 years experience working on a wide range of health and poverty-related issues. She joined HCFA in late 1999 from the Center on Budget and Policy Priorities where she directed the Center's health policy work at both the federal and state levels, focusing on Medicaid and child

health programs. She has written extensively on policy issues relating to Medicaid and SCHIP and provided technical assistance on these matters to state and federal policymakers and state policy organizations. Mann has worked in Massachusetts, Rhode Island and New York on health and welfare issues, state and federal health care reform, and state tax and budget matters.

Janet Schalansky is the Secretary of the Kansas Department of Social and Rehabilitation Services overseeing a \$1.6 billion budget that provides social services to thousands of Kansans. Prior to her appointment to this position in October 1999, she served as Deputy Secretary to Secretary Rochelle Chronister. Schalansky has over 25 years experience with the Kansas Department of Social and Rehabilitation Services and has worked with most of its programs and services including disability determinations, mental health, retardation services, and adult services. Schalansky also served as director of the Area Office in Topeka where she oversaw the KanWork program, childcare services, training and community relations programs. She also coordinated the SRS welfare reform initiative, *Actively Creating Tomorrow for Kansas Children and Families*.

Writers

Billie Hall, *M.S.P.H.*
 Susan Kannarr, *J.D.*
 Kansas Health Institute
 212 SW Eighth Avenue
 Suite 300
 Topeka, KS 66603-3936
 Tel: 785 233-5443
 Fax: 785 233-1168
 Web Site: www.khi.org

President

Robert F. St. Peter, *M.D.*

Kansas Health Policy Forums Project Director

Billie Hall, *Vice President for Public Affairs*
The Kansas Health Institute is an independent, non-profit health policy and research organization based in Topeka, KS. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.



Introduction

The issue of uninsured children has come to the forefront of national health policy discussions over the past few years becoming a priority on the national and state levels. This is evidenced by the passage of the State Children's Health Insurance Program (SCHIP) in 1997 and the ensuing response by states in implementing innovative new programs and revamping old programs in an effort to find and cover more children. The Medicaid program has been in existence since 1965 and is the largest single insurance program for children in the United States. In 1998, Medicaid covered about 22 million children, which represents one in every four children nationally¹. The latest numbers indicate that 3.3 million children have been enrolled in programs funded through SCHIP since 1999². The passage of SCHIP has focused national attention on the number of children without health insurance, the limitations of current programs such as Medicaid, and the complexities in designing and funding state-based health insurance programs. In the debate surrounding these issues, one thing is clear... children's health insurance is an evolving state and national concern that will benefit from the insight of past experiences and continued dialogue. *It is a work in progress.*

Objectives of This Brief

- To acknowledge health insurance coverage for children as a major health policy issue.
- To introduce innovative approaches to public health insurance for children and families.
- To identify the major program and policy issues facing states regarding public health insurance for children.
- To acknowledge that providing public health insurance to low-income, uninsured children has been and continues to be a shared responsibility of the federal government and the states.
- To examine the status of Kansas Medicaid and HealthWave programs, including challenges, opportunities and potential future enhancements.
- To provide a brief history and descrip-

tion of Medicaid and SCHIP.

- To provide policymakers with new ideas and information — stimulating further discussion on the challenges and opportunities facing Kansas.

Innovative Approaches to Children's Public Health Insurance

After several years of SCHIP experience, states are evaluating the successes and failures of this program in reducing the number of uninsured children and improving access to care while comparing their experiences to Medicaid. Mirroring private insurance seems to be the goal, pressuring states to question past performance and 'business as usual' practices regarding public health insurance. Discussions at the state and national level are focusing on innovative program features and measures of success for Medicaid and SCHIP.

States have used a wide variety of approaches to improve and expand children's public health insurance programs since the advent of SCHIP. These innovations include both SCHIP and Medicaid funded initiatives. As always, not all options will work in every state or with every type of program. States' ability to create innovative programs hinges on a variety of factors including pre-existing programs, the type of SCHIP implemented, financial

resources, state priorities, political climate and social attitudes.

Expanding Coverage

SCHIP was the incentive for states to expand coverage to greater numbers of uninsured children as specified in the federal legislation, although the income eligibility thresholds vary greatly among states. Some states have gone far beyond the 200 percent of the federal poverty level (FPL) eligibility limits to cover children in families with incomes as high as 350 percent of the FPL.

Expanding coverage to parents of eligible children has also become a serious policy issue. There is evidence that expanding parents' access to health care coverage may facilitate the enrollment of children in health insurance programs and increase children's use of health services... compelling information that has triggered significant interest by states in exercising their flexibility for family coverage under SCHIP. The Health Care Financing Administration (HCFA) outlined federal waiver options for states to implement family coverage in July 2000. *[A waiver is granted by the federal government to allow states to bypass or "waive" certain federal regulations to allow them more flexibility in designing state programs. Several different types of waivers have existed in Medicaid for a number of years.]* The first three states to receive federal SCHIP waivers to cover families were announced in January 2001 (NJ, RI, WI). A few states have implemented programs to provide premium assistance to families to purchase family coverage through their employer (MD, MA, VA, WI). Some states have implemented full cost buy-in programs where higher income families are allowed to purchase SCHIP coverage at the full premium price with no state subsidy (CT, FL, NY, NC). Nearly all states implementing family coverage or buy-in programs have either Medicaid expansion or combination programs.

Integrating Programs

Creating a seamless system of health care for children and families seems to be a dri-

TABLE OF CONTENTS

Innovative Approaches to Children's Public Health Insurance	3
Issues Facing States	4
Kansas' Experience.....	5
Overview of Children's Public Health Insurance Programs	6
Conclusion	13

Kansas Facts are noted by ☉

Key terms are defined within the text



ving force behind state efforts to integrate their public programs. Umbrella programs such as BadgerCare in Wisconsin, Mass Health in Massachusetts, Rte Care in Rhode Island and New Jersey's KidCare and FamilyCare are examples of integrated programs administered and marketed under one name. Combining programs may also give states more leverage in negotiating contracts with health plans because of greater program volume and ease of administration.

Enrollment Processes

With renewed emphasis on reaching eligible children and greater flexibility in program administration, SCHIP called attention to the need to develop public programs that are outcome driven and customer friendly. States began to move away from the traditional bureaucracies of Medicaid and develop public health insurance programs that operate more like private insurance. Most states have simplified application and eligibility processes including shortened, mail-in applications; elimination of face-to-face interviews and asset tests; less income documentation; toll-free telephone help lines; implementation of continuous eligibility periods; etc. All of these features are designed to make public health insurance programs easier to access and use. As of July 2000, 10 states allowed self-declaration of income in both their SCHIP and Medicaid programs³. Some states, like Georgia, have gone so far as to eliminate active re-enrollment as a way of assuring continued coverage of eligible children.

Outreach and Marketing

SCHIP changed the culture of state-directed public health insurance programs, as states were expected to develop effective outreach strategies that would reach the target population and result in significant increases in enrollment. Attention was focused on enrollment, requiring states to be creative in promoting their new programs. Marketing and outreach were new to most state public health insurance programs and many states contracted these activities to private organizations. The variety of strategies used for outreach

in states is almost endless and many states used multi-media approaches along with community-based strategies to reach the target population. For the first time, states were held accountable for their efforts in enrolling eligible children and state policymakers became interested not only in the results but also in the methods used. Attention shifted to enrollment, perhaps to the oversight of other important issues such as keeping eligible children enrolled. One of the interesting outcomes of SCHIP outreach efforts was the large numbers of Medicaid-eligible children that were identified through these efforts.

Issues Facing States

Access to health insurance and SCHIP expansion are among the "hot" issues that state lawmakers are addressing in 2001 according to the annual State Health Priorities Survey, conducted by the National Conference for State Legislatures Health Policy Tracking Service. How states address these issues and the types of programs they consider vary significantly. As states evaluate both current and proposed changes and expansions, several issues are important to consider:

Context

With all of the focus on SCHIP, remembering that while important, it is a small piece of the overall puzzle and insures far fewer children than does Medicaid. These programs do not operate in a vacuum and they can impact and be impacted by other pieces of the health care system including safety net providers and the private market.

Unfortunately there is not a great deal of coordination within the entire health care system or even within the public health care system. This can create inefficiencies and can even result in gaps or duplication of services for children.

Vision

An often overlooked factor in the success of any public policy initiative such as children's health insurance is

the existence of a vision.

- What is the state's commitment to providing health insurance to all uninsured children, regardless of family income?
- If coverage is income-based, what income levels should be included?
- How will states pay for programs? Will state funds be allocated to pay for all costs that exceed federal matching monies?
- What is the responsibility of private employers and what role should the state take in regard to private sector participation?
- What about parents of uninsured children?
- What about immigrant populations (some of these may be excluded by federal law and states would have to supply all of the funding for their coverage).

These decisions can be complex and can be influenced by political ideologies, fiscal resources and public support. Public perception of health insurance programs as welfare or charity can create difficulties for policymakers in designing effective programs and in allocating public monies.

Understanding the Target Population

Another critical factor in the long-term success of children's public health insurance is understanding the target population. Factors such as geographic location, family characteristics, racial and ethnic background, employment status, reasons for lack of insurance, etc., can be important to know in targeting outreach and providing services. Additionally, employment and insurance status may change frequently for many families.

⊕ The Kansas Insurance Department has received a 12-month planning grant from the Health Resources and Services Administration (HRSA) to learn more about the uninsured in Kansas including an 8,000 household survey, the largest ever done in Kansas. Results are expected in September 2001.

Outreach and Enrollment

One of the significant changes in public health insurance brought on by SCHIP was the concept of outreach — planned



marketing efforts to reach the target population, something not previously associated with Medicaid. Public health insurance programs, while available to eligible individuals, were not actively promoted. Effective marketing requires an understanding of the racial, ethnic, cultural, geographic and language characteristics of the target population. Without this information, outreach efforts may fall short resulting in little or no response by the target population.

The success of particular outreach strategies can be difficult to measure because it is often hard to tell what motivated families to apply for health insurance coverage. As states gain experience in outreach, efforts to find eligible families, and in particular “hard to reach” families, will improve.

Retention

Reducing the number of uninsured children in the years to come will require not only reaching eligible children, but also assuring continued coverage for eligible children. Early analysis of SCHIP enrollment data from several states suggest that children may be leaving the program before their eligibility expires. Reinforcing the importance of continuous coverage to families will become a major component of outreach programs. States also are recognizing the need to develop effective retention strategies to reduce dropout of eligible children. Ideas such as simplification of re-enrollment, extending periods of eligibility, aligning eligibility and enrollment systems, and further breaking the link between insurance programs and traditional welfare programs are some of the techniques that states are using to deal with this problem.

Resource Allocation

For states considering expanding programs the question of funding is paramount. State revenue shortfalls can have an impact on the ability of states to expand or even maintain current levels of support for existing programs. Other financial considerations include provider reimbursement rates and their

effect on provider participation in public health insurance programs.

Program Structure

There are a number of issues around program structure that may be important to policymakers as they plan for the future of public health insurance programs.

■ **Ease of use** — Programs must be accessible and easy to use for beneficiaries and providers in order to be successful in enrolling and retaining children and maintaining access to quality care.

■ **Access to care** — Access to care may be the supply of providers (discussed in the next bullet) or it may be the ability of families to access the existing providers effectively. Geographic issues, transportation, cultural variations, language barriers and a number of other factors can impact access. Access can also be families’ knowledge about how to access care in a health insurance system and their motivation to do so.

■ **Provider supply** — Adequate provider participation is necessary to meet the health care needs of the enrolled population. The rural areas of Kansas pose challenges to the availability of all types of providers (primary care, specialty, etc.). Shortages of dentists and lack of participation of dentists in public health insurance programs are also major concerns in Kansas. Provider participation in public health insurance is affected by reimbursement rates, efficient payment processes, welfare stigma, and the perception of public health insurance as charity care.

■ **Benefits** — Medicaid requires states to provide a comprehensive benefit package covering all medically necessary services for eligible children. States with separate SCHIP programs, like Kansas, have more options regarding benefit plans and thus more decisions to make regarding potential tradeoffs between the comprehensiveness of services, the cost of those services and any desire to mirror the commercial market.

■ **Crowd-out issues** — The importance of crowd-out, or substitution of private

insurance for public insurance, is an important issue for policymakers. Program features such as waiting periods can be used to control this issue.

■ **Coordination between SCHIP and Medicaid** — Policymakers must decide the degree to which they want to coordinate policies between the new SCHIP and the old Medicaid. Federal law requires a certain amount of coordination especially with respect to the eligibility determination (“screen and enroll” requirement). The degree to which the coordination exists in areas such as enrollment, benefit packages, applications, outreach, service delivery and quality assurance is largely up to the states. There are considerations to understand when making coordination decisions such as the potential to influence the perception of the new SCHIP with the negative ideas about Medicaid or to do the opposite and improve the image of Medicaid with the positive feelings towards SCHIP. The potential for children to move between programs, for families to have children in more than one program and the families’ experience in those situations can also influence a state’s decision on coordination.

Kansas’ Experience

Since the implementation of HealthWave in 1999, much attention has been focused on enrollment, outreach efforts and the number of uninsured children. Although 49,800 more Kansas children were covered under Medicaid and HealthWave after the first 24 months of the new HealthWave program, some policymakers are questioning the effectiveness of the state’s outreach efforts. Additionally, early program data reveal that despite the intention of the state, many of the children enrolled in HealthWave and Medicaid are not staying in the program for the full 12 months for which they are eligible. This high turnover rate of children in Kansas public health insurance programs centers on large numbers entering and leaving the programs and



children transferring between the two programs, which may lead to potential gaps in insurance coverage.

Another major issue in Kansas has been the estimated number of children eligible for public health insurance programs (children in families with income at or below 200% of the FPL). Based on data from the Current Population Survey (a three-year rolling average between 1993-95), the number of uninsured children under 200% FPL in Kansas was estimated at 60,000 prior to the implementation of HealthWave. More recent pre-HealthWave data suggest the estimated number may be somewhat lower (42,000 according to CPS rolling average between 1996-98). However, CPS estimates are highly volatile and have been criticized for potential inaccuracies. As a result, there is some question about how well the state is doing in reaching the target population. This debate is not unique to Kansas as other states are experiencing similar concerns about their estimates.

Because HealthWave is a separate SCHIP and not a Medicaid expansion there may be coordination issues for families after children are determined eligible. Medicaid eligibility in Kansas is “stair-stepped” based on the age of the children. This may result in some families having children in both Medicaid and HealthWave. While eligibility rules have been coordinated between the programs, the structure of the delivery systems have not. Medicaid benefits are available on a fee-for-service basis until a child is enrolled in a health plan under the PrimeCare program or with a Primary Care Case Manager in the HealthConnect program. The family must also be given a choice of health plans in PrimeCare or be given the option of choosing the HealthConnect program. Benefit coverage does not occur in HealthWave until the child is enrolled in a health plan which is generally the first of the month following eligibility determination. There is no fee-for-service system in SCHIP to pay for services in the time period between eligibility and enrollment in a health plan. The differences between

the programs can cause confusion for families and may require them to see several separate providers for their children. Beginning in July, the state will immediately enroll SCHIP eligible children in a health plan upon determination of eligibility and then cost settle with the health plan for the time between eligibility determination and enrollment. This will eliminate the delay in coverage for HealthWave. Other administrative changes are underway to help eliminate as many program differences as possible, at least from the families’ perspective.

Kansas is planning to integrate Medicaid and SCHIP into a single “umbrella” program on July 1, 2001. At that time, HealthWave will be used to refer to both the SCHIP and Medicaid program (for non-disabled children). The goal is to make the difference between the two programs as invisible as possible thereby lessening the potential confusion and hassle to families, many of whom have children in both programs. One of the biggest challenges to this goal is the lack of participation by health plans in Medicaid managed care. Plans are much more willing to participate in SCHIP because of the ability to bid and negotiate capitation rates. This is in contrast to Medicaid where capitation rates are determined by the state based on fee-for-service rates and plans have almost no ability to negotiate capitation rates.

Kansas is also in the process of further streamlining and de-linking current eligibility processes from other assistance programs. Kansas Department of Social and Rehabilitation Services (SRS) is planning on moving responsibility for eligibility determination for medical programs within SRS to the Health Care Policy Division. SRS believes this will allow much greater separation of public health insurance eligibility from other programs and will hopefully decrease the level of movement between and out of Medicaid and HealthWave. The separation of eligibility determination processes may require families to fill out two applications if they seek both health insurance coverage and assistance from other programs such as food

stamps. Additional eligibility simplifications are under consideration as well as revisions to the to the joint HealthWave-Medicaid application to increase access to the program. Child advocates have been concerned from the beginning of HealthWave that the 6-month period of uninsurance required for HealthWave participation is a barrier to needy families. Legislation has been introduced in the 2001 Session that eliminates the 6-month uninsured “waiting period” before being eligible for HealthWave.

Overview of Children's Public Health Insurance Programs

Reviewing the evolution and structure of both Medicaid and SCHIP is helpful to looking ahead at the future of public health insurance for children. The focus of the discussion will be on programs for non-disabled, low-income children and will not include Medicaid services for the elderly and disabled.

Evolution of Public Health Insurance

Medicaid was enacted in 1965 as a health care program for those receiving cash assistance, covering children and their mothers, the disabled and the elderly. This initial association with “welfare” was the beginning of a negative perception that continues today. Since that time, Medicaid has been expanded incrementally beyond its ties with cash assistance programs. Coverage has been expanded to increasing numbers of low-income pregnant women, children and families⁴. The divergence from cash assistance became clearer in the 1996 federal welfare reform legislation, which broke the direct link between eligibility for Medicaid and eligibility for cash assistance programs. Although not necessarily its intention, this divergence has been blamed for overall decreases in Medicaid enrollment during the mid to late 1990s which seems to have accompanied (even larger) declines in the number of welfare recipients. This trend seems to have stabilized during 1999.⁵



During the late 1980s and continuing in the 1990s, states began to implement Medicaid managed health care programs as the Federal government began to allow states greater flexibility through the use of the waiver process. Managed care was used by states to improve access and contain costs, which sometimes helped facilitate coverage expansions⁶. The 1997 Balanced Budget Act, allowing states to mandate managed care enrollment for certain populations without a federal waiver, has contributed to an increase in Medicaid managed care since that time.

Both the passage of the 1997 Balanced Budget Act and the creation of SCHIP moved public health insurance further away from cash assistance and dramatically increased states' incentive and ability to cover additional children. SCHIP was created to help insure children whose families have incomes beyond Medicaid income limits but who do not have private insurance coverage. This population is sometimes referred to as the "working poor."

SCHIP changed the way many states approached health insurance. With higher Federal match rates, states were able to craft programs, such as HealthWave in Kansas, which focused on finding eligible children and emphasizing the importance of having health insurance coverage. There was a new focus on positive images for public health insurance and a renewed interest in reaching more uninsured children. States made an effort to "de-stigmatize" public health insurance through SCHIP. The enthusiasm for SCHIP appears to be spilling over to Medicaid programs and may bring about changes to improve that program, including eligibility simplifications, outreach and a focus on access to care.

Medicaid and the State Children's Health Insurance Program (SCHIP)

Medicaid was created under Title XIX of the Social Security Act as a partnership between the federal government and the states. Medicaid is an enormous and com-

plex program serving certain groups of low-income, aged, blind and disabled people. The aged, blind and disabled populations comprise the smallest number of beneficiaries in the program but represent the largest expenditures⁴. In Kansas, these populations make up about 30 percent of the beneficiaries but account for 80 percent of the expenditures.⁷ This is comparable to national Medicaid enrollment and expenditure data.⁴

SCHIP was enacted as Title XXI of the Social Security Act. The program was targeted towards uninsured children under age 19 who live in families with incomes under 200 percent of the federal poverty level (\$34,100 for a family of 4 in 2000).

States had the option to use SCHIP funds to expand their Medicaid programs, create separate programs or implement a combination of the two under the federal legislation. *[Expansion generally refers to increasing eligibility limits. In other contexts it can mean including additional groups of people.]* States choosing to implement Medicaid expansions must apply all Medicaid rules to their programs. States responded enthusiastically to the SCHIP opportunity and by Fall 1999, two years after the law was enacted, every state and the District of Columbia had SCHIP⁸. Nearly a year later in August 2000 there were 15 separate state programs, 23 Medicaid expansion programs, and 18 combination programs among the states and territories⁹.

✪ Kansas implemented SCHIP as a separate state program under the name HealthWave on January 1, 1999.

✪ Kansas public health insurance programs (Medicaid and SCHIP) combine to be the third largest insurer in the state and the largest insurer of children. The Department of Social and Rehabilitation Services administers all aspects of these programs in cooperation with other state agencies and private contractors.

The chart on page 8 compares significant features of the Kansas SCHIP and Medicaid programs.

Who is eligible and how do people apply?

States have fairly broad discretion in selecting the financial eligibility standards for their Medicaid programs and as a result, programs can vary substantially from state to state. States are required to cover certain groups of people and have the option to include other groups. In many instances, particularly for children and pregnant women, the federal eligibility rules require states to cover a group up to a certain income level. For instance, states must cover children under age 6 with family incomes at or below 133% of the FPL. States can increase eligibility above these minimum income levels with virtually no federal limits.

Federal SCHIP legislation gave states flexibility to establish eligibility standards, particularly those states implementing separate programs. Although the federal legislation specifically targeted children under 200 percent of the federal poverty level states have options to exceed that level. States that had Medicaid eligibility expansions already in place could go 50 percentage points beyond existing eligibility levels. Additionally, states can increase allowable income levels using eligibility determination rules and processes that allow higher income families to qualify for coverage. (These rules and processes have been used in Medicaid for some time to expand eligibility for pregnant women and children).

The federal SCHIP legislation created some restrictions on states' ability to shift enrollment or choose to serve children in SCHIP programs as opposed to Medicaid or state funded programs.

■ States cannot "roll back" or decrease their Medicaid eligibility limits below what they were in June 1997.

■ States must screen all SCHIP applications for Medicaid eligibility and if eligibility for Medicaid is determined, the child must be served by that program (if



Kansas Public Health Insurance for Children Program Comparisons

	Medicaid (non-disabled children)	SCHIP (HealthWave)
Family Income Limits	Under age 1 < 150% Federal Poverty Level (FPL) Ages 1-5 < 133% FPL Ages 6-18 < 100% FPL	Ages 0-18 < 200% FPL, but above Medicaid eligibility (\$34,100 or less for family of 4 in 2000)
Eligibility Requirements	U.S. citizen or qualified alien	Uninsured for six months; not eligible for Medicaid; U.S. citizen or qualified alien; excludes children of public employees eligible for state employee health insurance
Application Process	4-page mail-in application (or can fill out longer application at a SRS office); no assets test; 2 months income verification; immigration documents if applicable; assistance available by phone through toll-free helpline; notification of eligibility by mail.	4-page mail-in application (or can fill out longer application at a SRS office); no assets test; 2 months income verification; immigration documents if applicable; assistance available by phone through toll-free helpline; notification of eligibility by mail.
Period of Eligibility	Eligibility redetermined once every 12 months; families must complete a 2 page renewal application	Eligibility redetermined once every 12 months; families must complete a 2 page renewal application
Program Type	Federal Entitlement	Non-entitlement program
Funding	No spending caps for services or administration	Capped spending; Administrative expenses limited to 10% of expenditures for services
Federal Match	60% Federal for services; 50-90% for administration	72% Federal for services and administration
Benefits	All medically necessary physical, dental and mental health services. Prescription benefits included. No restrictions on pre-existing conditions.	Medicaid equivalent. No restrictions on pre-existing conditions. Prescription benefits included.
Program Structure	Mandated managed care statewide through one of two options for physical health: 1) health plan (capitated managed care) or 2) Primary Care Case Manager (PCCM) system. Dental, mental health and substance abuse services offered on a fee-for-service basis or through grants. Benefits begin first day of the month in which eligibility is determined and can be extended to 3 months prior to determination. Beneficiaries can access services on a fee-for-service basis before enrolled in a managed care plan.	All services delivered through contracting health plans providing capitated managed care statewide. Benefits begin the first of the month following eligibility determination and enrollment in a health plan. No coverage for services before health plan enrollment.
Enrollment in Managed Care	Beneficiaries must be given a choice of health plans (if available) or a choice of delivery systems (health plan vs. primary care case manager).	Beneficiaries are not required to have a choice of health plans.
Health Plan Reimbursement	Payments to health plans based on equivalent fee-for-service Medicaid reimbursement rates and costs cannot exceed fee-for-service expenses for an equivalent population. State calculates and sets rates.	Payments to health plans are negotiated between the plans and the state; no federal restrictions on payments.
Cost Sharing	Cost-sharing (e.g., co-payments, deductibles) is not allowed for children and pregnant women.	Family premium of \$10 or \$15 for families over 150% FPL; failure to pay premium does not result in termination of benefits for current period, but may result in family being disallowed to re-enroll for the next coverage year until current on premiums.

KHI 2001

the state's SCHIP is a Medicaid expansion the child's services must be funded with standard Medicaid funds and not the enhanced SCHIP funding). This is referred to as the "screen and enroll" requirement. Many states, like Kansas, facilitated this process by using joint applications that are used to determine eligibility for both programs. [Screen

and Enroll refers to the federal requirement that all SCHIP applications must be screened for Medicaid eligibility and children must be enrolled in Medicaid if they are determined to be eligible for that program.] This restriction has received criticism from a number of parties for limiting states' flexibility especially in a program with

spending limits. Many argue that it may result in children continuing to be uninsured if families refuse to participate in Medicaid.

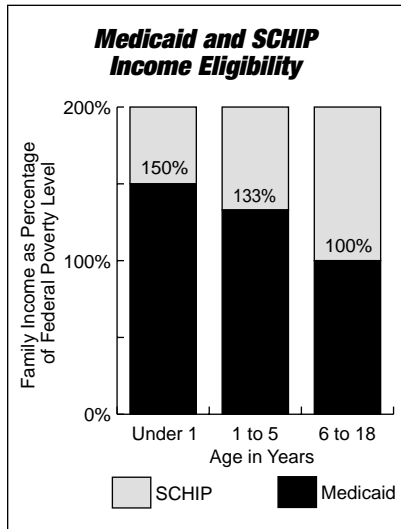
■ Children of public employees who are eligible for state employee health insurance are ineligible for SCHIP. The message appears to be that states should take responsibility for insuring children of its



own employees. This is another provision in the federal law that has prompted criticism from states and other parties as being inequitable to families whose children may remain uninsured simply because of where their parents are employed. This restriction does not exist in the traditional Medicaid program.

✦ In Kansas, Medicaid eligibility for non-disabled children is “stair-stepped” based on the age and family income of the child. Infants under age 1 are eligible up to 150 percent of the federal poverty level (FPL); children from 1 through 5 are eligible up to 133 percent FPL; and children 6 to 18 are eligible up to 100 percent FPL.

✦ HealthWave covers children under age 19 with family incomes under 200 percent of the federal poverty level (approximately \$34,100 for a family of 4 in 2000) but above Medicaid eligibility.



KHI 2001

✦ Children in HealthWave and non-disabled Medicaid children have 12 months of continuous eligibility. This means that a child’s eligibility only has to be reviewed once every 12 months. Concurrent with the implementation of HealthWave, Medicaid eligibility for non-disabled children was simplified. This was done to align the application process for both programs and facilitate a joint-application. One step that exists

in Medicaid but not in HealthWave is the required referral to Child Support Enforcement (CSE). By federal law, information on Medicaid-eligible children must be forwarded to the CSE office to investigate the existence of medical support orders. This referral requirement has been anecdotally blamed for many families’ choice not to participate in Medicaid even though children are eligible.

✦ Kansas’ eligibility simplification features include a reduction in income documentation, elimination of the assets test (i.e. the state does not ask families about assets to determine eligibility), elimination of the face-to-face interview requirement and allowing mail-in applications; implementation of continuous eligibility (essentially lengthening the time between required eligibility redeterminations); and reducing the length and complexity of applications. Kansas now uses a 4-page application that can be picked up at locations across the state or by calling the toll-free helpline. Kansas’ ability to completely separate public health insurance from other assistance programs is affected by the use of a single automated eligibility determination computer system for all assistance programs. Actions taken regarding other unrelated programs (such as food stamps) may affect inadvertently a child’s Medicaid or HealthWave eligibility.

✦ Kansas contracts with private vendors to carry out many day-to-day administrative functions for both Medicaid and HealthWave. In HealthWave, MAXIMUS operates the clearinghouse that performs a variety of functions including marketing/outreach; application distribution and receipt; premium processing; eligibility determination; health plan enrollment; capitation payment to health plans; and operation of the toll-free helpline. Likewise, many of the day-to-day administrative functions in Medicaid are contracted to Blue Cross and Blue Shield of Kansas, the State’s fiscal agent that operates the Medicaid Management Information System (MMIS).

What about children who are already covered by private insurance?

When SCHIP legislation was passed, there were concerns that privately purchased insurance would be dropped in favor of low or no cost public coverage available under SCHIP (crowd-out). The potential for this phenomenon has been around for years with Medicaid but became more of an issue with the passage of SCHIP. In fact, children can be covered by insurance and still be eligible for Medicaid (Medicaid then becomes secondary to the private coverage). Federal SCHIP regulations require states to control for substitution of private insurance coverage or crowd-out. *[The term crowd-out refers to the potential that targeted, low-income uninsured children may be “crowded-out” of SCHIP, which has spending caps, by children who were insured but whose private coverage was discontinued in favor of public coverage.]*

The dropping of private insurance coverage to access public coverage can be difficult to identify and quantify. Substitution could take the form of employers reducing coverage or raising premiums for dependent children to encourage families to use publicly funded insurance. The more straightforward example is a family who “uninsures” their child(ren) to make them eligible for SCHIP. Issues around substitution of coverage include its potential affect on the commercial and employer-sponsored insurance market, a fear that uninsured children who really need SCHIP coverage will be crowded-out by insured children dropping coverage and will remain uninsured and the belief that benefits to society of having children insured outweigh the risks. In general, there is not a great deal of agreement on the extent, impact and importance of substitution of coverage or crowd-out.

✦ Kansas, like many states, chose to require a specified period of uninsurance before children are eligible for SCHIP, often referred to as a “waiting period.” Children whose private coverage has been discontinued within the last 6 months are



not eligible for HealthWave. If there are good cause reasons for the discontinuation of private coverage such as involuntary loss of coverage, the waiting period is waived. Enrollment in Medicaid does not count as coverage for this purpose.

How are Medicaid and SCHIP funded?

Federal and state governments share the cost of SCHIP and Medicaid programs. The Federal matching percentage varies by state according to the Federal Medical Assistance Percentage or FMAP. *[The Federal Medical Assistance Percentage or FMAP refers to the percentage of program costs the federal government will pay and is based on the average personal income in the state.]*

✪ In Kansas, the federal government provides 60 percent of the funding for Medicaid services and the state provides 40 percent. States receive increased matching percentages for SCHIP eligible children as compared to the Medicaid match rates. These also vary by state and are calculated by taking 70 percent of the Medicaid FMAP and adding 30 percentage points or using an 85 percent rate, whichever is lower.

✪ Kansas receives 72 percent of the cost of serving children in SCHIP and must match that amount with 28 percent state dollars.

Medicaid is an entitlement program meaning that if a person is eligible under the established eligibility rules they cannot be denied services due to a lack of funding. (Social Security and Medicare are also entitlement programs). States can control spending to some extent by tightening eligibility standards, eliminating coverage for optional populations or restructuring benefits. **SCHIP is not an entitlement program** and children may be denied enrollment due to funding limitations. States implementing Medicaid expansion programs are in the position of operating an entitlement program within a non-entitlement funding structure.

In general, there is no set limit on federal payments to states for Medicaid as long as

a state pays its portion of expenditures and funds are used appropriately. SCHIP is funded by the federal government on a capped-match basis meaning that states have a set amount of federal funding each year to draw down by expending the required percentage of state money. The initial federal allocations to states were calculated using formulae accounting for the number of uninsured children under 200 percent of the federal poverty level (FPL) in the state based on Current Population Survey (CPS) data and adjusted for health care costs.

States have 3 years to spend each year's allocation and funds are reallocated after each of those three-year cycles among states. This reallocation caused a great deal of controversy in the Fall of 2000 (the end of the first 3-year cycle) due to uncertainty about how funds would be reallocated among states. Most states, including Kansas, did not spend their entire initial allotment for a variety of reasons¹⁰. The reasons included start-up lag times, restrictions on coverage of certain groups (state employees' children and those enrolled in Medicaid through the SCHIP application process), and potential inaccuracies in the CPS estimates⁹. Both Medicaid eligible children and children of public employees were counted by the CPS as uninsured children under 200 percent FPL and were included in the SCHIP allocation.

✪ In Kansas, Medicaid expenditures in state fiscal year 2000 were \$1.3 billion (\$509 million from state funds) serving a total of over 261,000 people. Expenditures for low-income children, pregnant women and families receiving cash assistance were \$183.2 million (\$73.3 million state funds) and serving nearly 149,500 individuals. These low-income pregnant women and children represent approximately 57 percent of the total beneficiaries and only 14 percent of total expenditures. These figures are similar to national Medicaid enrollment and financial data. In contrast, the federal SCHIP allocation for Kansas is approximately \$31 million per year with a required state

match of \$12 million. Proposals to increase eligibility limits or provide family coverage must be funded within this block grant or be funded entirely through state money.

What about administrative costs?

Medicaid does not restrict the amount a state may spend for administrative services as long as the functions financed meet federal guidelines. *[Administrative services include a variety of operational functions including staffing; computer systems used to determine eligibility and make payments to providers; outreach and marketing; processing premium payments; and customer service functions.]* The federal match rate for administration is 50 percent although higher federal match rates of 75-90 percent are available for some functions. Unlike the Medicaid program, administrative expenditures are limited in SCHIP but states receive the same enhanced match rate as they do for services. Under federal law, states may only spend 10 percent of the amount expended for providing services on administration, including outreach and marketing activities.

The 10 percent administrative limit has created challenges for states implementing new, separate programs as opposed to Medicaid expansions. Administrative restrictions can limit outreach and marketing as well as a state's ability to create new administrative structures to operate separate programs. The 10 percent limit is based on expenditures for services but administrative functions must be in operation to find and enroll those children. The federal government has allowed states some flexibility to retroactively claim administrative matching funds after program expenditures have increased. States may also request special exceptions to this restriction, referred to as a waiver, but it is unknown at this time what type of exceptions will be granted. States implementing Medicaid expansions must work within the 10 percent limit but once it is reached they can expend regular Medicaid administrative dollars (i.e., will



receive 50 percent reimbursement instead of the enhanced SCHIP rate).

✦ Kansas has experienced the restraints of the SCHIP administrative cap but has tried to avoid negative impacts by allocating costs among different financial resources. This is especially true in the operation of the centralized clearinghouse where many costs are able to be allocated to Medicaid, based on the number of children determined to be Medicaid eligible through a HealthWave application.

How do beneficiaries receive services?

Once they are in the program, Medicaid and SCHIP beneficiaries may receive services from a variety of providers including physicians, hospitals, clinics, Federally Qualified Health Centers, Rural Health Centers, local health departments, dentists, Community Mental Health Centers or a number of other providers. The process for accessing these services will depend on how the state has structured its program.

States may deliver medical services through a traditional fee-for-service system or through some form of prepayment system. [*Fee-for-service: beneficiaries choose a Medicaid physician who then submits a bill to the state and is reimbursed for each service provided.*] In the fee-for-service system, beneficiaries seek services through a Medicaid enrolled physician who then submits a bill to the state and is reimbursed based on the State's fee schedule for each service provided. States have a great deal of discretion in establishing their fee schedules. In a pre-paid health plan system (often referred to as capitated managed care or a Health Maintenance Organization) the health plan receives pre-payments for each beneficiary (referred to as capitation payments) usually on a monthly basis to provide all covered services. [*Capitated managed care refers to a system where a health plan or Health Maintenance Organization receives a set payment in advance for each beneficiary assigned to them. They are then responsible for providing all covered services. The pre-payments are generally*

referred to as capitation payments because the amount of money the health plan will receive is capped.]

The rules under which capitated managed care systems operate are different in Medicaid and SCHIP. In Medicaid, beneficiaries must be offered a choice of health plans or be allowed to choose another way to access services. If a beneficiary does not choose within a set period of time they may be assigned to a health plan or provider. There is no such requirement for choice in separate SCHIPs. Under federal Medicaid rules, the cost of the managed care program may not exceed the cost of the fee-for-service equivalent (referred to as the Upper Payment Limit or UPL). Some contend that this restriction is unfair because health plans provide coordination and preventive services beyond the Medicaid benefit package¹¹. States implementing separate SCHIP programs can set rates at their discretion and are not limited by federal rules in setting capitation rates. States implementing a Medicaid expansion program must apply the Medicaid rules.

✦ Nationally, Medicaid enrollment in managed care has increased from 23.2 percent in 1994 to 54.5 percent in 1999¹². Following this trend, Kansas began implementing a mandatory managed care program in 1995. Since that time all Medicaid low-income pregnant women, non-disabled children and families receiving cash assistance have been required to participate in managed care. As of February 2001, 113,300 or 55.5 percent of Kansas Medicaid beneficiaries were enrolled in managed care.

✦ Kansas currently operates two types of physical health managed care programs for low-income families.

✦ **PrimeCare** is a prepaid or capitated managed care program. The state contracts with health plans to provide all physical health services to beneficiaries who choose a plan or are assigned by the state (with some limited exceptions). Individual providers are paid on a negotiated

fee-for-service basis by the health plan. Currently, Kansas only contracts with one health plan, First Guard Kansas, to provide coverage for the PrimeCare program. Only physical health services are provided through health plans. Dental services are provided on a fee-for-service basis. Mental health and substance abuse services are paid for through a more complex system of grants and match programs. PrimeCare, the smaller of the two types of managed care, is available in 62 of the 105 counties and has 39,700 beneficiaries enrolled for February 2001.

✦ **HealthConnect** is a Primary Care Case Manager (PCCM) program which is a more limited form of managed care. Beneficiaries are assigned to or choose a physician who acts as a "gatekeeper" and case manager. Beneficiaries must access services through their PCCM or receive a referral. The assigned PCCM physician (or a referred provider) bills the state for services on a fee-for-service basis. The PCCM receives a small monthly case management fee (\$2 per beneficiary per month). HealthConnect also serves Supplemental Security Income (SSI) beneficiaries. HealthConnect is available statewide and had February 2001 enrollment of 73,600 beneficiaries.

Challenges to Capitated Managed Care in Kansas

✦ The adequacy of pre-payments or capitation rates has been one of the biggest struggles for Kansas in implementing capitated managed care. Fee-for-service reimbursement rates in Kansas are low compared to other states resulting in comparably low capitation rates¹³. The issue of capitation rates has been around since the beginning of managed care but became more evident when two of three health plans dropped out of the program at the end of 1998. The only remaining plan, Horizon, went out of business in the spring of 1999 due to financial struggles¹⁴. The Medicaid business was assumed by another health plan, First Guard Kansas, that is still serving as the single Medicaid health plan and as a participating plan in HealthWave.



✪ Capitated managed care is generally not well accepted by providers in Kansas, particularly in the western portions of the state. This can create challenges for health plans trying to establish and maintain adequate provider networks.

✪ The number and distribution of providers across the state also present challenges. Kansas has large rural and frontier areas that are sparsely populated. The supply and distribution of medical professionals, particularly dentists and specialists, in these areas makes it difficult for health plans to maintain adequate networks. Provider shortages are a problem for public and private health insurance plans, particularly those serving sparsely populated areas.

Kansas legislation required HealthWave to use capitated managed care to deliver services to all participants. Unlike Medicaid, all services including dental, mental health and substance abuse services are accessed through health plans. There are separate health plans for these services. Also unlike Medicaid, health plans can negotiate capitated rates based on their costs and are not restricted by federal limitations. The health plans are then free to negotiate fee schedules with the individual providers with whom they contract to provide services.

Can state programs purchase private employer-sponsored coverage for eligible children?

One alternative to standard program structure is the option to create a premium assistance program to purchase private insurance coverage for beneficiaries. [*A Medicaid premium payment program allows states to purchase commercial insurance policies for beneficiaries if it is cost-effective.*] Federal Medicaid law allows states to purchase coverage if it is cost-effective meaning the cost of purchasing the coverage is equal to or less than the cost to serve the beneficiary in the Medicaid program. Policies are generally purchased through employer-sponsored plans where the employer covers part of the cost making it more likely to be cost-

effective. The state picks up the employee's share of coverage for the Medicaid eligible beneficiary (most often dependent coverage for children). A benefit to this system is that other family members (such as older siblings) may be covered by this policy. The other benefit to the state is that it can result in cost savings and cost avoidance to the Medicaid program.

✪ Kansas, and six other states, operate some form of Medicaid Health Insurance Premium Payment System (HIPPS) program. The Kansas program is small and serves approximately 400 families statewide.

The ability of states to implement premium assistance programs under SCHIP similar to those in Medicaid to cover families is limited by federal requirements. To purchase employer-sponsored coverage states must show that employers make a significant premium contribution, the benefit package meets federal benchmark standards, and that the cost-sharing (e.g. deductibles, co-pays) do not exceed federal limits. Additionally, states must prove that the cost of providing family coverage through employer buy-in programs will not exceed the cost of covering the child in the public program and is therefore cost-effective. Finally, states must implement additional safeguards against substitution of coverage including a minimum 6-month period of uninsurance before being enrolled.

Federal guidance on the ability of states to bypass or "waive" selected SCHIP rules and implement family coverage and employer buy-in programs was issued in July 2000. This authority builds on experience from states that expanded Medicaid programs to cover families using similar Medicaid waivers. These waivers could be used to eliminate some of the barriers to enrolling children in premium assistance programs such as simplifying the cost-effectiveness calculation or benefit package requirements.⁵

✪ Kansas passed legislation during the 2000 session creating a purchasing cooperative for small businesses in Kansas with

low-wage employees. Included in the legislation was a goal to find ways to use SCHIP and Medicaid funding to provide subsidies to help purchase coverage for employees with Medicaid or SCHIP eligible family members.

What benefits do children receive?

Federal Medicaid law requires states to provide a comprehensive set of benefits to children including the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. The benefit package contains all preventive and primary care services as well as treatment with all medically necessary and non-experimental services. Services include inpatient and outpatient hospital services; vaccines; physician services; family planning services; laboratory and x-ray services; pediatric and nurse practitioner services; prescription drugs; transportation; rehabilitation and therapy services; dental services; mental health services and any other medically necessary services.

✪ In Kansas, the EPSDT program is known as Kan-Be-Healthy.

Federal benefit requirements in SCHIP leave states a significant amount of flexibility. States have the option to offer benefits equal to plans specified in the SCHIP legislation, to provide benefits which are actuarially equivalent to one of the specified plans, or to offer a benefit package approved by the Secretary of Health and Human Services. As in Medicaid, states cannot restrict benefits on the basis of pre-existing conditions. The federal law establishes almost no restrictions in the way states can deliver benefits, although Medicaid expansion programs must follow Medicaid rules.

✪ Kansas chose to make HealthWave benefits equivalent to the comprehensive benefits provided to Medicaid children.

What does it cost to participate?

Federal regulation allows only nominal cost sharing from some Medicaid participants (i.e., co-payments). There is no cost sharing allowed for services provided to children and pregnant women.



Cost sharing is allowed under SCHIP to a greater extent than in Medicaid. Cost sharing can include options such as premiums, co-payments, deductibles or enrollment fees. Unlike Medicaid, families participating in separate SCHIPs may be refused services or disenrolled because of non-payment of services. Cost sharing is federally limited to less than 5 percent of family income and does not apply to all services.

✦ In Kansas, families with incomes above 150% of the federal poverty level are required to pay a monthly family premium of either \$10 or \$15 based on their income. Children are not disenrolled for non-payment of premium but are not allowed to re-enroll after their 12 months of continuous eligibility until payments are current.

How does the state find and enroll eligible children?

The ability of Medicaid to serve all eligible children is hampered by several factors including outreach efforts, application requirements and negative perceptions. Historically, states have not actively engaged in outreach activities. Medicaid enrollment and application processes were often lengthy and complicated, requiring significant documentation of income and assets. Medicaid's history and association with cash assistance may have created a stigma that deterred some people from enrolling in the program. The perception that the Medicaid benefit package is less comprehensive than private health benefit programs may also be a barrier to enrollment. For these reasons, many who are eligible for Medicaid are never enrolled. Estimates of these "eligible-but-not-enrolled" children soon after the passage of SCHIP indicate that between 1.6 and 4.7 million children nationally may fit into this category¹⁵.

States have launched into outreach and marketing with vigor since the advent of SCHIP. A variety of catchy new program names and outreach campaigns have emerged designed to improve the image of public programs and encourage parents to apply for their children. States have used a near-

ly endless variety of outreach methods including school-based initiatives; printed materials; billboards; broadcast media; toll-free phone lines; web-based information; provider and employer-based methods; training of community organizations and volunteers; retail locations and booths at community events⁵.

✦ As in other states, SCHIP has changed the approach to children's public health insurance programs in Kansas. Outreach and marketing methods include many of those listed above as well as some unique to Kansas. Outreach takes place through two main mechanisms in Kansas. The state contracts with a private company, MAXIMUS, to conduct marketing and outreach services. The focus of this effort is to distribute information to as many locations, organizations and people as possible. Schools are a major focus of these outreach efforts. The state also received a grant from the Robert Wood Johnson Foundation called Kansas Covering Kids to conduct outreach and marketing targeted at populations that are more difficult to reach. The grant is administered by the Kansas Children's Service League, a private, non-profit organization. The Covering Kids project has a statewide campaign and three pilot sites all designed to help find these populations. Some factors that may make people hard-to-reach are language barriers, culture differences, geographic location and access to or use of mass media information.

✦ SCHIP outreach efforts have increased enrollment in the Medicaid program. Kansas did not expect the number of HealthWave applicants determined to be Medicaid eligible to be as high as it is (estimated to be slightly over 1 Medicaid child for every 1 SCHIP child).

✦ Measuring success in enrollment is complicated by the lack of a good baseline as to the number of children who are eligible. The estimated number of uninsured children under 200 percent of the federal poverty level upon which the federal

financial allotment was based was 60,000 children. This number became the enrollment goal in the mind of many. As the case in many other states, especially those with small populations, the accuracy of the original Current Population Survey (CPS) estimates is questionable¹⁵. Due to sampling issues and amount of time that has passed since those surveys were done, the number likely does not reflect the current numbers of uninsured children. It is also important to remember that the number of uninsured children is a dynamic number that is constantly changing. The number of uninsured children can be impacted by changes in the economy, changes in employment status and trends in the private insurance market.

✦ Important information regarding enrollment is being analyzed as part of a 3-year evaluation of HealthWave¹⁶. Enrollment data for HealthWave and Medicaid analyzed in this study indicates that children are moving in and out of both programs. Some children move between the two programs and others leave public health insurance altogether. Reasons for leaving the program may include moving out of state, enrolling in private coverage and choosing to drop public coverage, dissatisfaction with the program or inadvertent disenrollment by the eligibility system. The result is that more children than expected are receiving less than 12 months of eligibility in the same program. Re-enrolling children after their eligibility period ends is also proving to be a challenge. National information indicates that none of these experiences are unique to Kansas and are being experienced in a large number of states.

✦ Enrollment in the separate HealthWave program was 18,707 as of January 2001. The estimated increase in Medicaid enrollment since HealthWave's introduction was 31,084 as of January 2001¹⁷.

Conclusion

Kansas operates two children's public health insurance programs (Medicaid and SCHIP) that provide health insurance



coverage to thousands of children. With these programs, Kansas has established a strong foundation on which to build the future of public health insurance for children. However, questions and concerns exist about how to improve the effectiveness of these programs in reducing the number of uninsured children in Kansas, containing costs and in improving access to care. Hopefully, information in this brief contributes to a continued discussion among policymakers and others who will be involved in plotting a course for the future. This brief is intended to supplement the discussion at the first Kansas Health Policy Forum on March 9, 2001, The State of Children's Health Insurance: *A Work in Progress*.

The contents of this report are solely the responsibility of the authors and do not necessarily represent the views of the funding organizations.

Endnotes

¹ Children's Defense Fund, *All Over the Map: A Progress Report on the State Children's Health Insurance Program*, July 2000.

² These numbers are as of September 30, 2000 and represent the unduplicated number of children covered during the course of the year and do not represent the number of children enrolled on September 30. Source: Health Care Financing Administration, *SCHIP Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Year 2000* at www.hcfa.gov.

³ Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*, October 2000

⁴ Health Care Financing Administration, *Medicaid: A Brief Summary* online at www.hcfa.gov.

⁵ Academy for Health Services Research and Health Policy under The Robert Wood Johnson Foundation's State Coverage Initiatives Program, *State of the States*, January 2001.

⁶ Kaiser Commission on Medicaid and the Uninsured, *State Facts: Health Needs and Medicaid Financing*, February 1998.

⁷ Kansas Department of Social and Rehabilitation Services, *FY 2000 Major Eligibility Categories of the Kansas Medical Assistance Program*, August 2000.

⁸ Urban Institute, *Charting New Courses for Children's Health Insurance*, January 2001.

⁹ National Health Policy Forum, *SCHIP in the Formative Years: An Update*, September 2000.

¹⁰ Urban Institute, *Three Years into SCHIP: What States Are and Are Not Spending*, September 2000.

¹¹ National Journal, *What Ails Medicaid* by Marilyn Werber Serafini, December 9, 2000.

¹² *National Summary of Medicaid Managed Care Programs and Enrollment and Medicaid Managed Care State Enrollment – December 31, 1999* online at www.hcfa.gov/medicaid.

¹³ In a recent study by the Maternal and Child Health Policy Research Center Kansas' Medicaid capitation rates for children ranked 42nd out of 42 states in the study. Peggy McManus, Co-Director, Maternal and Child Health Policy Research Center, *An Analysis of Kansas' Medicaid Managed Care Capitation Policies Affecting Children*. Presented at Kansas' Medicaid Managed Care Capitation Rates for Children's Services Meeting on November 13, 2000 sponsored by the Kansas Health Institute.

¹⁴ For more information see the Performance Audit Report from the Kansas Legislative Division of Post Audit, *HealthWave: Reviewing the Program's Finances and Performance*, December 2000.

¹⁵ Urban Institute, *The State Children's Health Insurance Program: A Look at the Numbers*, March 1998.

¹⁶ This study is funded by a number of federal agencies and private foundations. Additional information is available from the Kansas Health Institute.

¹⁷ This information comes from Kansas Health Institute analysis of Kansas Department of Social and Rehabilitation Services data. The Medicaid enrollment changes represent the difference between Medicaid enrollment for non-disabled children under 19 years of age in December 1998 and January 2001.