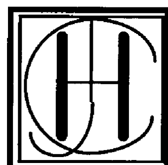
REPORT OF THE
JOINT COMMISSION ON HEALTH CARE



SCHIP WAIVER FOR LOW-INCOME ADULT PARENTS STUDY

(COPN FOLLOW-UP)

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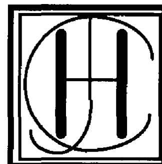

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I.
Authority for Study/Organization of Report

This Study Is Being Conducted As A Follow-Up To The Joint Commission On Health Care's Work In 2000 To Develop A Plan To Eliminate The Commonwealth's Certificate Of Public Need Program

Senate Bill (SB) 337 of the 2000 Session of the General Assembly directed the Joint Commission on Health Care (JCHC) to develop a plan to eliminate the Commonwealth's Certificate of Public Need (COPN) program. In developing the COPN deregulation plan, the JCHC recognized that one of the protections COPN provides to hospitals is the ability to "cost-shift" reimbursement received from paying patients to help offset the cost of providing care to persons who have no financial means (e.g., indigent and/or uninsured patients), and to subsidize the cost of certain services which generate relatively little revenue. In a deregulated environment in which services that currently are provided primarily in hospital settings are available from other providers outside of the hospital, the ability of hospitals to provide services for the indigent/uninsured is diminished in proportion to the number of paying patients who begin receiving these services from other providers.

To address this issue, the deregulation plan recommended by the JCHC included provisions to help cushion hospitals from the impact of being less able to cost-shift and subsidize indigent care, low revenue-generating services, and undergraduate medical education (at the academic health centers). One of the provisions included in the JCHC's three-phased deregulation plan called for increasing Medicaid eligibility for adult parents from the current level of 32% of the federal poverty level (FPL) to 100% FPL during Phases II and III as a means of increasing the number of persons with health insurance. Another of these provisions was a directive for the JCHC to study (during Phase I) the feasibility of securing a waiver under the State Children's Health Insurance Program (SCHIP) to cover uninsured adult parents with incomes between 100 and 200% FPL as a further means of increasing the number of persons with health insurance. While the JCHC's deregulation plan (as provided in SB 1084/HB 2155) was not approved by the 2001 Session of the General Assembly, at its May 1, 2001 meeting, the JCHC directed staff to complete this study.

This Report Is Presented In Three Major Sections

This first section discusses the authority for the study and organization of the report. Section II provides background information on the number of uninsured adults in Virginia and the relationship between parents having insurance and their children getting coverage. Section III discusses the provisions of a Section 1115 SCHIP demonstration project as established by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), and presents information regarding how such a waiver program could be implemented in Virginia.

Policy options are not included in this issue brief. The policy options regarding this issue will be developed and reviewed in the overall context of the JCHC's COPN Subcommittee's continuing work on a plan to eliminate COPN.

II.
Virginia's Uninsured Population: Expanding Health Insurance To Low-Income, Uninsured Adults With Children

The 2001 Health Access Survey Indicates That Virginia's Uninsured Population Has Increased Since 1996

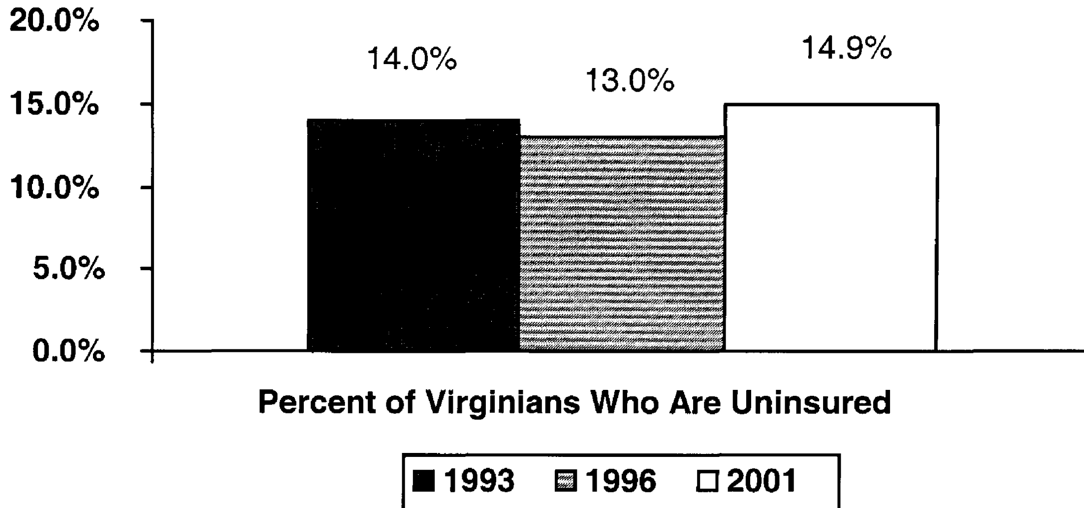
At the request of the Joint Commission on Health Care (JCHC), the Virginia Health Care Foundation (VHCF) commissioned a statewide health access survey of Virginia residents. This is the third survey conducted since 1993 which estimates the number of uninsured Virginians and identifies the demographic makeup of this population. Previous surveys were conducted in 1993 and 1996. These surveys provide critical information about Virginia's uninsured population and other health access issues for statewide policy analysis and program development.

The VHCF contracted with Southeastern Institute of Research (SIR), located in Richmond, to conduct the 2001 survey. The basic methodology used in each of the three surveys (i.e., 1993, 1996, and 2001) was the same so as to produce useful trend data. Moreover, a core set of questions regarding insurance coverage and other issues has been asked in each survey so that the results from year to year produce "apples-to-apples" comparisons. The 2001 survey results include data collected via telephone from 1,959 households; information was collected on 4,801 individuals.

As seen in Figure 1, the overall percentage of Virginians who are uninsured has increased above the uninsured rate in both 1993 and 1996. The total number of uninsured persons in Virginia has increased because of the higher uninsured rate as well as an increase in the overall population of Virginia from 6,464,795 in 1993 to 7,078,515 in 2000. (Figure 2).

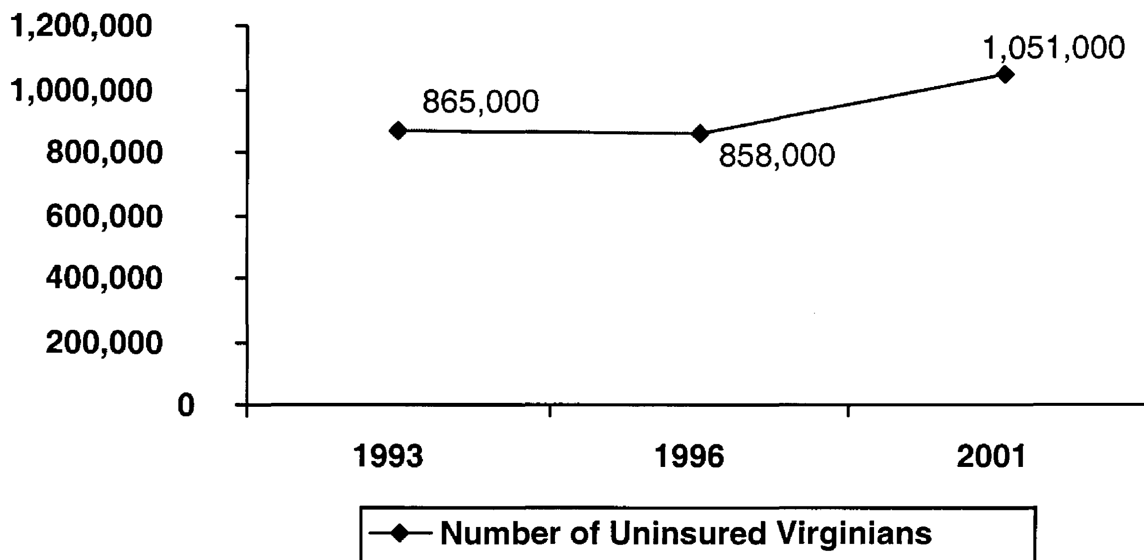
In addition to the overall increase in the number of uninsured persons, there are a number of other demographic changes that have occurred within the uninsured population from 1993-2001. However, because this study relates specifically to covering uninsured adults with children through a Section 1115 State Children's Health Insurance Program (SCHIP) demonstration project, the only survey results reported here are those which are related to this particular issue. Future JCHC briefings will incorporate other survey results as appropriate.

Figure 1
Percentage of Virginia's Total Population Who Are Uninsured



Source: Virginia Health Access Surveys, 1993, 1996, 2001

Figure 2
Total Number of Virginians Who Are Uninsured



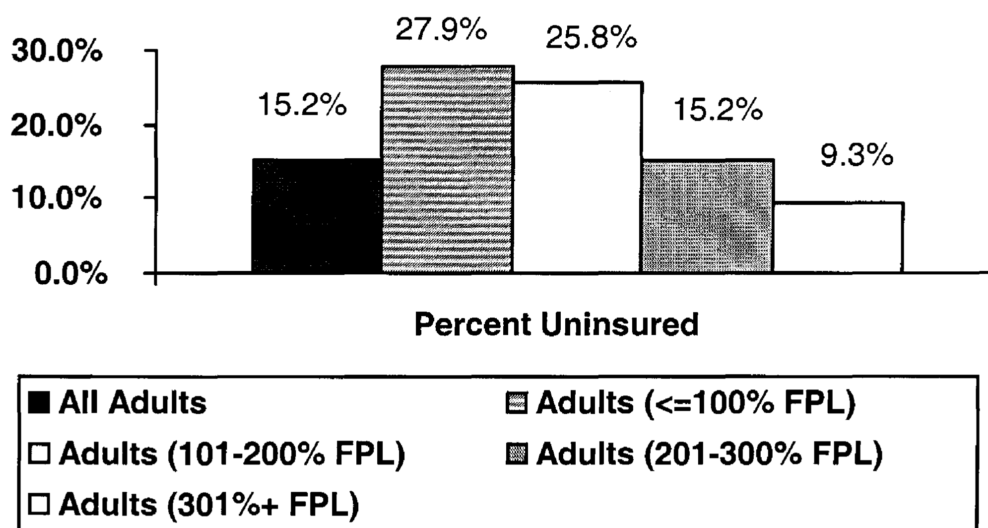
Source: Virginia Health Access Surveys, 1993, 1996, 2001

For Adults, The Highest Uninsured Rate Is Among Those With Incomes At Or Below 100% Of The Federal Poverty Level

The 2001 survey results indicate that, whereas the uninsured rate among all adults (age 18 and older) is 15.2%, the uninsured rate among low-income adults (incomes ≤ 200% of the federal poverty level [FPL]) is significantly higher. (See Figure 3.) Specifically, the uninsured rate for adults with incomes at or below 100% FPL is 27.9% (an estimated 167,300 persons statewide); and the rate for adults with incomes between 101-200% FPL is 25.8% (an estimated 241,483 persons statewide).

Figure 3

Uninsured Rates Among Virginia's Adult Population



Source: 2001 Virginia Health Access Survey

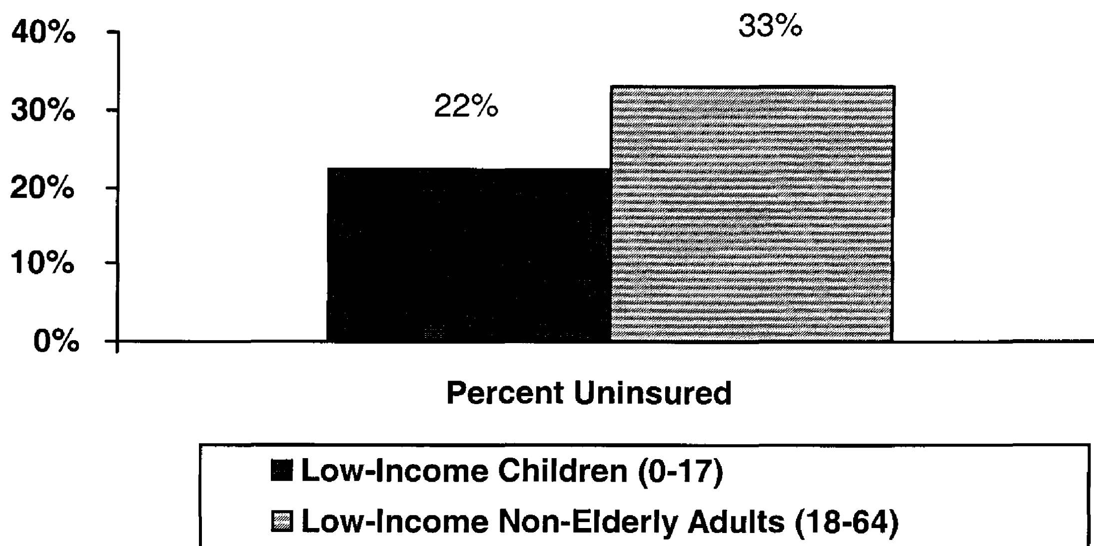
Consistent With National Studies, The Uninsured Rate For Low-Income Virginians Is Higher Among Adults Than Children; This Difference Is Due In Part To A Greater Availability Of Insurance For Children Through Medicaid And The State Children's Health Insurance Program (SCHIP)

National studies (e.g., Lambrew, George Washington University; and The Commonwealth Fund Task Force on the Future of Health Insurance) indicate that the uninsured rate among low-income adults (33%) is higher than that for low-income children (23%). The results of Virginia's 2001 Health Access Survey

confirm this disparity in coverage. About 22% of low-income children are uninsured as compared to 27% of low-income adults. The disparity is even more pronounced when children are compared to the non-elderly adult population (i.e., under age 65). As seen in Figure 4, the percentage of low-income adults under age 65 who are uninsured is 33%. (This percentage is higher due to the availability of Medicare coverage for adults age 65 and older.)

Figure 4

Uninsured Rates Among Virginia's Low-Income Children And Non-Elderly, Low-Income Adults



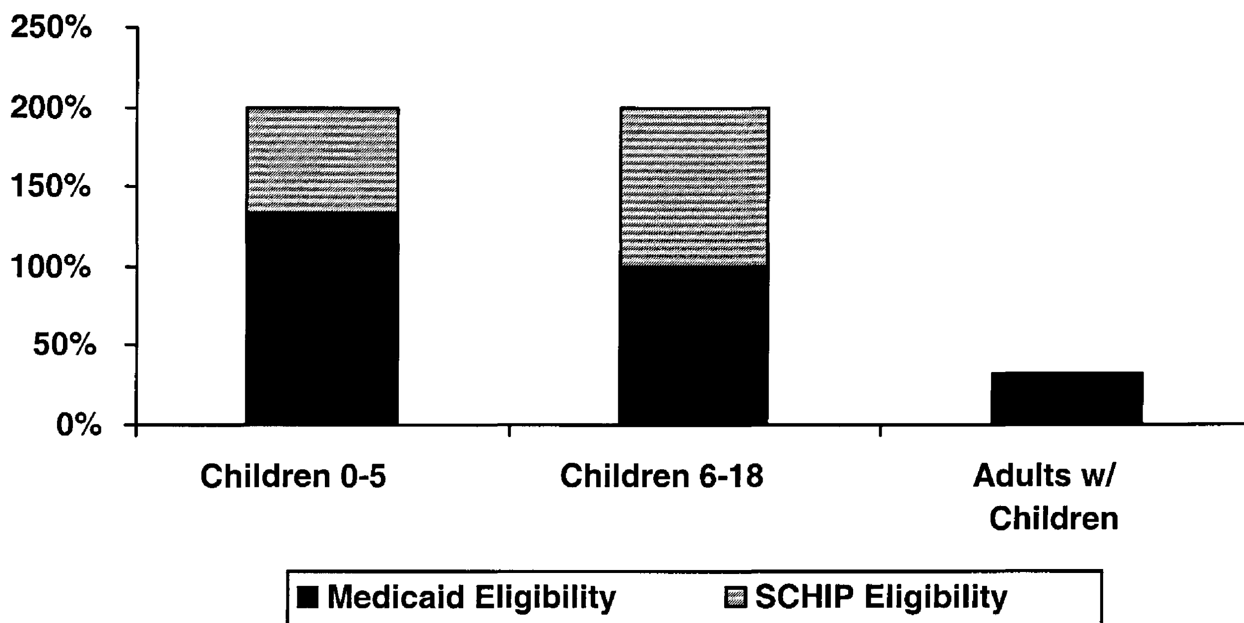
Source: 2001 Virginia Health Access Survey

Researchers generally attribute the wide disparity in the uninsured rates between low-income children and adults to a greater availability of insurance for children through Medicaid and SCHIP. For instance, the federal government mandates that states establish a minimum eligibility level for children from birth to age 5 at 133% FPL and from age 6-18 at 100% FPL. SCHIP allowed states to expand coverage even further for children up to 200% FPL along with enhanced federal matching dollars. However, with the exception of limited categorical eligibility for some adults (e.g., pregnant women at 133% FPL), the availability of coverage for low-income adults has been far more limited. This disparity in the

availability of Medicaid/SCHIP coverage for low-income adults and children is particularly striking in Virginia as illustrated in Figure 5.

Figure 5

Medicaid/SCHIP Coverage For Low-Income Children and Adults With Children In Virginia



Note: Eligibility for SCHIP is shown at 200% FPL; eligibility for Virginia's Children's Medical Security Insurance Program is 185% with income disregards; eligibility for the soon-to-be-implemented Family Access to Medical Insurance Security (FAMIS) Plan is 200% FPL

Source: JCHC Staff Analysis, Department of Medical Assistance Services "2000 Statistical Record of the Virginia Medicaid Program"

As Of June, 2001, Eighteen States Provide Medicaid To Families Who Earn Up To 100% Of The Poverty Level Or Higher

According to Families, USA, 18 states have extended Medicaid coverage to families through various Medicaid expansions and waivers or SCHIP waivers. Figure 6 identifies these states and the income eligibility level for each.

Figure 6

States Which Have Extended Medicaid Coverage To Families With Incomes At Or Above 100% FPL

State	Authority for Expansion	Income Eligibility Level
Tennessee	Medicaid Waiver	400%[1]
Minnesota	Medicaid Waiver	275%
District of Columbia	Section 1931	200%
New Jersey	Section 1931/SCHIP Waiver	200%
Rhode Island	Medicaid/SCHIP Waiver	185%
Vermont	Medicaid Waiver	185%
Wisconsin	Medicaid/SCHIP Waivers	185%
Connecticut	Section1931	150%
Maine	Section 1931	150%
New York	Medicaid Waiver	150%
Massachusetts	Medicaid Waiver	133%
Arizona	Medicaid Waiver	100%
California	Section 1931	100%
Delaware	Medicaid Waiver	100%
Hawaii	Medicaid Waiver	100%
Missouri	Medicaid Waiver	100%
Ohio	Section 1931	100%
Oregon	Medicaid Waiver	100%

Note:
[1] Enrollment for adults is now closed to new applications unless they are medically uninsurable or meet Section 1931 standards

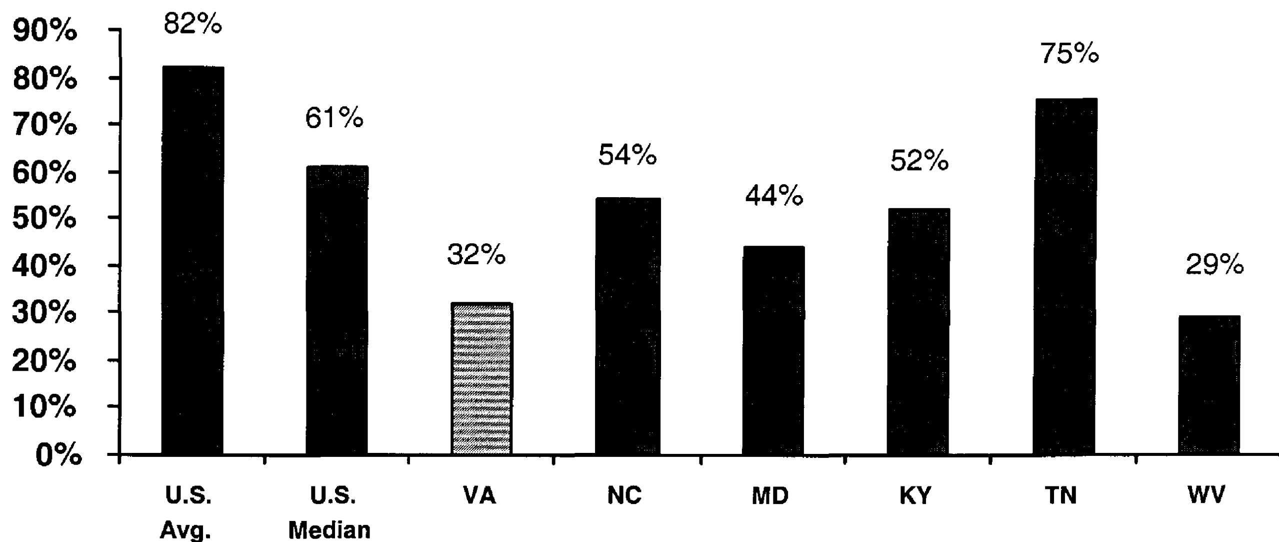
Source: Families, USA, June, 2001

Virginia's Medicaid Eligibility For Adults With Children Is Well Below The National Average And The Median Level In Other States

As noted in the JCHC's work last year on developing a plan to eliminate the Certificate of Public Need (COPN) program, Virginia's Medicaid eligibility for adults with children is restrictive in comparison to other states. Figure 7 indicates that Virginia's income eligibility for adults with children (32% FPL) is well below the national average and the median level in other states. The restrictive eligibility level for Virginia's low-income adults with children is a contributing factor to the high rate of no insurance among this population.

Figure 7

Medicaid Eligibility Levels For Adults With Children: Virginia And Other States



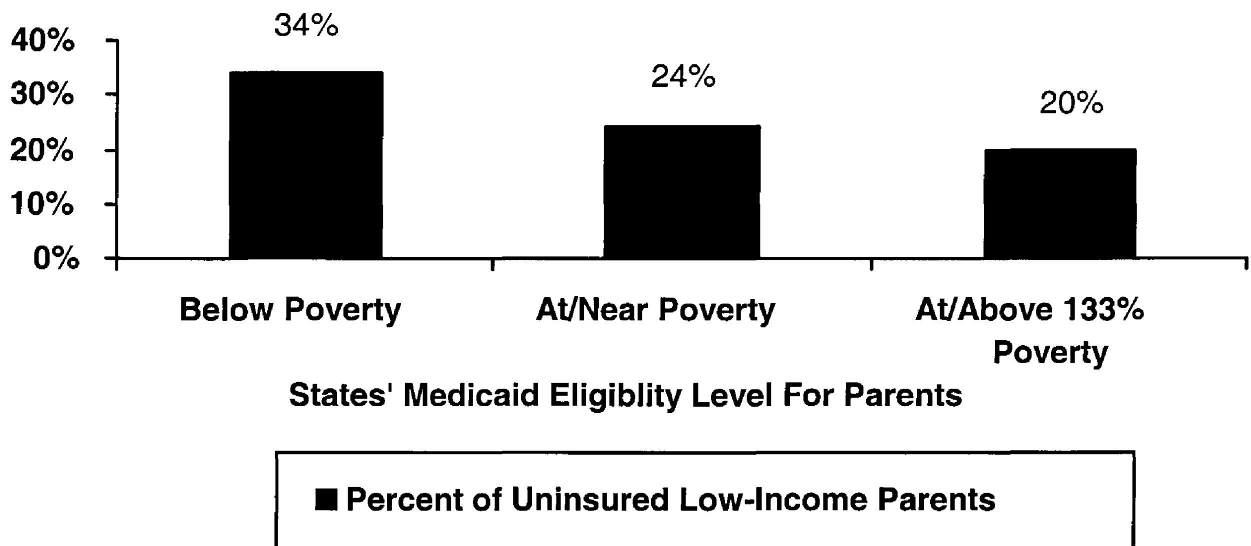
Source: Families USA and Center on Budget and Policy Priorities

States With More Restrictive Medicaid Eligibility Levels For Low-Income Adults With Children Have Higher Uninsured Rates Among This Population Than States With Higher Medicaid Eligibility Levels; Research Indicates That When Parents Are Insured, Children Usually Are Insured As Well

A study completed by George Washington University (GWU)/The Commonwealth Fund in May, 2001, concluded that states which had expanded coverage to parents have an uninsured parents' rate that is significantly lower than those states without expansions. As seen in Figure 8, the GWU/Commonwealth Fund study shows that states with an income eligibility level for parents below the federal poverty level (FPL) have a higher rate of uninsured parents than those states with parents' income eligibility level at or near the FPL; those states with expansions at or above 133% of the FPL had the lowest uninsured rate.

Figure 8

Uninsured Rates Of Low-Income Parents In States With Low Medicaid Income Eligibility Levels Compared To States With Higher Income Eligibility Levels



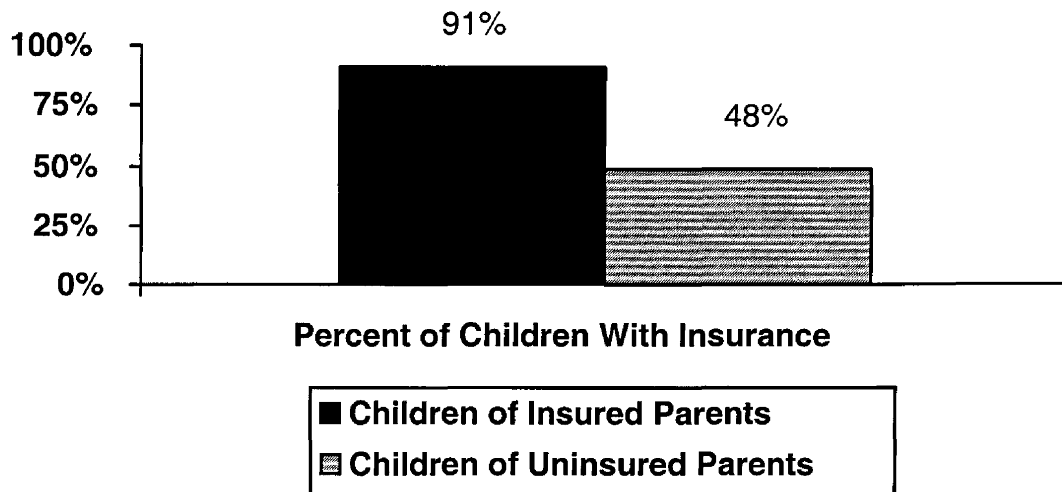
Source: "Health Insurance: A Family Affair, A National Profile and State-by-State Analysis of Uninsured Parents and Their Children," The Commonwealth Fund Task Force on the Future of Health Insurance; May, 2001

The GWU/Commonwealth Fund study also found that around 90% of low-income children who have insured parents are themselves insured. In

contrast, less than half (48%) of children with an uninsured parent have health insurance. (See Figure 9) This same research concluded that states which have higher income eligibility levels for parents also have lower rates of uninsured children. Specifically, the research findings suggest that in those states which limit parents' eligibility to below the FPL, the uninsured rate for low-income children is 25%; in those states where parents' eligibility is at or near the FPL, the uninsured rate for children is 18%; and in those states where the income eligibility for parents is at or above 133% of FPL, the uninsured rate for children is only 14%.

Figure 9

Percent Of Low-Income Children With Insurance: Insured vs. Uninsured Parents



Source: "Health Insurance: A Family Affair, A National Profile and State-by-State Analysis of Uninsured Parents and Their Children," The Commonwealth Fund Task Force on the Future of Health Insurance; May, 2001

The Centers For Medicare & Medicaid Services Authorized Use Of Federal SCHIP Dollars To Cover Parents As A Means Of Increasing The Number Of Children Enrolled In State SCHIP Plans

The research findings which indicate children of insured parents are far more likely to be insured than children of uninsured parents is one of the reasons why the Centers for Medicare & Medicaid Services (CMS) has decided to allow states to submit demonstration projects to cover parents of children eligible for

Medicaid and SCHIP. CMS views such demonstration projects as a means of accomplishing the original policy goal of SCHIP which is to expand coverage, and improve health care outcomes and access to health care services for low-income children. The next section of this report provides details about the SCHIP demonstration projects being considered by CMS and the potential for implementing such a project in Virginia.

III.
Insuring Low-Income Parents Through A Section 1115 Demonstration Project Under The State Children's Health Insurance Program

The U.S. Centers for Medicare & Medicaid Services (CMS) Issued Guidance To States In July, 2000 Regarding Section 1115 Demonstration Projects To Cover Low-Income Parents Under The State Children's Health Insurance Program

In a "Dear State Health Official Letter," dated July 31, 2000, the U.S. Centers for Medicare & Medicaid Services (CMS) issued guidance to states on its consideration of proposed demonstration projects under the authority of Section 1115 of the Social Security Act in the State Children's Health Insurance Program (SCHIP). In the letter, CMS indicated that "section 1115 demonstration projects may provide states additional opportunities to develop innovative methods for expanding children's coverage, promoting participation in SCHIP and Medicaid, and improving the scope and quality of the services available to children."

The CMS letter also notes that, as with all Section 1115 demonstration projects, the purpose of the SCHIP demonstrations is to allow states to illustrate how state-initiated innovations, not otherwise permitted under the law, will help them accomplish the goals of the program. Among the innovations that CMS will consider are demonstration projects that extend coverage to low-income parents of the children they are enrolling in Medicaid and SCHIP. CMS noted that, to the extent states meet certain conditions, "we support demonstration initiatives to extend coverage to low-income parents, within the constraints of the SCHIP law and available funds."

While a Section 1115 SCHIP demonstration project could include a variety of innovations to expand coverage for children, and improve health care outcomes and access to health care services, the following paragraphs pertain only to those provisions which are applicable to covering adults with children.

Through A Section 1115 SCHIP Demonstration Project, States Can Expand Coverage To Low-Income Uninsured Parents With Enhanced Federal Matching Dollars

As noted in Section I of this report, this study is being conducted as a follow-up to the work completed last year by the Joint Commission on Health Care (JCHC) to develop a plan for eliminating the Certificate of Public Need (COPN) program. One of the provisions of the COPN deregulation plan was to study the feasibility of implementing a Section 1115 SCHIP demonstration project to provide health insurance coverage to low-income, uninsured adults with children.

In authorizing Section 1115 SCHIP demonstration projects, CMS established the following key provisions regarding expanding coverage for low-income, uninsured parents:

- CMS must determine that the state is covering low-income children before SCHIP funds are spent on parent coverage (this issue is discussed in more detail later in this section);
- states' Section 1115 SCHIP demonstration projects must be determined to be a means of increasing enrollment of children;
- states can receive enhanced federal matching dollars rather than the regular Federal Medical Assistance Percentage (FMAP) matching dollars;
    - in Virginia, the enhanced federal match is 66.3%, as opposed to the regular FMAP of 51.8%
- states can receive the enhanced federal matching dollars for parents with children enrolled either in Medicaid or SCHIP;
- states must provide coverage to lower income parents before extending coverage to parents with higher income levels;
- states cannot exceed their SCHIP allotments to cover parents;
- states which utilize a separate program for SCHIP to cover parents are not eligible for additional federal dollars if the SCHIP allotment is exceeded; states which use a Medicaid expansion for SCHIP can receive regular Medicaid matching dollars if the SCHIP allotment is exhausted;
- states cannot use any "redistributed" federal dollars to cover parents (these are federal dollars that are forfeited by states who do not use their full allotment and "redistributed" to those states which have exceeded their allotments and request additional funds to cover more children).

The CMS Guidance To States Sets Out Several Conditions That Must Be Met By States In Order To Have A Demonstration Project Approved

The CMS guidance to states includes several factors that will affect the consideration given to states' Section 1115 SCHIP demonstration projects. These criteria were established to ensure that, before states spend a portion of their SCHIP allotment on parents, every effort is being made to enroll and retain children in the program. States must meet these conditions in order to have a project approved; however, meeting these criteria does not mean necessarily that the project will be approved. Figure 10 summarizes the factors that will be considered in reviewing states' proposed demonstration projects and identifies Virginia's current status with respect to each factor.

The criteria established by CMS in its July, 2000 letter were established during the Clinton administration. While no changes had been announced at the time this report was written, it is possible that the Bush administration may make changes to the guidelines that states must follow to cover low-income adult parents through a SCHIP demonstration project.

Based On Current CMS Guidance, Virginia Would Have To Make Changes To Its State Children's Health Insurance Program To Meet The Requirements For An Approved SCHIP Demonstration Project For Covering Low-Income, Uninsured Parents; DMAS Opposes Such Changes To FAMIS

As seen in Figure 10, Virginia meets most of the CMS requirements for a Section 1115 SCHIP demonstration project to cover low-income uninsured parents. It is unclear whether Virginia would meet the requirement that a state must demonstrate its application and redetermination process for SCHIP/Medicaid promotes enrollment and retention of eligible children. This is a subjective determination that could produce different results depending on who makes the determination. It is clear, however, that under the FAMIS program (Virginia's State Children's Health Insurance Program to be implemented later this summer), Virginia does not meet the criterion which requires states to have adopted three of the following five policies and procedures in its child health programs (i.e., Medicaid and SCHIP):

i. use of a joint mail-in application and a common application procedure (e.g., the same verification and interview requirements) for SCHIP and Medicaid;
ii. elimination of assets tests;
iii. 12-month continuous eligibility;

Figure 10
Criteria To Be Considered By The U.S. Department of Health And Human Services In Reviewing States' Section 1115 SCHIP Demonstration Proposals To Cover Low-Income Parents

What Criteria Will Be Considered In Reviewing States' Section 1115 SCHIP Demonstration Proposals?	Does Virginia Meet Criterion?
State must have at least one year's experience providing child health assistance under SCHIP	Yes
State must have submitted any evaluations required by Federal law, as well as required SCHIP enrollment reports	Yes
State must be covering children up to age 19 with family income up to at least 200 % FPL	Yes[1]
State must be enrolling children on a statewide basis and cannot have a waiting list or otherwise close enrollment of eligible children	Yes
State must demonstrate its application and redetermination process for SCHIP/Medicaid promotes enrollment and retention of eligible children	Unknown[2]
State must show that is has adopted at least 3 of the following 5 policies/procedures in its child health program (SCHIP and Medicaid)	
i. use of a joint mail-in application and a common application procedure for SCHIP and Medicaid	No[3]
ii. elimination of assets tests	Yes
iii. 12-month continuous eligibility	No
iv. procedures that simplify the redetermination/coverage renewal process by allowing families to establish their child's continuing eligibility by mail; and, in states with separate SCHIP programs, be establishing effective procedures that allow children to be transferred between Medicaid and SCHIP without a new application or gap in coverage	Unknown[4]
v. presumptive eligibility for children	No

Notes:

1 Under CMSIP, children are covered up to 185% FPL with income disregards; eligibility for FAMIS will be 200% FPL

2 This criterion involves a subjective review of each state's efforts to simplify and/or promote enrollment and retention of children; various reviewers may have different views on whether Virginia meets this specific criterion

3 Under FAMIS, there is a mail-in application, but not a "joint" mail-in application that can be used for both SCHIP and Medicaid

4 This criterion involves a subjective review of each state's efforts to simplify the redetermination/coverage renewal process; various reviewers may have different views on whether Virginia meets this specific criterion

Source: CMS Letter to State Officials dated July 31, 2000; Department of Medical Assistance Services

iv. procedures that simplify the redetermination/coverage renewal process by allowing families to establish their child's continuing eligibility by mail and, in states with separate SCHIP programs, by establishing effective procedures that allow children to be transferred between Medicaid and the separate program without a new application or a gap in coverage when a child's eligibility status changes; and

v. presumptive eligibility for children.

Based on the planned implementation of the FAMIS program, Virginia meets the requirement of item ii (elimination of assets test). It is unclear whether item iv (simplified redetermination/renewal process) would be met due to the subjective nature of the determination. However, even if this condition is met, Virginia would meet only two of the five provisions because requirements i, iii, and v clearly would not be met. While a mail-in application will be used for FAMIS, DMAS officials indicate that the program will not use a "joint" application that can be used for determining eligibility for Medicaid and FAMIS. DMAS indicated that a joint application will not be used due to concerns that the "stigma" of potentially being enrolled in Medicaid will result in some parents not completing the application. DMAS also indicated that requiring a joint application will have a significant cost impact on the program's centralized eligibility determination process. DMAS indicated that a 12-month continuous eligibility provision (item iii) is not included in FAMIS out of concern that circumstances can change during a 12-month period that could result in a child not being eligible for the program. The presumptive eligibility provision (item v) also is not included in FAMIS due to concern that a child could be enrolled for a certain period of time when, in fact, the child is not eligible.

DMAS officials indicated the agency would oppose changing the FAMIS program in order to meet the requirements of items i, iii, or v . Unless one of these provisions is changed in FAMIS, under current CMS guidance, Virginia would not be eligible for a Section 1115 SCHIP demonstration project.

Thus Far, Four States Have Had Section 1115 SCHIP Demonstration Projects Approved To Cover Low-Income Adult Parents; One Additional State Is Waiting For CMS Approval

The states of New Jersey, Rhode Island and Wisconsin have implemented CMS-approved Section 1115 SCHIP demonstration projects to expand coverage to low-income, uninsured parents. In New Jersey, the demonstration project expands health care coverage to parents of children eligible for the New Jersey KidCare program. The state will receive the enhanced federal match for parents

with income below 133% FPL who previously had been extended coverage through a Medicaid expansion. The Section 1115 SCHIP demonstration project also will provide coverage with enhanced federal matching dollars to parents with incomes between 134% and 200% FPL in the state's separate child health program. New Jersey reports that enrollment of parents has been far greater than anticipated. The original projection was that approximately 130,000 would enroll in the first three years. Within six months of approval, an estimated 106,000 had enrolled.

Rhode Island already had expanded Medicaid coverage to parents with incomes up to 185% FPL through a Section 1931 Medicaid expansion in 1998. The Rhode Island Section 1115 SCHIP waiver will secure the enhanced matching funds for parents between 100% and 185% FPL. Essentially, the Rhode Island demonstration project will replace regular Medicaid match dollars with enhanced SCHIP match dollars.

Like Rhode Island, Wisconsin also had expanded its Medicaid eligibility for adults prior to receiving approval of its Section 1115 SCHIP demonstration project. Wisconsin received approval of a Section 1115 Medicaid waiver in 1999 to expand Medicaid coverage for parents to 185% FPL. The state's Section 1115 SCHIP demonstration project will provide the enhanced federal match for all parents with incomes between 100% and 185% FPL.

Minnesota just received approval on June 18th to receive enhanced federal matching dollars to cover parents of Medicaid and SCHIP eligible children with incomes between 100% and 200% FPL. California has submitted a Section 1115 SCHIP demonstration project to expand coverage to parents. The application currently is being reviewed by CMS.

In Order For Virginia To Implement A Section 1115 SCHIP Demonstration Project To Cover Low-Income Uninsured Parents, Several Key Policy Decisions Must Be Made

In addition to having to make one or more revisions to the FAMIS program in order to receive approval of a Section 1115 SCHIP demonstration project, other key decisions regarding the project would have to be made.

Should A Section 1115 SCHIP Demonstration Project Be Considered As Part Of COPN Discussions Or As A Separate Initiative? In determining whether to seek a Section 1115 SCHIP demonstration project to cover low-income uninsured parents, the first decision that must be made is whether to do so as

part of the overall plan to deregulate the COPN program as envisioned in the JCHC's COPN bills (SB 1084/HB 2155) or pursue this initiative as a separate health policy issue and "de-couple" it from the COPN discussion. If it is decided to implement such a demonstration project as part of the overall COPN deregulation plan, it must be considered in the context of the other provisions of the plan, and it will be contingent upon the plan being approved by the General Assembly. If not, the demonstration project can be pursued as a separate health policy initiative and be approved or rejected on its own merits.

For What Population Of Low-Income, Uninsured Adults Should The Enhanced Funding Be Used? The CMS guidance to states requires that the lowest income parents be covered first in any SCHIP demonstration project; however, a decision still must be made as to how to finance the coverage expansion. As stated in Section I of this report, the JCHC's plan to eliminate the COPN program included a provision to expand Medicaid coverage to uninsured adult parents up to 100% FPL. At the time this provision was included in the COPN deregulation plan, the intent was to use the regular Medicaid FMAP (51.8% in Virginia) to help pay for the expansion. However, states can secure enhanced federal matching dollars (66.3% in Virginia) for parents of children in Medicaid through the Section 1115 SCHIP demonstration project. Therefore, a decision would have to be made regarding whether to use the enhanced match to cover parents beginning at the lowest income level (i.e., beginning at 33% FPL) or cover parents from 101% FPL to the upper income limit and receive regular FMAP for those parents in the COPN Medicaid expansion (i.e., 33%-100% FPL). At first, it would seem only logical to use the enhanced matching dollars to cover the lowest income parents; however, this limits the total number of parents that would be covered because no regular Medicaid dollars would be utilized, and the amount of SCHIP dollars that is available is limited to the state's SCHIP allocation.

What Upper Income Eligibility Limit Should Be Established? It is clear that, regardless of the financing mechanism (i.e., Medicaid or SCHIP), Virginia would have to expand coverage to the lowest income parents (i.e., beginning at 33% FPL) before covering parents with higher incomes. However, the Commonwealth could set the upper income eligibility at any level at or below 200% FPL. A higher income level allows more parents to be covered, but also increases the amount of state funding required to draw down federal matching dollars.

Should An Enrollment Cap Be Established? States which cover parents through a separate SCHIP program (e.g., CMSIP/FAMIS) can establish an enrollment cap to limit state expenditures. A decision would need to be made

regarding whether to establish such a cap. If one is established, the level of enrollment at which it should be set also would need to be determined.

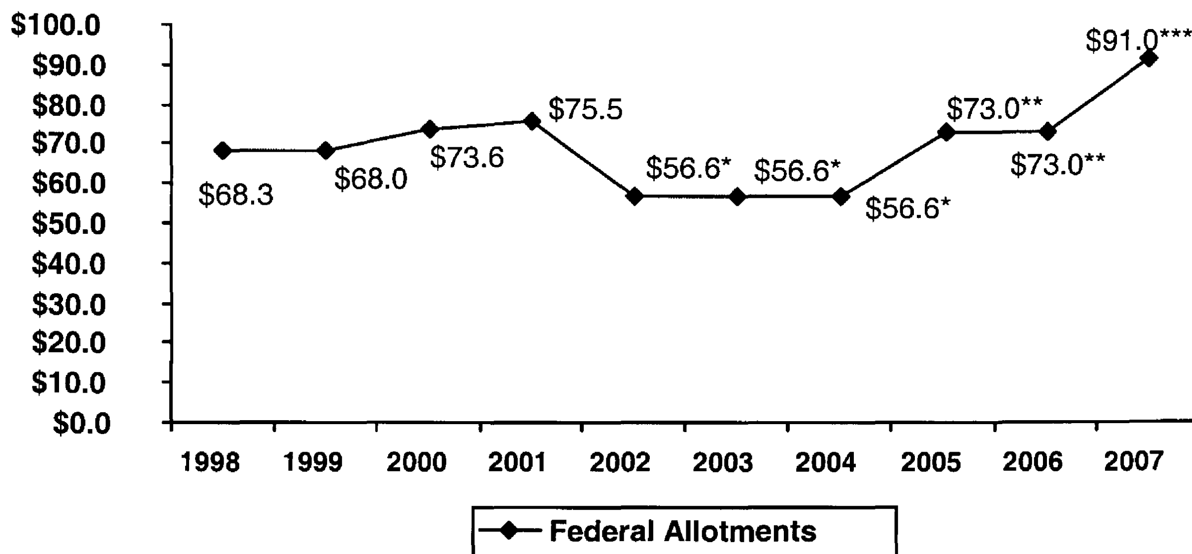
What Benefits Would Be Offered To Parents? Under a Section1115 SCHIP demonstration project, states can provide coverage to parents according to the same options available to states for covering children through SCHIP. However, states do not have to use the same benefit package for parents as that provided to children. Given that the FAMIS benefits for children include well-baby care and other child-specific coverages, it may be best to develop a more tailored package for parents. The benefits that are provided must meet one of the benefit standards in the SCHIP law which include certain "benchmark" coverages, a benchmark-equivalent plan, or a secretary-approved plan.

In Order To Secure Enhanced Federal Matching Dollars For A Section 1115 SCHIP Demonstration Project To Cover Low-Income Uninsured Parents, Virginia Would Have To Have Available Funds In Its Federal SCHIP Allocation; Thus Far, Virginia Has Spent Very Little Of Its Allocation

As stated earlier in this Section of the report, a state can use a portion of its SCHIP funding to cover low-income uninsured parents only up to the amount of the federal allotment; no additional federal dollars (with an enhanced match) are available for this purpose. As such, there must be available funds remaining in Virginia's SCHIP allotment in order to cover parents. Figure 11 identifies the actual federal allotments for Virginia in federal fiscal years (FFY) 1998-2001 (which is the period October 1-September 30), and the projected allotments for 2002-2007. As seen in Figure 11, the projected amounts for 2002-2004 reflect a decrease from earlier allotments. This decline is not based on any Virginia-specific issue. Instead, the Balanced Budget Act (BBA) of 1997 calls for the total amount allocated to states to decline from $4 billion per year during FFYs 1998-2001 to $3 billion per year during FFYs 2002-2004 (approximately a 25% reduction). (These reductions are not reflective of anticipated program growth; they were the result of overall budget constraints at the federal level at the time the BBA of 1997 was passed.) Total federal spending then is scheduled to return to approximately $4 billion per year in FFYs 2005 and 2006, and increase to $5 billion per year in FFY 2007.

Figure 11

Federal SCHIP Allotments For Virginia:
Federal Fiscal Years 1998-2007
(In Millions)



Note: * Projected amounts based on total federal funds decreasing to $3 billion in FFY 2002-2004
** Projected amounts based on total federal funds returning to $4 billion in FFY 2005-2006
*** Projected amount based on total federal funding increasing to $5 billion in FFY 2007
Source: Federal Register, Vol. 65, No. 101, May 24, 2000; Federal Register, Vol.66, No. 14, Jan. 22, 2001;

While the total federal allotment for Virginia is shown in Figure 11, Figure 12 indicates the amount of state dollars that have been appropriated for the CMSIP/FAMIS program, and the amount of federal matching dollars that the appropriated state funds can draw down. (While federal allotments were available in FFY 1998, the first year of state appropriations for the program was in state FY 1999.) The amount of federal dollars shown in Figure 12 is substantially less than the amount of Virginia's allotment that could have been accessed had more children enrolled in the program, and additional matching state dollars been appropriated.

Figure 12

Virginia's State Children's Health Insurance Program Appropriations: State And Federal Dollars For Fiscal Years 1999-2002

State Fiscal Year	State Dollars[1]	Federal Match Dollars	Total Appropriated Amount
1999	$2,260,541	$4,388,109	$6,648,650
2000	$6,053,092	$11,750,119	$17,803,211
2001	$21,990,856	$43,266,059	$65,256,915
2002	$22,246,577	$43,772,509	$66,019,086
TOTALS	**$52,551,066**	**$103,176,796**	**$155,727,862**

Notes:
[1] Includes both general fund and dedicated special revenue

Source: Appropriations Act (Chapter 935, 1999; Chapter 1073, 2000)

Actual Expenditures In Virginia's SCHIP Program (CMSIP) Have Been Far Less Than The Amount Of Available Federal Dollars; However, Expenditures Are Increasing Significantly

Based on expenditure data provided by DMAS, an estimated $62.5 million (total funds) will have been spent on CMSIP medical expenditures for the period FY 1999 through FY 2001. (This reflects actual figures for FY 1999 and FY 2000 and an estimated number for FY 2001). The DMAS figures do not include administrative expenses incurred by the Department of Social Services which, according to the BBA of 1997, can be no greater than 10% of total expenditures. The $62.5 million in total medical expenditures is substantially less than the $89.7 million that has been appropriated during the same time period. The amount of federal dollars spent thus far on medical expenditures (roughly $41.4 million) is about 14% of the total $285.4 million in federal allotments available in FFYs 1998,1999, 2000, and 2001.

While the amount of federal dollars expended thus far is low, a number of other states also have spent only a small portion of their federal allotment. The Urban Institute estimated that, on a national basis, states had spent only about 3% of the $4.2 billion available to states in FFY 1998. States' spending increased to approximately 21% of the FFY 1999 allotments.

Virginia Expenses Are Increasing: DMAS indicates that CMSIP program expenditures are increasing rapidly. DMAS data show that while medical expenditures in FY 1999 were only $3.9 million, this amount increased to $21.9 million in FY 2000 and is projected to increase further to $36.7 million in FY 2001. DMAS staff also project even higher expenditures in FY 2002, due in part to a heightened emphasis on outreach and enrollment as CMSIP is converted to FAMIS. While the expenses for FY 2001 represent a sizable increase over FY 1999 and FY 2000 spending, the FY 2001 amount still represents only about 56% of the amount appropriated for that particular year and a smaller percentage of the amount that could have been available had Virginia appropriated additional dollars to draw down the full federal allotment of $73.5 million.

Despite Increased Expenditures, Virginia Still Is Spending Federal Dollars From Its Initial 1998 Allotment

Currently, the federal dollars being spent by Virginia on CMSIP are still from the 1998 allotment of $68.3 million. Initially, states were given three years to spend a given year's allotment; any amounts not spent during the three year period were to be reallocated to states which had exhausted their allotments. However, Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) in December, 2000 that allowed states to retain 65% of their unspent 1998 funds. States have until September 30, 2002 to spend the retained funds. Virginia initially was going to have to return approximately $44.5 million; however, BIPA allowed Virginia to retain 65% of this amount ($28.9 million). This is the amount currently being spent for CMSIP. Through June 6, 2001, $19.6 million of this amount had been spent.

While CMSIP Enrollments And Expenditures Have Not Met Initial Estimates, DMAS Projects Significant Increases In FY 2002 And FY 2003 After FAMIS Is Implemented

In the State Child Health Plan submitted to CMS requesting approval to implement FAMIS, DMAS projected significant increases in both enrollments and expenditures during FFY 2002 and FFY 2003. As seen in Figure 13, DMAS projected in the state plan amendment that enrollments will increase to 45,905

children by the end of FFY 2001 (September 30th) and total expenditures (federal and state), including administrative costs, will increase to $47.6 million. By the end of FFY 2003, DMAS projects enrollments to be 61,564 and total expenditures to reach $91.1 million. DMAS based the projected increases in enrollment and expenditures on the program changes that will be incorporated into FAMIS and enhanced outreach. (Currently, there are approximately 33,000 children enrolled in CMSIP. As such, approximately 13,000 additional children will have to be enrolled by September, 2001 in order to meet the end of FFY 2001 projection of 45,905 enrollees.)

It Appears That Some Amount Of Federal SCHIP Dollars Will Be Available To Cover Adults With Children; However, More Detailed Analysis Is Needed

Based on a review of the current and projected spending for CMSIP and FAMIS, it appears that some amount of federal SCHIP dollars will be available to cover adults with children. However, a more detailed financial analysis is needed to develop a reasonable estimate of the amount. A financial model needs to be developed with varying assumptions on several different factors to provide a range of federal dollars that potentially could be available to cover adults with children in Virginia.

Figure 13

Projected Increases In CMSIP/FAMIS Enrollments And Expenditures: FFY 2001 – FFY 2003

Federal Fiscal Year	Projected Enrollment at End of FFY	Projected Expenditures		
		State	Federal	TOTAL
2001	45,905[1]	$16,056,627	$31,589,150	$47,645,777
2002	61,528	$27,028,516	$53,174,794	$80,203,310
2003	61,564	$30,693,019	$60,384,189	$91,077,208

Notes:
[1] Enrollment as of June 18, 2001 was 32,929

Source: Virginia State Child Health Plan Submitted By Secretary of Health and Human Resources on June 23, 2000;DMAS, CMSIP weekly enrollment figures

According To The 2001 Health Access Survey, It Appears That Approximately 204,000 Low-Income, Uninsured Adults With Children May Be Eligible If Virginia Implemented A Section 1115 SCHIP Demonstration Project Which Covered Adults Up To 200% FPL; A Smaller Number Of Persons Would Be Expected To Participate

Based on the results of the 2001 Health Access Survey, there are approximately 407,800 uninsured adults (age 18 and older) who have incomes at or below 200% FPL. Of this number, approximately 210,000 are in households with children. This number is somewhat inflated, however, because it includes 18 year olds who are eligible for Medicaid/CMSIP/FAMIS. It is estimated that approximately 6,000 18 year olds are included in the 210,000. If the number of 18 year olds is deducted from the 210,000, the remaining number would be approximately 204,000 which is the estimated number of adults with children who may be eligible for a Section 1115 SCHIP demonstration project with eligibility up to 200% FPL. (This number includes some adults with children at or below 32% FPL who are eligible for but not enrolled in Medicaid. It also includes some who may not be eligible for the program based on their relationship to the child.)

While 204,000 adults with children appear to be eligible for the program, a smaller number actually would participate in the program. There are various estimates of what the participation rate would be among this population; estimates typically range from 60% to 75%. Some researchers estimate higher participation rates among the lower income adults than those in the higher income brackets. Assuming the participation rate for the entire eligible population falls within the 60%-75% range, between 122,400 and 153,000 eligible adults with children could enroll in the program. The final number of enrollees would depend on the amount of available funding, the level of outreach, the benefits, and the final details of the plan (e.g., an enrollment cap).

The Center on Budget and Policy Priorities [CBPP] estimated the number of adults with children that would enroll in a Virginia program to be significantly less than the above estimate. The CBPP estimate, which is based on a different methodology and information sources (e.g., participation rate of 58%), is approximately 100,000.

The Cost Per Eligible Adult Appears To Be Approximately $1,720 Per Year

Because there are no cost data tied directly to the population of eligible adults with children, surrogate measures must be used. The closest population for which Virginia-specific cost data are available is the AFDC adult Medicaid population. The cost per AFDC adult in FY 2000 was $2008 per year. This amount, however, includes some pregnancy-related costs incurred by women who already are eligible for Medicaid up to 133% FPL. While there are no DMAS data available to isolate these costs, other states and national researchers estimate these pregnancy-related costs to be approximately 25-30% of the total. For this analysis, the AFDC adult cost of $2008 was reduced by 25% to yield a net cost of $1506 per year in 2000. The $1506 then was increased 14.2% (based on Congressional Budget Office inflation estimates) to arrive at a final estimated annual cost of $1720 per adult in FY 2002. (The Center on Budget and Policy Priorities calculated a Virginia-specific cost estimate of $1,820 per person.)

Preliminary Estimates Of The Cost To Extend Coverage To Low-Income Uninsured Adults With Children Through A Section 1115 SCHIP Demonstration Project Range From $71 Million To $89 Million (State Funds); However, Because Of The Cap On Federal SCHIP Dollars, State Expenditures Would Not Reach This Level; Further Analysis Is Needed To Determine Actual Expenditure Amount

Assuming a cost of $1720 per enrollee and a projected enrollment of 122,400 to 153,000, a preliminary estimate of the total cost to cover uninsured adults with children up to 200% FPL through a Section 1115 SCHIP demonstration project would range from $210.5 million to $263.2 million (total funds). The state share (33.7%) would be approximately $71 million to $89 million per year. However, the actual cost to the state would not reach this level because spending is limited to the amount of federal SCHIP dollars. The amount of available federal SCHIP dollars for Virginia would not support covering all low-income uninsured adults with children. Further analysis is needed to calculate an estimate of what the Commonwealth's expenditures would be, based on the level of available federal dollars.

(It must be noted that the above calculations reflect the cost to cover uninsured adults with children up to 200% FPL which would include those who would be covered under the Medicaid expansion (33%-100% FPL) that was included in Phase II and Phase III of the JCHC's COPN deregulation plan. The cost estimates provided in this report would <u>not</u> be in addition to the estimated cost of covering adults with children from 33%-100% FPL ($54 million in state

funds) included in the JCHC's 2000 COPN report. The costs reported here include this population and assume a higher federal match (i.e., 66.3% rather than 51.8%).)

States Have Considerable Control Over The Cost Of A Section 1115 SCHIP Demonstration Project; Virginia Could Set Its Income Eligibility For The Program At Any Level Above Current Medicaid Eligibility For Adults With Children (32% FPL) Up To 200% FPL, And/Or Could Cap Enrollment To Limit State Expenditures

While the preliminary cost estimate to cover uninsured adults with children up to 200% FPL is quite expensive, under a Section 1115 SCHIP demonstration project, Virginia could set the income eligibility limit at any level between 33% and 200% FPL. For example, Virginia could set the eligibility level at 100% FPL and obtain the enhanced matching dollars to lower the cost of covering adults with children included in the Medicaid expansion called for in Phase II and Phase III of the JCHC's COPN deregulation plan. Alternatively, eligibility could be set at a lower or higher level depending on available funding and other policy considerations.

Another method of limiting the financial impact of a Section 1115 SCHIP demonstration project is establishing an enrollment cap. Unlike a Medicaid expansion in which eligible persons have an entitlement to the coverage, an enrollment cap can be established in a separate SCHIP program demonstration project to limit the Commonwealth's financial exposure. For example, a policy decision could be made to cover adults with children up to a given income eligibility level (e.g., 75%, 100%, 150%, or 200% FPL), but once a pre-determined number of persons is enrolled, no additional enrollments will be allowed. Thus, while the estimates to cover all eligible persons would be very expensive, the Commonwealth has considerable control over the actual amount it wishes to spend on such an initiative.

It Appears That Some Portion Of Virginia's SCHIP Allotment Will Be Available To Cover Adults With Children, However, There Are Multiple Issues That Must Be Factored Into Virginia's Decision On Whether To Pursue A Section 1115 SCHIP Demonstration Project; A More Detailed Financial Analysis Is Needed Before Such A Decision Is Made

The decision regarding whether Virginia should implement a Section 1115 SCHIP demonstration project to provide insurance to low-income, uninsured adults with children involves consideration of multiple factors and issues. While

sufficient information is available to address some issues involved in the decision, others are more complex and require a greater level of analysis than that which could be completed in time for this report. Specifically, a more detailed financial analysis is necessary to gain a complete understanding of the amount of federal SCHIP dollars that will be available for the program, and how numerous factors affect the final cost estimates. As part of the analysis, different models need to be developed to generate results based on various assumptions and policy decisions. This financial analysis needs to incorporate, at a minimum, the following issues:

- how many children are projected to be enrolled in FAMIS during 2002 and beyond;
- what level of expenses will FAMIS incur each year during 2002 and beyond;
- what amount of federal SCHIP dollars will be available to cover adults with children in future years;
- what portion of the unused federal SCHIP dollars from FFY 1999 will Virginia be allowed to retain for use in covering children and adults with children;
- will Congress authorize states to retain a portion of any unused federal SCHIP dollars from FFY 2000 and beyond;
- will Medicaid be used to cover the lowest income adults with children (e.g., 33% -100% FPL), or will enhanced SCHIP dollars be used for all those eligible for the program;
- what impact will different income eligibility levels have on the cost of the program;
- how many additional children will be enrolled in Medicaid or FAMIS as a result of offering coverage to their parents and how will this affect the availability of SCHIP funds to cover parents;
- how will the fluctuation in federal funding during FFY 1998-2007 (i.e., $4 billion available in FFYs 1998- 2001; $3 billion available in FFYs 2002-2004; $4 billion available in FFYs 2005-2006; and $5 billion in FFY 2007) affect the ability of Virginia to cover adults with children during this time period;
- should an enrollment cap be imposed on adults with children, and, if so, at what level; and
- what amount of additional state funds will have to be appropriated to draw down the available federal dollars?

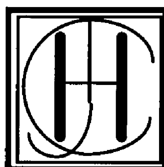
JCHC Staff Plans To Complete The Additional Financial Analyses In Coordination With The JCHC's COPN Subcommittee Which Will Be Meeting Later This Year

At its May 1, 2001 meeting, the JCHC agreed to continue its COPN Subcommittee this year to review and refine the deregulation plan proposed during the 2001 Session of the General Assembly. The Subcommittee plans to have its first meeting in early Fall. Inasmuch as the directive for this study originated from the COPN deregulation plan, this issue should be addressed in the overall context of COPN, at least until the JCHC decides which course of action to take regarding COPN. The JCHC staff plan to work with the affected state agencies and other interested parties to complete the financial analyses described above in time for the COPN Subcommittee to review during its meetings.

Policy Options Are Not Included In This Issue Brief; It Is Anticipated That The COPN Subcommittee Will Review Various Policy Options That Are Developed After The Additional Financial Analyses Are Completed

While JCHC staff issue briefs typically conclude with a range of policy options to be considered by the JCHC members, policy options are not included in this report. Given the import of the additional financial analyses that still need to be completed and the COPN Subcommittee's plan to review its deregulation plan this Fall, policy options will be developed and reviewed as part of the Subcommittee's work at that time.

APPENDIX A



JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
SCHIP Waiver for Low-Income Adult Parents

Organizations/Individuals Submitting Comments

A total of two organizations and individuals submitted comments in response to the staff report on a SCHIP waiver to provide health insurance coverage for low-income adult parents:

- Virginia Poverty Law Center, and
- Northern Virginia Family Services

Policy Options Included In SCHIP Waiver Staff Report

Because further analysis must be completed on this issue, no policy options were included in the issue brief.

Overall Summary of Comments

Both of the two commenters expressed strong support for pursuing a SCHIP waiver to provide health insurance coverage for low-income adult parents.

Summary of Individual Comments

Virginia Poverty Law Center (VPLC)

Jill Hanken, Staff Attorney for VPLC, recommended that "expansion of parent coverage should remain part of the overall Plan to Eliminate COPN, with a long term goal of reaching parents at 200% of the poverty line. However, initial increases in the

eligibility levels should be implemented as an independent initiative." Ms. Hanken commented that "as a modest first step, the income eligibility level should be increased to at least 66% FPL. This is what the COPN plan called for. This level is slightly higher than the median parent eligibility level for the U.S. (61%), but well below the national average (82%). This income level increase for parents should be accompanied by eliminating the resource test." In addition, Ms. Hanken stated that "as a policy matter, I support a single application, 12 month continuous eligibility as well as presumptive eligibility for children. . . Without such policy changes, Virginia is not likely to receive a Title XXI waiver. Thus, the expansion to at least 66% of poverty should proceed with Title XIX (Medicaid) dollars." Ms. Hanken attached a document to her comments entitled "Five Good Reasons For Virginia To Expand Family Coverage".

Northern Virginia Family Services (NVFS)

Carol Jameson, Director of Community Services stated that NVFS "supports the expansion of expanded health care options for low-income adults and parents." Ms. Jameson also commented that "[I]ll parents who do not receive timely treatment for illness may become more ill, making it difficult to care for their children and increasing the risk of neglect. Ultimately, the costs of not treating these illnesses far outweigh the investment in keeping parents and adults healthy."

JOINT COMMISSION ON HEALTH CARE

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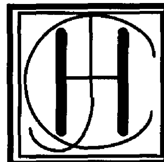

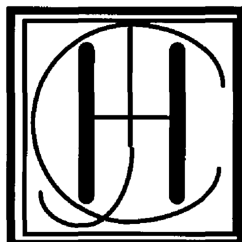

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