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Utah's Implementation of the State Children's Health Insurance Program

Highlights

- In 1997, the U.S. Congress passed the State Children's Health Insurance Program, or SCHIP. This new program allows states to expand health insurance to children under the age of 19 whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance. This initiative is the single largest expansion of health insurance coverage for children since the enactment of Medicaid.

- SCHIP entitles states to block grants which are allocated according to a state's share of uninsured children living below 200 percent of the Federal Poverty Level. States must supply matching funds, but the matching rate is lower than the Medicaid rate. The Department of Health and Human Services estimates that as of September 2000, the states have enrolled 2,684,300 in SCHIP.

- Utah passed House Bill 137 *Children's Health Insurance Program* in 1998, allowing it to receive the federal grants. Utah's program, nicknamed CHIP, was approved by the federal government in August 1998. State administrators believe that there are 30,000 children eligible for this program. They also believe that there are 15,000 children eligible for Medicaid not currently enrolled.

- Currently, there are about 21,000 Utahns enrolled in the CHIP program. The state's match, necessary for the federal grant, comes from the tobacco settlement money. The state has developed an aggressive outreach effort as part of its overall public health mission. Schools, churches, community health organizations, doctors, and the media have all been enlisted to make Utahns aware of the program.

- The effectiveness of CHIP will be evaluated in two ways: first, by achievement of performance goals and second, by changes in the number of uninsured low income children. The impact of CHIP policies, service quality, and cost on the health outcomes of the CHIP population will be observed and judged over time through standard public health measurements. Every five years, the state conducts a health status survey, which provides an indicator of a child's overall health status and measures health insurance coverage. The Department of Health states that questions specific to CHIP will be part of the next survey in 2001.

- To ensure an ample choice of provider networks, the state contracts with six managed care organizations. In areas, outside Weber, Davis, Salt Lake and Utah counties, CHIP enrollees have access to a broad Preferred Provider Organization network. If there is not a paneled provider within 30 miles of enrollees' residence, they may see a local provider.

- Health care concerns have been one of the dominant public issues for years. Rising costs, quality of care, and access to health care have been the three main health care concerns. Such an increase in the number of children now covered by the federal/state partnership called SCHIP nationally and CHIP in Utah is certainly a significant step forward in addressing one of these main health care issues.

Utah's Implementation of the State Children's Health Insurance Program

Unlike most developed countries in the world, the United States does not have nationalized health insurance. Rather, health insurance is largely provided by the private sector in the U.S. with national health insurance for certain segments of the population, namely the elderly (Medicare) and poor (Medicaid). One of the concerns of many Americans with this approach is that there is a segment of the population that remains uninsured. Many of these uninsured earn too much to qualify for Medicaid and too little to afford private insurance. Of particular concern to many is that a large percentage of the uninsured are children. In an attempt to address this particular problem, Medicaid rules have been changed over the last several years to allow more children to qualify for insurance.

In 1997, the U.S. Congress went a step further to address the problem of uninsured children by funding a new initiative to reach out to American children with no access to health insurance. This new program, called the State Children's Health Insurance Program, or SCHIP, allows states to expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance. According to the U.S. Department of Health and Human Services (HHS) this initiative is "the single largest expansion of health insurance coverage for children since the enactment of Medicaid."[1] This report focuses on this new program by providing an overview of its mission, goals, and its accomplishments in the first two years of existence both for the nation and for Utah.

What is SCHIP?

SCHIP was created as part of the Balanced Budget Act of 1997. Utah's Republican Senator Orrin Hatch along with Massachusetts Democratic Senator Edward Kennedy spearheaded the initiative which showed the bipartisan effort for the program. Congress implemented SCHIP through Title XXI of the Social Security Act. SCHIP provides approximately $24 billion over five years and $40 billion over 10 years for funding initiatives to expand health care to low income children. SCHIP entitles states to block grants which are allocated according to a state's share of uninsured children living below 200 percent of the Federal Poverty Level (FPL). States must supply matching funds, but the matching rate is lower than the Medicaid rate.

SCHIP is targeted to uninsured children through age 18 whose parents do not have employer-sponsored health insurance and who are not eligible for Medicaid. When Congress passed SCHIP, the National Survey of American Families (1997),[2] estimated that 9.2 million children ages 18 and under lacked health insurance in 1997. Of these children, 77 percent were in families with incomes below 200 percent of the FPL, and another 14 percent were in families making 200 to 300 percent of the FPL[3]. Sixty-two percent of the uninsured children were living in two-parent families, 32 percent in one-parent families, and 6 percent were living in families with no parents.[4]

Although Title XXI establishes SCHIP guidelines for program eligibility standards, scope of benefits, and out-of-pocket costs, states have considerable flexibility in designing programs to reduce the number of uninsured children. States have the option of either expanding Medicaid, developing a separate non-Medicaid program, or implementing a combination of both approaches. Of the 51 state plans submitted to

[1] "The State's Children Health Insurance Program Annual Enrollment Report," Executive Summary, U.S. Department of Health, (1/11/00).

[2] The 1997 National Survey of American Families is a survey of children and adults under 65 in over 44,000 households as part of the Urban Institute's *Assessing the New Federalism* (ANF) project. ANF is a multi-year project designed to analyze the shifting of responsibility for social programs from the federal government to the states.

[3] Ruth A. Almeida and Genevieve M. Kenney, "Gaps in Insurance Coverage for Children: A Pre-CHIP Baseline," *New Federalism: National Survey of America's Families,* B-19 (May 2000).

[4] More recent data for the uninsured shows that...

the Health Care Financing Administration (HCFA)[5] of the U.S. Department of Health and Human Services, 18 plans expand Medicaid, 17 create programs separate from Medicaid, and 16 do both.[6]

Results of SCHIP - First Year

In its first annual report of SHCIP covering the federal fiscal year 1998-99,[7] the Department of Health and Human Services estimated that 1,979,450 children under the age of 19 were enrolled in SCHIP. Of this total, 1.3 million were covered by a separate program and 695,063 were covered by Medicaid expansion. These are children that had no insurance coverage prior to being covered by SCHIP. All 50 states, the District of Columbia and the nation's federal territories had implemented SCHIP in their state or territory. Most states provide coverage to children whose families' income rises to 200 percent of FPL. However, some states go as high as 300 percent of the FPL.

According to the report, Utah enrolled 13,040 children during the 1998-99 federal fiscal year. Not surprisingly many of the most populous states have the largest enrollments. New York, the nation's third most populous state, has more enrolled than any other state, 521,301. California, the nation's largest state has 222,351 enrolled. Interestingly, Texas, the nation's second largest state, has only 58,000 enrolled.

HHS now[8] estimates that as of September 2000, the states have enrolled 2,684,300 in SCHIP. This is an increase of just over 700,000 in the second year. HHS estimates that Utah now has 21,000 enrolled. If this is the case, then Utah's Department of Health is about two-thirds of the way in enrolling the estimated 30,000 eligible children.

Among the states, 22 insure children with family incomes between 100 percent and 192 percent of the FPL; 20 insure children with family incomes up to 200 percent of FPL; and eight insure children with family incomes up to 300 percent of FPL.

Health Reform in Utah

Like most other states, Utah's state government has also struggled with health care issues for some time. Of particular concern has been increasing health care costs, the large number of uninsured Utahns and quality delivery. In 1993, Governor Michael O. Leavitt asked the legislature to establish the Health Care Policy Options Commission. The purpose of the commission was to recommend options for reforming the state's health care system. The legislature concurred with the governor and in its 1993 session created the Commission. The Commission went right to work and issued its final report in December of that year.

Governor Leavitt reviewed the Commission's recommendations and introduced *HealthPrint*, a market-oriented approach to reforming Utah's health care system. *HealthPrint* defines an incremental process for providing affordable health care coverage for all Utahns. The 1994 Utah Legislature established the Utah Health Policy Commission to carry out the goals of *HealthPrint*, which primarily are: increasing access to health care, containing health care costs, and improving the quality of health care. In 1994, one of the first and primary goals of *HealthPrint* was accomplished by expanding Medicaid to provide coverage for all children ages 11 through 17 who are

[5] The states using a Medicaid expansion are Alaska, Arkansas, District of Columbia, Hawaii, Idaho, Louisiana, Maryland, Minnesota, Missouri, Nebraska, New Mexico, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, and Wisconsin; the states with a separate program are Alabama, Arizona, Colorado, Delaware, Georgia, Kansas, Montana, Nevada, New Hampshire, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington, and Wyoming; and the states using a combined approach are California, Connecticut, Florida, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, New Jersey, New York, North Dakota, Texas, and West Virginia.

[6] Frank Ullman, Ian Hill and Ruth Almeida, "CHIP: A Look at Emerging State Programs," *New Federalism: Issues and Options for States,* A-35 (September 1999).

[7] The federal fiscal year runs from October 1 to September 30 of the following year.

[8] "State Children's Health Insurance Program (SCHIP)," Department of Health and Human Services, Status Report, October 27, 1999.

living in families with incomes below the FPL. Also in 1994, insurance reforms included guaranteed renewability; coverage for dependents up to the age of 26; and a high-risk pool for coverage of high-risk children and adults with severe medical conditions who are not eligible for Medicaid[9]. Medicaid was expanded in 1995 to cover all aged, blind and disabled individuals with incomes below 100 percent of the FPL. Other insurance reforms included portability, pre-existing conditions waivers, and the establishment of community rating bands. The state made progress in providing health care to children by reducing the number of uninsured children in Utah from 10.19 percent in 1991 to 8.57 percent in 1996.[10]

Utah CHIP[11] Legislation

In addition to the reforms made by *HealthPrint*, the state also took advantage of SCHIP. Governor Leavitt signed House Bill 137 *Children's Health Insurance Program* on March 23, 1998, creating a new program for expanding health care coverage to uninsured children ages 18 and under living in families with incomes between 101-200 percent of the FPL[12]. HB 137 accomplished several things: (a) amended the Medicaid restricted account; (b) provided the basic structure of the program; (c) established eligibility requirements and program benefits; (d) established the general duties of the Department of Health (DOH) under the program; (e) created an advisory council; (f) imposed an assessment on hospitals to fund the program; (g) created a restricted account; (h) permitted the Department of Health to contract with the Utah State Retirement Office; and (i.) repealed the Utah Medicaid Hospital Provider Temporary Assessment Act[13]. In order to pass both houses, the CHIP legislation had to be cost neutral - no new taxes for program funding.

The legislation established a two-year period to phase in the program, with estimated costs projected at $8,797,600 in FY 1999, and $16,861,600 in FY 2000. The major portion of the cost would be paid with federal funds - $6.8 million in FY 1999 and $13.3 million in FY 2000[14]. In other words, for every state dollar, the federal government would match with approximately $4 to fund Utah's CHIP program. The state's portion would be funded by the Hospital Provider Assessment Account, a General Fund restricted account, up to $5.5 million annually. Any funds from the assessment account that were not necessary to fund CHIP could be utilized in the Medicaid program. It was estimated that $3,551,500 of assessment funds would be diverted to the Medicaid program in FY 1999, and $1,969,900 in FY 2000. Clearly, the CHIP outreach program would result in additional Medicaid-eligible children, for whom the cost of services were covered in other FY 1999 appropriations. The cost of services in FY 2000 for Medicaid-eligible children as well as eligibility determination costs were estimated at $655,600 in FY 1999, and $7,396,000 in FY 2000 [15] (see **Table 1**).

The cost of services were based on the assumptions that there were 45,000 uninsured children in Utah - 30,000 of whom were eligible for CHIP and 15,000 of whom were Medicaid-eligible. It was also assumed that 70 percent of the uninsured children would be enrolled in either program, half in FY 1999 and half in FY 2000. The projected per member per month costs were $64 for the CHIP children and $107 for Medicaid children. The federal matching funds rates were assumed to be the same in FY 1999 and FY 2000.

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[9] State of Utah, *State Plan for Children's Health Insurance Program,* (1998): 5. Document on-line. Available from http://hlunix.hl.state.ut.us/hpc/CHIPStatePlan.html. Accessed 23 June 2000.

[10] *Ibid.*

[11] Utah chose to call its health insurance program for children provided through the federally funded SCHIP, CHIP.

[12] Utah Health Policy Commission, *Children's Health Insurance Program.* Data on-line. Available from http://hlunix.hl.state.ut.us/hpc/childrens.html. Accessed 23 June 2000.

[13] House Bill 137 *Children's Health Insurance Program,* (1998 General Session).

[14] *Ibid.*, 2nd Amended Note.

[15] *Ibid.*

Table 1
HB 137 Children's Health Insurance Program (CHIP) Funding.

	FY 99 Appropriation	FY 00 Appropriation	FY 99 Revenue	FY 00 Revenue
General Fund	327,800	2,093,000	0	0
Federal Funds	7,176,900	18,511,500	7,176,900	18,511,500
Dedicated Credits Revenue		123,600		123,600
Restricted Funds	5,500,000	5,500,000	5,500,000	5,500,000
TOTAL	**$13,004,700**	**$26,228,100**	**$12,676,900**	**$24,135,100**

Source: HB 137 *Children's Health Insurance Program* 2nd Amended Fiscal Note.

The 1999 Utah Legislature tried to make a significant change to the way CHIP was funded. It passed a bill repealing the hospital assessment tax which was the major state funding source for CHIP. The hospital assessment had been controversial from the beginning. Fortunately, the legislature was able to find an alternative source of revenue without raising taxes or taking funds from another program. The new source of revenue became the money from the 46-state Tobacco Settlement. The bill repealed the assessment tax upon the first annual payment of the tobacco settlement. Preferring a "wait and see" strategy, Governor Leavitt vetoed the bill. In December 1999, the State of Utah received its first of five initial one-time payments from the Tobacco Settlement. Over the next 25 years, Utah's portion of the settlement will be approximately $900 million. Subsequently, the 2000 Legislature passed Senate Bill 15 *Use of Tobacco Settlement Revenues*, which appropriated from that revenue the state's $5.5 million portion for funding CHIP. With the tobacco money in hand, Governor Leavitt signed the bill. Currently, Tobacco Settlement revenues are used to fund the CHIP program.[16]

Utah's State Plan

Utah was the 22nd state to submit its state plan and have it approved by HCFA. The plan was submitted on April 2, 1998, approved on July 10, and became effective August 3, 1998[17]. Utah's state plan is separate from Medicaid and run like private insurance. Due to the private/public partnerships invested in Utah's health care reform initiatives, and to ensure coordination of public and private efforts, the state determined that the Department of Health would administer CHIP. Within DOH, the Division of Health Care Financing (DHCF) contracts with the managed care organizations and purchases services from the health care providers. The State Plan benefits were designed around the benefits of the Utah Public Employees Health Program. Families covered by CHIP are not required to pay premiums, enrollment fees, or deductibles.

The required coinsurance/copayments are summarized in **Table 2**. The out-of-pocket maximum is $500 per family per year, with a 5 percent of family income cap. Member out-of-pocket data are provided on a monthly basis to DOH.

When DOH computer database shows that a member has paid out more than the 5 percent maximum, a letter is sent to the managed care organization and to the member indicating that no additional copayments are required from the member. The state will reimburse the member for

[16] For more information on the distribution of Tobacco Settlement Funds, see "Fiscal Summary of the 2000 Legislative Session," *Utah Foundation Research Report*, no. 633 (May 2000).

[17] Health Care Financing Administration, *Utah Title XXI State Plan Summary*. Data on-line. Available from http://www.hcfa.gov/init/chpfsut.htm. Accessed 12 June 2000.

Table 2
CHIP Health and Dental Plan Benefit Summary

BENEFITS	PLAN A - Family income is at or below 151% of the FPL	PLAN B - Family income is from 151% to 200% of the FPL
Office Visit or Urgent Care Center Visit	$5 co-pay per visit (No co-opay required for well child exams)	$10 co-pay per visit (No co-opay required for well child exams)
Immunizations and Well Child Exams	No co-pay, plan pays 100%	No co-pay, plan pays 100%
Emergency Room	$5 co-pay per visit for emergencies	$30 co-pay per visit for emergencies
Pre-existing Condition Waiting Period	No Waiting Period	No Waiting Period
Pharmacy	$2 per prescription, for prescriptions on approved list only	$4 per prescription, for prescriptions on approved list only
Laboratory	Plan pays 100%	Per lab: If less than $50, plan pays 100%. If more than $50, plan pays 90%.
X-rays	Plan pays 100%	Per x-ray: If less than $100, plan pays 100%. Per x-ray: If more than $100, plan pays 90%.
Out-patient Hospital	Plan pays 100%	Plan pays 90%
Inpatient Hospital	Plan pays 100%	Plan pays 90%
Surgeon	Plan pays 100%	Plan pays 100%
Hospital In patient Physician Visits	Plan pays 100%	Plan pays 100%
Ambulance - Ground and Air	Plan pays 100%	Plan pays 100%
Medical Equipment and Supplies	Plan pays 100%	Plan pays 80%
LIMITED BENEFITS	**PLAN A**	**PLAN B**
Dental Services Covered: • cleaning, exam, x-rays • fluoride and sealant • filling of cavities • space maintainers • pulpotomies • extractions	Plan pays 100% (for CHIP covered services listed at left)	Plan pays 100% for cleanings, exams, x-rays, fluoride, and sealants. Plan pays 80% for space maintainers, fillings, extractions, and pulpotomies.
Hearing Screening	Plan pays $30 per child for hearing screening, limit of one screening every 24 months	Plan pays $30 per child for hearing screening, limit of one screening every 24 months
Vision Screening	Plan pays $30 per child for eye exam, limit of one exam every 24 months	Plan pays $30 per child for eye exam, limit of one exam every 24 months
Mental Health and Substance Abuse (combined totals)	Inpatient: Plan pays 100% (30 days per plan year, per child limit) Outpatient: $5 co-pay for each visit (30 visits per child, per plan year limit) (Inpatient/Outpatient conversion available)	Inpatient: Plan pays 90% for the first 10 days, 50% for the next 20 days (30 days per plan year, per child limit) Outpatient: Plan pays 50% per visit (30 visits per child, per plan year limit) (Inpatient/Outpatient conversion available)
Physical, Occupational, and Chiropractic Therapy (combined total)	$5 co-pay per visit, 16 visits total per plan year, per child	$5 co-pay per visit, 16 visits total per plan year, per child

Source: Utah Children's Health Insurance Program, Utah Department of Health.

any excess amount paid.[18]

Eligibility criteria for Utah CHIP include (a) 18 years of age and younger; (b) living in a family with an income between 101% and 200% of the FPL; (c) legal resident of the United States, and a resident of Utah; (d) not covered by employer or individual insurance plan; and (e) not eligible for Medicaid. An applicant is not eligible for CHIP if he or she has "access to" other coverage. In Utah, having "access to" other coverage means that the applicant's accessible coverage costs less than 5 percent of the household income. The eligibility system and determination service is performed by Medicaid eligibility staff, which streamlines the enrollment process for enrollees in both programs. Eligibility is redetermined every 12 months. Regardless of income changes, CHIP eligibility is guaranteed for 12 months. Retroactive eligibility and presumptive eligibility are not provided by Utah CHIP, however, eligibility becomes effective the same day an application is approved.[19]

DHCF pursues outreach efforts as part of its overall public health mission. Outreach for CHIP is limited by HCFA's requirement to stay within the 10 percent budget cap for program administration and outreach. Nonetheless, CHIP has conducted an impressive outreach campaign.

In order to identify and enroll all uninsured children who are eligible to participate in public health insurance programs, DHCF has formed relationships with public programs that would be logical places for families to apply for Medicaid. There are 33 community locations statewide where a client can apply and maintain eligibility for Medicaid. Medicaid staff perform outreach, eligibility determination, data collection, and assistance with contract updates and negotiations. DHCF takes referrals from these locations and from similar public organizations. CHIP administrators rank allied public service organizations as good locations for outreach efforts, and schools/adult education sites as excellent locations for CHIP outreach[20].

The Department of Health is identifying and enrolling Medicaid-eligible and CHIP-eligible uninsured children through public-private relationships with hospitals, conferences and community events, Children with Special Health Care Needs Clinics, Families Agencies and Communities Together Initiative, school based/linked health centers, and the Blue Cross/Blue Shield Caring Program. Faith communities and grocery stores are also ranked as good locations for CHIP outreach efforts. CHIP is endorsed by the Intermountain Pediatric Society, Utah Chapter American Academy of Pediatrics, Utah Dental Association, Utah Nurses Association, Utah Children, Utah PTA, Catholic Community Services, Utah Issues, Utah School Nurse Association, Association for Utah Community Health, and Utah Association of Local Health Officers and Local Boards of Health.

The CHIP Hotline, 1-888-222-2542, handles about 1,300 calls a month. Operators answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m. A voice messaging system retrieves calls when operators are not on duty. Mondays are typically the busiest day and Fridays are the slowest for hotline operators, who also staff the Baby Your Baby and Check Your Health hotlines. The hotlines use AT&T's Language Line when translation services are needed. To assist callers with eligibility concerns, operators introduce CHIP and answer general questions about age requirement, access to other insurance including Medicaid, family size, and family's monthly gross income. In order to facilitate prompt enrollment, operators refer callers to the closest CHIP representatives in their local areas. However, applications and printed information can be mailed to the caller. Operators assist program evaluation and data collection by asking each caller where or how they heard about CHIP. In this manner, callers provide valuable feedback for developing and implementing outreach campaigns. Indeed, the hotline is an excellent resource for outreach and data collection.

[18] State of Utah, *State Plan for Children's Health Insurance Program,* 48.

[19] Utah Department of Health, *State Evaluation of Children's Health Insurance Program,* (March 2000): 22-25.

[20] *Ibid.,* 37-45.

Table 3
Insured and Uninsured Utah Children by Poverty Level, Age, Race/Ethnicity, and Wasatch Front Residence; Age 0-18, 1998.

Demographic Subgroups	Population Distribution*	Number of Uninsured Children*	Number of Insured Children*	Number Insured by Medicaid*	Number Insured by Private Plans*
1998 Utah Population†	736,109	62,500	673,600	34,400	639,200
Household Poverty Level					
<100% FPL	64,041	12,500	51,500	21,700	29,800
100%-133% FPL	68,458	10,600	57,900	4,600	53,200
133%-200% FPL	168,569	20,800	147,800	3,500	144,300
Over 200% FPL	435,777	19,300	416,500	4,600	411,900
Total, Children <=18	736,109	62,500	673,600	34,400	639,200
Age Group					
Less than 1 year	42,398	3,400	39,000	4,100	34,900
1 to 5 years	198,924	22,600	176,300	12,100	164,200
6 to 12 years	258,358	23,000	235,400	8,600	226,700
13 to 18 years	236,429	13,800	222,600	10,100	212,500
Total, Children <=18	736,109	62,500	673,600	34,400	639,200
Race/Ethnicity					
American Indian (non-Hispanic)	6,625	1,000	5,600	700	4,900
Asian/Pacific Islander (non-Hispanic)	8,833	200	8,600	0	8,600
Black (non-Hispanic)	3,681	600	3,100	800	2,300
White (non-Hispanic)	665,443	51,400	614,000	28,900	585,100
Hispanic	52,264	10,000	42,300	3,300	39,000
Total, Children <=18	736,109	62,500	673,600	34,400	639,200
Urban/Rural Residence					
Wasatch Front‡ (Urban)	562,344	45,500	516,800	24,400	494,400
Non-Wasatch Front (Rural)	173,765	17,000	156,800	10,000	146,700
Total, Children <=18	736,109	62,500	673,600	34,400	639,200

*Figures in these columns may not sum to the totals because of missing values on the grouping variables.
†1996 Utah Health Status Survey data were used to estimate 1998 population estimates.
‡Residents of Salt Lake, Utah, Weber, and Davis Counties.
Source: State of Utah, State Plan for Children's Health Insurance Program, 3-4.

In addition to these outreach programs, the Department of Health has a media campaign for CHIP that is similar to the state's successful Baby Your Baby campaign. A CHIP logo, posters, brochures, postcards and direct mail pieces, visual presentations, print advertisements, radio and television spots, videos, billboards, and bus boards are all being used. Prime-time TV advertisements have been the most effective medium for publicizing the CHIP hotline and insurance plan. CHIP advertisements have also been run on Utah's Spanish radio station. Smith's grocery stores play CHIP commercials over their intercom systems during busy shopping hours. Posters are hung in doctors' offices, clinics, schools, community centers, health fairs, government offices, and churches. Medicine spoons with the CHIP logo will soon be distributed through pharmacies.

Outreach presentations in educational settings have been quite effective in the community. CHIP administrative staff conduct training sessions for district superintendents and school principals, focusing on public programs such as child nutrition, school lunches, school breakfasts, Medicaid, and CHIP. Although the State Office of Education requires each school district to develop a plan for providing public programs and eligibility information, it is left up to the school districts to determine how that information will be disseminated. Jordan School District, the largest school district in Utah with more than 73,000 students, sends CHIP brochures home with each child in Title I schools. In the other Jordan schools, one brochure per family is sent home with students, and every school in the district displays a CHIP poster. Granite is the second largest school district with almost 72,000 students. Until recently, a CHIP poster in each school was the standard outreach practice. Currently, licensed social workers and other professionals are working with families to support the district's philosophy of outreach and accommodation through public programs such as CHIP.

CHIP administrators have worked with the Utah Office of Ethnic Health to exchange ideas about reaching families of various ethnic populations. Special efforts to foster positive working relationships with Hispanic and Native American groups are expected to increase Medicaid and CHIP enrollment. The Program Administrator has made presentations (in Spanish) to Spanish-speaking Catholic congregations, with Spanish-speaking eligibility staff on hand to assist with enrollment. CHIP brochures are available in Spanish, Tongan, and Samoan.

Delivery and Quality of Health Care

To ensure an ample choice of provider networks, DHCF contracts with six managed care organizations - IHC Health Plans, Med Utah (Regence Blue Cross/Blue Shield of Utah), United Health Care of Utah, University Health Network, PacifiCare of Utah, and American Family Care - to provide medical care for Medicaid and CHIP eligible children living in urban areas. In areas, outside Weber, Davis, Salt Lake and Utah counties, CHIP enrollees have access to a broad Preferred Provider Organization network. If there is not a paneled provider within 30 miles of their residence, enrollees may see a local provider not on the PPO panel. CHIP contracts require the contractor to minimize access problems due to language, cultural and geographic obstacles, and physical disabilities. On an as-needed basis, contractors are required to provide interpreter services for languages, extending to telephone and in person communication. Printed materials must be available in languages other than English when at least 5 percent of the population is non-English speaking. Hours of service, a general problem in the current health delivery system, are extended in clinics and urgent care centers to alleviate some of the access barriers. Other contract requirements include (a) accessible and appropriate services with respect to timeliness, amount, duration, and scope; and (b) established standards for waiting times at appointments and in the office[21].

To ensure that quality care is delivered in a cost-effective manner, DHCF requires contractors to meet all state licensing requirements, have an extensive quality assurance system in place, participate in community and internal quality improvement strategies, and report utilization and

[21] State of Utah, 40-43.

performance data to CHIP. CHIP requires contractors to have utilization management departments which conduct concurrent review, retrospective review, prospective review, and prior authorizations. The Department of Health also monitors quality assurance by conducting an annual on-site review, serving as patient advocates, and facilitating a complaint/grievance program for enrollees and providers. Enrollee satisfaction surveys are conducted annually from a random selection of CHIP clients enrolled in MCOs along the Wasatch Front. An independent survey research agency conducts the survey using a standardized survey instrument such as Consumer Assessment of Health Plan Survey, which enables enrollees to rate their overall satisfaction with their health plan, rate their satisfaction with specific aspects of their health care, report on their problems or complaints over the past six months, and assess their unmet medical needs.

The effectiveness of CHIP will be evaluated in two ways: first, by achievement of performance goals and second, by changes in the number of uninsured low income children. The impact of CHIP policies, service quality, and cost on the health outcomes of the CHIP population will be observed and judged over time through standard public health measurements. Every five years, the state conducts a health status survey, which provides an indicator of a child's overall health status and measures health insurance coverage. The Department of Health states that questions specific to CHIP will be part of the next survey in 2001.

CHIPS' First Progress Report

Pursuant to Title XXI requirements, the Department of Health, earlier this year, submitted its first evaluation of CHIP to HCFA. Five strategic objectives, specified in the State Plan, were evaluated by performance measures and progress toward achieving performance goals. The strategic objectives and performance goals are listed in **Table 4**.

By June 30, 1999, CHIP met its enrollment performance goals by enrolling 10,014 previously uninsured, low-income eligible children (1.1). As a result, the percentage of uninsured children decreased from 8.5 percent to 7.15 percent (1.3). Although the 6 percent goal was not reached, the estimated increase in Medicaid enrollment from screening CHIP applications for Medicaid eligibility, will further reduce the number of uninsured children in Utah. During its second year, CHIP enrolled another 7,000 children. As previously described, a statewide coordinated CHIP outreach program is in place (1.4). A CHIP specific survey, will be administered each year to measure any changes in purchasing private insurance ("crowd-out") that may be due to CHIP's implementation (1.5). Data relating to increased enrollment of Medicaid-eligible children will be reported in the Utah CHIP 2000 Evaluation (1.2).[22]

With respect to increasing access to care, CHIP met its performance goal of 90 percent of the children enrolled in CHIP having an identified usual source of care (2.1). According to the 1999 CHIP survey, 94 percent of the 833 survey respondents identified a primary source of care (doctor or clinic) after enrolling in CHIP. Prior to enrolling in CHIP, 6.8 percent of the respondents indicated that they had no access to a primary source of health care (2.2). Access to dental care for five-year-old CHIP enrolled children (2.3) will be included in the Utah CHIP 2000 Evaluation. Performance goals related to the use of preventive care, such as immunizations and well-child care (3.1, 3.2, 3.3, 3.4, 3.5), will also be included in the 2000 Evaluation.

A change (or no change) in the annual rate of readmission for asthma hospitalizations for CHIP-enrolled children (4.1) will be reported in the 2000 Evaluation. CHIP achieved its performance goal of establishing an ongoing method for quality care data collection and monitoring quality care indicators (4.2). A list of Utah CHIP HEDIS[23] reporting requirements has been established and distributed to

[22] Utah Department of Health, 4-7.

[23] Health Plan Employer Data and Information Set (HEDIS) is a core set of performance measures designed by the National Committee for Quality Assurance. HEDIS allows health plans and employers to accurately track health plan performance in a comparative manner. (From *Glossary of Terms Commonly Used in Health Care* (Washington, D.C.: Alpha Center, 1994).

Table 4
Utah CHIP Strategic Objectives and Performance Goals for Each Strategic Objective.

(1.0)	**Reduce the percentage of Utah children, from birth to 19 years of age, who are uninsured.**
(1.1)	By June 30, 1999, at least 10,000 previously uninsured low-income eligible children will be enrolled in Utah CHIP.
(1.2)	By June 30, 2000, the percentage of Medicaid-eligible Utah children younger than 19 years of age who are enrolled in Medicaid will be increased from 80 to 90 percent.
(1.3)	By June 30, 1999, the percentage of Utah children from birth to 19 years of age without health insurance will be decreased from 8.5 percent to 6 percent.
(1.4)	By December 31, 1998, a coordinated statewide outreach program for the identification and enrollment of CHIP eligible children into the Utah CHIP will be established.
(1.5)	By December 31, 1999, a mechanism will be established to measure any change in rates of individuals purchasing or employers offering private insurance ("crowd-pit") that may be due to implementation of the Utah CHIP.
(2.0)	**Increase access to health care services for Utah children enrolled in Utah CHIP.**
(2.1)	By June 30, 1999, at least 90 percent of children enrolled in Utah CHIP will have an identified usual source of care.
(2.2)	By June 30, 2000, there will be a decrease in the proportion of CHIP enrolled children who were unable to obtain needed medical care during the preceding year.
(2.3)	By June 30, 2000, at least 50 percent of five-year-old CHIP enrolled children will have received dental services prior to kindergarten entry.
(3.0)	**Ensure that children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.**
(3.1)	By June 30, 2000, at least 50 percent of children who turned 15 months old during the preceding year and were continuously enrolled in Utah CHIP from 31 days of age, will have received at least four well-child visits with a primary care provider during their first 15 months of life.
(3.2)	By June 30, 2000, at least 60 percent of three, four, five, or six-year-old children who were continuously enrolled in Utah CHIP during the preceding year will have received at least one or more well-care visits with a primary care provider during the preceding year.
(3.3)	By June 30, 2000, at least 85 percent of two year old children enrolled in Utah CHIP will have received all age-appropriate immunizations.
(3.4)	By June 30, 2000, at least 90 percent of 13 year old children enrolled in Utah CHIP will have received a second dose of MMR.
(3.5)	By June 30, 2000, at least 50 percent of CHIP enrolled children eight years of age will have received protective sealants on at least one occlusal surface of a permanent molar.
(4.0)	**Ensure that CHIP-enrolled children receive high quality health care services.**
(4.1)	By June 30, 2000, the annual readmission rate for asthma hospitalizations among CHIP-enrolled children will have decreased compared to the rate during the previous year.
(4.2)	By June 30, 1999, a set of quality care indicators will be selected and methods established for ongoing data collection and monitoring of these indicators.
(4.3)	By June 30, 2000, at least 90 percent of CHIP enrollees surveyed will report overall satisfaction with their health care.
(5.0)	**Improve health status among children enrolled in Utah CHIP.**
(5.1)	By June 30, 2000, no more than 20 percent of the Utah CHIP enrolled children ages six through eight years old will have untreated dental caries.
(5.2)	By June 30, 1999, a method will be established and a survey instrument developed and/or adapted for use in assessing overall health status among Utah CHIP enrollees over time and as compared to other groups of children.

Source: Utah Department of Health, *State Evaluation of Children's Health Insurance Program,* (March 2000): 4-16.

Source: U.S. Census Bureau, State and County *Quickfacts.* Data on-line. Available from http://www.census.gov/cgi-bin/qfd/state.... Accessed 17 September 2000.

contracted managed care organizations. As of March 2000, three of the four managed care organizations were prepared to report HEDIS data for the 1999 calendar year. CHIP achieved its performance goal of 90 percent of enrollees reporting overall satisfaction with their health care (4.3). Of the 1999 CHIP survey respondents, 91.7 percent rated their satisfaction of CHIP health care between seven and ten, with ten being the highest possible score. Interestingly, 45.6 percent of the survey respondents rated their CHIP health care as the best health care possible. The CHIP survey will be an instrument for assessing overall health status of CHIP-enrolled children over time and compared to other groups of children (5.2). Data regarding untreated dental caries (5.1) will be included in the CHIP 2000.

Conclusion

Health care concerns have been one of the dominant public issues for years. Concern over rising costs, quality of care, and access to health care have been the three main health care concerns not only for Utahns but Americans. In 1998 a bi-partisan effort in Congress passed the State Children's Health Insurance Program. This new program expanded public health insurance to children under the age of 19 who live in families without insurance and with incomes between 101 percent and 200 percent of the federal poverty level. An October 2000 report from the Department of Health and Human Services indicates that 2.8 million children who were previously uninsured are not covered by SCHIP.

In Utah, the federal government estimates that about 21,000 children have been insured. Utah's state Department of Health estimates that about 30,000 children may be able to be covered by CHIP and another 15,000 children may be able to be covered by Medicaid through its outreach efforts. The Department of Health has implemented an aggressive outreach program using the media, schools, churches, and community organizations to find and enroll eligible children. Such an increase in the number of children now covered by health insurance is certainly a significant step forward in addressing one of the main health care issues facing Utahns.