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REPORT

FINAL REPORT

Congressionally Mandated Evaluation of the Children's Health Insurance Program: A Case Study of Utah's *CHIP* Program

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I. BACKGROUND AND RECENT HISTORY

The State of Utah's *Children's Health Insurance Program (CHIP)* is a "separate" program under Title XXI, launched in the summer of 1998, just shy of a year following the creation of the State Children's Health Insurance Program (SCHIP) by the Balanced Budget Act of 1997. Utah was the 30th state to adopt SCHIP and has always extended coverage to children through age 18 in families with incomes up to 200 percent of the federal poverty level (FPL). Throughout its history, *CHIP* has been one of the smaller Title XXI programs in the nation—currently ranked 30th—with enrollment peaking at approximately 62,000 children ever enrolled in 2010 (DHHS, 2011).

Traditionally a politically conservative state, Utah has rarely been expansive with its public health and social services programs. A notable exception to this rule, however, has been its approach to maternal and child health programs; Utah was a leader in the late-1980s in expanding coverage to pregnant women and young children under Medicaid, and its large and multi-faceted marketing and outreach campaigns garnered national attention (Hill, 1988). Some of this progressivity rubbed off on the *CHIP* program after the creation of Title XXI, as evidenced by the state's relatively quick adoption of the children's health coverage expansion. Not surprisingly, though, political leaders embraced Title XXI's flexibility to adopt a separate program model rather than a Medicaid expansion, and aimed to implement a program that more closely mirrored private health insurance, with features such as consumer cost sharing and, unique among the 50 states, periodic open enrollment. Largely because of this design, *CHIP* has enjoyed strong political, provider, and consumer support over the years.

Both *CHIP* and Medicaid are administered by the Utah Department of Health (DOH). Since 2006—the end of the study period for the previous Congressionally Mandated SCHIP Evaluation—Utah has implemented a number of important changes for *CHIP*.

- Most significantly, in 2008, the program dropped its policy of only opening enrollment for brief periods once a year, and switched to continuous open enrollment. This brought Utah's *CHIP* into alignment with all other programs across the nation, stabilized coverage opportunities for eligible children, and led to steady enrollment increases.
- In a second important change, Utah switched its benchmarks for both health and dental benefits, in 2007 and 2009 respectively, from the State Employees Health Benefit package to that of the HMO and dental plan with the largest enrollment in the state. These changes led to decreases in benefits coverage and increases in cost sharing, as will be discussed below.
- Also in 2009, a new health plan (Select Health) began participating in *CHIP* after another longstanding plan left the program—this change was a direct result of a 2008 state law that required *CHIP* to establish risk-based contracts with at least two health plans through a competitive bidding process.
- In 2006, the state added a "premium assistance" component to *CHIP* called the *Utah Premium Partnership*, as a "bridge" to private coverage by subsidizing families' enrollment into employer sponsored insurance.

- And finally, beginning in 2008, Utah consolidated the eligibility function of all its public benefits programs into a single state agency—the Department of Workforce Services (DWS)—in an effort to enhance efficiency and to facilitate the roll-out of a new rules-based eligibility/IT system. This removed eligibility determination responsibilities from the DOH, which had traditionally performed this function for families applying for only Medicaid or *CHIP* coverage. DOH continues to set policy for medical program eligibility, and more broadly administers all other aspects of both *CHIP* and its larger sibling, Medicaid.

According to key informants interviewed for this study, these changes—and particularly the adoption of continuous open enrollment—have helped Utah make inroads in reaching its remaining uninsured children. Still, the state lags most other states in the rate of *CHIP* and Medicaid participation, and covers just 76 percent of eligible uninsured children (DHHS, 2011). Over the last several years, the number of uninsured children in the State has slowly dropped, but more recently plateaued, at roughly 107,000 children, about half of which are in families with incomes that fall within the Medicaid or *CHIP* eligibility range of at or below 200 percent of FPL (Lynch, et al, 2010).

All of these factors set an uncertain stage for Utah as it plans for health care reform under the Affordable Care Act (ACA). Since the Supreme Court’s ruling that the ACA’s Medicaid expansion is optional for the states, Utah officials have not declared, one way or the other, how the state will proceed. Regardless of whether Medicaid is expanded to all residents with incomes up to 138 percent of FPL, however, 2014 will see a large number of current *CHIP* enrollees transferred into Medicaid as a result of two different ACA provisions—one that requires states to eliminate Medicaid asset tests and another that requires the state to transfer *CHIP* enrollees with incomes up to 138 percent of the FPL into Medicaid. Key informants estimate that both changes could result in the transfer of nearly three-quarters of current *CHIP* enrollees into Medicaid. Some stakeholders confess that, after this transfer, it might not be practical to maintain what would be a much smaller separate program, while others strongly believe that the very popular *CHIP* will be maintained well into the future, regardless of its smaller size.

This case study is primarily based on a site visit to Utah conducted in August 2012 by staff from the Urban Institute. Utah was one of 10 States selected for study in the second Congressionally-mandated evaluation of the Children’s Health Insurance Program (*CHIP*) called for by the *CHIP* Reauthorization Act of 2009 (*CHIPRA*) and overseen by the Assistant Secretary for Planning and Evaluation (*ASPE*). The evaluation’s reports build upon findings of the first Evaluation’s case studies and highlight changes to state programs that have occurred since 2006, with a particular focus on state responses to provisions of *CHIPRA*. The site visit to Utah involved interviews with 30 key informants, including State *CHIP* and Medicaid officials, legislators, health care providers and associations, health plans and associations, children’s advocates, and community-based organizations involved in outreach and enrollment. (See Appendix A for a list of key informants and site visitors). In addition, three focus groups were conducted—in Salt Lake City and Logan—two with parents of children enrolled in *CHIP*, and one with parents whose children are enrolled in the *Utah Premium Partnership*, the state’s premium assistance program. Findings from these focus groups are included throughout the report and serve to augment information gathered through stakeholder interviews.

The remainder of this case study report will describe recent *CHIP* program developments and their perceived effects in the key implementation areas of: eligibility, enrollment, and retention; outreach; benefits; service delivery, quality, and access; cost sharing; crowd out; financing; and preparation for health care reform. The report concludes with cross-cutting lessons learned about the successes and challenges associated with administering Utah's *CHIP* program.

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II. ELIGIBILITY, ENROLLMENT, AND RETENTION

Utah’s *CHIP* program is noteworthy for its centralized, highly automated, internet-based eligibility system administered by the state Department of Workforce Services (DWS). As mentioned above, the state consolidated the eligibility function for its health programs—*CHIP* and Medicaid—with those of the rest of its public benefits programs—Temporary Assistance for Needy Families (TANF), the Supplemental Nutritional Assistance Program (SNAP), and child care subsidies, among others—in 2008. The move was made to create a “one stop shopping” experience for individuals and families seeking assistance, enhance efficiency, save money, and facilitate the roll-out of a new rules-based eligibility system that would support all programs. Utah’s *CHIP* and Medicaid programs are also noteworthy for their lack of community-based application assistance structures for families interested in obtaining coverage. These dual circumstances have resulted in an enrollment and renewal system that is quite easy and accessible for populations that have Internet access and are facile with technology, and conversely difficult and relatively inaccessible for disadvantaged, harder-to-reach populations that might need help applying for coverage.

This section describes Utah’s policies and procedures related eligibility, enrollment, and renewal.

Eligibility Standards. Once again, the most important eligibility policy change in Utah during the study period was the decision to move to year-round open enrollment in 2008, a critical improvement that brought Utah into alignment with *CHIP* programs across the country. Over the years, policymakers in Utah had seen how beneficial the program was for children, and witnessed the very urgent response among parents with uninsured children each year when enrollment opened. Furthermore, state officials perceived that this pent-up demand meant that children were entering the program “sicker” and very much in need of care. Under the leadership of then-Governor Jon Huntsman, and with strong advocacy from the non-profit *Voices for Utah Children*, consensus was reached that the state’s families would be better served by having *CHIP* always available for uninsured children.

Utah’s separate *CHIP* program is, thus, now continuously open to all children under the age of 19 living in families with incomes up to 200 percent of the federal poverty level (FPL). In contrast, the upper eligibility levels for Medicaid vary by income level and age. As illustrated in Table II.1, infants and children ages one to six in families with incomes up to 133 percent of poverty are eligible for Medicaid, while children ages six to 19 are eligible for Medicaid only if family income does not exceed 100 percent of poverty. Notably, Utah is one of the only remaining states with an assets test for children applying for Medicaid coverage. As such, *CHIP* also includes a small number of children ages six to 19 who meet the income criteria for Medicaid, but are ineligible due to the presence of excess assets.

Table II.1. Eligibility Rules, By Age and Income (as % FPL) for Medicaid and CHIP

	Age Categories		
	Infants	1 to 5	6 to 18
Medicaid	133%	133%	100%
CHIP (<i>Children’s Health Insurance Program</i>)	200%	200%	200%

Utah’s other eligibility requirements are detailed in Table II.2. *CHIP* requirements can be characterized as quite generous. Medicaid’s criteria, on the other hand, are considerably more stringent, as state policymakers have never much favored easing eligibility rules for the program. In addition to the programs’ differences with regard to assets (mentioned above), *CHIP* provides 12 months of continuous eligibility regardless of fluctuations in income, while Medicaid requires families to recertify eligibility each month. Per federal law, Medicaid provides three months of retroactive eligibility once program eligibility is established, while *CHIP* does not. Social Security numbers are requested of applicants by both programs, but citizenship is verified after the fact through a data match with the Social Security Administration. Neither program covers legal immigrant children or pregnant women in their first five years of residency in the U.S.

Enrollment Process. Once again, the most important recent change to Utah’s enrollment process occurred in 2009 when the Department of Workforce Services (DWS) rolled out the new Electronic Resource and Eligibility Product system—called “eREP”. As mentioned above, it is a rules-based system that uses an online “universal application” to determine eligibility for multiple health and social support programs, and responds to applicants’ input—in real time—by systematically determining for which programs individuals and/or families are eligible. Once

Table II.2. CHIP and Medicaid Eligibility Policies

	CHIP	Medicaid	Details
Retroactive Eligibility	No	Yes, 3 months	
Presumptive Eligibility	Yes, 2 months	No	
Continuous Eligibility	Yes, 12 months	No, monthly recertification required	
Asset Test	No	Yes	
Income Test	Gross income	Net income after deductions	Documentation required
Citizenship Requirement	Self-declare	Self-declare	Utah conducts data match with SSA to verify citizenship
Identity Verification	Yes	Yes	Income, insured status, residency require documentation at the time of application
Redetermination Frequency	12 months	Monthly	

eREP “pre-screens” a family, their application is then sent to a DWS team specialized in a specific program. Until recently, DWS eligibility workers were organized regionally; a regional team processed applications from their assigned region, for all programs. The move to statewide, specialized teams marked a major structural change for the agency, which they hoped would make program administration more efficient and reduce error rates, since eligibility workers would have greater expertise in their program areas.

Merging the eligibility processes for Medicaid, CHIP, TANF, SNAP, and other programs has, indeed, led to a significant increase in the number of families enrolled in multiple

programs—from 50 percent before eREP to 70 percent in 2012. And it has led to dramatic increases in the proportion of applications that are received through the universal application via the Internet; at the time of this writing, approximately 70 percent of all applications for coverage were being received through the online eREP system.

With this online system, applicants can interact with eREP from any location with a broadband connection. In addition, though, individuals can go to any one of 33 Employment Centers across Utah to apply for assistance. Unlike traditional “welfare offices,” however, Employment Centers are not staffed by eligibility workers nor do applicants sit down with workers to complete their applications. Rather, given the automated nature of the process, applicants visiting Employment Centers can sit at a computer workstation and apply through the same eREP portal that they would use at home. Staff at the Centers can help applicants with the computerized application, or answer any questions that applicants may have. But, once again, there is no formal “interview” during which an application is completed.

Applicants can also receive assistance with the process via eREP’s “online chat” capacity. Whether from home or at an Employment Center, applicants can click on a “help” tab and then interact in real time with DWS personnel, typing questions and receiving answers as they work through their applications. A final form of assistance is through the DWS statewide “call center.” Individuals and families can call the toll-free number and ask general questions about program eligibility, check the status of applications they may have submitted, or even complete an application by phone.

Other innovative capacities of eREP include the option for applicants to create “My Case” accounts, through which they can monitor the progress or status of their applications, track whether verification documents have been received and approved, and receive email notifications from DWS about their eligibility or need to renew coverage. So far, about 25 to 30 percent of participants have chosen to participate in this “paperless” option. People creating “My Case” accounts also have the option to extend access to their accounts to third parties. This could allow, for example, an outstationed eligibility worker at a hospital to assist with completing an application or monitoring its status through the system.

Beyond eREP and its universal application, people can still apply for “medical only” coverage using the joint Medicaid/*CHIP* application, a 9-page document that can be filled out manually and submitted by mail. Medical only applications are most often completed, however, at provider sites, such as hospitals and Federally Qualified Health Centers (FQHCs). Referred to as “outreach sites,” these providers are traditionally staffed by DWS outstationed eligibility workers who help uninsured individuals establish insurance coverage at the time they seek care in these facilities. Outreach sites comprise both “seeded” sites, where the provider pays a portion of the salary of the worker (most often hospitals and nursing homes), as well as “unseeded” sites, where staff are fully funded by DWS (most often FQHCs).

Unlike applications received via eREP, which have already been pre-screened to determine eligibility for Medicaid or CHIP, applications submitted through the mail must first be reviewed by a DWS eligibility worker before being sent to a specialized eligibility team. Once this process has been completed, all applications—whether universal or medical only—are reviewed by DWS using its E-Verify system, a tool that brokers data exchange between DWS and 21 other databases at the federal and state levels, as well as certain private sources, and allows verification of income, assets, employment and other items to occur behind the scenes. Typically, the turn-around time for applications involving medical coverage is roughly 20 days, though state officials believed that applications resulting in CHIP coverage are processed consistently in seven days.

Noticeably absent from

Utah's enrollment system is any formal system for providing hands-on application assistance to individuals and families. A strategy that was widely adopted by states after the creation of SCHIP, application assistance was seen as an effective means of helping hard-to-reach families understand what coverage options were available to them and then to navigate the often confusing application process (Hill et al, 2003). Application assistance, often provided by staff of community-based organizations, is generally viewed as especially important for disadvantaged and non-English speaking populations, where trusted, culturally representative members of the community succeed where others can't in connecting with families, dispelling misunderstandings about rules, and helping fill out forms and gather needed documents. Utah has never invested significant resources in such assistance, beyond its support for outstationed eligibility workers. With the transition of eligibility determination to DWS and an emphasis on

Focus Group Findings: Enrollment

Many parents described how their children were seamlessly rolled into CHIP when they became ineligible for Medicaid. Others completed the application online or by mail. While parents felt the application itself was easy, some found the documentation and assets questions onerous and confusing.

"[We were] already on Medicaid...and then when my income went up, they just sent me the papers and I just signed them and they automatically put me on CHIP."

"I just went online trying to find out what kind of benefits there were...and so then I just did [the application] online."

"I called them, and they told me where to get the papers, which I printed offline. And then I mailed them...I would say it was easy."

"The hardest part for me was just the hassle of pulling up the bank account information...and pulling up different balances and...the information for the verification that they wanted."

"It was confusing when they would ask questions [about] your assets...how much my car is worth, how much I have in my bank account, how much my house is worth...I didn't know how much they really needed.."

Participants in Utah's Premium Assistance Program (discussed in Section X of this report) completed the same application as those enrolled in CHIP and Medicaid. For some, the process was easy. However, others were not fully satisfied with the process and felt that the eligibility requirements made it very difficult to qualify.

"It's just one application...and then they called us and said...you qualify for CHIP and UPP. Which one do you want?"

"To qualify for UPP...was pretty difficult. You had to be without insurance at the time, but your company has to have insurance available."

Parents of children enrolled in both CHIP and UPP were frustrated by the lack of available application assistance.

"The one I worked with over the phone...was extremely good...[but I] waited on hold for an hour and a half [to speak with him]."

"It's extremely frustrating to get a hold of somebody."

"The employment specialist...[didn't] know anything about UPP...and there's no way to contact anybody for UPP."

"I had several of them tell me I didn't qualify [for UPP]...so I was educating the worker on what UPP was!"

cost containment and efficiency undergirding the eREP system, support for outstationed workers has also been cut. To address this gap, two groups in Utah—the Association for Utah Community Health and the Indian Walk-In Center—pursued and received CHIPRA Outreach Grants, which both embrace a strong applications assistance model. These efforts are discussed in detail in the Outreach section of this report, below. Summary characteristics of Utah’s application requirements and procedures are presented in Table II.3.

Renewal. Utah’s renewal process shares key characteristics with the state’s enrollment system. First, DWS’ eREP system was extended to incorporate renewal in 2011, and already nearly 30 percent of enrollees are completing their eligibility renewals online. Second, there are distinct differences between *CHIP*’s and Medicaid’s renewal rules, differences that dramatically affect retention rates and churn across the two programs.

With regard to renewal through eREP, enrollees must first create “My Case” accounts in order to receive email notices informing them that it’s time to renew coverage. Accessing the renewal form online, families will see that the form is “pre-populated” with information from the initial application. Parents are only required to verify that the information on the form is still correct, or submit updated information for anything that has changed. DWS workers again rely on the E-Verify system to check income and other information while processing renewals received through My Case. If DWS is unable to verify income, parents are asked to submit new income documentation before coverage can be renewed. For those not using the online approach, a paper renewal form is mailed to families in the month leading up to the child’s anniversary of enrollment. Like the online version, the paper form is pre-populated with family and child information, and only updates and income verification need be submitted for processing to occur. State officials reported that turn-around time for online renewals is typically nine days, while processing of paper renewals takes closer to 15 days. Despite a quicker turn-around time, higher rates of wrongful termination have been reported for families who renew through the eREP system. Though *CHIP* coverage is renewed on an annual basis and often (as described above) in a passive manner, enrollees must undergo a mandatory review every three years—at that time families must actively submit specific income documentation to the state.

Table II.3. Current CHIP Application Requirements and Procedures

Form	
Joint Application with Medicaid	Yes – There is a “universal” application that determines eligibility for not only CHIP and Medicaid, but also TANF, SNAP, and child care subsidies. A shorter “medical only” application is used in provider and outreach sites and serves only to determine eligibility for CHIP and Medicaid.
Length of Joint Application	9 pages (“medical only” app); 6 pages of application; 2 pages on ESI status, to be completed by employer; 1 page of instructions
Languages	English, Spanish

Table II.3 (Continued)

Application Requirements	
Age	Yes – self declaration allowed if the child successfully matches through the SSA data matching process. If not, age documentation is required.
Income	Yes – documentation required at the time of application
Deductions	No deductions are allowed for CHIP; deductions permitted for Medicaid include a disregard of current earned income, a \$90 work allowance, and child care
Social Security Number	Yes – requested at application for everyone in the household; used in the matching process with SSA.
Citizenship	Yes – uses Social Security Administration Data Match to verify citizenship
Enrollment Procedures	
Express Lane Eligibility	Yes – for purposes of renewal only, uses State income tax system and state 'Adjusted Gross Income' to determine ongoing eligibility; families must opt in to system
Mail-In Application	Yes
Telephone Application	No
Online Application	Yes – application available via Internet or at any of 33 Employment Centers across state
Hotline	Yes -- toll-free call center can assist applicants with application by telephone
Outstationed Application Assistors	Yes – at hospitals and Federally Qualified Health Centers
Community-Based Enrollment	No – No state-sponsored, but grant funded application assistance programs do exist in some locations across state

Families with children enrolled in Medicaid can also renew coverage online or via a manual, paper process. Neither renewal form is pre-populated in the case of Medicaid, however, so the process is more “active” than “passive,” as families have to complete forms anew, and resubmit income and assets documentation. More critical, Medicaid rules require that eligibility be re-established each month, forcing families to go through the process over and over again, especially if income is variable. (Key informants noted that, while Medicaid eligibility must technically be re-established monthly, caseworkers have some discretion in this area and can—and often do—choose to review cases on a more infrequent basis, especially if steady employment suggests income hasn’t changed.) (Renewal procedures for *CHIP* and Medicaid are summarized in Table II.4.)

In one of many recent policy changes made to qualify for CHIPRA Performance Bonus funds, Utah adopted and received federal approval of an Express Lane Eligibility (ELE) plan amendment in April 2012. Utah’s ELE initiative, interestingly, is

Focus Group Findings: CHIP Renewal

Parents mostly found the renewal process easy because they received a pre-populated form in the mail they sent back with updated information. However, some who were self-employed found the process more burdensome.

“They just send you a notification in the mail with a [renewal] app. I thought it was fairly easy.”

“It’s definitely...gotten easier over the years.”

“When you’re self-employed, it is a full time job.”

“I have piano students and speech students...[and] I have to have three documents per job per month, which makes six documents a month. So handing in all that paperwork at the end of the year is cumbersome.”

focused only on facilitating renewal, not initial enrollment. Specifically, families can opt in to a system whereby their Adjusted Gross Income from the state’s income tax system will be used to assess their children’s ongoing eligibility status, and must give DWS permission to access their tax records. As a safeguard, Utah’s ELE policies allow any family that does not agree with the determination reached through state income tax assessment to fall back on a traditional renewal review. This “do over” was built in to give families assurance that opting into ELE would not adversely affect their children’s coverage. To date, a relatively small proportion of families—fewer than 100 in total—have signed up for ELE renewal. State officials, at this early point, believe that the approach is advantageous for families with stable, steady income, and less so for families with intermittent or sporadic earnings. In any case, this ELE effort is more evidence of Utah’s effort to streamline processes and minimize administrative costs, and state officials hope that the process will become more widely used.

Table II.4. Renewal Procedures in Utah CHIP and Medicaid

	Renewal Requirements	
	CHIP	Medicaid
Passive/Active	Passive	Active
Ex-Parte	No	No
Rolling Renewal	No	No
Same Form as Application	No - separate for CHIP and Medicaid	No - separate for CHIP and Medicaid
Preprinted/Pre-populated Form	Yes	No
Mail-In or Online Redetermination	Mail-in, online, or ELE	Mail in or online
Income Documentation Required at Renewal	Yes, except for ELE	Yes
State Administratively Verifies Income	Yes	Yes
Other Verification Required	No	No

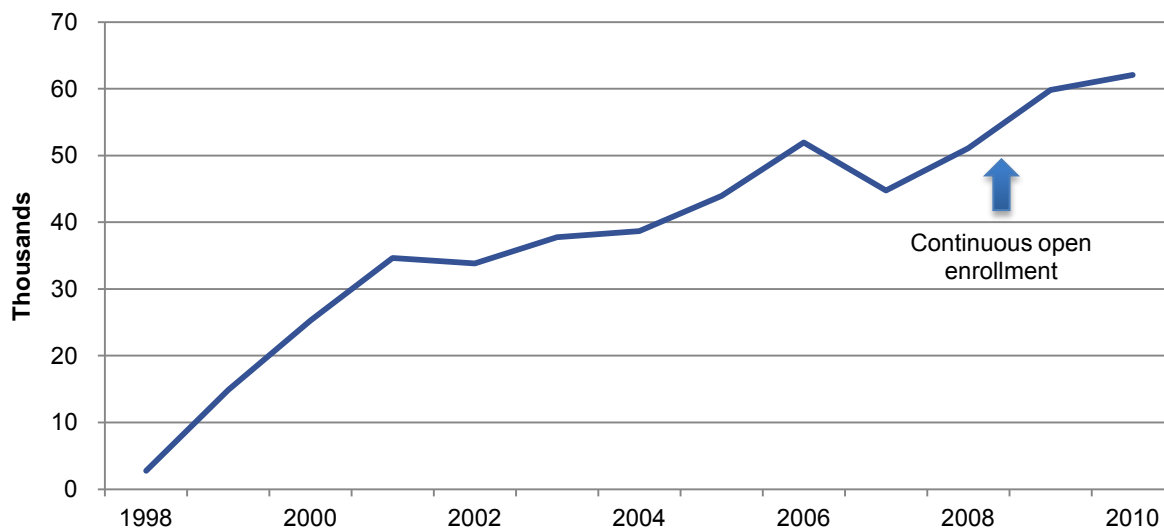
Discussion. Utah’s enrollment and renewal systems possess some remarkable strengths, primarily their use of a rules-based, automated system that consolidates eligibility determination for multiple health and social services programs. But the systems also possess serious weaknesses, including the lack of community-based resources to provide hands-on application assistance to disadvantaged populations that might benefit from such help, as well as dramatically different policies for Medicaid and *CHIP*, differences that make the latter more accessible and user friendly than the former.

Budget pressures and the need to contain costs, especially during the Great Recession, have driven system and policy formation in Utah. Arguably, the move to consolidate the eligibility function for all programs within DWS had as much to do with saving administrative costs as it did with increasing multi-program access. Similarly, retaining such outdated policies as month-to-month recertification for Medicaid succeeds in keeping enrollment levels and, by extension, costs in check. Even the recent push by state officials to pursue enrollment and renewal simplification strategies was driven by the need to obtain new revenues to support *CHIP* and Medicaid—through the CHIPRA Performance Bonus initiative—as much as any desire to streamline access to coverage. In 2012, Utah succeeded in adopting five of the eight strategies needed to qualify for a performance bonus, including: no assets test for *CHIP*; no in-person interview; joint application for *CHIP*/Medicaid; administrative renewal; and presumptive

eligibility. They planned to apply for a bonus payment later in 2012. However, its presumptive eligibility program was described as “tiny” in that it only applies to children with a sibling transitioning out of foster care to come back into the home. And, in the words of leading children’s advocates in Utah, the state failed to adopt the “right” simplification strategies—namely, 12-month continuous eligibility for Medicaid, and no assets test for Medicaid—because the costs of doing so were deemed too high. Finally, given fiscal pressures, it is likely that the 2008 decision to allow year-round open enrollment would have been reversed in recent years, had it not been for federal Maintenance of Effort protections put in place by the American Recovery and Reinvestment Act and the Affordable Care Act. Specifically, the state legislature approved budget cuts to Medicaid in 2009 that would have reduced eligibility levels, but the state was required to restore eligibility to pre-2009 levels due to maintenance of effort requirements.

These characteristics combine to create a system that suffers from low participation among eligible children, relative to the national average. As seen in Figure II.1, the number of children ever enrolled in *CHIP* grew quickly after adoption of year-round open enrollment in 2008, peaking at over 62,000 in 2010. However the ‘ever-enrolled’ numbers mask a leveling out of end-of-year enrollment counts, which actually dropped in 2010 to just under 38,000 children from over 42,000 children in 2009, likely due to the Great Recession and more families qualifying for Medicaid. Overall, only 76 percent of children eligible for Medicaid and *CHIP* in Utah are enrolled in these programs, compared to 85 percent of children nationally.¹

Figure II.1. Number of Children Ever Enrolled in *CHIP* (1998-2010)



Source: State-by-State FY 2010 Medicaid and CHIP Enrollment Data, Statistical Enrollment Data System (SEDS).

¹ Utah’s rate is the third lowest among states (after Nevada and North Dakota). KFF State Health Facts, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=868&cat=4>

III. OUTREACH

Utah was once a pioneer in designing and implementing high-end, professional marketing campaigns for its public programs. For example, the *Baby Your Baby* campaign was launched to raise awareness of the state's large Medicaid expansion for pregnant women and infants in the 1980's. State health officials, investing relatively few state dollars, were able to leverage the donated professional expertise of Salt Lake City's NBC affiliate—KSL—to develop attractive and engaging public service announcements (PSAs) for television and radio, as well as a broad range of eye-catching collateral materials—such as billboards, bus placards, brochures and posters—to blanket the state and help achieve a recognition rate of over 90 percent for the *Baby Your Baby* “brand.” (Hill, 1988).

According to key informants interviewed for this case study, Utah's *CHIP* benefited from similar marketing investments over the years, always with the focus on statewide campaigns, rather than community-based efforts. The program, in contrast to Medicaid, was always strongly supported and presented to the public as coverage akin to private insurance. During annual open enrollment periods, for example, television and radio PSAs, along with newspaper press releases, advertised the availability of children's health coverage and urged families with uninsured children to sign up. Annual “Back to School” campaigns were another primary outreach strategy of the Utah DOH, with brochures and application forms distributed widely to children in public schools across the state. When Utah moved to continuous open enrollment in 2008, a large new outreach campaign advertised the change to ensure that families knew that *CHIP* was available year-round for their uninsured children. A small fleet of vans, wrapped in the *CHIP* logo, traveled widely across the state to appear at community events, distribute materials, and generally increase visibility of the program. Meanwhile, throughout, Medicaid was never advertised, and legislators and governors were distinctly uninterested in “drumming up” enrollment in the entitlement program.

Like many states, however, Utah cut its *CHIP* outreach budget significantly when the Great Recession hit. From 2009 on, there has been no advertising and *CHIP* vans are no longer on the road, leaving only small scale efforts to include *CHIP* brochures with students' back-to-school materials each fall.

To take up the slack, a number of non-governmental organizations have worked to raise and maintain public awareness of the availability of coverage. The advocacy group *Voices for Utah Children*, for example, this year held a large event to celebrate the 15th anniversary of *CHIP*'s creation, holding a press conference, releasing a *CHIP* “storybook” to showcase—through personal recounts—how *CHIP* and Medicaid helped families with children, and to more generally rally a “call to action” to address the state's problem with uninsurance among children. Social media strategies were incorporated to help make the effort more statewide in its reach, including postings on *Voices*' Facebook page. The event received strong newspaper, television, and radio coverage and was widely believed to have been a success. *Voices*—which was a Robert Wood Johnson Foundation *Covering Kids and Families* grantee and also a “finish line” grantee supported by the David and Lucile Packard Foundation's *Insuring America's Children* initiative—has continued to convene its broad based coalition to focus attention and advocacy on children's coverage issues and promote policies to expand coverage and access.

More recently, the *Utah Health Policy Project*, a not-for-profit research, advocacy, and education organization affiliated with the United Way of Salt Lake, has worked to promote coverage and identify ways that Utah can prepare for federal health reform and maximize the opportunity for decreasing uninsurance. Their efforts have entailed helping individuals and families to apply for coverage in both Medicaid and *CHIP*, focusing primarily in high need communities, immigrant welcome centers, and Title I schools in the Salt Lake Valley. The group's intent, over time, is to foster the development of a "navigator assistance community" to support the roll-out of coverage under health reform.

The two health plans participating in *CHIP*—Select Health and Molina—have recently joined forces to promote *CHIP* at the community level. With DOH's somewhat reluctant blessing, the plans have each invested \$50,000 to hire a marketing firm and develop joint outreach materials to promote children's coverage and inform families about how to apply. DOH appreciates the role that these health plans can play, especially in light of the state's budget cuts, but is also very wary of the potential for inappropriate marketing. State officials have thus carefully overseen the development of materials to ensure that *CHIP* is what's being marketed, and *not* the individual plans. Meanwhile, Select and Molina—both nonprofits—see the marketing effort as a "win-win" that supports both the public policy goal of increasing coverage and the business goal of increasing plan enrollment. Marketing efforts, which have thus far focused on setting up information booths at community fairs and other events, were only launched in spring 2012, so data or even opinions on their effects were not available at the time of the site visit.

Finally, CHIPRA Outreach Grants have played a fairly prominent role in Utah, especially at the community-level. The state received four outreach grants in all, and interviews were held with two of these organizations—The Association for Utah Community Health, and the Urban Indian Center of Salt Lake. Both agencies concentrate their efforts on community-based outreach and direct application assistance, as described below.

- ***The Urban Indian Center of Salt Lake*** (formerly called the Indian Walk-In Center) is part of the Indian Health Service's urban program, and represents one of 34 such entities across the country that exist to provide culturally-acceptable, affordable health services to meet the unique needs of American Indians residing in cities. The Center provides referrals to social and health services in the community, disease education and prevention programs, health screenings, as well as direct behavioral health services, such as mental health counseling. In 2010, the Center was one of 33 organizations to receive CHIPRA Outreach Grants under the cycle set aside for tribal organizations and health care providers that serve American Indians, with the explicit goal of increasing participation of eligible, but not enrolled, American Indian and Alaska Native children in *CHIP* and Medicaid. In Utah, this population numbers approximately 16,000 along the relatively urban Wasatch Front portion of the state; in addition, there are seven land-based tribes in the state. Needs assessments have found that these are among the poorest populations in the state, and that only 10 percent of Utah's American Indian children are enrolled in *CHIP* or Medicaid, despite the huge poverty disparity. With the grant support, amounting to \$299,000 over three years, the Center has hired two full-time staff who work in the community, as well as in the Salt Lake City office, to raise awareness of *CHIP* and Medicaid among Indian families, and to help families enroll their children into coverage. Other efforts have

focused on outreach at powwows and working closely with staff at Title VII Indian Education coordinators to provide information about *CHIP* and Medicaid and to set up appointments with families to help them with program applications. To date, the Center has taken roughly 1,500 applications on behalf of children, representing a 13 percent increase in American Indian applications statewide. The vast majority of these children—about 80 percent—have qualified for Medicaid, rather than *CHIP*. With the end of the grant on the near horizon, Center leadership are working with DWS to explore the potential of obtaining state monies to support the staff who have developed expertise and cultural competency in working with American Indian families.

- **The Association for Utah Community Health (AUCH)**, the state primary care association

representing FQHCs and community health centers in Utah, has had a long history of housing outstationed eligibility workers from DOH to help clients apply for Medicaid and *CHIP*. Recognizing the value of providing hands-on application assistance to uninsured consumers, AUCH applied for a Cycle I CHIPRA Outreach Grant and received approximately \$763,000 for a two-year period ending September 2011. AUCH used the

Focus Group Findings: Outreach

Parents reported hearing about CHIP from a variety of sources, including state and local agencies, schools, friends and family members, and advertisements.

"[I] first heard about it when a pamphlet was brought home from school."

"I was originally on Medicaid, and then I made too much money, so they referred me to CHIP."

"I heard about it when I was on WIC."

"I heard of the program...on the news or the radio."

"I [heard] from my sister-in-law who had her kids on CHIP."

Parents receiving premium assistance heard about UPP from a similar array of sources. However, many also expressed the opinion that the program was not well advertised.

"I actually didn't even know it was available and I was on Food Stamps and...my caseworker told me that I would possibly qualify for it."

They did have some ads on the TV, which is how I initially learned about it...I think when the program was first starting up."

"I was on Medicaid [then my husband] found another job...and we'd be getting health insurance...[so] my caseworker told me about UPP."

"They really don't advertise the UPP [program]."

"I don't see much in terms of exposure... Different communities [and] ethnicities don't know that something like this is available...so I think they should have [more] community outreach."

grant to hire seven full-time application assistors and, wishing to test the efficacy of the model in different settings, deployed these staff across two large urban FQHCs, one small rural center, and one Healthcare for the Homeless clinic. AUCH officials reported that the model worked extremely well in the urban sites, where high volumes kept the application assistors busy and many clients succeeded in gaining coverage. The model was found much less effective in the rural setting, where not only was volume low, but the community was so small that consumers were generally reluctant to disclose personal and sensitive information to staff who lived in the same community. The homeless healthcare site was also deemed quite successful, given the high health needs of these families, though considerable extra effort was often needed to successfully track down and follow up with these transient families.

Across the two-year grant period, a total of 10,000 families were assisted, resulting in roughly 8,000 children being enrolled into coverage, about 85 percent of whom were found to qualify for Medicaid, rather than *CHIP*. After the conclusion of the grant, one of the urban centers and the homeless center were able to sustain their model with other sources of funding.

Some key informants were hopeful that cuts in outreach had not seriously undermined the reach and recognition among the general public of the well-regarded and well-known *CHIP*. But most pointed to the program's slowing as evidence that cuts to outreach were, indeed, having a deleterious effect on the program and its mission. Efforts by outside agencies were certainly viewed as important and valuable, but not sufficient to completely replace earlier state investments in outreach, prior to the recession.

Still, some focus group participants expressed that they wished the program was marketed more aggressively so that any family with an uninsured child could know of *CHIP*'s available benefits.

IV. BENEFITS

Federal guidelines allow states to select from several options in creating a benchmark for coverage in separate CHIP programs. When it established *CHIP* in 1998, Utah chose to provide a “benchmark-equivalent” benefit package that was actuarially equivalent to the plan provided to state employees. *CHIP*’s comprehensive benefit set included coverage for preventive and ambulatory care; hospital services; inpatient and outpatient behavioral health care; prescription drugs; durable medical equipment; dental, vision, and hearing services; home health and hospice care; and, physical, speech, and occupational therapies.

The benefit package remained largely unchanged over the next decade, until a 2007 state law required *CHIP* to adopt a commercial health plan benefit package for its benchmark—specifically the largest HMO plan sold in the commercial market. And in an unusual twist, the law required that the *CHIP* package be updated annually to maintain its actuarial equivalence with the HMO benchmark. A legislator and CHIP Advisory Council member with experience as a health insurance broker in the private market championed the benchmark change; he and other supporters reasoned that *CHIP* benefits should be as comprehensive—no more and no less—as coverage available to children in the commercial market. More specifically, he believed that *CHIP* had indeed become more generous than typical private coverage and, therefore, wanted to bring it more in line with what privately insured families were experiencing. The current *CHIP* benchmark is the Select Health Small Business Account plan.

Adoption of a new benchmark has had the largest impact on enrollee cost-sharing, as the annual update process to maintain actuarial equivalence with private market coverage usually results in cost-sharing (e.g., copayment) increases, particularly for enrollees in the highest-income cost-sharing tier (see the *Cost-Sharing* section below for further discussion). The benchmark change has also resulted in tighter restrictions on some services, like behavioral health.

Another consequence of the benchmarking change was that, when *CHIP* updated benefits in 2009 to comply with CHIPRA’s requirements for mental health parity, the program chose to reduce physical health benefits to bring them to par with behavioral health benefits. The opposite scenario, followed by most states, of raising behavioral health benefits so that they were equal to more generous physical health benefits, would have shifted *CHIP* out of actuarial alignment with the commercial benchmark. Overall, however, the benefit changes made by the state to comply with both the commercial benchmark and CHIPRA’s mental health parity requirement were relatively minor, according to informants, and appear to have been implemented with few challenges or concerns.

CHIP also made significant changes to dental coverage during the study period. Per the CHIPRA requirement that states use a separate benchmark for dental benefits, in 2010 the program adopted the dental plan with the largest non-Medicaid enrollment in the state as its dental benchmark. *CHIP* dental benefits became more comprehensive as a result, especially for non-preventive services, and the state even added coverage of orthodontia services up to a \$1000 lifetime limit. After CMS clarified that benchmark equivalency requirements did not extend to orthodontia, however, the state added a medical necessity requirement for this type of care in 2011. This restriction—which effectively limits coverage to children experiencing severe

malocclusion—was prompted by unexpectedly high rates of orthodontia service utilization that dental plans warned could drive up premium costs. Another recent change to the dental benefit structure involves the benchmark certification period, which was extended from one to three years via a 2012 state law. This modification prevents frequent benefit changes that can be disruptive for providers and enrollees, and is expected to create more stability in coverage levels.

Key informants, as well as parents participating in our focus groups, described *CHIP* benefits as comprehensive and as meeting enrollees' needs, with few exceptions. Some suggested that dental coverage was inadequate, particularly in light of the program's recent restrictions on orthodontia. These

Focus Group Findings: Benefits

Parents of children enrolled in CHIP and UPP were similarly satisfied with the benefit package offered to their children. However, they also noted some gaps in developmental, orthodontia, and vision coverage.

"My son needs speech therapy and...it's not covered unless he's had a traumatic brain injury."

"We got my son the transition lenses...we had to pay the difference between the regular lenses and the transition lenses, even though it was his eye doctor that said he needs to have sunglasses."

"I got my daughter in braces, and they were supposed to cover \$1,000. And then in July, they decided they're not covering it anymore."

changes were especially problematic for families in the middle of orthodontia claims processing when the change took effect (i.e., children had begun treatment without a medical necessity requirement but then needed to document medical necessity for claims to be paid). Some program and dental plan officials also expressed frustration that the federal CHIPRA dental benchmark requirements do not provide states with the flexibility to tailor *CHIP* dental benefits in a way that would "make more sense for clients," for instance, by allowing states to meet benchmark tests by providing benefits that are actuarially equivalent but not identical to the chosen benchmark. Because Utah's dental benchmark is not child-specific, it does not cover some services that would be suitable in a children's dental program—such as fluoride varnish or oral sedation—yet the state has little latitude to modify the package.

In general the *CHIP* benefit package is considered comparable to what children on Medicaid receive, though Medicaid coverage is more comprehensive because it includes Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services and protections, as well as long-term care such as nursing facility or personal care services. Given that *CHIP*'s benchmark model is a commercial plan, it is not surprising that program benefits were also described as comparable to what privately insured children receive through the commercial market.

V. SERVICE DELIVERY, ACCESS, AND QUALITY OF CARE

CHIP benefits are delivered entirely through managed care networks. The state currently contracts with two health and two dental managed care organizations, and requires these plans to meet certain access and quality requirements. This section describes the *CHIP* service delivery model, as well as perceptions of key informants regarding how well the program extends broad access to care for children. State efforts to improve and monitor the quality of care for children are also discussed.

Service Delivery. *CHIP* has used a managed care service delivery model since its inception, and for most of the program's history enrollees have had a choice of two statewide health plans. Participating plans currently include Molina Healthcare, a national, for-profit plan that serves only government-sponsored insurance programs (including Utah Medicaid managed care); and, Select Health, a nonprofit plan associated with the largest health and hospital system in the state, Intermountain Health Care. Select Health serves *CHIP* and commercial markets now and will begin participating in Medicaid managed care in 2013.

Until 2010, the two longstanding *CHIP* health plans were Molina and the Public Employees Health Plan or PEHP, the administrator of the state employee health plan. According to informants, PEHP played a critical role in *CHIP*'s early years, when uncertainty about the new program kept other, privately run plans from participating. Over time, however, policymakers became concerned with PEHP's inability (as a nonprofit trust) to bear risk, which prevented *CHIP* from adopting a fully risk-based managed care model where all plans have an equal incentive to control costs.² When a 2008 law required *CHIP* to establish risk-based contracts with at least two health plans through a competitive bidding process, PEHP was no longer able to participate in the program.³ The following year, at the conclusion of the competitive bidding process, the state awarded full-risk contracts to Molina and Select Health. Though the move from PEHP to Select Health represented a significant administrative change for *CHIP*, key informants noted that from an enrollee perspective there was still a great deal of continuity because PEHP used a Select Health provider network. The Medicaid program will soon follow in *CHIP*'s footsteps as, beginning in 2013, its mandatory managed care program—which operates in the four-county Wasatch Front region—will be completely risk-based. (Currently, only one of several plans participating in Utah's Medicaid managed care program has a full risk-based contract.) The state will employ an Accountable Care Organization model, which will pay ACOs a risk-adjusted capitation rate and which also incorporates the medical home concept.

² Under *CHIP*'s arrangement with PEHP (1998-2010) the state paid the plan a prospective capitated monthly premium, and retained the risk for expenditures exceeding the premium payments (via an annual cost-settlement process). Under *CHIP*'s current arrangement with Molina and Select Health, the health plans are paid a prospective capitated monthly premium, but retain full risk for expenditures exceeding the premium payments. *CHIP* has a unique financing arrangement with Select Health that resembles an administrative profit cap, where the plan returns any program payments that exceed a predetermined threshold (but is still liable for costs beyond that threshold). In the most recent fiscal year (2012) the plan provided a refund of over \$2 million to the *CHIP* program.

³ Utah HB370, Available at: <http://le.utah.gov/~2008/bills/hbillenr/hb0370.pdf>. The legislation specifically requires that *CHIP*'s contract with health plans include risk sharing provisions in which the health plan must accept at least 75% of the risk for any difference between the department's premium payments per client and actual medical expenditures.

CHIP pays each health plan an individually negotiated per member per month (PMPM) premium that is based on health plan encounter data and updated annually. At the time of our site visit Molina and Select Health were paid on average \$110 and \$144 PMPM, respectively. According to informants, the discrepancy between the plans' rates is due to differences in underlying encounter data—i.e., Select Health enrollees are higher-cost and use more services when compared to Molina enrollees.

Health care providers interviewed for this study had generally positive views of *CHIP* health plans, reporting that the plans are well respected, pay claims in a timely manner and—especially in the case of Molina—are willing to negotiate with some providers for reimbursement rates that are higher than the Medicaid fee schedule. The plans typically pay providers on a fee-for-service basis. Providers' chief complaint with the health plans involved the administrative burdens associated with participating as a network provider in multiple *CHIP* and Medicaid managed care plans, each with its own unique set of rules, forms, and processes.

Focus Group Findings: Selecting a health plan

While some parents in our focus group had prior knowledge of the available health and dental plans under *CHIP*, many arbitrarily selected a plan during the enrollment process.

"I switched my son to Select [Health] because there's certain providers that are covered."

"Eenie, meenie, miney, mo...didn't know, didn't care."

"After my kids were on it, I did find out about some differences [between the health plans]...I made a good choice, but I didn't know I was making a good choice at the time. I just kind of got lucky."

CHIP health plans provide all medical, behavioral, and pharmacy services to enrollees. Dental care is the only service excluded from health plans' coverage responsibilities. *CHIP* has always had a dental carve-out, and for more than a decade (1998-2010) dental services for all enrollees were provided by PEHP. When *CHIPRA* was enacted, however, program officials determined that the provider network and benefit structure of the PEHP dental plan did not meet the law's new requirements. In 2010, therefore, the program awarded risk-based contracts to two commercial dental plans—DentaQuest (operating only in the four-county Wasatch Front region) and Premier Access (operating statewide). *CHIP* pays dental plans a monthly capitation rate adjusted for geography—the average rate was roughly \$20 PMPM at the time of our site visit. According to key informants, some dentists were unhappy about the transition from the state-administered PEHP to privately-run dental plans because the private plans have reduced payment rates to certain providers—particularly pedodontists—and employ more stringent utilization review and shorter timely filing periods. Dentists have continued to participate in *CHIP*, however, and most informants agreed that transitional issues have generally subsided.

CHIP enrollees can choose their health and dental plans at the time of application or after eligibility is approved. DWS also conducts voluntary *CHIP* orientation classes on a regular basis, during which new enrollees can get assistance with plan selection. Enrollees that do not select a plan are auto-assigned using a formula that distributes enrollees equally between plans. According to key informants, most families make a plan selection based on the plans' respective hospital networks, and appear to be satisfied with their health plans; fewer than five percent switch plans during the health plans' annual open enrollment periods. Enrollees also have the option to select a primary care physician (PCP) at the time of health plan enrollment; once again, one is assigned to enrollees if they don't proactively select one, based on past relationships or geography. Plan representatives described PCP selection as a "soft requirement" since *CHIP*

members in either plan can visit any PCP or specialist they like; though referrals are encouraged by the plans, they are not required.

Access. Key informants thought *CHIP* enrollees' access to physical and behavioral health services was good. Health plans must comply with *CHIP*'s network adequacy requirements (e.g., provider to enrollee ratios) and both plans have broad networks that span almost the entire state and collectively include all the major hospital and health systems. Still, a few informants suggested that Select Health enrollees have better access to providers than their Molina counterparts because Select Health pays higher reimbursement rates that are more aligned with commercial rates, while Molina uses its Medicaid fee schedule for *CHIP*.

Though access to dental care was also generally described as good—especially when compared to Medicaid—some informants thought that it might be difficult for *CHIP* enrollees to find a participating dentist in their area. Both dental and health plan representatives noted that access limitations are most pronounced in Utah's frontier counties, where it is particularly challenging to create adequate networks for *CHIP* or any other insurance plan (commercial or public) because very few providers reside there. All *CHIP* plans (health and dental) are contractually required to include the state's FQHCs in their provider networks, though informants suggest that these safety net providers play a much larger role in delivering care to uninsured and Medicaid beneficiaries than to *CHIP* members, who more often receive care in a private practice setting. Nonetheless, state officials reported that FQHCs had benefited from the *CHIPRA* requirement that state *CHIP* programs use the cost-related prospective payment methodology that Medicaid uses to reimburse its FQHCs.

In general, key informants were more concerned about access to care in Medicaid than *CHIP*, particularly with regard to dental and specialty care. Fewer providers participate in Medicaid because the program pays lower reimbursement rates. At the same time, some suggested that provider participation in Medicaid is higher than in many other states because Utah's provider workforce is more inclined to provide Medicaid services as a form of "charity care" and giving back to the community. Both *CHIP* health plans participate in Medicaid managed care—Molina has a Medicaid plan, and Select Health currently leases its provider network to Medicaid but will operate its own Medicaid plan starting in 2013. Though Medicaid managed care provider networks are somewhat more limited than those in *CHIP*, there is considerable overlap

Focus Group Findings: Access to care

Parents with children enrolled in *CHIP* and *UPP* were very happy with the primary care providers serving their children, including both the availability of providers and the quality of care their children were receiving.

"They just sent me a list of the different providers, and it was a big list."

"They have a lot of providers...you can just go online [to] find the providers. That was helpful."

*For some parents, however, finding a quality dentist or specialist was more difficult, particularly in rural areas where there were fewer choices. Those enrolled in *UPP* had no difficulties accessing dental or specialty providers, although many needed a referral before seeing a specialist.*

"There wasn't a choice. It was dentist or no dentist."

"There's a lot of dishonest dentists here in Logan, and I've been to one of them."

*"It took me awhile to find a dentist... I called like probably ten places and they were like, oh no, we don't cover [*CHIP*]."*

"We've seen one specialist, and I don't remember needing a referral...he's very accessible, easy to get if I need him."

"[The specialists] have been amazing...I think they're top of the line in their field."

"I couldn't get any specialists to see her at all [in Logan]...we were forced to go down to Salt Lake."

between the two. This promotes continuity and coordination of care for “mixed” families with children in both Medicaid and *CHIP*, and for families whose children transition between the two programs because of changes in income or family size.

Quality. *CHIP*’s contracts with managed care plans have always included requirements to collect and report data on health care quality and enrollee satisfaction. Both health and dental plans regularly submit the full set of Healthcare Effectiveness Data and Information Set (HEDIS®) measures to the state, though only a few of these are reported publicly via program annual reports and the federal CHIP Annual Reporting Template System (CARTS). Of the 24 CHIPRA quality measures that states were asked to submit voluntarily in the FY 2010 CARTS reports, Utah reported on just three, whereas the median state reported seven measures (Sebelius, 2011). However, state program officials expect *CHIP* to begin reporting on additional CHIPRA quality measures in the coming years as a result of Utah’s CHIPRA quality demonstration project (described below). The three measures that *CHIP* reports currently are: 1) well-child visits in the first 15 months of life; 2) well-child visits for children in the 3rd, 4th, 5th, and 6th years of life; and, 3) children’s access to primary care practitioners. According to *CHIP*’s most recent annual report, in 2010 the program exceeded the national average for access to PCPs but fell below the average in both well-child visit indicators (Utah CHIP, *Annual Report 2011*).

CHIP plans also survey enrollees annually on their access to and satisfaction with health care using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) tool. Though CHIPRA included a new requirement that all CHIP programs use CAHPS beginning in 2014, Utah’s program has always required this of participating health plans. The state is trying to encourage meaningful use of HEDIS and CAHPS data from *CHIP* and other health insurance programs (public and commercial) through a consumer-friendly website called Utah HealthScape, which includes a tool to compare plans and providers across summary measures of health care quality and access. HealthScape’s administrator is currently conducting trainings for community-based organizations across the state on how to help families use the website to select plans and providers based on cost and quality.⁴

The CHIPRA provision requiring all CHIP managed care programs to engage an independent External Quality Review Organization (EQRO) entailed a change for Utah’s program, as the state had previously handled CHIP quality monitoring in-house. *CHIP* decided to merge its EQRO process with that of the Medicaid managed care program, using HCE Quality Quest as the contractor. As part of the EQRO process each health plan must conduct its own pediatric-focused performance improvement project, but *CHIP* does not have any “pay-for-performance” quality improvement programs. Uncertainty about *CHIP*’s future makes officials reluctant to implement this type of effort; as one program official explained, “It’s hard to put effort into those initiatives if, in two years, the program goes away or, a year from now, a large chunk of [*CHIP*] children go to Medicaid.”

Several different patient-centered medical home (PCMH) efforts are underway in Utah, mostly in the public sphere. Medical homes are a cornerstone of the state Medicaid program’s Accountable Care Organization initiative, as each Medicaid client will have access to a PCP

⁴ The Utah HealthScape website is: <http://utahhealthscape.org>

responsible for coordinating care within the ACO provider network. FQHCs across the state are also pursuing national PCMH certification. The PCMH concept is also central to Utah's CHIPRA quality demonstration grant, a five-year \$10.3 million grant awarded in 2010 to develop (in partnership with Idaho) a regional quality system guided by the medical home model. The demonstration is focusing on ongoing improvement of health outcomes for children and youth with special health care needs through the use electronic health records, health information exchanges, and other health information technology tools. As part of its medical home activities, the two states will pilot a new administrative service using medical home coordinators embedded in primary and sub-specialty care practices (Sebelius, 2011).

Utah boasts a high rate of electronic health record (EHR) adoption, and key informants described the state as "far ahead" in terms of using health information technology to connect providers. The primary example of this is the state's Clinical Health Information Exchange (cHIE), which was launched in 2011 and currently includes the state's four major health and hospital systems as well as a growing number of clinics, rural hospitals, and independent practices. It is also notable that Utah was one of just two states with full EHR adoption in its FQHCs in 2011.

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VI. COST SHARING

Utah designed its separate CHIP program to resemble a private insurance product, and as such includes cost sharing. Unlike most states, however, Utah goes beyond imposing monthly premiums and copayments to also charge deductibles and coinsurance.⁵ All cost sharing varies based on families' income level.

As illustrated in Table VI.1, there are three tiers of cost sharing in *CHIP*: Plans A, B, and C. Families with incomes below 100 percent of federal poverty level are enrolled in Plan A and are excluded from paying premiums, deductibles, and coinsurance, but do have to pay copayments on a limited number of services. For example, copayments range from \$3 for a doctor visit and \$1 to fill a prescription. Children enrolled in Plan B, in families with incomes between 101 and 150 percent of poverty, face slightly higher copayments (e.g., \$5 for a doctor visit and \$5 to fill a prescription) in addition to a \$30 quarterly per family premium, a \$40 per family deductible, and 5 percent coinsurance on a range of services. Plan C was designed by policymakers to represent a "bridge between public and private insurance" and to acclimate enrollees to the levels and types of cost sharing that they would encounter in private-sector health plans. As a result, Plan C families with incomes between 151 and 200 percent of poverty face substantially higher copayments (e.g., \$25 for a doctor visit and \$15 to fill a prescription) and coinsurance levels (e.g., 20 percent), as well as \$75 quarterly per family premiums and deductibles of \$500 per child up to a maximum of \$1500 per family.

Currently, *CHIP* premiums can be paid by mail, phone, or online. Over the last several years, some improvements have been made to the DWS premium collection process, including the ability to pay online. In 2010, DWS began staggering collection of families' quarterly premiums, spreading the collection process over the entire quarter instead of at the end of each quarter—this administrative change prevents a "crush" of premium payments from all enrollees in the same month, and reduces the potential for error at DWS. Although this has led to better retention rates, the premium collection still presents a challenge to families in *CHIP*. According to many informants, the premium collection process, rather than the cost of the premiums themselves, is responsible for the majority of case closures. For example, Utah does not allow premiums to be automatically deducted from family bank accounts, thus parents must proactively make their payments each month. However, informants told us that many families overlook the premium payment notices because they look like other DWS notices, causing them to miss their payment deadline. In addition to advocating for a newly designed premium notice that won't be so easily missed, advocates in the state are also pushing for policy change that would allow automatic payment deductions to further simplify the premium payment process and improve retention in the program. The State does have a 30-day grace period for nonpayment of premiums before closing a case. However, Utah does not have a lock out period, allowing cases to be re-opened immediately once a premium is paid.

⁵ Utah and Louisiana are the only two states that impose premiums, copayments, deductibles, and coinsurance.

Table VI.1. Cost Sharing in Utah's CHIP Program

Program	Income Level	Premium/Child/Year	Copayments	Deductibles and Coinsurance
<i>CHIP Plan A</i> ⁶	Up to 100% FPL	\$0	\$3 doctor visits, specialty visits, ER visits; \$50 inpatient hospital; \$1 generic and preferred drugs	No deductible or coinsurance
<i>CHIP Plan B</i>	101-150% FPL	\$30/family/quarter	\$5 doctor visit/specialty visit, ER visits; \$150 plus deductible for inpatient hospital services; \$5 generic drug	\$40 family deductible; 5% of approved amount for various services including ambulance, surgery, and medical equipment
<i>CHIP Plan C</i>	151-200% FPL	\$75/family/quarter	\$25 doctor visits; \$40 specialty visits; \$300 ER visits; \$15 generic drug	\$500/child, \$1500/family deductible; 20% of approved amount for various services including outpatient hospital, ambulance, surgery, and medical equipment
Medicaid	<133% of the FPL: ages 0-5 <100% of the FPL: ages 6-19	\$0	\$0	No deductible or coinsurance

Providers are responsible for collecting copayments and retain the money they collect as part of their reimbursement. However, informants reported that many providers in the state do not collect copayments from families, particularly in hospitals when Plan C families can't afford to pay the \$300 emergency room copayment. The federal CHIP law stipulates that total annual cost sharing for any child cannot exceed five percent of family income. In Utah, families are responsible for keeping track of their out-of-pocket costs through the "shoebox" method" by saving all receipts related to cost sharing. State officials reported that, in 2011, there were 110 *CHIP* families who reached this cap. They suggested that more families likely reach and exceed the maximum, but are unaware of the 5 percent limit.

⁶ Utah is one of few states with an asset test for children in Medicaid. Children enrolled in Plan A are those who would otherwise be enrolled in Medicaid, but are ineligible due to assets, and are therefore enrolled in CHIP and as such, do face cost-sharing.

Since the implementation of *CHIP*, cost sharing levels have increased several times. Since the state adopted a commercial benefit package benchmark for *CHIP* in 2008, for example, (described in the *Benefits* section, above) cost-sharing levels have been updated annually to maintain actuarial equivalence with the benchmark, which keeps them closely aligned with cost sharing in the private market. Although some informants felt that cost sharing levels were fair, others worried that they were becoming “quite expensive” and might begin posing barriers to service use, initial enrollment, and retention. One informant acknowledged that, as premiums continued to rise for Plan C, the potential for adverse selection could rise as families drop coverage when their children are healthy, and then re-enroll in *CHIP* only when they needed medical care. On the other hand, key informants uniformly believed that families in Utah appreciate paying for a portion of their children’s insurance coverage as it gives them a sense of responsibility and pride. Parents participating in our focus groups generally confirmed that they appreciated being able to contribute to their child’s health coverage and felt that *CHIP* was affordable, particularly when compared with the cost of private coverage.

Focus Group Findings: Cost sharing

Parents in our focus group felt that *CHIP* premiums, copayments, and deductibles are affordable and fair. All of the parents asserted that they were happy to contribute to their health insurance, often making references to the absence of cost sharing in Medicaid.

“It feels very fair to me....because if it wasn’t affordable, they wouldn’t have coverage.”

“I would be willing to pay more. I’m so grateful to have it.”

“I think when you have to pay for it; it makes you more grateful for it, instead of something that you just get. Like when we had Medicaid, I didn’t even really think about it.”

“I think it’s good to keep that awareness of even though what you’re putting in...doesn’t cover the cost...you’re still contributing.”

*“[Under *CHIP* you have] your deductibles and your co-pays, which I don’t mind because I don’t like freeloading...off the state. So it makes me feel like I’m kind of doing something right.”*

“We’re working hard. We’re trying to earn this money. We’re paying towards this insurance; even though it’s a miniscule amount toward what they get out of it...I’m not just getting a handout.”

Conversely, parents enrolled in UPP faced high deductibles, copayments, and coinsurance that often created barriers to service use.

“We’re basically paying out of pocket for everything and the insurance is there for a catastrophe.”

“You think twice about going to the doctor. You make sure your child is very sick.”

“It’s hard. I never thought I’d be in this position, to have to think about whether to go to the doctor or not. I hate it.”

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VII. CROWD OUT

Utah has had several policies in place since the start of *CHIP* to protect against crowd out. First, the state imposes a 90-day waiting period before a child can enroll in *CHIP* when private coverage is terminated voluntarily. A child may be exempt from this waiting period if they were involuntarily terminated from an employer-sponsored insurance plan. Other exceptions are made for voluntary termination of:

- COBRA coverage
- *HIPUtah* (Health Insurance Pool) coverage
- Coverage by a non-custodial parent
- *UPP* reimbursed, employer-sponsored coverage
- A health plan that does not operate in Utah

In 2008, the Utah legislature passed the Health System Reform bill that, among other things, increased the waiting period for *CHIP* to 6 months. Notably—and despite objections by the advocacy community—the provision did not include an exception for families who lose their private coverage because it becomes unaffordable. Ultimately, however, this change was not approved by CMS because it was judged to violate maintenance of effort rules. In addition to imposing the 90-day waiting period, DWS works to prevent crowd out by screening the health insurance status of all applicants. The application includes several questions for parents on present and past coverage, as well as a section to be completed by employers regarding the availability of employer-sponsored insurance. Children who have access to employer-sponsored insurance that costs less than 5 percent of a family’s annual income are ineligible for *CHIP*. If the employer-sponsored insurance costs more than 5 percent of a family’s annual income, the child is eligible for Utah’s premium assistance program, *Utah Premium Partnership (UPP)* (discussed in more detail below). Families found to be eligible for *UPP* and *CHIP* are permitted to choose between the two programs during the enrollment process.

Finally, over the last several years, cost sharing levels in *CHIP*, particularly those in Plan C, have risen to closely resemble those found in private coverage. The higher cost sharing levels are seen as another tool to deter working families with higher incomes from dropping their children’s private coverage and switching to public coverage.

Informants held mixed opinions on the presence of crowd out in Utah. As one informant noted, it is possible that some families choose to enroll in public coverage, even if they have access to employer-sponsored insurance, because benefits offered under *CHIP* may be perceived as more comprehensive (e.g., by including dental coverage). On the other hand, there has been no quantitative evidence of crowd out occurring since enrollment was opened on a year-round basis, and most informants felt that it has not been a problem in Utah given the safeguards in place. Recently, however, there has been renewed interest in crowd out as the state debates whether or not to adopt the Medicaid expansion option under the ACA.

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VIII. UTAH PREMIUM PARTNERSHIP

Since the inception of CHIP, Utah legislators have looked for ways to bridge public and private coverage. In 2002, the State used Medicaid Section 1115 waiver authority to establish the Primary Care Network (PCN) program. PCN, which is still in existence today, provides uninsured adults with incomes under 150 percent of FPL with limited coverage of basic primary care services. In 2003, the State created a Medicaid-funded premium assistance program, Covered at Work, using the same 1115 waiver authority. Covered at Work targeted adults who were eligible for PCN, but who did not qualify because they were offered private coverage through their employers. By helping to subsidize the cost of employer-sponsored insurance, the state hoped to encourage participation in private coverage. However, the program's low payment rate (\$50 per month) was often not sufficient to cover the cost of premiums and led to low participation in the program; by 2005, only 71 people were enrolled in Covered at Work.

The legislature replaced Covered at Work with the Utah Premium Partnership (UPP) in 2006. While several aspects of the program remained the same, such as the adult eligibility level of 150 percent FPL, the state made several notable changes in an attempt to improve it. Most important, the state chose to use Title XXI funding to expand UPP to children under 200 percent of FPL. Payments to families enrolled in UPP were also raised to stimulate increased enrollment. Adults now receive \$150 per month to help with the cost of ESI (funded through Medicaid), while the size of the CHIP-funded subsidy for children depends on whether or not the child has dental coverage through the employer-sponsored insurance plan. If dental coverage is provided, a family receives \$120 per child per month; if not, the reimbursement drops to \$100 per month and the child is eligible to enroll in CHIP dental coverage. Families are responsible for any additional costs of their health and dental insurance, including coinsurance, deductibles, copayments, and any remaining monthly premium.

Despite these changes and improvements to the original program, informants still contend that UPP is underutilized, and enrollment data appear to confirm this contention. In 2011, there were 393 children enrolled in the program, and roughly 200 adults. Informants reported that several different factors contribute to this low enrollment. First, the UPP program is not well understood or widely advertised. Due to budget constraints, DWS has been unable to conduct any large-scale outreach for UPP. Although the state did provide a UPP training for insurance brokers, informants did not believe that brokers were actively promoting the program and said that many employers remain unsure of how the program works.

Key informants also asserted that a confusing and strict eligibility process likely contributes to low enrollment. Currently, children and adults have different eligibility levels—150 percent and 200 percent, respectively—which can prevent parents who are ineligible from applying on behalf of their children. In addition, an individual applying for UPP must be uninsured for 90 days prior to the time of application and must apply for the program before their employer-sponsored health benefits start. However, many people are prompted by their employers to sign up for health insurance benefits immediately when they begin a new job, which makes them ineligible for UPP. Furthermore, the employer must pay at least 50 percent of the employee's premium costs and the ESI plan must:

- Cover physicians' visits, well child exams, hospital inpatient services, child immunizations and pharmacy;
- Have a deductible of no more than \$2,500 per person;
- Have a lifetime maximum of at least \$1,000,000;
- Pays at least 70 percent of inpatient costs after the deductible; and
- Exclude coverage for any abortion services except in cases of rape, incest, or where the mother's life is endangered.⁷

Some parents participating in our focus groups expressed frustration that the latter requirement regarding abortion coverage had limited their plan choices. These parents suggested that despite having multiple plan options available through their employer, few (and sometimes only one) of those options qualified for UPP because of the program's restrictions on abortion coverage. *For instance, one parent noted, "In talking with my caseworker...she said, yes, you can pick any one, but if you want to remain on UPP, you have to pick that one...[because of] the abortion rule."*

If an individual qualifies for UPP, they are required to complete the universal application that allows DWS eligibility workers to also screen for standard CHIP and Medicaid eligibility. If a child is found to be eligible for CHIP, the eligibility worker will contact the family to see whether they prefer CHIP or UPP. Informants reported that the majority of families will choose UPP because it allows the entire family to be covered under the same plan. Parents participating in our focus group concurred that they prefer enrolling their entire family in private coverage, and thus most often select UPP over CHIP.

Despite some challenges to the program, informants were satisfied with UPP and applauded its availability as an alternative to full public coverage. Some informants also believed that UPP saved money compared to standard CHIP coverage, by setting fixed premium subsidies below the cost of providing direct coverage and by giving the state budget certainty. Moreover, many informants felt that UPP could have an important role in the future of health reform if the state decided to not expand Medicaid, as it could provide low-income families another option for more affordable coverage.

⁷ In April 2010, the Utah Department of Health concluded that an existing federal and a state law limiting when public funds can be used to pay for abortion services applied to the UPP. Since then, UPP subsidies have been restricted only to plans that do not provide abortion coverage in circumstances greater than when a pregnancy is caused by rape or incest, or when the pregnancy threatens the life of the mother.

IX. FINANCING

With the passage of CHIPRA, federal funding for CHIP was extended through 2013. The ACA then extended that funding for two more years, through 2015. CHIPRA set new total annual allotments for the program and also revised the formula for calculating state-specific allotment amounts. This new method for determining state allotments was designed to account for states' actual and projected spending, adjusting for inflation and child population growth, rather than focusing on each state's share of uninsured/uninsured-low-income children, as was previously the case. Drafters of the rule changes believe that it will lead to more appropriate distribution of CHIP funds at the beginning of each year and avoid the need for massive re-allocations of funds from states unable to spend their allotment at the end of each year.

During the first few years of *CHIP*, Utah received larger federal allotments than it could spend. In 2001, however, Utah outspent its federal allotment for the first time, causing the state to cap program enrollment at 24,000 enrollees. The cap was raised twice after that; in late 2002 to 28,000 and again in 2005 to 40,000 enrollees. In 2008, as discussed above, the legislature removed all enrollment caps and authorized continuous, year-round enrollment in *CHIP*, transforming the program in the eyes of the public. At the same time, Utah saw a 58 percent increase in its federal CHIP allotment—from \$41.3 to \$65.3 million—as a result of CHIPRA's new allotment formula, helping to offset the increased cost of continuous enrollment. Since the inception of *CHIP*, Utah's share of funding has remained fairly constant at around 20 percent. Utah's CHIP Allotments and Expenditures from 2006-present can be seen in Table IX.1.

In recent years, as a result of the Great Recession and shrinking state revenues, the state budget for *CHIP* has come under increasing pressure. Utah's portion of the tobacco settlement fund provides approximately \$10.5 million annually to support the state share of *CHIP*. In the past, an additional \$2 to \$3 million was set aside from the tobacco settlement fund as discretionary funding for *CHIP*. Over the last several years, the tobacco settlement fund has decreased, eliminating the potential for additional discretionary funding for *CHIP*. At the same time, federal maintenance of effort requirements included in the ARRA and the ACA have locked the state into the open enrollment period it adopted in 2008, and forced the state legislature to "step up and fill the gap with the general fund." In the last session, the legislature allotted \$2.6 million from the general fund to offset the loss in tobacco settlement discretionary funding.

Table IX.1. CHIP Allotments and Expenditures (in millions of dollars)

FFY	Federal Allotment	Federal Expenditures	Federal Matching Rate
2006	\$32.2	\$45.3	79.53
2007	\$40.5	\$38.9	79.10
2008	\$41.3	\$50.3	80.14
2009	\$65.3	\$55.6	79.50
2010	\$69.9	?	80.18
2011	\$63.9	?	79.79
2012	\$67.8		79.69

Like many states, Utah has had to impose budget cuts across public programs over the last several years. Although CHIP enjoys relative security in Utah, particularly compared to Medicaid, the state has made several efforts to cut costs within the program. Several informants reported that saving money was the motivation behind many of the recent changes to the program, including the simplification and streamlining of enrollment processes at DWS and the decision to put the health plans offered in *CHIP* out for competitive bid. In addition, the outreach budget for *CHIP* has been almost completely eliminated, pushing the burden of outreach onto community based organizations and health plans. Utah also raised premiums for the highest income enrollees, in Plan C, in an attempt to increase revenue for *CHIP*. In the coming year, state officials plan to apply for Utah's first CHIPRA performance bonus. Informants were hopeful that the bonus would provide additional relief to the *CHIP* budget.

X. PREPARATION FOR HEALTH CARE REFORM

Utah's response to the Affordable Care Act has been largely framed by political opposition. Immediately after the federal health reform law was passed in March 2010, Utah enacted a law prohibiting implementation until state agencies could complete a careful analysis and report to the state legislature on the potential impacts of the ACA on Utahans and the state's own healthcare reform efforts. Utah was also among the 26 states that challenged the constitutionality of the ACA in the case decided by the Supreme Court in June 2012, and both Governor Herbert and a number of state legislators have publicly criticized the law. Key informants interviewed for this case study agreed that many political leaders in Utah remain hopeful that the ACA will be repealed if Republicans gain control of the presidency and the U.S. Senate in the upcoming 2012 elections—as a result, the state has adopted a wait-and-see approach, putting off most key decisions related to health reform implementation until after the November election. Utah leaders have also been reluctant to accept ACA-related funding out of concern that these financial opportunities invite increased federal oversight. For instance, the state has not pursued health insurance exchange establishment grant funds (though it did accept a planning grant) or Consumer Assistance Program grants, and is one of the only states in the nation that has not yet taken advantage of the temporary enhanced Medicaid funding for ACA-related Medicaid and CHIP eligibility system investments.⁸

As a practical matter, however, Utah has taken some preliminary steps towards ACA implementation. So far, the primary vehicle for ACA-related activity has been the Health System Reform Taskforce, originally established in 2008 to oversee implementation of the state's Health Insurance Exchange for small businesses, and reauthorized in 2011 to evaluate options for bringing the state's Exchange into compliance with the ACA. The Taskforce is currently chaired by a legislator on the CHIP Advisory Committee, and meets regularly to make Exchange and other reform-related decisions. For instance, it recently selected the PEHP Basic Plus Plan for the state's Essential Health Benefit (EHB) package benchmark.

Utah currently operates a clearinghouse-model Exchange for small businesses that—while not ACA-compliant as currently structured—is expected to meet the ACA's Small Business Health Options Program (SHOP) Exchange requirements with minimal modifications. It is less clear how the state will approach establishment of an Exchange for individuals, and debate is ongoing about whether to create a state-based Exchange, adopt a Partnership model with the federal government, or cede Exchange establishment entirely via a federally facilitated exchange model. Most informants expected that, given political leaders' aversion to increased federal involvement in state programs, Utah would adopt a state-based exchange or Partnership model. Moreover, state officials indicated that they were planning as if the state will administer both the SHOP and individual Exchanges itself, but will not “pull the trigger” on a decision to do so until

⁸ States can receive an enhanced Medicaid matching rate (90 percent) for spending to upgrade or overhaul Medicaid and CHIP eligibility systems. This temporary 90 percent match rate is available through 2015, though states will receive a 75 percent match rate to maintain those systems beyond that point. Utah is one of the only states that has not reported plans to use the enhanced federal funding for eligibility and enrollment system investments. See: <http://www.kff.org/medicaid/upload/8312.pdf>

after the November 2012 elections, suggesting that Utah may still be able to meet DHHS' mid-November deadline for state-based Exchange blueprints.

Similarly, Governor Herbert has publicly announced that Utah will not make a decision until post-election about whether to implement the now-optional ACA Medicaid expansion to individuals with incomes up to 133 percent of FPL.

Policymakers are concerned about the costs of such an expansion, despite the

fact that the federal government will pay 100 percent of related costs through 2017, and then 90 percent of costs from 2019 on (after phasing in a 10 percent state share over two years). State officials reason that, even with enhanced federal funding for coverage, Utah will only receive the standard administrative match rate of 50 percent for the cost of administering benefits (e.g., agency staffing and other resources) to the 160,000 additional Utahans who are estimated to enroll if the expansion is fully implemented (Blavin et al., 2012). Further, even without expanding the program, Utah expects to experience a considerable increase in enrollment beginning in 2014 among those who are currently eligible for Medicaid or CHIP but not enrolled, because many of these individuals are expected to come forward when they learn about new coverage options in the individual Health Insurance Exchange, and about the penalty for failing to obtain coverage. Utah has a higher proportion of these eligible but not enrolled individuals than most other states. Given these cost concerns, the state's current fiscal environment, and the lack of political support for the option, most informants thought that Medicaid expansion was unlikely in Utah. There has also been almost no discussion of establishing a Basic Health Plan. Though some advocacy-oriented informants expressed support for a BHP, they acknowledged that it would be a "tough sell" in Utah, particularly in the absence of a Medicaid expansion.

Focus Group Findings: Health reform

Many parents in our focus group had heard about health care reform and were worried about what it meant for them and how it would affect quality.

"I heard that it was going to cover people that don't have health insurance, which I was excited to hear. But I don't know if that's...going to happen."

"I've heard it's going to be like car insurance...people are going to be forced into buying it unless they are under a certain income...and it could be really bad for people."

"I worry that we'll have a lot less options [of providers]."

"The doctors are going to get paid less, and so they're going, why am I going to sit here and spend 40 minutes with you?"

"I hate it because everything run by the government fails."

"I want my own choices, and the freedom to act."

Regardless of whether Utah opts to expand Medicaid, the state must make certain changes to comply with ACA requirements for streamlined, automated, and consumer-friendly eligibility and enrollment processes that are coordinated across Medicaid, CHIP, and the Exchange. Even prior to the ACA, Utah had taken strides to automate the eligibility and renewal processes for Medicaid and CHIP, spending an estimated \$100 million on its eREP system (described in greater detail in the *Eligibility and Enrollment* section) over the past several years. Unlike many other states, Utah already uses rules-based software and electronic verification processes for Medicaid and CHIP. The state will launch plans to update the system rules to comply with the ACA requirements (e.g., using Modified Adjusted Gross Income—MAGI—to determine eligibility, and eliminating the asset test) once a decision about the Medicaid expansion is made. Overall, informants felt that Utah was in "good shape" in terms of establishing a fully automated eligibility and enrollment system that can make real-time eligibility decisions by 2014.

It seems likely that the existing Medicaid and CHIP rules-based system will also be used to determine eligibility for Exchange-based health insurance subsidies. Though a firm decision about this will only come after Utah decides whether to establish a state-based Exchange, state officials felt strongly that the Exchange should not create a duplicate system. It is possible, however, that the Exchange will have its own web-based portal separate from the one used for Medicaid and CHIP. Regardless of which portal an application comes through, DWS (and Exchange eligibility workers, if separate from DWS) will screen and direct applications to the correct program behind the scenes, in compliance with the ACA's "no wrong door" requirement.

Exactly how *CHIP* will fit into the Utah coverage landscape in 2014 (and beyond) is unclear. On the one hand, key informants described the program as quite popular among legislators, who find *CHIP* appealing because it resembles private coverage (with requisite cost-sharing) and is focused on children. For this reason, some found it hard to imagine that there would be much support for dismantling *CHIP* in the post-health reform world. But many others thought that, as a practical matter, the state must consider whether it is administratively efficient to continue operating *CHIP*—and whether health plans will still want to participate in the program—given expected large reductions in enrollment in the near future. When Utah eliminates its Medicaid asset test to comply with ACA requirements in 2014, some current *CHIP* enrollees will be transferred to Medicaid. Moreover, regardless of whether the state opts to expand Medicaid, the ACA stipulates that *CHIP* enrollees with family incomes below 138 percent of the FPL (i.e., those between 101-138 percent of the FPL) must be transitioned to the Medicaid program. Together, both ACA provisions have the potential to reduce *CHIP* enrollment from its current level of around 38,000 children to only roughly 10,000 children.⁹

Program officials noted that the state could transition to a Medicaid-expansion CHIP model in the future, which would alleviate the burden of administering a small separate program with an entirely different benefit structure. Policymakers, however, may be unwilling to support moving higher-income beneficiaries currently subject to private sector-like cost sharing into Medicaid, where cost-sharing is prohibited. A more politically palatable option, according to informants, might be to transfer *CHIP* enrollees to private subsidized coverage in the Exchange. This would effectively eliminate *CHIP* but, if Exchange coverage is more affordable than *CHIP*, could be more beneficial for families. Moreover, uninsured parents of *CHIP* enrollees are likely to be eligible for Exchange subsidies, and families might prefer being covered wholly under the same program, in a single health plan. Though a number of informants noted these potential advantages of covering children through the Exchange instead of *CHIP*, some also shared concerns that children's needs may not be met as well by Exchange-participating plans as they are in *CHIP*, a program designed specifically for children.

⁹ At the same time, some children currently in Medicaid may transition to *CHIP* because of ACA-required changes to the methodology used to determine eligibility for the programs (i.e., family income will be counted differently and for some children, may be higher than it is under current methodology). For a more detailed discussion of how this would work in another state with a separate CHIP program (California) see: Stan Dorn. *The future of Healthy Families: Transitioning to 2014 and beyond*, The Urban Institute, February 2012, <http://www.urban.org/uploadedpdf/412508-The-Future-of-Healthy-Families-Transitioning-to-2014-and-Beyond.pdf>

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X. CONCLUSIONS AND LESSONS LEARNED

Utah's *CHIP* program is quite popular in this very conservative state, primarily because it is child focused, but also because it is modeled after private insurance, not Medicaid. Historically, the program has enjoyed considerable bipartisan support from policymakers, is well regarded by health care providers and plans, and is very much appreciated by families with children. *CHIP* was not heavily impacted by CHIPRA, and state officials described generally smooth transitions in response to the law's protections (see Table X.1). However, in the opinion of some state officials interviewed for this study, recent federal law changes made *CHIP* "more like Medicaid" in that it imposed more uniformity, and thus perceived that some of the program's political support has eroded. How these factors will combine to affect *CHIP* as the ACA is implemented is unclear at this time.

Other conclusions and lessons learned from this case study of Utah's *CHIP* program include:

- ***Utah's automated, integrated eligibility system is a model that has promoted increased multi-program participation and broad access via the Internet.*** Key informants universally praised most aspects of the accessible, attractive, rules-based and user-friendly eREP system, and believed that the Department of Workforce Services had done a good job of rolling out this new system with minimal "bugs" or disruptions.
- ***The lack of available hands-on applications assistance, however, was seen as a major gap in the CHIP and Medicaid enrollment and renewal process.*** While eREP was seen as increasing access to public assistance for the roughly three-quarters of Utahans with facility with IT and access to the Internet, the new system was viewed as equally inaccessible to the one-quarter of residents who are more disadvantaged, face geographical or language barriers, who do not have reliable Internet access, who could benefit from hands-on assistance in completing applications for children's health coverage. CHIPRA Outreach Grants supported important, short-term efforts to provide such assistance, but informant widely agreed that families with children eligible for CHIP and Medicaid would greatly benefit from having more application assistance resources available to them. Whether Utah officials will place a priority on these needs, especially given current budget conditions, seems unlikely however.

Table X.1. Utah's Compliance with Key Mandatory and Optional CHIPRA Provisions

Provision	Implemented in Utah?
Mandatory CHIPRA provisions	
Mental health parity required for States that include mental health or substance abuse services in their CHIP plans by October 1, 2009	Yes
Requires States to include dental services in CHIP plans	Yes
Medicaid citizenship and identity documentation requirements applied to Title XXI, effective January 1, 2010	Yes
30-day grace period before cancellation of coverage	Yes
Apply Medicaid prospective payment system to reimburse FQHCs and RHCs effective October 1, 2009	Yes
Optional CHIPRA provisions	
Option to provide dental-only supplemental coverage for children who otherwise qualify for a State's CHIP program but who have other health insurance without dental benefits	No; children enrolled in <i>UPP</i> , however, can purchase dental coverage through <i>CHIP</i> if it is not covered under their employer-sponsored insurance
Option to cover legal immigrant children and pregnant women in their first 5 years in the United States in Medicaid and CHIP	No
Bonus payments for those implementing five of eight simplifications	No; will be applying for bonus payment in October 2012—no asset test for CHIP/asset simplification for Medicaid; joint application Medicaid and CHIP; presumptive eligibility, continuous eligibility CHIP, no interview; simplified renewal
Contingency funds for States exceeding CHIP allotments due to increased enrollment of low-income children	No
\$100 million in outreach funding	One grantee has received CHIPRA outreach grant funding
Quality initiatives, including development of quality measures and a quality demonstration grant program	In the Federal FY 2010 CARTS report, 3 voluntary quality performance measures were reported

- Lack of outreach is another gap that contributes to less-than-optimal participation in CHIP and Medicaid among eligible children.*** Utah was justifiably proud of past investments in statewide outreach and marketing for its state maternal and child health programs. CHIP, in fact, benefited from significant and ongoing marketing during its first decade or more. With the economic downturn, however, outreach funding was cut and most key informants believed that program enrollment was suffering as a result. Parents participating in our focus groups generally confirmed that the program did not seem well advertised, or as well known to families as it “should” be.
- Overall, parents and other key informants described CHIP benefits as comprehensive and as meeting enrollees’ needs.*** Though there have been several modifications to the benefit package over the past several years—primarily related to the program’s adoption of new commercial health plan benchmarks for CHIP medical and dental coverage in 2007 and 2009, respectively—these changes appear to have been relatively minor and were implemented with few challenges or concerns. An exception is the program’s recent restrictions on orthodontia, which negatively

affected a number of families with children who had already begun orthodontia treatments.

- ***Utah’s commitment to modeling CHIP after a private insurance product, coupled with budget shortfalls, have led to several increases in premiums and copayments, and the imposition of deductibles and coinsurance.***

Both key informants and families worried that the heavy cost sharing burden in CHIP was beginning to discourage enrollment and

service utilization, particularly for families enrolled in Plan C. Despite these concerns, cost sharing requirements were still viewed as a positive facet of CHIP that gave families a sense of responsibility and distinguished the program from Medicaid.

- ***The expansion of Utah Premium Partnership was seen by many as a positive change that would allow families in Utah to remain in the private insurance market and lead to savings within CHIP.*** However, confusing eligibility and enrollment requirements, as well as a lack of outreach and education, have led to relatively low program enrollment and no conclusive savings. State officials predicted that UPP will likely grow in upcoming years due to changes being implemented under health reform efforts.
- ***The recent exit and entry of different health and dental plans into the CHIP market—a direct result of Utah’s 2008 decision to contract only with risk-bearing managed care organizations—were major program changes in an administrative sense, but did not lead to disruptions in care continuity for families.*** One longstanding participant, the Public Employees Health Plan, exited the CHIP market in 2010, but the replacement health plan (Select Health) used a very similar provider network. The entry of two risk-based, national, dental MCOs into the CHIP market (also in 2010) resulted in more significant changes in service delivery—including tighter utilization controls and some reductions in dental provider reimbursement—but transitional issues have generally subsided.

Focus Group Findings: Conclusions

Parents with children enrolled in CHIP and UPP were unanimous in their appreciation for having health insurance for their children.

“It’s everything.”

“If every dime was going to health, you couldn’t do anything else for them. CHIP is...one of the greatest blessings, and it’s fair, and it’s right, and...it has to keep going.”

“It can give you a sense of freedom in a sense that you’re not so worried...when you’re on insurance of any kind...you feel a little more free to let them go do what they want to do; go let them be kids.”

“It’s really hard to have your kids grow up and be like, no, you can’t have this...and so to know that their health and their well-being is taken care of... I know they’re going to be healthy.”

However, many participants suggested that application assistance could be improved for both CHIP and UPP. In addition, parents in UPP thought that the program could be better advertised.

“Make sure that people who are in the program knew who to contact when there’s a problem.”

“I want to be able to call them and ask them a question and have them answer me...in 10 minutes.”

“I think it would be nice if [there was someone]...you could actually sit down, face-to-face with.”

“[UPP is] presented in a way that makes it feel like it’s welfare, but it’s not. Everybody needs help sometimes.”

- ***CHIP's managed care delivery systems appear to be running smoothly, and informants suggested that enrollees have good access to medical, behavioral and (though somewhat less so) dental care, with the exception of those who live in Utah's sparsely-populated frontier counties where few providers reside.*** In general, key informants were more concerned about access to care in Medicaid than CHIP, which they attributed to the former program's lower reimbursement rates (and resultant lower rates of provider participation). With regard to ensuring high-quality health care, CHIP health and dental plans are contractually obligated to collect and report data on the quality of and satisfaction with the care their members receive. CHIP-participating plans and providers are also actively involved in efforts to promote electronic medical record use as well as the patient-centered medical home concept, including through the state's five-year CHIPRA quality demonstration project that targets children and youth with special health care needs.
- ***Utah has not been very active in implementing key ACA provisions, largely due to political opposition to the federal health reform law.*** With regard to decisions about establishing a Health Insurance Exchange and the optional ACA Medicaid expansion, the state is taking a wait-and-see approach, delaying all official decisions until after the upcoming 2012 elections. At the same time, DOH and DWS officials are moving ahead with planning for changes to Utah's Medicaid and CHIP eligibility systems (already more modern and automated than many states') to meet ACA requirements for streamlined and consumer-friendly eligibility and enrollment processes that are coordinated across Medicaid, CHIP, and the Exchange.

Exactly how CHIP will fit into the Utah coverage landscape in 2014 and beyond, once the ACA coverage expansions take effect, is unclear. Some informants suggested that because of the program's popularity among policymakers and consumers, it is likely to continue operating well into the future. Others thought that, given expected reductions in *CHIP* program enrollment as certain ACA provisions are implemented, it may no longer be efficient to continue administering the program, especially when new Exchange-based coverage options become available. Time will tell what will happen to this popular, effective, and appreciated program.

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APPENDIX A
SITE VISITORS AND KEY INFORMANTS

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Utah Site Visit

August 6-9, 2012

Site Visitors

Urban Institute

Ian Hill
Brigette Courtot
Margo Wilkinson

Key Informants: Salt Lake City

Utah Department of Health, Division of Medicaid and Health Financing

Emma Chacon
Nate Checketts
Aaron Eliason
Michael Hales

Department of Workforce Services

Kevin Burt
Shauna Havey
Mario Kljajo

Governor's Office of Planning and Budget

Cliff Strachan

Voices for Utah Children

Karen Crompton
Lincoln Nehring

Utah Health Policy Project

Judi Hilman
Randall Serr

Molina Health Care of Utah

Amy Bingham
Karen Warren
Nalani Namaau

Select Health

Jesse Liddell

University of Utah, Primary Children's Medical Center

Dr. Charles Pruitt

Indian Walk-In Health Center

Leanna Van Keuren
Victoria Migoli

Oquirrh View Community Health Center

Lynn Partridge
Marcela Cubas

Association for Utah Community Health

Alan Pruhs
Janida Emerson

Utah House of Representatives

Representative Jim Dunnigan

Utah Medical Association

Michelle McOmber

Premier Access

Tyrette Hamilton
Rene Canales

Key Informants: Logan

Department of Workforce Services

Debbie Sparks
Lyle Ward
John Manning

APPENDIX B
APPLICATION

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Please tear off this page and keep for your information.

Application Information

CHIP • PCN • UPP • Medicaid

What Am I Applying For?

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children’s Health Insurance Program):** Provides medical and dental insurance for uninsured children in families who qualify based on family size and income. For more information, visit: www.health.utah.gov/chip
- **PCN (Primary Care Network):** Provides primary preventive health coverage for uninsured adults who qualify based on family size and income. For more information, visit: www.health.utah.gov/pcn
- **UPP (Utah’s Premium Partnership for Health Insurance):** Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer’s health plan or COBRA. For more information, visit: www.health.utah.gov/upp
- **Medicaid:** Provides medical assistance for low-income families, children, pregnant women, and disabled, blind and elderly individuals. For more information, visit: www.health.utah.gov/bep

What Do I Need to Do Next?

- You can turn in the first 2 pages of this application to begin the application process, but you will be asked to provide the information on the rest of the application before we can determine your eligibility for benefits.
- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. **If you have not heard from DWS within 10 days, please call toll free 1-866-435-7414.**
- Fill out this application and return to:
Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 801-526-9500
Toll-free Fax: 1-877-313-4717
- You may be asked to have your employer fill out the “Employer’s Health Insurance Form” (attached). Please keep this form in case you are asked to do so.

Where Can I Get More Information?

- For questions about how to complete the application, your application status, or to find out if you qualify, please access your information online at www.jobs.utah.gov/mycase. If you have questions about how to complete the application or you are unable to access the website, please call DWS at 1-866-435-7414.
- For general questions about the health care services covered by Medicaid or PCN, call the Medicaid hotline at 1-800-662-9651.
- For general questions about CHIP, PCN or UPP, call the Health Information Hotline at 1-888-222-2542.

Information on the cHIE

- Medical assistance (Medicaid, CHIP, UPP, PCN) recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). The cHIE provides a safe place for participating healthcare providers to share and view patient medical information.
- Once your consent status has been set to PARTICIPATE, it will remain in effect for five years or until you turn 18 if you are a minor. Recipients have the right to not participate in the cHIE or to change their consent status at any time. For more information or to opt out of the cHIE participation, visit www.mychie.org or talk to a healthcare provider.

DOH/61MED 4/12

Case #: _____

Application

CHIP • PCN • UPP • Medicaid

A Applicant Information

Name: _____
first (start with yourself) middle initial maiden last

E-mail: (optional) _____

Street Address: _____
street apt. # city state zip

Mailing Address: _____
street apt. # city state zip

Home Phone: (____) _____ Cell/Other Phone: (____) _____

B Household Information

List all the people who live in your home. Start with yourself.

Name (first, m.i., last)	Relation to You	Social Security Number or Legal Alien ID*	Birth Date mm/dd/yy	Sex M/F	Race **	Ethnicity ***	Marital Status ****	Student Y/N	Utah Resident/ U.S. Citizen*
(Start with yourself)	self								<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen
									<input type="checkbox"/> Utah Resident <input type="checkbox"/> U.S. Citizen

*Social Security Number and citizenship information are only needed for the people applying for benefits.
 **Race codes: AI-American Indian/Alaskan Native, AS-Asian, BL-Black, PI-Pacific Islander, WH-White (You may choose more than one.)
 Ethnicity codes: H-Hispanic/Latino, N-Non-Hispanic *Marital status: Single, Married, Divorced, Widowed, etc.

C General Information

Please answer the following questions to help us select the program for your household.

1. How many people in your household are employed? _____
- Yes No 2. Is any adult in your household unable to work? (injury, illness, cancer, kidney disease, etc.)
If yes, explain: _____
- Yes No 3. Has anyone in your household been determined disabled by Social Security?
If yes, who: _____
- Yes No 4. Has anyone in your household been in a jail, hospital or nursing home for 30 days or more within
the last 3 months? If yes, explain: _____
- Yes No 5. Does your household have more than \$3,000 in assets? (Do not include the home you live in.)
- Yes No 6. Has anyone in your household received medical services in the past 90 days?
If yes, who: _____ Dates of Service: _____
- Yes No 7. Is anyone in your household currently pregnant or has been pregnant in the last 90 days?
If yes, who: _____ Due date(s): _____
Has she smoked or used tobacco in the past 6 months? Yes No
(This question is for survey purposes only and does **not** affect eligibility.)
- Yes No 8. Is anyone in your household a legal alien? (This information is only needed for people applying for benefits.)
If yes, who: _____

Yes No 9. Does anyone in your household have a major medical need?
(This includes pregnancy/cancer/kidney disease, etc.)
If yes, who: _____
What is the medical need? _____

D I Understand That:

*The State of Utah (the State) references below include the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- I assure that all household members applying for medical coverage or reimbursement are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. I understand that I do not have to report citizenship information for household members who are not applying for coverage or reimbursement. The State will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). The State will not report undocumented household members to USCIS.
- The State does not discriminate on the basis of race, ethnicity, religion, gender or disability.
- I give permission for any information provided to be verified when I apply and after I receive benefits.
- I authorize the State to give health care providers information about my eligibility for medical benefits. The State may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.
- I must report any changes in my address, phone number, household size and access to coverage by another health insurance program within 10 days.
- The medical benefits I receive are limited to those described in the Provider Manual established for the program, as applicable. I understand that these manuals may be amended without my consent or consideration.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I understand that I am responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.
- If I receive a medical card, I will allow only the people named on the medical card to use the card.
- I must follow the medical assistance program rules. My spouse and/or children, as applicable, also must follow these rules.
- I must cooperate with the States in pursuing any third party responsible for medical expenses.
- I must cooperate with the State to establish medical support for my family, if required, unless I have good cause to not cooperate.
- My benefits may be reduced, denied or stopped because of reported information. I understand that giving any false information or failing to report changes may result in prosecution for fraud. If I receive benefits that I am not eligible to receive, I will be responsible for repaying the benefits received.
- If the State pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the State any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the State and will hold harmless any party making payment to them.
- I may ask for a fair hearing if I disagree with the decision made on this application.
- The Utah Statewide Immunization Information System (USIIS) is a registry that keeps complete up to date records of your child's immunization history. For more information, or to withdraw your child from USIIS, call the Immunization Hotline at 1-800-275-0659.
- In the event of my death and my spouse's death, the State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older. The state does not have the right to recover from my estate those costs paid as a benefit of eligibility for a Medicare cost-sharing program (QMB, SLMB, QI).
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.
- The Utah Clinical Health Information Exchange (cHIE) is an electronic system that gathers my medical history from participating cHIE healthcare providers. The cHIE provides a safe place for my healthcare providers to share my medical information. For more information or to opt out of the cHIE participation, visit www.mychie.org or contact your health care provider.

I, (print name) _____, have read or had someone read to me the statements on this page. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.

Signature (check one): Applicant Authorized Representative _____ Date

Yes No I would like someone to act as an authorized representative and have access to the information regarding my case. Please send me a release form to sign and return.

Name: _____ SS or Case #: _____

E Assets

- Yes No 1. Do you or anyone in your household have any of the following financial assets?
(Check all that apply)
- Annuities 401K / Retirement Checking Account \$ _____
 IRA Money Market Funds Savings Account \$ _____
 Stocks Trust Funds Other: _____
 Bonds Time Certificates

- Yes No 2. Do you or anyone in your household have any of the following assets? (Check all that apply)
- Land Cemetery Plots Mineral or Timber Rights Life Estate
 Home Life Insurance Rental / Investment Property Time Shares
 Tools Campers / Trailers Burial Plans / Funds Livestock
 Other: _____

- Yes No 3. Do you own any vehicles?
If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snowmobiles, motorcycles, motor homes, boats/motors, ATV's or other vehicles.

Make	Model	Year	Licensed Y/N	License Plate #	State	Owner/Joint Owners	Amount Owed

F Health Insurance Information

- Yes No 1. Have you ever received medical assistance such as Medicaid or CHIP in the last 6 months?
If yes, who: _____
Where & when? _____
- Yes No 2. Is anyone in your household enrolled or eligible for COBRA coverage or continued health insurance through an employer?
- Yes No 3. Does anyone in your household currently have health insurance (including VA Health Care System benefits), have insurance available but not enrolled, or has had insurance in the past 6 months? If yes, please complete the chart below. (Do not list Medicaid, Medicare, CHIP or PCN)

<input type="checkbox"/> Enrolled <input type="checkbox"/> Not enrolled, but available <input type="checkbox"/> Ended, date ended: _____	Name(s) of individual(s) covered: _____
	Name of insurance company: _____ Phone #: _____
	Address of insurance company: _____ Group #: _____
	Policyholder name: _____ Policy #: _____
	Policyholder birth date: _____ Policyholder SS#: _____
	If insurance is through an employer, list employer's name and phone #: _____
	Premium cost: \$ _____ Date due: _____ How often: _____

- Yes No 4. Has anyone in your household been injured in an accident or been a victim of assault in the last 12 months?
- Yes No 5. Is someone outside of your household required to pay for medical services?
6. If you answered yes to questions 4 or 5, please fill out the following information:
 What type of incident? automobile assault work-related slip/fall
 medical malpractice dog bite other, please explain: _____
 Name of person(s) injured: _____ Who is responsible? _____
 Date of incident: _____ Was a police report filed? Yes No
 Police Department: _____ Police Report #: _____
 Name of Attorney: _____ Phone #: _____

G Income

Yes No 1. Does anyone in your household have earned income?
If yes, list any income received by all people who live in your home.

Employed Person (name)	Employer Name	Pay Rate Before Taxes (\$900/mo., \$6/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Self - Employed (Yes/No)
		/			
		/			
		/			

Yes No 2. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain: _____

Yes No 3. Do you or anyone in your household have/receive any of the following? (Check all that apply)

<input type="checkbox"/> School Financial Aid	<input type="checkbox"/> Child Support	<input type="checkbox"/> Veteran's Benefits
<input type="checkbox"/> Retirement	<input type="checkbox"/> Alimony	<input type="checkbox"/> SSI
<input type="checkbox"/> Social Security	<input type="checkbox"/> Lump Sum Payments	<input type="checkbox"/> Unemployment
What type: _____		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Settlements	

Yes No 4. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment or Worker's Compensation?
If yes, explain: _____

Yes No 5. Does anyone help you pay mortgage/rent, food, or utility bills?
If yes, explain: _____

Yes No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?
If yes, explain: _____

Yes No 7. Does anyone in the household pay for dependent care so he/she can go to work?
If yes, list name and amount paid: _____

Yes No 8. Does anyone in your household that has been determined disabled by Social Security, pay child support or alimony?
If yes, list name and amount paid: _____

H Voter Registration Information

Yes No If you are not registered to vote where you live now, would you like to apply to register to vote here today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

I Return Completed Form To:

You have now completed the application. For more information please review the "Application Information" cover sheet. Please return this completed for to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 1-801-526-9505
Toll-free Fax: 1-888-522-9505

Please tear off this page and keep for your information.

Your Rights & Responsibilities

You Have the Right to:

- Apply or re-apply any time you wish for any medical program. Some programs are only available during open enrollment periods. If you need help, someone will help you apply.
- Receive a notice that we have either approved or denied your application and the reasons for the decision. For medical assistance, we have 30 days to process your application. We have 90 days, if you claim to be disabled, unless you need more time.
- Be notified explaining why we reduce, stop or hold your assistance. In most instances, we must mail the notice 10 days before we do this.
- Do the following things if you do not agree with decisions made regarding your case:
 - A. Talk to your worker. Make sure you are not misunderstanding each other.
 - B. Talk to your worker's supervisor.
 - C. Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
 - D. Request a Fair Hearing within 90 days of the decision; 10 days to get benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process.
 - E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 1-801-394-9431 or Salt Lake, 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 1-801-531-9075.
- Look at information in your case. Information about you and your case is confidential. We may give information to other agencies to administer a program to help you.

Your Responsibilities:

- Security number for each household member who wants medical assistance. If you are applying only for emergency Medicaid, you do not have to provide a Social Security number. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number.

Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with Job Service, Immigration and Naturalization, Social Security, and Internal Revenue Service records. We may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about your household. You must provide proof showing that you are eligible for assistance. The Department will not report undocumented household members to USCIS.

- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 1-801-538-6872 or the Immunization Hotline at 1-800-275-0659.
- Cooperate - You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure.
- Medical assistance (Medicaid, CHIP, UPP, PCN) recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). For more information or to opt out of the cHIE participation, visit www.mychie.org or contact your health care provider.

You and your household must also follow the medical assistance program rules.

Please tear off this page and keep for your information.

Changes You Must Report

Remember that **YOU** are required to report changes in your situation **WITHIN 10 DAYS** of the day you learn of the change. Do not delay reporting changes. Changes can affect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount. To report changes, contact DWS online at www.jobs.utah.gov/mycase or call 1-866-435-7414.

If you receive CHIP, PCN, UPP, or Medicaid benefits, you must report:

- **Change in Marital Status or Living Arrangements**

Getting married, separated, or divorced; moving in with a roommate; change of address or phone number; absent parent moves in; birth of a baby or end of a pregnancy; household member moves in or out; death of a household member; hospital stays for more than 30 days; or if anyone in your household goes to jail or prison; receiving help with your household expenses, etc.

- **Change in Insurance Coverage**

Changes in access to insurance, coverage, or enrollment in any health coverage plan (including Medicare or VA Health Care System benefits) for anyone in the household. You must also report accidents or injuries which may be payable by a third party.

If you receive Medicaid, you must also report:

- **Change in Source of Income**

Getting a job, terminating a job, changing jobs, working for temporary services, obtaining educational income, SSI, SSA, or unemployment compensation, etc. Receiving a lump sum. Going on strike.

- **Change in Amount of Earned or Unearned Gross Monthly Income**

Working more OR less hours, overtime, getting a raise, etc. Change in the amount of SSI, SSA, Unemployment Compensation, etc.

- **Change in the Legal Obligation to Pay Child Support**

- **Gain or Loss of a Vehicle (Licensed or Unlicensed)**

Car, truck, van, motorcycle, camper, trailer, recreational vehicle, etc.

- **Change in Any Asset(s)**

Report changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, cash, opening and closing of bank accounts, etc. for all household members. (Includes joint ownership of any asset with spouse, parents, children, etc.)

- **Change in Allowable Deductions**

Child care expenses, health insurance expenses, etc. If you are age 65 or over, blind, or disabled, you must also report changes in alimony or child support paid by a spouse or parent and work related expenses.

DOH/Form 116M 4/12

Case #: _____

Employer's Health Insurance Information

- This form **MUST** be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.
- A form must be completed for each employed household member. You may copy this form.

A General Information

Employee Name : _____ SS#: _____

Company Name: _____ EIN: _____

Yes No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

Yes No 2. Is your health insurance offered through the Utah Health Exchange (UHE)?

Yes No 3. Is the employee eligible to enroll in any insurance plan offered?

If no, please explain: _____

If yes, when is/was the employee eligible to enroll? (mm/dd/yy) _____

Yes No 4. Is the employee or any family member enrolled in any insurance plan offered?

If yes, name(s) of persons enrolled: _____

Yes No 5. Has this employee or any family member dropped/changed coverage in the last six months?

If yes, name(s): _____

If yes, when did coverage end/change? (mm/dd/yy) _____

B Employer's Least Expensive Plan or UHE Default Plan

Questions below refer to the **employer's least expensive** plan or the **UHE Default Plan**.

Yes No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy) _____

3. When does the company's next open enrollment begin? (mm/dd/yy) _____

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + spouse	\$	
Employee + child	\$	
Family	\$	

(continued)

Employee Name: _____ SS or Case #: _____

C Employee's Health Plan Choice

Questions below refer to the plan that the employee has selected.
Questions 3-7 refer to "in-network" benefits.

- 1. Insurance company and plan name: _____
- 2. Policy number, if known: _____
- Yes No 3. Is the deductible \$2,500 or less per individual?
- Yes No 4. Is the lifetime maximum benefit \$1,000,000 or more?
- Yes No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?
- 6. What benefits are covered under this plan? (Check all that apply.)
 - Physician visits Hospital inpatient services Pharmacy/Rx
- Yes No 7. Does the plan cover abortion services?
If yes, under what circumstances:
 - Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
 - Other, please describe: _____
- 8. Complete this chart only if it is different from the chart on the front page (section B). **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$ _____	\$ _____
Employee + spouse	\$ _____	
Employee + child	\$ _____	
Family	\$ _____	

- Yes No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): _____

D Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 1-801-526-9500
Toll-free Fax: 1-877-313-4717

If you have general questions about this form or the medical programs, please call 1-866-435-7414.

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